MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

46 yr old Iraqi EPW - GSW - (R) thigh & (R) calve
& Femur Fx (R) & ? Tib-Fib Fx (Left). Wounds
are 11 days ~~old~~ old.

PMH: 0
Allergies: NKA
MEDS: 0 Recent Anesth
T - 99.6 P - 110 B.P. 126/71 RR - 18 Pulse ox - 94%
alert HEENT
Lungs - clear HOP Heart - RR NO (M)
~~Abd - soft, BS - Normal No masses~~

PHYSICAL EXAMINATION

Back - clear
(R) Leg - thigh - severe echymosis (R) thigh
Small wound (R) Lateral thigh
(L) lower leg - entrance wound & exit wound. medial aspect - calve.
X-ray - Femur Fx (R) ~~? tib fib fx (R) lower leg~~

PROGRESS (Enter date of discharge and final diagnosis)

A) Fx (R) Femur GSW (R) Femur
GSW (R) lower leg

(b)(6) - 2

SIGNATURE OF PHYSICIAN [redacted]	DATE 7 Aug	IDENTIFICATION NO.	ORGANIZATION

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

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

539-106

[redacted]

(b)(2)-2

EPW [redacted]

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

06 Aug 03 Gunshot wounds (L) thigh -
(L) calf -
entry only -

PH - Entirely 11 days old.
denies any medical problems
NKA Allergies

exam: Head -
Lungs -
Heart WNL
Abd - soft
Ext - [illegible]

2118 1g ANCEF IV

Xray left femur - displaced fx of femur c bullet fragments present

Left - leg gunshot wound

A 11 day old gunshot wound -
(L) femur displaced fracture

P - to CSH - ortho - in A - (b)(6)-2
1gm Ancef given now [redacted] [illegible]

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

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

EPW (b)(6)-24

[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

MEDCOM - 16242

gl shot to L
fex

2200 pt transfer to holding Hair Traction splint in place
on (L) leg. Veins present on this zone. IV infusing carefully
[redacted] CPT. Ron

(b)(6) - 2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

7 Aug 03 1455

Rec'd pt from EMT via litter Dx: GSW (L) thigh, (L) femur fx & (L) tib-fib fx condition: stable. pt awake & alert. VSS. NEV (L) FA infusing LR @ 200 cc/hr 3 diff, (-) S/Sx of infection noted. lungs CTA, abd soft nontender BS(+) FA (L) thigh c̄ severe ecchymosis, thigh very tight, taunt calf area c̄ sm hole infection noted, pus, yellowish oozing from area. (L) foot (+) pulse, edema noted to (L) ext. RLE c̄ full ROM (+) pulse. BLE c̄ full ROM (+) pulses. pt is NPO until further per MD orders. 2x2 dressing applied to hole in calf area. pt is on call for OR. (-) complaint of pain voiced @ this time. Will cont to monitor — [redacted] 91WM6

(b)(6) - 2

7 Aug 03

Op Note
Pre-op Dx - GSW to (L) femur c̄ fracture
Post op - same, c̄ hematoma (L) knee effusion
Surgeon [redacted] / [redacted] (b)(6)-2
Surgery - Spanning Ex-fix (L) femur
Aspiration of (L) knee
I&D (L) calf.
Pt tolerated procedure well.

[redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

EDW

[redacted]

(b)(6) - 24

PROGRESS NOTES
Medical Record

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

7Aug03 2005 pt returned from surgery via ICU 2. pt's (L) leg c̄ ex-fix dressing ace wrap, ace wrap CDI, Kerlix under ace wrap c̄ pinkish color drainage noted, toes swollen < 3 sec cap refill. foley cath to gravity intact, draining, ↓ diff. IV fluids Δ'd to D5½NS c̄ 20meg KCL @ 200cc/hr. Will cont to monitor — [redacted] (b)(2)-2 9IWMe

7Aug03 21:27 Rec'd c/o pt @ 21:00. Restraints x 2 (B) wrist/ankle. VS WNL ↑ temp 101.2° ⅱ Tylenol given. Will retake Temp in 1°. Awake and alert in bed. Perrla (B) WNL. Pupils size 2. LCA (B). HR tachy S. S2 WNL. Tachy has been baseline for pt. BS (B) x4. (+) PP (B). (L) thigh ex-fix in place c̄ ace wrap dsg intact. Pin sites c̄ copious amt. bloody drainage. (L) foot cool to touch. (-) sensation from (+) pedal pulse to digits. c/o pain 3mg MSO4 given will cont. to mon. [redacted] (b)(6)-2 2LT/AW

Addendum FTG draining CYU. PIV (R) F/A infusing D5NS c̄ 20meg KCL @ 100cc/hr [redacted] (b)(6)-2 2LT/AW (b)(6)-2 [redacted]

7Aug03 Pt temp ~~taken~~ @ 2200, 101.0 [redacted] 2LT/AW

7AUG03 0044 temp 99.3 [redacted] (b)(6)-2

0219 3mg MSO4 given for c/o pain. (L) ex-fix pin site dsgs c̄ mod amt serosang drainage noted. Ecchymotic area @

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	

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

PROGRESS NOTES
Medical Record

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USAPA V1.00

EPW (b)(6)-4

[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 0215	Pt care assumed @ 2100. VSS, sleeping awakens to verbal stimuli, no pain. Lung sounds CTA, ~~pulses~~ SS bs hyporactive except in llq. Foley d/c'd @ 2100, pt voided 300cc clear amber urine @ 2330. IVF DC'd, hL, IVABX. Dsg c̄ early draining small amount of blood, intact. + sensation and movement of toes in lle. Pt npo p̄ breakfast, possible surgery at night. Continue to monitor. [redacted] 9Aug03 (b)(6)-2
9Aug03 0800	POD #2 Tm 100.2 HR 100 BP 139/80 Doing well Needs repeat Xray today. then to OR if need adjustment of ex fix [redacted] (b)(6)-2
9Aug03	1030 - Pt alert & oriented ~~OUB pt for~~ error on [redacted] to x-ray. Pt utilized crutches & [redacted] assistance from PT. Gave 6mg MSO4 for pain. HL to (R) forearm. Ext fix intact to (L) thigh c̄ ace wrap. Moderate drainage noted on dress. VSS, temp 99.1, lungs CTA, BS(+), pulses (+) x4. Some edema noted to (L) foot + upper thigh area. Will cont to monitor. [redacted] Jr. (b)(6)-2

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

EPW

[redacted]

(b)(6)-4

RECORDS MAINTAINED AT: ▶ (b)(6)-2

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	superior to ACE wrap dsg. Will cont to mon.
(b)(6)-2	[redacted]
0415	Pt c/o tight throbbing pain to (R) thigh. 4 mg MSO4 given will cont. to mon [redacted]
	(b)(6)-2
8 Aug 03	0940 - Pt alert + oriented lying bed. Ext fix to (L) thigh c̄ Ace wrap dsg intact. Large amount of Serosang fluid noted on Chux. Doctor aware of amount stating it is to be expected. Gave 4mg MSO4 for pain. VSS, temp 99.6, lungs CTA, HR reg, BS ⊕ x4, pulses ⊕ x4, IV D5½NS c̄ 20k @ 100cc/hr into (R) arm. Tolerated breakfast. Voiding ∅ complaints at this time. Will cont to monitor.
	(b)(6)-2 [redacted]
8 AUG 03 1300	- Rec'ved PT alert in bed. PT is [illegible] + Temp of 100.1. Will encourage coughs + deep breathing. HR R. BS x4. Wheezing + crackles noted ~~on~~ B. Intermittently. Pt no respiratory distress. SAT 97%. Ex fix to (L) thigh with dressing CDI. No S/S of infection noted. PT has ⊕ ROM to toes, slight swelling noted on (L) foot. PT has Foley draining yellow clear urine. IV D5½NS c̄ 20K running @ 100cc/hr in (L) arm CDI. Will cont to monitor PT. [redacted] CPN
	(b)(6)-2

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
26 JUN 03 1930	Ortho Op Note Pre Op Dx - (L) Femur Fracture Post Op Dx - Same Procedure - Closed reduction (L) Femur, Surgeon [redacted] / Alvin (b)(6)-2 GSW - (R) Findings - Unable to improve length. Improved AP angulation. Appears to have IT pinning in thigh. No x-ray evidence yet, but very firm. PLAN - X-RAY. Will observe. (b)(6)-2 [redacted] CDR 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.)*	REGISTER NO.	WARD NO.
ID [redacted] (b)(6)-4		

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

USAPA V2.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
25aug03 @	Received pt resting in bed, CSS, NPO for OR. A+Ox, speaks Arabic. Amb to toilet x1 w/ PT and staff. Ex fix in place. No remarkable assessment findings. (D)LE warm w/ palpable pulses + brisk cap refill, c/o pain, medicated ~~#~~ percocet. Will cont to monitor. [redacted] (b)(6)-2
25aug @ 2330	Pt a/ox3, vss, pulse [redacted] tachy. c/o pain to (D) thigh, ex fix intact. drsg dd to leg + thigh. Meds given. pulses to (D) leg palpable c brisk cap refill. Tol. PO well. Voiding, ⊆ difficulty. Will cont to monitor. (b)(6)-2 [redacted] 9lumle
	Benadryl given for itching @ 2300 — (b)(6)-2 [redacted] SP
26Aug03 0700	VSS. A+O. NPO on call for O.R. (D) LE ex fix intact. Pen care done. ~~Pt~~ crustation removed + moist cotton tip swab. Muth small wound to (D) LE. Dsg as ordered. Serosanguinous drainage noted on old packing. (D) LE pulses palpable (D) toes warm with capillary refill < 3sec. Tolerating regular diet. No pain or distress noted or voiced. — [illegible]
26 aug @ 1900	Pt back from OR - ~~#~~ washout, A+Ox3, vss, (D) LE fix. intact, drsg dd to thigh + calf CDI. ∅ pain or distress noted. Pulses palpable, brisk cap refill to (D) LE. 2 pt restraints on. circulation assess

STANDARD FORM 509 (REV. 5/1999) BACK

(CONT)

[redacted]

(b)(6)-4

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
23AUG03	(cont) place on (L) thigh. Pin care done. Drsgs to GSW Δd c̄ iodoform gauze packed into wounds. Wet-dry drsgs Δd on calf. Pt voiding s̄ difficulty. 2 point restraints in place. monitoring [redacted]
23AUG03 2100	JSS. AO. (+) pulses to LUE and pedal. Warm to touch. CR x2. PSG's to pins COI. Denies pain @ this time. Performed ROM. Rest comfortably in bed. — (b)(6)-2 [redacted]
24AUG03	Received pt resting in bed, USS, Alert, speaking arabic, able to communicate needs via gesture. Medicated w/ ½ percocet for pain relief noted. PT in to see pt for ROM/exercise. Pin care done and drsg Δ's (wet-dry on back of thigh + iodoform on front of thigh) Δ'd. ∑ SIGS, restraints in place. LSCTAB, HRR, pulses equal & bilat. w/ w/ con to monitor [redacted] (b)(6)-2
24AUG03 2000	JSS. AO. Mild c/o pain to (L) thigh, but pt tolerated it ∑ medication. Ambulated x1 to BSC and had formed BM x1. No other c/o pain, N,V,D. Rest comfortably. — [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, Ser. Date of Birth: Rank/Grade)	REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
25 Sept 05 1200	Received pt resting in bed. OOB + amb w/ crutches in hallways. BBM, SWS, ∅ c/o pain this shift. A+OX3, LSS. Perform ADL care w/ pins. Restraints in place per OPM protocol, ∅ skin breakdown or circulatory issues noted. ∅ other remarkable observations. will cont to monitor [redacted]
	[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.

C #

[redacted]

(b)(6) - 4

PROGRESS NOTES
Medical Record

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
15Sep.03 1845	Pt resting in bed, AtOx3, VSS, LS CTA (B), (+) BS x4, abd soft flat nontender, pain controlled c̄ percs, Ex Fix LLE in place dsg's on pins CDI, pt ambulates c̄ crutches, voiding s̄ difficulty, proper circulation + skin integrity on pts of restraint. (b)(6)-2 [redacted] (b)(6)-2 [redacted]
16SEP03	(1210) Assumed care of pt @ 0800 p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs/TID mornn. Ex. fix. in place on (R) thigh. Pt amb c̄ crutches s̄ difficulty. (+) pedal pulse equal bilat. Pin care done this am. Rom c̄ ue done by pt. Pt tol reg diet well. Voiding s̄ difficulty. (+) bm. 2-point restraints in place s̄ s/sx complications. Will cont. to monitor. (b)(6)-2 [redacted]
16Sep.03	Pt resting in bed, AtOx3, VSS, LS CTA (B), (+) BS x4, abd soft flat nontender, Ex Fix LLE, dsg's on pin CDI, ambulates c̄ crutches s̄ difficulty, ø c/o pain @ this time, proper circulation + skin integrity on pts of restraint. [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17Sep03 0710	Pt A&O x3. LSCTA (B), S_1 S_2 present HRRR. (+) BSX 4 quads. External fixator to (D) LE, CDI NO S/S of infection noted. Denies pain at this time. Will continue to monitor — [redacted] Spc. 91WMH (b)(6)-2 (1700) I concur c̄ above assessment. [redacted]
17 Sep.03 1630	Pt sitting in bed, A+Ox3, VSS, LS CTA (B), (+) BS x 4, abd soft flat nontender, Ex Fix LLE, dsg's on pins CDI, ∅ c/o pain @ this time, pt ambulated c̄ crutches s̄ difficulty, proper circulation + skin integrity on pts of restraint. — (b)(6)-2 [redacted] 91W — (b)(6)-2 [redacted]
18Sep03 0800	Pt Awake & A&O LS CTA (B) S_1 S_2 Present (+) BS x 4 Quads. Drsg to Ex Fix (D) LE CDI. NO S/S of Infection Noted. Denies Pain at this time. Will continue to monitor — (b)(6)-2 [redacted] Spc 91WM
18Sep.03 1800	Pt sitting in bed, A+Ox3, VSS, LSCTA (B), (+) BS x4, Ex Fix LLE, dsg's on pins CDI, pt ambulates c̄ crutches, voiding well, abd soft flat nontender, ∅ c/o pain @ this time, proper circulation + skin integrity on pts of restraint (b)(6)-2 [redacted] 91W
19Sep03 1539	Received pt resting in bed, VSS, [redacted] analgesic. Denies. Amb w/ crutches to [redacted] x-ray thru and amb on return. X-rays of (D) femur done. Pin care done this afternoon! small amt serous drainage noted. H2O2 ½ strength used

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

CONT

19 Septm 1339 w/ bleeding. Medicated @ x11 for pain w/ # tabs percocet. Tol PO. @ other remarkable assessments noted. Will cont to monitor [redacted] (b)(6)-2

20 sep @ 0345 Assumed care @ 1800; All VSS; pt AOX3, ⊕ CMS, NV intact, medicated ⊖ perc ⊖ restoril for pain; pt amb to BR X1, ⊕ BM; Ex fix in place, dsg ~~GDF~~, ⊖ drng; ROM completed pt voiding QS, clear yellow urine; restraints in place, ⊕ circulation, ⊖ skin breakdown; Cont to monitor [redacted] (b)(6)-2 (b)(6)-2 [redacted]

20 Sept 03 @ 0800 VSS Alert & Oriented. Lungs clear. BS ⊕ x 4 quad. Peripheral pulses palpable +2. OOB to BR for ADL Care. Ambulating ⊖ too much wt bearing. Tolerates well. Pain Care done to ⓛ external fix. Will continue plan of care (b)(6)-2 [redacted] CTA

20 sep @ 2380 Assumed care @ 1800; VSS; AOX3, ⊕ CMS, NV intact, ⊖ c/o pain or discomfort @ this time; pt ↑ OOB to amb in hall ⊖ BR ⊖ difficulty; amb ⊖ too much wt bearing; ⊖ Δs in assessment; restraints in place; ⊕ circulation, ⊖ skin breakdown; Cont to monitor (b)(6)-2 [redacted]

21 Septm 0800 Alert & Oriented VSS. OOB ad lib to BR. External fix in place to ⓛ thigh. Pin care done. Peripheral pulses +2. Lungs clear. BS ⊕ x4 quad. (b)(6)-2 [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

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

PROGRESS NOTES
Medical Record

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
21 Sept 1920	External fixator to left thigh intact, NO sign of infection, tissue looks healthy. Pt walked around 15min, with crutches. (b)(6)-2 [redacted] RN
22Sep03 1327	Assumed care of pt. @ 0000 Assessment completed. PERRLA, Lungs CTA(B), NSR, voiding per toilet, Abd. soft non-tender. Pin care completed. Pt. Ambulate to BR well. ambulated x20 muns. Performed am care. will cont. to monitor pt [redacted] (b)(6)-2
22sep03@1945	Assumed Care @1800; All VSS; pt A&Ox3, (+) CMS, NV intact throughout; Ex-fix in place, (-) s/sx infection; pin care completed, dsg CDI; pt OOB to BR, amb in hall x1 for 20 min.; restraints in place, (+) circulation, (-) skin break ↓; cont to monitor (b)(6)-2 [redacted]
23 sep 03 0730	Assumed care of pt. A+Ox3. VSS Ø c/o pain or discomfort @ this time. External fixator to (L) LE ambulates c crutches pin care complete wrapped kerlix at pin insertion site with minimal drainage. Will cont to monitor (b)(6)-2 [redacted]
23sep03@1840	Assumed care @1800; VSS, pt A&Ox3 speaking arabic; (+) CMS, NV intact throu Ex-fix in place, (-) s/sx of infection; pin care completed; dsg CDI; pt ↑ amb in

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(cont) hallx1 for 10 min; ⊖Δ in assessment, cont c̄ PO abx; restraints in place, ⊕ circulation, ⊖ skin break ↓; cont to monitor (b)(6)-2 [redacted]
24 Sep 03 0830	-Assumed care of pt. A+O x3. Ambulated c̄ crutches to the BR VSS. Consumed 100% of breakfast this AM. c/o pain to (L) LE external fixator. Scheduled morphine 800 mg given for pain relief. Lungs clear bilat. HRRR. Voiding ū difficulty. Will cont to monitor (b)(6)-2 [redacted] (1200) I concur c̄ above assessment. (b)(6)-2 [redacted]
24SEP03 2300	VSS; AO. ⊕ pulses to LE. Pins & dsg intact. Ambulated x1 to BR c̄ difficulty and returned. All other systems WNL's. (b)(6)-2 [redacted]
[illegible]	Received pt resting in bed this am. VSS w/ T of 103. gave ti percocet for pain w/ ↑ tylenol T↓ 101.9. Dress Δ done w/ bacitracin on suture line. Saline drsg on upper arm and pin care. Bilateral wounds on thighs covered w/ bacitracin, ⊕ sutures intact, ⊖ staples intact. pt cont to have ↓ mmot and feeling/sensation in LLE. HL [illegible] patent, flushing easily. ambulates. restraints in place per CPW protocol, ⊖ skin breakdown or circulation issues noted. ⊖ other noticeable assessments. ⊖ histone - Will cont to monitor [redacted] (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

NSN 7540-00-634-4178 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9Aug03 1550	assumed care @ 1300 VSS - no c/o pain @ this time - NPO, O/C to OR today - SL patent - (D) femur ex fix in place, ace wrap in place on (D) leg, small amount of drainage in calf area of ace wrap - neurov's WNL in (L) foot (b)(6)-2 [redacted] CR, A2
9Aug03 2025	LR @ 125 cc/hr infusing due to continued NPO status - medicated for pain c 4mg MSO4 IVP c good results (b)(6)-2 [redacted] CR, A2
9 Aug 03 21:12	Rec'd pt @ 21:00. Restraints x2 (O) wrist/ankle. Pt. awake and alert in bed. LCA (+) HPL SSR, BS (+) x4. PERRLA x pupils only dilate + contract slightly. Skin WD. (D) leg ex-fix in place (+) odor (+) bloody and yellow drainage noted. (D) ↑ thigh (+) 2 pitting edema. (D) foot (+) 4 pitting edema noted. (+) Pedal pulse (+) warmth (+) sensation (+) <3 sec cap refill. PIV (L) @ KVO infusing (D) F/A. c/o pain @ this time. will cont to mon (b)(6)-2 [redacted] 2LT /AN
0230	Returned from recover on ICU 2. VS WNL per FS. Voided 400cc CYU. PIV (D) FA infusing D5 1/2 NS c 20mEq KCL. (D) ex-fix S/P washout. mod amt yellow colored drainage noted @ pin site dsg's. ACE wrap dsg intact. (+) 4 pitting edema noted (+) PCM (+) <3 sec cap. refill (+) Pedal pulse (+) warmth. c/o pain to (L) ex-fix area 5mg MSO4 given will cont. to mon (b)(6)-2 [redacted] 2LT /AN

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

(b)(6)-4

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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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
10 Aug 03 0630	Pt. asleep in bed easily aroused by verbal stimuli. HR Reg, Lung sounds clear x (L) upper lobe c̄ inspiratory crackles, bowel sounds (+) x 4 quads. IV D5½NS c̄ 20meq KCl @ 100cc/hr infusing c̄ difficulty or s/s of infection or infiltration. (L) LE ext. fix ↑ on folded blanket, ace wrap CDI, (+) sensation in (L) digits, <3sec cap refill, minimal ROM in digits. Pt c̄ complaints @ this time. VSS, temp slightly ↑ @ 101.2, tylenol given. Will continue to monitor. (b)(6)-2 [redacted] /AN
1400	Pt stable at this time. AAOx3. PERRLA. Lungs CTA bilat, ∅ resp distress. NSR. Abd soft, non-tender, bowel sounds active x 4 quads. Pt c̄ c/o diarrhea, given Immodium. Voiding sufficient amts to urinal. (L) leg elevated, dsg CDI. Strong pulses and brisk cap refill to bilat LE. ∅ complaints (b)(6)-2 [redacted] /AN
2045	Dsg to (L) leg D'd. Plain gauze wrapped to pins. Sites cleaned c̄ 50/50 H_2O_2/H_2O soln. Small packing to wound to (L) thigh. Wrapped c̄ Kerlix and ace wrap. Wounds x 2 to (L) calf packed c̄ plain gauze, 4x4's applied then Kerlix c̄ ace wrap. Wounds c̄ serous drainage. (b)(6)-2 [redacted] /AN
8/10 2132	Pt. care assumed @ 2100. VSS HR Reg. lungs CTA, BS (+) x4. (L) LE ex-fix intact, dsng CDI. (L) ft edematous c̄ pulse 2+, (+) ROM, (+) sensation, brisk cap refill. Will cont to monitor. (b)(6)-2 [redacted] /AN
2147	PO2 95% (b)(6)-2 [redacted] /AN

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
110530 Aug 03	NURSING ASSESSMENT: Assumed pt care. AAO,3. Airway intact, breathing even and unlabored, LS CTA (B). Abd soft, nontender, ± distention. BS(+)x4. Voids spontaneously, ~~CF~~ clear, yellow urine. FROM and NV intact to (B) UE and RLE. LLE has ex fix (4 pins) to thigh, laterally. Pins wrapped ± bulky gauze & ACE wrap (ACE from toes to groin), with moderate serous drng. Pt able to wiggle (L) toes, pulse 2+, brisk cap refill. Some mild edema noted to (L) foot. IV in (R) AC running ± s/s infection or infiltration. (b)(6)-2 [redacted] RN
111100 Aug 03	NURSING NOTE: Drsg to pins (six pins), anterior thigh (wet-pack) and posterolateral ~~wound~~ thigh replaced. Pins wrapped ± cleaning ± ½ H_2O_2 and ½ H_2O. Redressed wounds ± 4x4 cover sponges, Kerlix roll, and ACE wrap. Drsg to posterior (L) calf not redressed or reinforced. Some serous drng noted to Kerlix at calf wound. [redacted] RN
11Aug03 2030	assumed care @ 1300 - VSS - medicated for pain - c/o Percocet @ 1700 c good results - IVF infusing as ordered - dsg Δ due to (L) leg, thigh & calf, serosang drainage noted, neuro WNL in (L) foot - [redacted] (b)(6)-2
12Aug03 0800	Pt care assumed @ 0100. VSS, alert and aware, c/o Percocet given for pain @ 0100. Lung sounds CTA, ~~pulse~~ bs+x4. Dsg ± ex fix on lle CDI, (+) rom and wiggling of toes. No new complaints, will continue to monitor. (b)(6)-2 [redacted] 911 MB
120530 Aug 03	NURSING ASSESSMENT: Assumed pt care. AAOx3. Airway intact, breathing even and unlabored, LS CTA (B). Abd soft, nontender, ± distention. BS(+)x4. Voids spontaneously. FROM and neurovascularly intact to (B) UE and RLE. LLE has ex fix to thigh (continued over)

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SPONSOR'S NAME	ORGANIZATION	
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

#[redacted] b(6)-4

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
120530 Aug 03	(continued) x6 pms. Pressures and drsg saturated c̄ sensations dmg. Drsg will be changed later this AM. IV to (R) FA flowing well, c̄ s/s infiltration or infiltration. (b)(6)-2 [redacted]
12Aug03 2045	assumed care @ 1300 - VSS - medicated c̄ ii Percocet tabs PO 3.5 mg MSO4 prior to dsg Δ, pi-care dore, thigh wounds dry packed, w→D dsg dore on calf wounds, Kerlix and ace wraps applied - IVF infusing as ordered, IV site patent - neuro V'S WNL in (L) foot, +2 pitting edema in same foot (b)(6)-2 [redacted] cr
12Aug03	VSS - Alert x3 - IV to (L) Arm at WA [illegible] @ [illegible] ml/hr infusing O s/s infiltration, drsg to (L) leg dry & intact. PearLA 5 m - Lungs sounds CTA B/L @ [illegible] Reg. BS (+) x4 quads. Radial pulses +3 - (R) Pedal +3 (R) Pedal cms > 3 sec All other extremities > 3 sec to (L) foot +4 pitting edema. Restraint to (R) arm in place and secure (b)(6)-2 [redacted]
13 Aug 03 05-1200	Pt Dsg to (L) femur with [illegible] drainage. Pt alert and oriented x3. Pt [illegible] DS [illegible] 20 mg [illegible] [illegible] for [illegible] of IV PB. No change in VS signs. Pt [illegible] [redacted] (b)(6)-2
13Aug03 1300	Pt stable. AAO [redacted], PERRLA. Lungs CTA bilat, ∅ resp distress. NS [redacted] soft, non-tender, bowel sounds active x4 quads. Ex fix to (L) femur intact, drsg c̄ minimal drainage. Drsg to (L) LE CDI. Strong pulses and brisk cap refill to (L) foot. ∅ complaints (b)(6)-2 [redacted]

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13Aug03 2030	Dsg Δ done to (L) leg. W→D dsg to (L) Calf. Purulent drainage noted to wounds x2. Slight odor noted when dsg removed. W→D then wrapped c̄ Kerlix. Pin care done, pin sites c̄ serosanguinous drainage noted at insertion. Cleaned c̄ H2O2/H2O. Wrapped c̄ dry plain gauze. Wounds x 2 the (L) upper thigh c̄ tunneling noted. Packed tightly c̄ dry Iodoform gauze. Wounds wrapped c̄ Kerlix and ace (b)(6)-2 [redacted]
0030	Pt care assumed @0100. VSS, pt awake and alert
14 Aug 03	with no c/o pain. Lung sounds CTA, pulses (+) x4, bs(+) x4. Dsg on lle CDI, pt c̄ (+) sensation and able to wiggle toes. Pt states he wants his tooth pulled out, tooth is loose in upper portion of mouth. (b)(6)-2 [redacted] stated it would be removed tomorrow. No new complaints, will continue to monitor. (b)(6)-2 [redacted] 911WM6
14Aug 03	0615 Assume pt care @ 0500. Pt awake and alert. D5½ NS c̄ 20kcl @ 100cc/hr to (R) FA no s/s redness/infiltration. (R) LE ex-fix intact, dsg to top pin c̄ sm amt sed drainage. Ace wrap CDI. Edema noted to (R) foot, (+) pulse. C/o pain to pin sites @ this time. VSS. HR reg. Lungs CTA. Abd soft. tender to (cont)

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*
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(b)(6)-4

RECORDS MAINTAINED AT:

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
14 Aug 03 0615	(Cont) BUQ. Sm BM this am. Will cont to monitor (b)(6)-2 [redacted] 9/4/MG
	1115 pt seen by dental. Dental says refer to Dr [redacted] for removal - due to their supplies not available (b)(6)-2 [redacted] 9/4/MG
	OMPS procedure note
14 AUG 03 @ 1519	Extracted tooth #9 C gauze and 1cc 2% lidocaine 1:100K epin. ⊘ complications. (b)(6)-2 [redacted] MAJ/DC
14 Aug 03 2030	assumed care @ 1300 - VSS - medicated C percocet for pain @ 1515 & 1930 C good results, 5mg MSO4 given @ 2000 prior to dsg Δ - top pin sites C bloody drainage on dressing, skin around pin sites very edematous and red, dsg placed on thigh & calf wounds - SL site Δ'd to (R) FA, IVF infusing as ordered - neuro V's WNL in (L) foot (b)(6)-2 [redacted] CRTA
14 Aug 03	VSS - Alert x3 - IV of D5W/NS @ 20mL/hr (R) FA is patent & sits infiltration. Pearl lab sm - Lungs - CTA B/L Reg even. HR - NSR - BSB x4 quads Radial pulses +3 Pedal (R) +3 (L) +2. Drsgs to (L) leg dry and intact small amt of blood seen through. Pins intact and ⊘ drainage noted. edema to upper thigh +4 around ankle and top of (L) foot. uses urinal urine light yellow output sufficient. Restraints to UE in place and secure. Percocet 1 tab PO given for pain. (b)(6)-2 [redacted]

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
15 Aug 03 0700	assumed PT care at 0545. PT A O x3. PT has D5 w/ 20meq KCL running into R forearm. Bowel sounds + lungs CTA. Heart rate reg. Pulses + in all extremities even in LLE. L leg in ext fix w/ all dressings C I. PT complained of pain & was given 2 percocet after which he ate then bathed. (b)(6)-2 RC [redacted]
15Aug03 2000	assumed care @ 1300 - VSS - medicated c ii percocet 7.5mg msay prior to PT session - dsg D and pin care done, moderate amount of bloody/serosang. drainage from top pin sites, calf wound decreasing in size c pink tissue visible - IV site patent, D5 1/2 NS c 20meq KCl @ 100cc/hr - neuro V's WNL in (D) foot - pt. doing ankle mobility (b)(6)-2 exercises as instructed by PT - [redacted]
15Aug03 2130	VSS - Alert x3 IV of D5 NS @ 100cc/h to (R) FA is patent @ s/s infiltration. Percocet ii Po for c/o (D) leg pain. Dress to (D) leg dry and intact. pins intact and clean @ s/s of infection. Peaula 2m - lungs CTAB. Resp even Reg HR - NSR - B s (D) x 4 @ quads. Radial and Pedal pulses @ 3 (D) foot +3 pitting edema - Pulse +2. Restraints to UE and LE in place and secure. Ø40 @ present. - Sat [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

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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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
16Aug03 0320	confused and agitated up till 2Am. Restless, quietly upto present. Awake. Cover w/Ray PT/Kn
16Aug03 0320	Resting quietly w further c/o Ⓓ leg pain. IV q-D5½NS @ rate infusing patent w s/s infiltration. Restraints in place and secure. (b)(6)-2 [redacted]
16August03 0550	Pt. awake & alert complaining of pain, ⅡI percocet given. VSS. HR Regular. Lung sounds clear bilat, bowel sounds (+) x 4quads, ABD slightly distended, pt states that he has a lot of gas. IV in Ⓡ FA infusing @ 100cc/hr of D5 ½NS c̄ 20meq KCl c̄ s/s of infection or infiltration. Ext. fix to Ⓛ thigh intact, 2rd pin draining dark red bld, DSG to Ⓛ calf CDI. Ⓛ Pedal pulse palpable, (+) sensation, <3sec cap refill, full ROM of digits & ankle, ∅ ROM of Ⓛ knee. Pt. c̄ other complaints @ this time. All other assessment findings WNL. Will continue to monitor (b)(6)-2 [redacted]
1030	Pin care & packing towards completed. Pin insertion sites 3&4 draining moderate amts of clear yellowish fluid. 2 wounds on Ⓛ thigh repacked c̄ sterile iodoform both sites c̄ s/s of infection. [redacted]
16Aug03 2020	assumed care @ 1300 - VSS - medicated for pain - c̄ II Percocet prior to PT @ 1330 & prior to dsg Δ @ 1900 - bloody drainage from lower pin sites, serosang drainage from upper pin sites, thigh wounds packed and W→D dsgs placed on calf wounds - IV site patent - PT did ROM c pt. to 90° today - neuro's WNL in Ⓛ foot, edema remains +1 in ankle [redacted] (b)(6)-2

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
16Aug03 2130	VSS - Alert x 3 - IV of D5½NS @ 100ml/hr infusing to (R) FA is patent & s/s infiltration. Pearl 4mm - Lungs CTA B/L Resp reg even unlabored. HR - NSR - BS (+) x 4 quads. Radial Pedal pulses +3. Drsg to upper thigh and calf dry intact pins intact and clear to (L) leg. L foot +3 pitting edema. Restraints to UE and LE in place and secure. — SGT [redacted]
17Aug03 0330	Benadryl 50mg given for c/o itchy, Percocet for c/o pain. Resting quietly c̄ ø further c/o pain or itchy. (b)(6)-2 (b)(6)-2 SGT [redacted]
17Aug03	Assume pt care @ 0500. Awake and alert. No c/o pain. D5½NS c̄ 20KCl @ 125cc/hr. to (R) FA ō redness/infiltration. VSS. HR reg. Lungs CTA. Abd soft BS x 4 no c/o pain/tenderness c̄ palpation. (L) thigh ex-fix intact. Dsg CDI. Swelling to (L) knee, +3 edema to (L) foot, elevated (+) pulse (+) sensation. Will continue to monitor [redacted]
0650	pt c/o pain @ IV site. IV d/c'd. c/o pain @ (L) thigh around top pin. ¹⁄₂ percocet given (b)(6)-4 [redacted]
1300	pt seen on rounds. Ace wrap from toes to thigh per doctor request. (b)(6)-2 [redacted]
17Aug03 2015	assumed care @ 1300 - VSS - medicated for pain prior to dsg Δ, upper pin s/c serosang drng on dsg, thigh wounds packed, ace wrap placed from toes to thigh on (L) leg, neuro V/S WNL, +1 edema in (L) ankle

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EPW [redacted]

(b)(6)-4

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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)
17 Aug 03 Cont.	elevated on sheet, all pin sites have serosang drainage - no c/o pain @ this time [redacted] (b)(6)-2
17 Aug 03	VSS - Alert x3 - Pearl Lungs CTA B/L Resp Eff HR - NSR - Radial and Pedal pulses +3. Pins to (R) leg clean swelling noted to leg around pins. Percocet II Po given for c/o pain. BS(+) x4 quads Abd soft NT. Restraints to UE and LE in place and secure. (b)(6)-2 Sgt [redacted]
18 Aug 03	Percocet II Po given for c/o (R) leg pain @ 0730 has had no further c/o pain @ present. Resting quietly. Restraints in place and secure. (b)(6)-2 Sgt [redacted]
18 0730 Aug 03	Nursing Note: Assumed pt care. AAOx3. Airway intact, breathing easy, adequate, LS CTA (b). Abd soft, nontender, & distended. BS(+)x4. Urinating spontaneously. Afebrile and neurovascularly intact to (R) UE and RLE. LLE has limited ROM 2° Ex fix to lateral thigh & pain. Drsg to pins (x6), anterior thigh drsg clean, serosang drsg, lateral calf drsg is CDI to ACE wrap. Ø IV access. Dorsalis neurovascularly intact to LLE. (b)(6)-2 [redacted]
18 Aug 03 2030	assumed care @ 1300 - VSS - medicated c̄ II Percocet PO prior to dsg. Δ, pin sites c̄ small amount of serosang drainage; thigh wounds packed loosely c̄ iodoform, both wounds decreasing in depth, calf wounds c̄ granulation tissue present, size decreasing on both calf wounds - PT not into see pt. today (b)(6)-2 [redacted]
19 Aug 0030	Care assumed @ 2100. VSS, alert and awake, c/o pain between the pin insertion sites, percocet was given @ 2000. Lungs CTA, pulses (+) x4, bs(+). Dsg c̄ ex fix on lle. c/o pt c̄ good ROM and (+) sensation. Pt on PO Abx, will continue to monitor. (b)(6)-2 [redacted] 9 Kumke

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19Aug03	0543 Assume pt care @ 0500. pt asleep easily to awake. No C/o pain or discomfort @ this time. VSS. HR reg. Lungs CTA. Abd. distended non-tender BS x4. (L) thigh ex-fix intact. Swelling noted to knee and @ 1st pin site. 1st pin site dsg intact c̄ red drainage. Dsg to (L) calf intact. (+) sensation (+) pulse limited ROM to (L) LE. No PIV site @ this time. Restraints x2 in place. Pt encouraged to keep (L) LE elevated. Will cont. to monitor (b)(6)-2 [redacted] 9MM
19Aug03 1330	Awake and alert. PERRLA. Lungs CTA bilat Ø resp distress. NSR. Abd soft, non-tender, bowel sounds active x4 quads. Ex fix to (L) femur intact, dsg CDI. Strong pulses and brisk cap. refill to bilat LE. Ø complaints (b)(6)-2 [redacted] CU/RN
2015	Dsg to (L) leg N'd. Pin Care done to ex-fix pin. Betadine. Plain gauze to pin sites. W→D dsg to (L) calf. Purulent drainage noted to old dsg. Ø complaints (b)(6)-2 [redacted] CU/RN
19Aug 2300	Care assumed @2300. VSS, pt awake. Ø c/o pain. Lungs CTA, ~~abs (+)~~ x4, ~~bs (+)~~. Dsg ~~and~~ SSC ex-fix on lle. N'd @2000, dsg CDI. Pt able to wiggle toes and has (+) sensation in (L) foot.

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CHRONOLOGICAL RECORD OF MEDICAL CARE
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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	lle elevated on pillow. Pt's complaints at this time, will continue to monitor. (b)(6) - 2 [redacted] allum
20Aug03	1300 - Pt a&o x3. VSS, lungs CTA, BS@, pulses @x4. Ext fix intact, pin care done by pt. Dsg x 2 ∆'d. V'ving ∅ complaints. Will cont to monitor. [redacted] (b)(6) - 2
8/20/03	ortho staff - Pin sites clean b(2) - 2 needs xr when transfer to [redacted] (b)(6) - 2
20Aug03 1330	Pt awake and alert. Lungs CTA bilat, ∅ resp distress. NSR and Dept, non-tender, bowel sounds active x4 quads. Ex-fix to (L) femur intact, ∅ S/S infection. Dsg to pin sites CDI. Dsg to (L) calf CDI. Strong pulses and brisk cap refill to bilat LE. ∅ complaints (b)(6) - 2 [redacted]
2030	Dsg Δ done to (R) femur ex fix, (L) thigh and (L) calf. (L) calf dsg done w→D, purulent greenish drainage noted to old dsg. (L) thigh wounds #2 packed c Iodoform gauze and covered c plain gauze. Pin care done c H2O2/H2O soln. 1st, 2nd and 4th pins c large wounds. 1 & 2 packed c Iodoform, pin 4 packed wet to dry. All pins wrapped [redacted] (b)(6) - 2

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2350 20 Aug	Care assumed @ 2100. Vitals stable, a&o x3 c̄ c/o pain. Lung sounds CTA bilaterally, pulses (+) x4, bs active x4 Quads. Ex fix c̄ dsg on lt CDL, pt able to wiggle toes and has (+) sensation in (L) foot. Pt resting, will continue to monitor. (b)(6)-2 [redacted] gilmore
21 Aug 03 0845	assumed care @ 0500 - VSS - medicated c̄ ti percocet for c/o (L) leg pain - dsg intact on (L) thigh & calf, ~~ext~~ pincare site c̄ small amt. of drainage on pin dressings, neuro V's WNL in (L) foot, ankle edema greatly decreased, knee remains swollen - Am dsg Δ and pincare to be done later in morning (b)(6)-2 [redacted]
21AUG03	(1015) Assumed care of pt via litter in stable condition @ 1200. Pt A/O speaking Arabic. VSS. lungs CTA (B). (+) bs x4 quads. Pt moves (L) leg c̄ difficulty. Drsgs Δd this am. Wet → dry drsgs placed on back of (L) calf. GSW drsgs to (L) thigh Δd and packed c̄ iodoform drsg. Pin care done. Pt tol. procedure well. Pt medicated c̄ ti Percs for pain in (L) leg c̄ good relief. (+) bm. Voiding c̄ difficulty. monitoring (b)(6)-2 [redacted] (USA)

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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)
21 AUG 03 2300	VSS. Alert. Denies pain @ this time. Performed pin care & PSG's. LLE elevated. ⊕ pulses. ⊕ swelling to thigh. Tolerating PO well. Pt resting w/ NL. PSG's CDI. Cont pain but ≈ some serosanguinous drainage. Resting comfortably. (b)(6)-2 [redacted] RN
22AUG03	(1130) Assumed care of pt @ 0700 p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pt medicated c̄ ⅡPerc this am for pain c̄ good relief. Ex fix in place on ⊖ thigh. Pin care done this am. ∅ s/sx infection @ pin sites. ⊖ thigh slightly swollen compared to ⊕ thigh. Wet + dry drsgs Δd on back on ⊖ calf. GSW sites packed c̄ iodoform gauze. ∅ s/sx of infection @ sites. Pt moving ⊖ leg s̄ difficulty. ⊕ pedal pulses equal bilat. Cap refill <2 secs. Pt voiding s̄ difficulty. Pt did own am care. 2 point restraints in place. Pt resting quietly @ this time. Will continue to monitor. (b)(6)-2 [redacted] RN
22AUG03 2030	VSS. AO. PERRLA. S1, S2. BS⊕x4. LLE elevated per routine. PSG's CDI reinforced x1 WTD @ L calf/belly. ⊕ pulses in all extremities. Able to move LLE s̄ difficulty. ⊖ s/s of infection @ pin sites. Voiding s̄ difficulty and resting comfortably in bed. (b)(6)-2 [redacted] RN
23AUG03	(1430) Assumed care of pt @ 0700 p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pt medicated c̄ ⅡPerc this am for pain in LLE c̄ good relief. LLE elevated on blankets. Pt moves LLE s̄ difficulty. ⊕ pedal pulses equal bilat. Cap refill <2 secs. Ex fix in

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
26Aug @1900	(cont) back from OR: Tol. 60% dinner well. ØN,V noted. IVF infusing ⅓ s/lx infection/infeltration. Will cont to monitor (b)(6)-2 [redacted] 9Lwm6.
26Aug @1910	Reflex D/C'd after this dose per MD orders. ~~X-ray forms done~~ Per MD Will cont to monitor [redacted] 9Lwm6
26Aug 2010	Pt c/o pain to extr. II Percocet given. Will cont to monitor (b)(6)-2 [redacted] 9Lwm6
26Aug03 @2300	Pt resting in bed. IVF LR@125 infusing ~~s/lx~~ ⊕ s/lx infection/infeltration Will cont to mon (b)(6)-2 [redacted] 9Lwm
26Aug03 @0050	Pt c/o pain @ ex-fix site. II Percocet given (b)(6)-2 [redacted] SPC-
@0115-	Pain c above assessments [redacted]
27Aug03 0800	Alert & Oriented VSS c/o pain @ 0700 to (b)(6)-2 lower extremity rated 3/10 Tylenol 650 mg P.O given & effective. ⊕ FA IV Saline locked. Tolerated Reg Diet well. Urine clear yellow urine. Removed small amt of crustation from top pin site. Remove & reapplied restraints. Will check restraints & circulation [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.

CPW # [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

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)*
27 Aug 03 @2100	Pt a/o x3, VSS, lungs CTA (B) + BS x4 qds. c/o pain to (L) thigh. ex-fix intact. Drsg to thigh & calf changed. Brisk cap refill & good pedal pulses. Tol. Reg diet. HL patent & flushing easily. (L) leg elevated. Will cont to monitor (b)(6)-2 [redacted] 91WM6
@2300	- 1 hour to above assessment. (b)(6)-2 [redacted]
28 Aug 03 1000	VSS A&O x3 Lungs clear Bilateral. BS (+) x4 general. (L) thigh ~~ex~~ ex-fix intact. Pen care done. Cleaned thigh & calf (L) wound and irrigated as needed. Percocet given for pain. HL D/C'd. Pulses to left lower extremity palpable. Capillary refill <3 sec to (L) toes. Restraints released and unapplied. Will check restraints & circulation frequently. (b)(6)-2 [redacted]
28 Aug 03 @1930	Pt a/o x3 VSS, HRRR, lungs CTA (B), (+) BS x4 qds, (L) ex-fix intact. pulses to extr. palpable & brisk cap. refill. circulation assessed often. 2 pt restraints on & checked frequently. ∅ c/o pain @ this time. Drsg's changed to (L) calf & thigh. Will cont to monitor, [redacted] 91WM (b)(6)-2

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

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* | REGISTER NO. | WARD NO. [redacted] (b)(2)-2

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
28AUG03	PTS - I concur c̄ above assessment. [redacted]
28Aug03 @ 2100	Pt c/o pain to (L) thigh. II Percocet given c̄ relief. Will cont. to mon [redacted] SPC
29AUG03	(0920) Assumed care of pt @ 0600 p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs. Pt amb in hallway c̄ crutches s̄ difficulty. Ex fix in place on LE. ⊕ pedal pulses equal bilat. Cap refill <3secs. (L) thigh swollen compared to (R) thigh. LE elevated on blanket. Pin care done this am. Wet → dry dsgs Δd to wounds on (L) thigh and calf. Φ s/sx infection @ wound sites. Voiding s̄ difficulty. ⊕ BM this am. Tol reg diet well. AM care done by pt. 2 point restraints in place - Φ s/sx complications c̄ circulation/skin break. Will continue to monitor. (b)(6) - 2 [redacted]
29AUG.03 1920	Pt A+O x3, resting in bed, LS CTA (B), ⊕ BS x4, S1 S2 present, c/o pain (L) thigh, dsg on (L) thigh CDI, Ex fix in place c̄ LLE elevated, cap ref <3 sec, peripheral pulses palpable, (L) thigh swollen, Φ s/sx of infex on wound sites, proper circulation and skin integrity on pts. of restraint. [redacted] 9Lwpb
2100	Pt had a BM small formed sol [redacted] 9Lwpb (b)(6) - 2
30AUG03	(0955) Assumed care of pt @ 0600 p̄ report from night shift. Pt alert, 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). ⊕ pedal pulses equal bilat. Cap refill <3secs. Wet → dry

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

(cont) drsgs Δd on Ⓛ thigh and calf. Ø sisx infection. Pt voiding s difficulty. Tol. reg diet well. AM care done by pt. 2 point restraints in place - Ø sisx complication c̄ circulation/skin breakdown. Will cont. to monitor. —

(b)(6)-2 [redacted] (4)/AN

30AUG03 2025 Pt resting in bed, Alert and speaking arabic. LS CTA Ⓑ, ⊕ BS x4, Ø c/o pain @ this time, abd soft flat nontender, had a BM this PM, Ex fix on LLE, Ⓛ thigh swollen compared to Ⓡ, elevated c̄ blanket. dsgs on Ex Fix CDI. — [redacted] 9/WM

[redacted]

0430 Dsg Δ pin care given. (b)(6)-2 [redacted] 9/WM6

30aug03@1200 Received pt resting in bed, VSS, A+O x 3. AM care provided. Ex fix Ⓛ thigh in place, cast intact, Ø bleeding noted. pulse good, toes warm, able to wiggle toes. Ø other abnormal assessment findings. [redacted] Will cont to monitor pt.

(b)(6)-2 [redacted]

31Aug03@2400 Assumed care @ 1800; VSS; pt A+O x3 speaking only arabic; NV intact ⊕ movement & sensation; Ex-fix intact c̄ dsgs CDI, Ø drainage.

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)
	S1 S2, ⊕ pulses x4 ≈ brisk cap Ref; LS CTA (B); ⊕ BS x4; pt voiding QS, clear yellow urine; restraints in place, circulation & skin integrity intact; medicated X1 ≈ II perc ≈ good relief; ∅ c/o pain or discomfort ⊕ this time; cont to monitor (b)(6)-2 [redacted]
31 Sept 1800	Received pt resting on bed, VSS ∅ TOX 3, pin care done, ⊕ thigh ex fix intact. Serous drainage of ∅ noted on old dsgs. Swelling @ pin sites appears increased. Skin integrity & circulation good. Restraints sites, restraints in place per EPW protocol. No other remarkable assess. next pending. Will cont to monitor [redacted] (b)(6)-2
1 Sep. 03 1930	Pt resting in bed, [redacted] X3, LS CTA (B), ⊕ BS x4, pt ambulated around ward, had a BM this PM. Ex Fix in place, LLE elevated ≈ blanket, Dsgs on LLE CDI, ∅ c/o pain @ this time, proper circulation + skin integrity on pts. of restraint [redacted]
2 Sept 03 0900	VSS Pt alert & oriented, Resps clear, BS (B) (b)(6)-2 Pt ambulated to BR and down hall way with Physical therapist. Medicated with Percocet prior to therapy. Pin care and W/D dsg done to (L) thigh, wounds. Restraints assessed and supplied skin under restraints intact will check restraints, skin integrity & circulation to extremities frequently [redacted]

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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)*
5 Sep.03 1815	Pt sitting in bed, A+Ox3, LS CTA (B), (+) BS x4, Ex Fix LLE, dsg's CDI, LLE elevated, pedal pulses equal bilat, ∅ c/o pain @ this time, proper circulation + skin integrity on pts of restraint. [redacted] 9WN (b)(6)-2 [redacted]
06SEP03	(0910) Assumed care of pt w/ ∅∅∅∅ ⊽ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs. Ex fix in place on (R) thigh. Pin care done this am. ∅ s/sx infection. (+) pedal pulse equal bilat. skin warm to touch. Pt amb to BR c̄ crutches s̄ difficulty. (+) BM. voiding s̄ difficulty. Tol. reg diet well. Am care done by pt. wet → dry dsgs ∆d on calf. wounds healing well. 2 point restraints in place. s̄ s/sx complications of skin breakd/circulation. Will cont. to monitor. (b)(6)-2 [redacted] WDA
6 Sep.03 1930	Pt sitting in bed, A+Ox3, VSS, LS CTA (B), (+) BS x4, pedal pulses equal (B), pain controlled c̄ percs, Ex Fix LLE, elevated, dsg's CDI, voiding c/y urine, proper circulation + skin integrity on pts. of restraint. — [redacted] 9WN16 (b)(6)-2 [redacted]

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

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

#[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)
5 Sept 2003 1000	Received pt resting in bed. VSS, A+OX3, speaks arabic. Intermittently dozing. LS CTAB, HRR, abd soft, nontender, BS+x4. Ex fix l/o (L) thigh in place, pin care done, small amt of serosang. drainage and yellow thick drainage noted on old dsgs, current dressing c/d/i. (L) thigh swollen, cont w/o additional swelling noted. Amb to BR for BM x1, PT unto see pt. Medicate per mar. No c/o burning on urination. Will cont to monitor [redacted] (b)(6)-2
7 Sep 03 @ 1920	Assumed care @ 1800, pt A&O X3 speaking only arabic; (+) sensation/movement UU intact; Ex-fix in place; S1 S2 (+) pulses x4, LS CTA (B); (+) BS x4, no BM this shift; dsg clean, & intact; sm amt serosang. drainage noted, (L) thigh remains edematous; (-) c/o pain @ this time; 2 point restraint in place, circ & skin integrity intact; Cont to monitor (b)(6)-2 [redacted]
8 Sept 03 1350	Received pt this am in stable condition. VSS, A+OX3. (L) LE w/ Ex fix intact (L) thigh. Pin care done and w to D dsgs x3 this am. Pin care done w/ additional betadine for wound infection prevention. Old dsg noted to have yellowish opaque drainage and sero sang. drainage. Amb x2 BR x1 Stop no c/o burning on urination [redacted] (b)(6)-2
8 Sept 03 @ 2030	Assumed care @ 1800; VSS; pt A&OX3, (-) c/o pain or discomfort @ this time; pt T amb c crutch assistance x2; Ex-fix in place, (L) Leg remains edematous; dsg CDI; (-) BM this shift; pt voiding QS; 2-point restraint in place; skin integrity & circ. intact; Cont to monitor (b)(6)-2 [redacted]

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STANDARD FORM 600 (REV. 6-97) BACK

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
9 Sept 03 1200	VSS. Alert & oriented OOB ambulated c crutch to BR Tolerated well. Lungs clear. BS (+) x4 quadrants. Abdomen soft - nondistended. Consumed regular diet for breakfast. Arm care done. Pen care done. Betadine used as ordered. Sanga drainage noted on old dsg. Percocet given for pain. Restraints removed and rewrapped. Skin under restraints intact. Peripheral pulses palpable. Will continue to monitor. (b)(6)-2 [redacted] 2175
9 Sep 03 1900	Pt lying in bed, A+O x3, VSS, LS CTA (B), (+) BS x4, abd soft flat nontender, Ex Fix LLE elevated, dsg's CDI, voiding c/y urine, OOB to BR, had a BM, ∅ c/o pain @ this time, proper circulation + skin integrity assessed on pts of restraint. (b)6 [redacted] 91WM6
2015	(b)2)6 [redacted] Pt OOB to BR, had a [redacted] Rivera 91WM6
10 Sept 03 0800	VSS A&O lungs clear BS (+) x4 quad. Abdomen soft. Pen care + dsg sel to L Thigh. OOB ambulate c crutches to BR. Percocet given for pain. [redacted] removed & rewrapped c skin intact under restraints. [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.

[redacted]

(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
10 Sep 03 1915	Pt resting in bed, A+Ox3, VSS, LS CTA (B), (+) BS x4, OOB to ambulate ⊂ crutches, (-) c/o pain @ this time, Ex Fix LLE, dsg's (L) thigh CDI, voiding c/y urine, proper circulation + skin integrity assessed on pts of restraint. [redacted] (b)(6)-2 [redacted] 9/WM16
11 Sept 03 0800	VSS Alert & oriented. Lungs clear Bilaterally BS (+) x4 quadrants. Abd soft non distended. Tolerating regular diet last BM yesterday AM care completed. Pin care and wound to (L) thigh completed. Restraints removed and reapplied skin intact under restraints — (b)(6)-2 [redacted]
11 Sept 03 0900	Ambulate with crutches ⊂ toe touch weight bearing to (L) leg. Tolerated well. Percocet given for pain.. (b)(6)-2 [redacted]
11 Sept 03 1200	Physical Therapy done Rt c/o pain 8/10 Percocet given (b)(6)-2 [redacted] Pin care done bleeding noted to distal pin site; to PT. (b)(6)-2 [redacted]
11 Sep 03 @ 1930	Assumed care @ 1800; VSS, pt A&OX3, (+) movement & sensation in all extremities; NV intact (-) c/o pain or discomfort @ this time; ex-fix in place, extremity remains edematous; (-) drainage @ s. site; dsg CDI; pt voiding QS, c/y urine (-) BM this shift; restraints in place, skin integrity & Circ intact; Cont to monitor [redacted] (b)(6)-2

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STANDARD FORM 600 (REV. 6-97) BACK

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
12 Sep 03 0700	Assumed care of pt. awake alert and oriented x3 VSS. c/o pain to (L) extremity. Scheduled morphine administered c̄ external fixator applied care given to pins GSW to calf 2x2 dressing applied CDI minimal drainage lungs CTA HRRR Active BS x4 quads. Will cont to monitor [redacted] (b)(6)-2
12 Sep 03 1300	– After physical therapy pt. c/o pain to (L) leg medical c̄ percocet II tabs for relief. Will cont to monitor (b)(6)-2 [redacted]
12 Sep 03 1930	Pt sitting in bed, AtOx3, VSS, LS CTA (B), (+) BS, abd soft + flat nontender, Ex Fix LLE, dsg's CDI, ∅ c/o pain, ambulates c̄ crutches, proper circulation + skin integrity on pts of restraint. [redacted] (b)(6)-2 [redacted]
13 Sep 03 0730	Assumed care pt AtO x3 c/o pain to LLE med. c̄ scheduled morphine for relief. LLE c̄ external fixator pin care dressing A this morning minimal drainage from site of pin placement. Lungs CTA HRRR S1S2 present. Good appetite tolerating PO well. Will cont to monitor (b)(6)-2 [redacted]
(1030)	I concur c̄ above assessment. (b)(6)-2 [redacted]

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

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

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

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
13Sep03 2030	Pt sitting in bed, A+Ox3, VSS, OOB to BR, LS CTA (B), (+)BS x4, abd soft flat nontend Ex Fix LLE, dsg on pins saturated c̄ on upper part of Ex Fix had blood drainage, pin care done, pt medicated for pain c̄ 2 percs, proper circulation + skin integrity on pts of restraint. [redacted] (b)(6) -2 [redacted]
14 Sep 03 0700	- Assumed care of pt. A+Ox3 VSS - Lung CTA HRRR Active BS x4 quads Tolerating PO well. Encouraged to OOB ambulation to BR c̄ crutches. External fixator to LLE pin care complete wrapped c̄ kedix for minimal drainage around pin site. Ø c/o pain @ this time (b)(6)-2 [redacted]
15sep03@0200	Assumed care @ 1800 p̄ receiving report from dayshift; All VSS; pt A&Ox3, pt c/o pain, medicated c̄ percs x1 c̄ good relief; Ex-fix in place; (+) CMS x4, NV intact throughout; pt amb x1 to BR s̄ difficulty c̄ assistance from crutches; (+) BS x4, (-) BM this shift; (-) drainage around pinsite; ROM completed; 2-point restraint in place; (+) circulation, (-) skin breakdown; Cont to monitor (b)(6)-2 [redacted]
15SEP03	(1125) Assumed care of pt @ (0600) p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs. Ex fix in place on (L) thigh. Pin care done this am. Pt able to move LLE. ROM done by pt. (+) pedal pulse equal bilat. Skin warm to touch. Pt amb c̄ crutches s̄ difficulty. Tol. reg diet well. Voiding s̄ difficulty. (+) BM. 2 point restraints in place s̄ sign complications. Will cont. to monitor. (b)(6)-2 [redacted]

558-104

7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER	TREATMENT FACILITY
RECORDS MAINTAINED AT	

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS:

CITY: STATE: ZIP CODE:

SEX: M

AGE: 46

DUTY/LOCAL PHONE — AREA CODE: NUMBER:

HOME PHONE — AREA CODE: NUMBER:

ARRIVAL

DATE *(Day, Month, Year)*: 7 Aug 03

TIME: 1242

TRANSPORTATION TO FACILITY: Air Evac

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: Ø

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: Poss. Fracture RT Leg

CATEGORY OF TREATMENT

☐ EMERGENT

☒ URGENT

☐ NON-URGENT

TIME: 1242

INITIALS: [redacted] b(6)-2

VITAL SIGNS

TIME 1242					
BP 125/71					
PULSE 110					
RESP 18					
TEMP 98.6					
WT 62Kg					

LAB ORDERS

X	CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT	
	URINE C&S	UA MSCC/CATH		X	CHEM: 12+Lytes
	BLOOD C&S X				

X-RAY ORDERS

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

ORDERS

☒ PULSE OX 93%

☐ MONITOR

☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1430	X-RAY RT Leg	[redacted]	1430		
1300	Hot Toxol'd				
1315	Ancef 1gm				

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] EPW [redacted]

(b)(6) -4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

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			SUP 02	PH	PO2 9 gk	RESULTS	
H/H			PCO2	SAT	OTHER		
PLT							
PT			U/A	DIP		EKG INTERPRETATION	
APTT	BHCG	ETOH / GLU		MICRO			

PROVIDER HISTORY/PHYSICAL

S) 11 day old. GSW (L) leg (was stealing a car)
GSW - (L) thigh
(L) calf - entrance
Femur fx (L)
Had close area

A/Allergies: 0
P/PH: 0
MED: Had close Area

O) T-99.6 P-110 B.P. 125/71 R.R.-18 Pulse ox-92%
alert HEENT
lungs - no wheezes or rhonchi Heart-RR NO (M)
Abd - soft, N.T B.S. - wnl
Rt leg - wnl
(L) Leg - thigh - swollen, calf swollen
entrance wound (L) calf
Pulse - at

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

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

DIAGNOSIS
1) GSW (L) thigh, calf Femur fx ~~[illegible]~~ fx

CODES

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

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

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

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
2 Sep. 03		2030	Pt A+Ox3, VSS, LS CTA (B), (+) BS x4, medicated for pain c̄ 2 percocets, Ex fix in places LLE, (R) LE elevated c̄ blanket, dsg's CDI, voiding c/y urine proper circulation + skin integrity on pts. of restraint. — [redacted] 9(NH1 (b)(6)-2 [redacted]
3 Sep 03	0800		VSS Alert & Oriented. [illegible] BS(+) x4 quadrants. Medicated for pain c̄ Percocet. (A) thigh left fix pins w/dent drainage. Pin care completed. Ambulated to BR c̄ crutches under supervision. Restraints removed & repositioned. Skin intact under restraints. Will check restraints, skin integrity, and R extremity circulation frequently. (b)(6)-2 [redacted] 2LTVR
3 Sep. 03		1900	Pt sitting in bed, A+Ox3, LS CTA (B), (+) BS x4, abd soft flat nontender, Ex fix in place LLE, (R) leg elevated c̄ blanket, dsg's CDI, ∅ c/o pain @ this time, assessed for proper circulation + skin integrity on pts. of restraint. — [redacted] 9(NH1 (b)(6)-2 [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)

[redacted]

(b)(6)-4

[redacted]

REGISTER NO.

WARD NO.

NURSING NOTES

Medical Record

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4 Sept 03 0500			VSS Alert & Oriented. Resp clear MS (+) & 4 quad. Consumed Regular diet. Peripheral pulses +2. (L) leg Ex fix. Pin sites with small amt of purulent drainage. ∅ swelling. Pin care done. AM care completed. Urine clear yellow urine. Denies pain @ this time. Restraints removed and applied. Pt turned under restraints. Will doff restraints, skin integrity and circulation frequently (b)(6)-2 [redacted] 2CTR
4 Sep		1910	Assumed care @ 1800; VSS, pt Alert & Oriented speaking only arabic; ∅ c/o pain or discomfort @ this time; S1S2, (+) pulses x4; LS CTA(B); (+) BS x4, pt voiding QS, clear yellow urine; BM x1 this shift; Ex fix in place (-) drng noted; dsg to b Δd this evening; restraints in place, circulation & skin integrity intact; Cont to monitor (b)(6)-2 [redacted]
05SEP03	0850		Assumed care of pt @ 0800 p report from night shift. Pt alert, speaking arabic (-) c/o pain @ this time. VSS. Pt amb to BR c̄ crutches s̄ difficulty. (+) BM. Voiding s̄ difficulty. Pt tol reg diet well. Ex fix in place on (L) thigh. (+) pedal pulse equal bilat. Skin warm to touch. Pin care done this am. (-) S/Sx infection @ pin sites. AM care done by pt. 2 point restraints in place s̄ S/Sx complicatio of circulation/skin break. Will monitor [redacted]

CLINICAL RECORD	NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
2Aug	2240		Applied (D) (D) foot splint CMS (D)
7 aug 83		0120	orders noted. Pt awake + conversing.
			Transfer to CSH in am. [redacted] SPC
		1039	Ok to leave [redacted] HCT SP
			(b)(6)-2

Continue on reverse side

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

EPW

[redacted]

(b)(6)-4

EPW [redacted]

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CONSULTATION SHEET

REQUEST

TO: [redacted] (b)(6)-2	FROM: (Requesting physician or activity) [redacted] Col. MC	DATE OF REQUEST 2 Aug 03

REASON FOR REQUEST (Complaints and findings)

fracture @ femur - 2° gunshot wound

PROVISIONAL DIAGNOSIS

fracture @ femur

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	
[redacted] Col MC		☐ 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 [redacted]

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: 46

HEIGHT:

WEIGHT: 62 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) leg. (L) femur Ex Fix

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition
Tobacco | ppd X___ yrs. Body Piercing Ø Diabetes (Y) (N) ROM ASA/Motrin w/72 hrs (Y) (X)
ETOH (+) 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 AM ! 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. ✓ 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 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 _____ 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.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

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

(b)(6)-2 [redacted] RN 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 BREATHING EASY: (Y) (N)

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

12. PREOPERATIVE EVALUATION PREPARED BY (Signature [redacted] RN (b)(6)-2

DATE: 7 Aug 03 TIME: 1345

13. POSTOPERATIVE [redacted] BY (Signature and Title) [redacted]

DATE: 7 Aug 03 TIME:

REVERSE OF FORM 5179, JUN 91

USAPA V1.0

MEDICAL RECORD | **INTRAOP. DOCUMENT**

For use of this form, see AR 40-66, the propo. 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 1LT [redacted] (b)(6)-2

3. DATE 7 Aug 03 TIME PATIENT ARRIVED IN SUITE 1540

4. PATIENT IN ROOM
TIME 1540 NUMBER 2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies:
NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted] 91D (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	1LT [redacted] 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt. supine on padded OR table. BUE on padded armboards <90°

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

COMMENTS: Normal anatomic body alignment maintained

8. SKIN PREPARATION

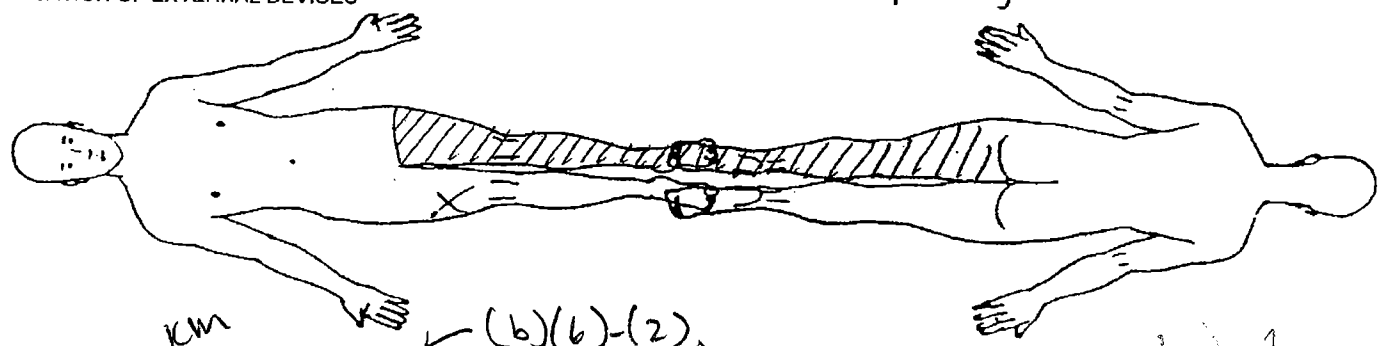
HAIR REMOVAL ☒ YES ☐ NO Dr [redacted] (b)(6)-2
DONE BY: ☒ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP

COMMENTS: No nicks or cuts noted

PREP SOLUTION *(Specify)* Betadine / Betadine
SITE: Left leg BY WHOM: 1LT [redacted]
SITE: BY WHOM: (b)(6)-2

COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



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

Initial: SSG [redacted] 1LT

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No				SSG [redacted]	1LT [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]

(b)(6)-4

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

☒ ESU NO: #3 cut 30 coag 30
GROUND PAD: BRAND VL REM Polyhesive II
LOT NO: 689316 2005-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.01

13. PROSTHESIS, IMPLANTS [X] YES [ ] NO IF YES NAME: ID NUMBER; MANUFACTURER

Hoffman II Load # 0321701 5018-6-180

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

4920-2-140 x 4 5029-8-840 x 2

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Lidocaine Jelly 2% Lot 0P06962 Exp 10-04	20 ml	intra-op	local application	International Medication Systems	Dr. [redacted] (b)(6)-2

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

0.9% NaCl - 0.S.

OTHER ORDERS	TIME	CARRIED OUT BY
N/A		

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES [X] NO [ ] C-Arm IF YES, SITE Left Thigh

16. LABORATORY SPECIMENS

SPECIMEN (S) YES [ ] NO [X]	NAME	NAME
FROZEN SECTION (FS) YES [ ] NO [X]	NAME	NAME
CULTURE (C) YES [ ] NO [X]	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

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

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

18. DRESSING/IMMOBILIZATION *(Specify)*

[redacted]

(b)(6)-2

19. ADDITIONAL INFORMATION

WC

Surgeons: Dr. [redacted] Dr. [redacted] Anesthesia: CRNA [redacted] Anesthesia Type: GETA

(b)(2)-6

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

12Fr Foley cath placed by Dr. [redacted]

(b)(6)-2

DA 5179 initiated.

20. OPERATION(S) PERFORMED

I&D Left leg

Ex Fix Left femur

21. PATIENT TRANSFERRED TO [redacted] TIME See DA 7389 METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] 11T/N

(b)(6)-2

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 wheeled litter BY Anesthesia	2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted]
3. DATE 10 AUG 03 TIME PATIENT ARRIVED IN SUITE 0000	4. PATIENT IN ROOM TIME 0000 NUMBER 1-1

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	
(b)(6)-2			
ASSIGNED CIRCULATOR	CPT [redacted] RN	RELIEF CIRCULATOR	
	CPT [redacted] RN		

7. POSITION AND POSITIONAL AIDS *(Specify)* PT on Padded OR Bed Head on foam doughnut. Arms extended out to sides <90° in CAP secured c safety straps.

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

LLE prepped into field.

COMMENTS: correct body alignment maintained.

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine

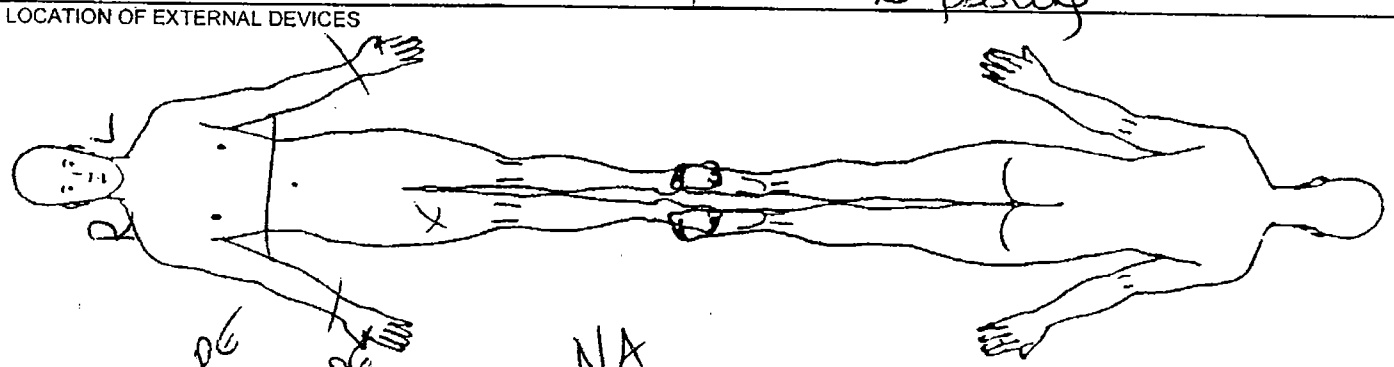
SITE: (L) LE BY WHOM: [redacted]

SITE: BY WHOM:

COMMENTS: Ø pooling

b(4)

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	☐ 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 Rem Poly II

LOT NO: 08936

☐ 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): 0.9% N.S

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. ½ x 2ft Iodoform	2.	3.
SITE	1. (L) leg	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

19. ADDITIONAL INFORMATION
WC
Surgeons: [redacted] Anesthesia: [redacted] Anesthesia Type: ~~IV sedation~~ Mask/General
[redacted] RN assist. (b)(6)-2

Bovie Pad site intact pre-op CF; post-op CF Bovie Settings: Coag/Cut
Tourniquet Site intact pre-op N/A; post-op
Tourniquet Time: Up Down

DA Form 5179 previously done on 07 AUG 03

20. OPERATION(S) PERFORMED
(L) LG I+D

21. PATIENT TRANSFERRED TO ICU-2 TIME 0:38 METHOD litter

22. REGISTERED NURSE SIGNATURE [redacted]

REVERSE OF DA F[redacted] USAPA V1.01

(b)(6)-2

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

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

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

3. DATE 26 Aug 03 TIME PATIENT ARRIVED IN SUITE 1756

4. PATIENT IN ROOM TIME 1756 NUMBER [redacted] (b)(6)

5. PREOPERATIVE EMOTIONAL STATUS (b)(6)-2

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

COMMENTS:

6. NURSING PERSONNEL

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

8. SKIN PREPARATION

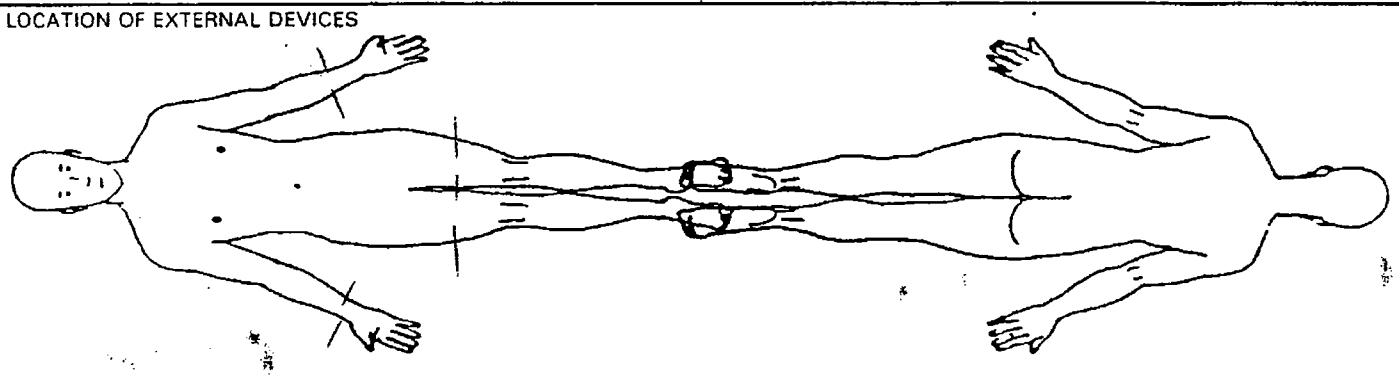
HAIR REMOVAL [ ] YES [X] NO
DONE BY: [ ] OR [ ] NURSING UNIT
METHOD: [ ] DEPILATORY [ ] RAZOR [ ] CLIP

COMMENTS:

PREP SOLUTION *(Specify)* None
SITE: BY WHOM:
SITE: BY WHOM:

COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	[ ] Yes [X] No					
Needle Sharp	[ ] Yes [X] 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)

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

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

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

[ ] BIPOLAR NO:

MEDCOM - 16294

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 YES ☒ NO ☐ IF YES, SITE (L) Femur 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.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

2x2
Kerlix
Tape

19. ADDITIONAL INFORMATION

Surgeon: [redacted]
Anesthesia: [redacted] b(6)-2

- DA5179 on chart, ∅ Δ's noted

20. OPERATION(S) PERFORMED

Ex Fix Adjustment (L) Femur

21. PATIENT TRANSFERRED TO PACU | TIME Sel: DA7389 | METHOD Ulter

22. REGISTERED NURSE SIGNATURE [redacted] CPT IAN

REV [redacted] USAPA V1.01

b(6)(6)-2

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR: August 2003

DAY: 7, 8, 9, 10, 11, 12, 13

HOUR

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

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°

PULSE (O)
180
170
160
150
140
130
120
110
100
90
80
70
60
50
40

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

SpO_2

Record special data only when so ordered

IVD5W/NS 20K

Ancel 75m

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

EDW [redacted]

(b)(6)-24

REGISTER NO. [redacted]

STANDARD FORM 511 (REV. 7-95) BACK

[redacted]

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR 19 2003 — DAY: 14, 15, 16, 17, 18, 19, 20 — HOUR

PULSE (O) — TEMP. F (•)

PULSE (O)	TEMP. F (•)	TEMP. C
	105°	40.6°
180	104°	40.0°
170	103°	39.4°
160	102°	38.9°
150	101°	38.3°
140	100°	37.8°
130	99°	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

	14		15		16		17		18		19		20	
Resp.	16	16	16	18	16		16	18	20	16	16	16	16	16
BP	122/84		102/70		120/74	120/80	122/84		120/82		114/76		110/70	
	100/80		100/80		110/70		124/78		120/70		130/82		100/84	
	98	92	94	98	98	98	95	95	97	97	92	95	96	97

Record special data only when so ordered

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. [redacted]

VITAL SIGNS RECORDS

Medical Record

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY: 1 2 3 4

POST- DAY

MONTH-YEAR / DAY: 21 21AUG03 22AUG03 23AUG03 24AUG03 25 Aug 26th 27th

19 / HOUR: 0600 1 8 1 8 1 1 0800 2 1

PULSE (O) / TEMP. F (°): 105°, 104°, 103°, 102°, 101°, 100°, 99°, 98.6°, 98°, 97°, 96°, 95°

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)

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

RESPIRATION RECORD: 20 8 8 16/17 12/11 12/11 18

BLOOD PRESSURE: 114/80 124/75 110/65 110/70 110/65 112/69 110/66 112/66 (89) 120/97 116/68 120/66

P105 98.3 97.3 97.3 98% 97% 99% 99% 98%

HEIGHT: WEIGHT →

Record special data only when so ordered: Q Soft

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

REGISTER NO. [redacted]

[redacted]

(b)(6)-4

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.2

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 26 | 27 AUG | 28 Aug | 29 Aug | 30 AUG | 31 AUG | 1 Sept

19 | HOUR: 0 | 1700 | 2 | 0800 | 8 | 1700 | 20 | 8 | 1 | 3 | 19 | 8 | 1 | 5 | 19

PULSE (O) | TEMP. F (•)

TEMP. C (Centigrade Equivalents, for Reference only)

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°

PULSE (O)	
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)*

REGISTER NO.

WARD NO.

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

[redacted]

(b)(6)-4

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY										
POST- DAY										
MONTH-YEAR	DAY	25Sept	25Sep.	3Sep	4Sept	05SEP03	06SEP03	07Sep		
19	HOUR	0700	19	8	0730	8	18	8	18	09

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

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°

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

RESPIRATION RECORD

Record special data only when so ordered										
BLOOD PRESSURE	112/68	113/69	116/6	120/70	114/67	120/71	107/65	120/70	106/65	115/57
	101	91		50	99	116/76	92		88	
	R-16	98.3		98.2	98.1		98.2		97.3	
HEIGHT: WEIGHT →	T-98.3				98.2 (OH)					
		96%	97%	97%	R-14	96% (RA)	97%	97% (RA)	97%	97% (RA)
	R-16		NA							
	98%	9								

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

REGISTER NO.

WARD NO.

EPW [redacted]

(b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY: 0

MONTH-YEAR: 08 Sept | 09 Sept 03 | 10 Sept | 11 Sep | 12 Sep | 13 Sep | Sept 14

19 HOUR: 08 | 18 | 0 | 18 | 0 | 18 | 0700 | 18 | 0730 | 18 | 0715

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: 18 | 18 | 8 | 8 | 18 | 18 | 19

BLOOD PRESSURE: 112/71 124/79 | 112/73 T 97.6 H 94 | 99% | 99% RA | 124/74 107/88 | 88 | 98 | 96 | 96 | 112/69 | 111/61 | 124/72 109/62 | 112/73 | 95 | 98.1 | 97 | 99% 97% | 99% 98% | RA | RA

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

[redacted]

(b)(6)-4

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY

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° / 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		

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted]

(b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY															
POST- DAY															
MONTH-YEAR	DAY	21		22 Sept	22 Sept		23 Sept 03			24 Sep		25 Sept.			
19	HOUR	1815		0700	1816		1 8 2 4 6			0430	1825	0800			

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															
		16								16		18/19			
Record special data only when so ordered	BLOOD PRESSURE	134/68		82	110/72		100/72			109/60	122/70				
				9-F/cH	79	T	T96.1			H87	96	93			
				H91	97.5	H	H84			T 97.5	97.9	T 98.1			
	HEIGHT: WEIGHT →	99.5		T96.8			98%			97%	98%	97%			
										RA		RA			

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

REGISTER NO.

WARD NO.

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

[redacted]

(b)(6)-4

(b)(6)-4

ID: [redacted]
MB

07-08-03
13:09

				Patient Limits	
WBC	11.4	H	x10^3/uL	4.5	10.5
RBC	3.45	L	x10^6/uL	4.00	6.00
Hgb	10.3	L	g/dL	11.0	18.0
Hct	33.4	L	%	35.0	66.0
MCV	96.8		fL	80.0	99.9
MCH	29.8		pg	27.0	31.0
MCHC	30.8	L	g/dL	33.0	37.0
Plt	508.	H	x10^3/uL	150.	450.
LY%	19.0	*L	%	20.5	51.1
LYM	2.2	*	x10^3/uL	1.2	3.4

---

i-STAT EC8+

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

Pt Name:_____

Glu_____102 mg/dL

BUN_____11 mg/dL

Na_____132 mmol/L

K_____3.7 mmol/L

Cl_____103 mmol/L

TCO2_____31 mmol/L

AnGap_____3 mmol/L

Hct_____29 %PCV

Hb*_____10 g/dL

*via Hct

pH_____7.460

PCO2_____41.4 mmHg

HCO3_____29 mmol/L

BEecf_____6 mmol/L

Sample Type_:

07AUG03 13:15

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

Physician:_____

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

Ver: JAM5046A
CLEW A93

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

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:

(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	[redacted]	

Coagulation Studies			**Blood Bank Unit Crossmatch** (b)(6)-2 **(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:** 7 Aug 03	**LAB ID NO.:**

Ward/Section: EMT	REQUES[redacted]N: (b)(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI [redacted] (b)(6)-4	DATE 7Aug	TIME 1300	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%
BLxcf		(-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

(b)(6)-4

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

07/08/03 13:15

REFERENCE RANGE: MALE

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

GENERAL CHEMISTRY 12

DISC LOT #: (b)(6)-3142AA4

OPER #: [redacted] DR #: 000

SERIAL #: [redacted]

(b)(6)-4

ALB	2.5*	3.3-5.5	G/DL
ALP	73	26-84	U/L
ALT	26	10-47	U/L
AMY	34	14-97	U/L
AST	30	11-38	U/L
TBIL	0.7	0.2-1.6	MG/DL
BUN	9	7-22	MG/DL
CA++	8.0	8.0-10.3	MG/DL
CHOL	143	100-200	MG/DL
CRE	0.9	0.6-1.2	MG/DL
GLU	101	73-118	MG/DL
TP	5.8*	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
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
CO_2		18-33 mmol/l

REMARKS:

REPORTED BY: (b)(6)-2 [redacted]	DATE: 7Aug03	LAB ID NO.:

---

i-STAT EC8+

Pt: [redacted]

Pt Name:_____

(b)(6)-4

Glu_____117 mg/dL

BUN_____8 mg/dL

Na_____135 mmol/L

K_____4.3 mmol/L

Cl_____101 mmol/L

TCO2_____31 mmol/L

AnGap_____9 mmol/L

Hct_____31 %PCV

Hb*_____11 g/dL

*via Hct

pH_____7.349

PCO2_____52.7 mmHg

HCO3_____29 mmol/L

BEecf_____3 mmol/L

Sample Type_:

15AUG03 01:57

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

---

i-STAT CREA

Pt: [redacted]

Pt Name:_____

Crea_____1.3 mg/dL

Sample Type_:

15AUG03 01:59

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

Ward/Section: TCW 2	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI. [redacted] (b)(6)-4	DATE 15Aug	TIME 0153	SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY: [redacted]	DATE: 15Aug03	LAB ID NO.:

(b)(6)-2

PT/PTT

Ward/Section: [redacted] (b)(2)-2	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
[redacted] (b)(6)-4	18Aug		

(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	15.6	9.8-13.6 secs
APTT	48.6	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: [redacted]	DATE 18 Aug 03	LAB ID NO.:

(b)(6)-2

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

ICW#1

MISC	SPECIMEN/LAB RPT. NO.
URGENCY: ☐ ROUTINE ☐ TODAY ☐ ☐ PRE-OP ☐ STAT	PATIENT STATUS: ☐ BED ☐ AMB ☐ OUTPATIENT ☐ ☐ NP ☐ DOM
	SPECIMEN SOURCE (Specify)

PATIENT'S MED. RECORD

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

REQUESTING PHYSICIAN'S SIGNATURE	REPORTED BY	DATE	LAB ID NO.
[redacted]	[redacted] TECH		

REMARKS

(b)(6)-2

TEST(S)	SPECIMEN TAKEN		REQUESTED	RESULTS
	DATE	TIME A.M. P.M.		
UA	31A	1710		color - yellow clarity - cloudy Glucose - neg Bili - neg Ketone - neg Specific gravity - 1.025 blood - mod pH - 6.0 protein - trace urobili - 0.2 nitrite - pos WBC - TNTC RBC - 25-50 Epi - 1-5 bact - Heavy

557-107

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

Ward/Section: [redacted]	TING PHYSICIAN: (b)(2)-2	L. ORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
EPW [redacted] (b)(6)-4	18 Aug	1430	

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	7.9	4.8-10.8 x 10^3
RBC	3.53	4.7-6.1 x 10^9
Hgb	10.6	14-18 g/dl (M) 12-16 g/dl (F)
Hct	33.6	42-52% (M) 37-47% (F)
MCV	95.2	80-94 fl (M) 81-99 fl (F)
Plt	668	130-500 x 10^3 verified
Lymph %	22.9	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted] (b)(6)-2	18 Aug 03	

MEDICAL RECORD - ANESTHESI

Tobacco

NKDA

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML; "|" = CONSTANT INFUSION													
DRUG	(Units)												
Midazolam	(mg)	2											
Fentanyl	(mcg)	50	<200>		50	50	50	50					
MSO4	( )	4 -	6										
Propofol	( )	120	- 50										
Sux	( )	60											
	( )												
VOLAT AGENT	ISO % del / % e.t.		1.0 ~ 1.5	~	1.5 ~ 1.5		1.5 ~ 1.7		2.0X				
AIR	L/Min												
N2O	L/Min												
O2	L/Min	10	~ 2	~ 2	2	2	2	2	2	10			
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS →													

FLUIDS													
LINE site 18G (L) A	☐ Warmed	LR #1				500				1000 - #2			
	☐ Warmed												
	☐ Warmed												
	☐ Warmed												
LOSSES	EST BLOOD LOSS					75	125	150	200				
	URINE -					200		225					

TOTALS	TOTAL EBL
2	200
10	TOTAL URINE
170	225
60	

FLUIDS - SUMMARY
CRYSTALLOID- 1100 mL
COLLOID- 0
BLOOD- 0

REMARKS
Code drugs with numbers, events with letters
(1) Pre-op assessment NPO, consented & interpreter.
(2) Room, monitors, induced, ETT taped
(3) B.P. when albuterol 8 puffs BS CTA = (B)
(4) OG + nasal tube probe
(5) 50mL of peroxyl [illegible] prepared & cleaned
(6) 2 Dr. Jerzion consult for intraoperative placed 12FR foley. Complications. [illegible] 1650 Begin 10m [illegible] HR [illegible] RR [illegible] 30BPM; Tv 74mL/[illegible] ETCO2 <50. Estimated [illegible] complications
(7) OP [illegible] RR [illegible] 30BPM; Tv 74mL/[illegible] ETCO2 <50. Estimated [illegible] complications
(8) TO ICU-2 report to RN. Lungs Course + [illegible]

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

BODY WEIGHT: 62 (KG) LB

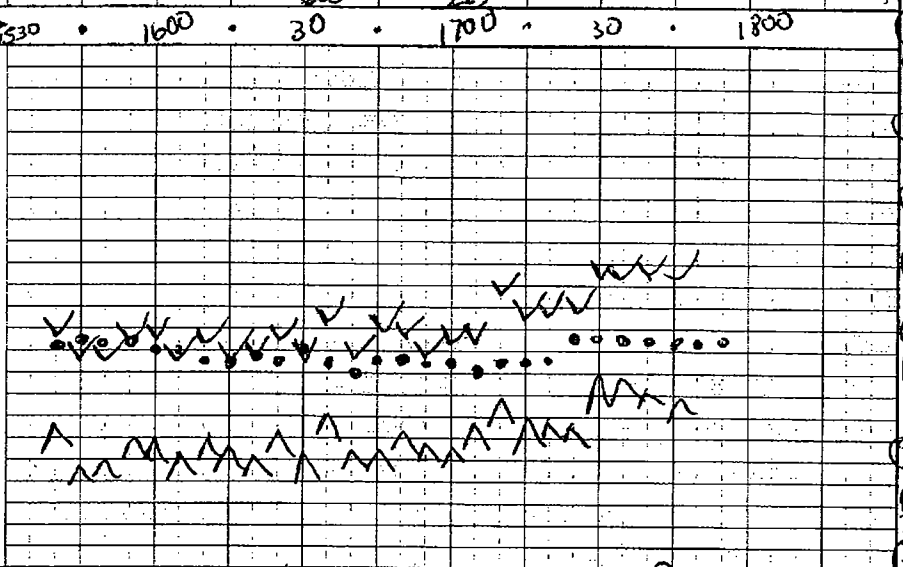
HEMATOCRIT: 28

INITIAL DATA: BP- 109/65; HR- 107

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? JR; TIME- 1530

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



VENTIL											
VT - ml		—	650	740	740	710	700	720	750	790	600
f - breaths/min		—	10	8	8	9	9	6	2-6	6-8	12
Peak inf pres / PEEP		—	22	24	24	24	24	25	—	—	—
MODE - S(pon), A(ssist), C(on)		S C	C	C	C	C	C	C	S/A	S	S
MONITORS/ACCESSORIES											
BP/Auto Cuff	ET CO2 (torr)		44	34	34	34	34	37	36	45	+
BP/oth	FIO2 (Frac or %)	0.87	0.87	0.87	0.87	0.97	0.87	0.87	0.86	0.86	0.86
ART line	SpO2 (%)	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site	—	Nasal	—	36.6	36.9	36.7	36.6	36.4	36.5	X
	N-M Block (T/4)										
	BS	+	—	—	+	—	—	—	+		
Warming blkt	x1 Blanket	→			→		→		→	→	
Conv warmer											

Mark with letters & symbols, explain under REMARKS EVENTS → (1) (2) (3) (4) (6) (5) (7) (8)
Position

RECOVERY AT: 1742
PACU ICU 2 (Specify)
OTHER T-98.3
CONDITION: Stable
RESP- 19 SpO2- 98-10
BP- 13/87 HR- 110

ANESTHESIA/PROCEDURE TIMES

	Start	Room	End
ANES	1530	1540	1755
	Ready	Begin	End
PROC	1550	1620	1729

PROCEDURES and CPT Codes:
(L) leg I&D Ex fix (L) femur

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
GETA

RSI Cricoid pressure @ lip style

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

#[redacted]

(b)(6)-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
DL x1 MAC 3 blade, view 8.0 ETT 19cm @ lip style 8mL air, [illegible] BBS, Sust ETCO2

SURGEON [redacted]

PROCEDURE LOCATION: 2
DATE: 7 Aug 03

[redacted] MAJ/CRNA

PAGE 1 OF 1

DA FORM 7389, FEB 1998 MEDCOM - 16313 COPY [redacted] NT'S MEDICAL RECORD USAPA V1.00

(b)(6)-2

Preop
MEDS
25mg Phenergan

MEDICAL RECORD - ANESTHESI

...se of this form, see AR 40-66; the proponent agen... ...e OTSG

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

DRUG	(Units)														
Propofol	(mg)	50/50													
Fentanyl	(ug)	100/100/50/100/50													
	( )														
	( )														
	( )														
	( )														
VOLAT AGENT	150 % del / % e.t.	1.0/1.0/1.0													
AIR	L/Min														
N2O	L/Min														
O2	L/Min	3/3/3/3													

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

FLUIDS

LINE site														
18g LLE	☐ Warmed	LR — 1000												
	☐ Warmed													
	☐ Warmed													
	☐ Warmed													

LOSSES: EST BLOOD LOSS; URINE -

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 150 KG (LB)

HEMATOCRIT:

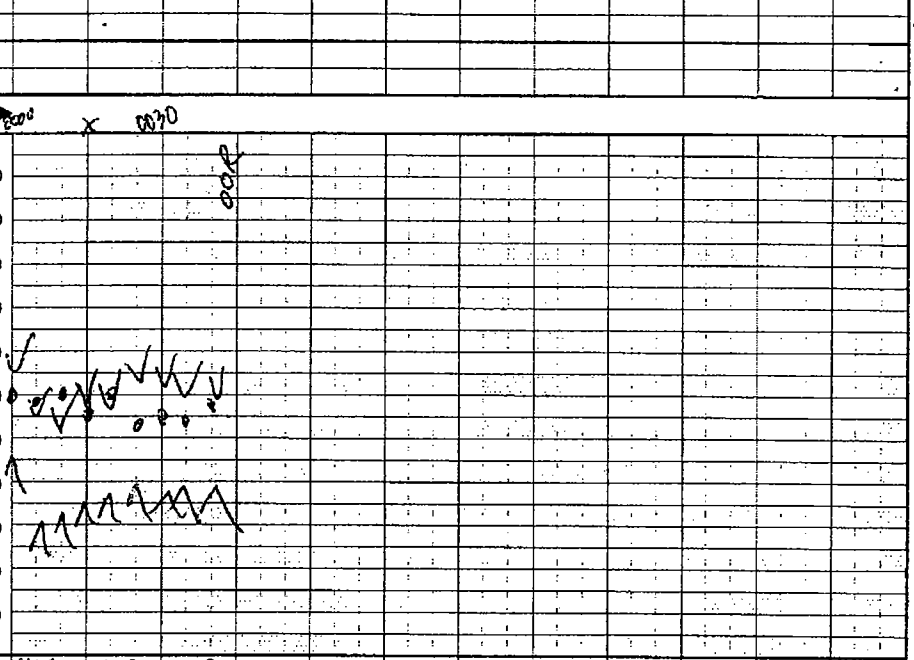
INITIAL DATA: BP- 135/94; HR- 117

EQUIP CHECK: OK?- Y N

PATIENT RECHECK: OK for PROCEDURE? TIME-

TIME → 2000 X 0020

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



VENTIL

VT - ml	700	1020	900
f - breaths/min	11	9	6
Peak inf pres / PEEP	/	/	/
MODE - S(pon), A(ssist), C(on)	S	S	S

MONITORS/ACCESSORIES

BP/Auto Cuff	✓ ET CO2 (torr)	37	45	36
BP/oth	✓ FIO2 (Frac or %)	.89	.89	.89
ART line	✓ SpO2 (%)	100	100	100
Steth- PC/ES	✓ ECG	ST	ST	ST
Gas analyzer	✓ TEMP-site	Axill		
	✓ N-M Block (T/4)			
Warming blkt				
Conv warmer				

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

TOTALS	TOTAL EBL
100	M19
400	
	TOTAL URINE
	Ø

FLUIDS - SUMMARY: CRYSTALLOID- 600; COLLOID- /; BLOOD- /

REMARKS

Code drugs with numbers, events with letters

2350 PT ID, Ø Δ from PREOP form
2400 RSI, O2, MCV
0002 OOR TO ICU
RPT TO CPT [redacted], RN

RECOVERY AT 0042

PACU ICU 2 (Specify)

OTHER

CONDITION: 99%

RESP- 12 SpO2- 99

BP- 124/82 HR- 107

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	2350	0001	
PROC	Ready	Begin	End
	0007	0026	0040

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

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

[redacted]

(b)(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GA - MASK

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* PT maintains SU & OA in place

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

ANE[redacted] (b)(6)-2 CPT CRNA

PROCEDURE LOCATION: OR 1

DATE: 10 AUG 03

PAGE 1 OF

Keflex
Lorenox
percocet

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)	1800	x 30	x 1900	x 30	x 2000
Versed	(mg)	<5>				
Fentanyl	(cc)	1 1	1 1			
Propofol	(mg)	150	20			
Zofran	(mg)	40				
Neosty/Robin	(mg)		3/.4			
	( )					
VOLAT AGENT — FOR	% del	X2 —	1.5 —	XX1.5X		
	% e.t.					
AIR	L/Min					
N2O	L/Min					
O2	L/Min	6 —	2 —	2 —	6	

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

FLUIDS

LINE site		1800	x 30	x 1900	x 30	x 2000
LA	☐ Warmed	400 —	600 —	1000		
	☐ Warmed					
	☐ Warmed					
	☐ Warmed					

LOSSES

EST BLOOD LOSS						
URINE -						

TOTALS	TOTAL EBL
5 / 5	∅
	TOTAL URINE
	∅

FLUIDS SUMMARY

CRYSTALLOID- NS 1000

COLLOID- ∅

BLOOD- ∅

REMARKS

Code drugs with numbers, events with letters

Pmp PIV NPO
agree to GA
OR, O2, monitors
Steth IV Anbetic
1800. LTC [redacted]
Relief [redacted]

06 OP
Sector SV
extubated
awake
Comfort
cooperative

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 75 LB

HEMATOCRIT:

INITIAL DATA: BP- 110/60 HR- 102

EQUIP CHECK OK?- Y N

PATIENT RECHECK OK for PROCEDURE? Yes TIME- 1740

TIME → 1800 x 30 x 1900 x 30 x 2000

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

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

VENTIL.

VT - ml		900	570	
f - breaths/min		9	6	18
Peak inf pres / PEEP		21	16	
MODE - S(pon), A(ssist), C(on)	SC	C	C	S

MONITORS/ACCESSORIES

X BP/Auto Cuff	✓ ET CO2 (torr)	+	31	37	
BP/oth	X FIO2 (Frac or %)	.9	.9	.9	
ART line	X SpO2 (%)	100	100	100	
Steth- PC/ES	X ECG	ST	ST	ST	
Gas analyzer	TEMP-site				
	N-M Block (T/4)				
Warming blkt					
Conv warmer					

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

RECOVERY AT 1837

PACU ICU _____ (Specify)

OTHER _____

CONDITION:

RESP- 10 SpO2- 92 on

BP- 111/64 HR- 112

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1745	1755	1875
	Ready	Begin	End
PROC	1805	1810	1826

PROCEDURES and CPT Codes:
Adjust (L) Femur fx. Fix.

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

[redacted]

(b)(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
DLX1, gel I min, 8.0 x 11.1 min, 35-B

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
+ETCO2

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

ANESTHETISTS: [redacted] LTC

PROCEDURE LOCATION: OR2

DATE: 8.26.03

PAGE 1 OF 1

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 46 DAYS MOS YRS Sex ( ) MALE ( ) FEMALE

ASA Physical State 1 2 3 4 5 E
WT: 62 KG/LB HT: ____ IN.
ALLERGIES: NKDA

PROPOSED PROCEDURE: WASHOUT (R) LEG & possible Ex fix
SURGICAL SERVICE:
NPO SINCE:

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

CURRENT MEDICATIONS:
( ) = ordered as premed
(✓) Ancef 1gm IVPB @ 1315
( )
( )
( )
( )
( )

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

LABORATORY STUDIES:
HB/HCT: 10.9 / 28
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	abdominal hernia
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 DENT'N (R) SIDE MISS
Trachea: ML
TMJ/Neck: 3+
Oropharnyx: MPZ
Nares
CHEST: CTA
CARDIAC: S1 S2
EXTREMITIES:
IV Access: (R) A
Ulnar Filling:
BACK:
OTHER:

NPO Since

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

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian. (b)(6)-2

The patient/legal guardian signs to understand and agrees. Questions answered.
Signed: [redacted] Date: 07 AUG 03 Time: 1455 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

10 AUG 03
0000
Ø charge [redacted]

Patient Identification: (Ward) ICW2 - ICU2

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

10.3
33.4

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

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

EPW [redacted]

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

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

1) Admit to ICW 2 Ortho ✓

2) Dx: GSW (L) thigh, calf (L) Femur fracture (L) tib-fib fx ✓ Condition stable ✓

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER HOURS

3) I.V at 200 cc/hr LR

4) Ancef I gm Ancef q 8 hour (last close 1300 - 4 Aug in E.R)

5) CBC, Chem 12, Lytes, Type & Hold, X-ray h 109 — done in E.R.

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER HOURS

6) NPO till further notice ✓

7) Activity: Bedrest ✓

8) V.S. per routine ✓

9) Notify ortho of patients room #

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

7 Aug 03

1) MSO4 2-6 mg IVP Q 2 mg prn

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

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

(b)(6)-2

7 Aug 03 1525

☆ U.S. G MEDCOM - 16317 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

EPW # [redacted]

(b)(6)-4

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

DATE OF ORDER: 07 Aug 03 | TIME OF ORDER: _____ HOURS | LIST TIME ORDER NOTED AND SIGN

Admit to PR → ICW 2
[redacted]
(1) femur fracture
s/p GSW
(2) femur Exfix
allergies unknown
(b)(6)-2 [redacted]

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT: ICW#2 | ROOM NO. | BED NO.

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

IVF D5-½NS c 20mEq KCl at 100cc/hr
Foley to gravity
Ancef 1gm IVB q8°
Clear advance as tolerated
~~AP + lat femur in a~~
(1) AP + lat full length femur
(b)(6)-2 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

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

Bedrest
Vital q per routine
MSO4 2-6mg IVP q 2° p
Coverox 70mg #Sutg bid
Phenergan 12.5mg IVP q 4-6° p
(b)(6)-2
DXP [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

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

noted
[redacted]
(b)(6)-2 9 Aug 03
2010

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

For use ... CAL RECORD - DOCTOR'S ORDERS
... form, see AR 40-66, the proponent agency is O

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.
	24°/s	9Aug03

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
5 Aug 83	2115 HOURS	
(1) [illegible]		
(2) [illegible]		
(4) [illegible]		
(3) [illegible]		
0210 [illegible]	[redacted]	

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
8Aug03	2130 HOURS	
V.O from Dr [redacted] SPC [redacted]		
D/C [redacted] HI TV [redacted]		
(b)(6)-2		

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
9Aug 03	0815 HOURS	
Full length femur (L) AP + Lat today.		
[redacted]		
(b)(6)-2		

PATIENT IDENTIFICATION

EPW (b)(6)-4

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW2		6

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

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
EPW [redacted] (b)(6)-4			8 Aug	0300 HOURS	
			VO		noted
			Tylenol 650mg PO q 4-6°		0800
			PRN		8 Aug
			Dr [redacted]		
NURSING UNIT	ROOM NO.	BED NO.			
ICW2		6			

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER
EPW [redacted] (b)(6)-4			10 Aug 03	0300 HOURS
			Admit pt #2 the to ICW-2 ✓	
			S/P Wrist out-ex wound ✓	
			Ex-fix (D) Fem ✓	
			Vital qn routine ✓	
			IVF D5 1/2NS @ 100cc/hr ✓	
NURSING UNIT	ROOM NO.	BED NO.		
ICW2		6		

10/Aug 03 noted @0830 [redacted]

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER
# [redacted] (b)(6)-4			10 Aug 03	HOURS
			MSO4 2-6 mg IVP q 2-4° ✓	
			Phenergan 12.5 mg IVP q 4° ✓	
			Ancef 2 gm IVPB q 8° ✓	
			Coverlop 40 mg 1 tablet q 12° ✓	
NURSING UNIT	ROOM NO.	BED NO.		
ICW2		6	(b)(6)-2 [redacted]	

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER
[redacted] noted 10 Aug 03 1630			10 Aug 03	HOURS
			Parkinson to (D) thigh bed	
			& pelvic packing gauze	
			[redacted] p.o.	[redacted]
NURSING UNIT	ROOM NO.	BED NO.	(b)(6)(2)	

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

(b)(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-2

[redacted]

(b)(6)-4

noted [redacted] 10 Aug 03 1730

NURSING UNIT	ROOM NO.	BED NO.
	24°V	5

DATE OF ORDER: 10 AUG 03 TIME OF ORDER: 1225 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Percocet, 1-2 P.O. Q4-6 hrs PRN
(2) Tylenol 325 mg # 1235 P.O. Q4 hrs PRN

(b)(6)-2 [redacted]

[redacted] MAN. 8/10/03 2129.

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW2		6

DATE OF ORDER: 12 Aug TIME OF ORDER: HOURS

noted [redacted]

(b)(6)-2

(1) Wet-to-dry NSS dressings TID to (L) calf change BID
(2) Colace 100 mg po BID ~~PRN~~ Constipation
(3) Physical Therapy for ROM exercises for LLE

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW2	24°V5	6

DATE OF ORDER: TIME OF ORDER: HOURS

(4) Dry Dofirm packing gauze to (R) thigh change BID

(b)(6)-2

[redacted]

PATIENT IDENTIFICATION

24°V5 0030 14 Aug [redacted]

EPW [redacted]

(b)(6)-4

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW2		6

DATE OF ORDER: 15 Aug 2333 TIME OF ORDER: HOURS

16 Aug 03 1600

pt pulls own IV Taken by [redacted] noted

(1) DC IVF
(2) Ceftriaxone [redacted] 1630
(3) Keflex 500 mg [redacted] per Dr [redacted]

(b)(6)-2

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY [redacted]

(b)(6)-2

☆ U.S. GO

MEDCOM - 16321

710

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

DATE OF ORDER: 8-17-03 TIME OF ORDER: 0137 HOURS

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

① 50mg Benadryl PO x 1 now

[redacted]

NURSING UNIT: ICW2 ROOM NO.: BED NO.: 6

PATIENT IDENTIFICATION: EPW (b)(4) [redacted] (b)(6) 2

DATE OF ORDER: 7 AUG 03 TIME OF ORDER: 1400 HOURS

① CBC 18,200

② PT, PTT 40022

③ ~~Lovenox 40~~

[redacted] noted 2030

NURSING UNIT: ICW2 ROOM NO.: 0415 BED NO.: 6

0415 18 Aug 03 [redacted]

PATIENT IDENTIFICATION: (b)(6)4

DATE OF ORDER: 8/22/03 TIME OF ORDER: 1400 HOURS

① - XR ② femur AP+LAT

[redacted]

Noted [redacted] 22 AUG 03 1630

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

24/2325 [redacted]

PATIENT IDENTIFICATION: [redacted]

DATE OF ORDER: 8/24/03 TIME OF ORDER: 1625 HOURS

① NPO

② PO 0h in a.m.

[redacted] 8/24/03

NURSING UNIT: ICW#1 ROOM NO.: BED NO.: 24 8/24/03 [redacted]

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

(b)(6)-2

U.S. GOVERNMENT PRINTING OFFICE: 1996—409-924

"USE BALL POINT PEN—PRESS FIRMLY. NO CARBON PAPER REQUIRED"

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.
		[redacted]

DATE OF ORDER: 25 AUG 03 TIME OF ORDER: 1428 HOURS

LIST TIME ORDER NOTED AND SIGN

1. VO for Resident + NPO.

[redacted] (b)(6)-2

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
2300	25aug03	[redacted]

DATE OF ORDER: 25aug03 TIME OF ORDER: 2245 HOURS

1. Benadryl 50mg po x 1 now
V.O. [redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.
2300	0120	[redacted]

DATE OF ORDER: 26 AUG 03 TIME OF ORDER: 1830 HOURS

Dietrich 1900

1. RESUME PHYSICAL ACTIVITY
2. REGULAR DIET
3. IV - LR KT 125 cc/hr [redacted]
LABOR WHICH FAILED P.O. WITH
4. D/C ILETIX. START NEXT [redacted]

PATIENT IDENTIFICATION

[redacted]

b(6)-4

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
[redacted]	24°	[redacted]

DATE OF ORDER: 31aug03 TIME OF ORDER: 1630 HOURS [redacted]

1. Send UA w/ next void
[redacted] VO per Dr [redacted] b(6)-2
[redacted] 1-09 Cipro 500 mg PO BID

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

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

(b)(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

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

NURSING UNIT: KW#1 | ROOM NO.: [redacted] | BED NO.: 2 1604C

DATE OF ORDER: 9 SEPT 03 | TIME OF ORDER: 1613 HOURS | LIST TIME ORDER NOTED AND SIGN

(1) DP + LAT X-RAYS (2) FLUID, IV NS
(3) NAROLD SYU 500 mg BID
b(6)-2 [redacted]
(b)(6)-2
24°/2125 9SEP03 [illegible]

PATIENT IDENTIFICATION

b(6)-4 [redacted] Noted 10 Sept 03 [redacted] b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 10 Sept 03 | TIME OF ORDER: 1130 HOURS

Δ Naproxyn to Motrin 800 mg P.O TID [redacted]
(b)(6)-2

PATIENT IDENTIFICATION

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

NURSING UNIT: [redacted] | BED NO.: 1052 1600

DATE OF ORDER: 10 SEPT 03 | TIME OF ORDER: 1630 HOURS

(1) TOE TOUCH W/ RIGHT BENDING
(b)(6)-2 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

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

CLINICAL RECORD - 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: ICW | ROOM NO. | BED NO.

DATE OF ORDER: 15 SEPT 03 | TIME OF ORDER: 1700 HOURS | LIST TIME ORDER NOTED AND SIGN

(1) Restoril 15 mg P.O. Q HS PRN
NIGHT PAIN, INSOMNIA

[redacted]

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

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

DATE OF ORDER: 15 SEPT 03 | TIME OF ORDER: 1730 HOURS

Restoril 30 mg P.O. Q HS
PRN night pain, insomnia

[redacted]

b(6)-2

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

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

DATE OF ORDER: 15 SEPT 03 | TIME OF ORDER: 1620 HOURS

(1) BP + LOS (2) [illegible]
b, m,

[redacted]

(b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES E MEDCOM - 16325 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: 24 SEPT 03 TIME OF ORDER: 1405 HOURS

LIST TIME ORDER NOTED AND SIGN

1. DISCHARGE TO GPW CAMP 25 SEPT 03
2. MOTRIN 800 MG PO TID PRN
3. FOLLOW-UP IN 3 WEEKS FOR X-RAY.
4. PROVIDE SUPPLIES FOR PIN CARE, ENSURE PATIENT CAN DO IT HIMSELF (b)(4)-
5. CIPRO 500 MG P.O. BID #40 [redacted]

PATIENT IDENTIFICATION

[redacted]

Not [illegible] 24SEP03 1440

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER _____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER _____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

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]	VS: per routine	06	[redacted]													
			18														
7	[redacted]	ACT: BR	6														
			18														
7	[redacted]	Regular Diet	6														
			18														
12	[redacted]	W→D NSS drsg to (R)	10														
		calf ~~+ dry iodoform~~	22														
		~~packing gauze to (R)~~	X														
		~~thigh BID~~ [redacted]	X														
12	[redacted]	PT to do ROM c̄ LLE	6	[redacted]													
			18														
05 SEP03	[redacted]	Pin care q day	10														
		c̄ betadine															
10 SEP03	[redacted]	Betadine w/ dressing	06														
			18														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW extix (L) leg S/P washout

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[illegible]

#[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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 09 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
09 SEP 03	[redacted]	AP/LAT XRAY (L) FEMUR in AM	10 SEP 03	1D200		[redacted]
15 SEP 03	[redacted]	~~Resume previous orders~~	13 SEP 03			[redacted]
27 SEP 03	[redacted]	D/C to ERW camp [redacted]				
b(6)-2	[redacted]	(b)(2)-2				

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 A1

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
7 Aug	[redacted]	VS per routine	6	/	[redacted]												
			14	/													
			21														
7 Aug	[redacted]	Activity, Bedrest	6	/	[redacted]												
			14	/													
			21														
7 Aug	[redacted]	Diet ~~NPO~~ ~~CL Advance~~ ~~as tolerated~~ Reg	6	/	[redacted]												
			12	/													
			17														
7 Aug	[redacted]	Foley to gravity	6	/	[redacted]												
			14	/													
			21	cm													
10 Aug	[redacted]	Packing to (L) thigh BID to plain packing gauze	08	/	/	/	/	[redacted]									
			20	/	/	/	[redacted]										
			/														
			/														
12	[redacted]	W→D NSS dsg to (L) calf & dry iodoform packing gauze to (L) thigh - BID	08						/	[redacted]							
			20					/									
			/														
			/														
			/														
12	[redacted]	PT to do ROM CLLE	QD	/	/	/	/	/	[redacted]								

Add See below [redacted]

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS:

GSW (L) thigh, (L) femur fx, (L) tib fib fx S/P Ex-Fix (L) leg s/p washout

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

EDW

#[redacted]

(b)(6)-2

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

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 08 Yr 03

Verify by Initialing: Order Date	Verify by Initialing: Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
7Aug	[redacted]	admit ICW 2	7Aug	today	1455	[redacted]
7Aug	[redacted]	Dx: GSW (L) thigh, calf, (L) femur				
		fracture, (L) tib-fib fx				
7Aug	[redacted]	Condition: Stable				
7Aug	[redacted]	xray AP + lat full length femur	7Aug	today		
8Aug	[redacted]	npo p̄ breakfast	9Aug	AM		
17Aug	[redacted]	Soma Benadryl POX1 now	17Aug	0138	0138	
18	[redacted]	CBC/PT/PTT today	18	200	200	

b(6)-2

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

USAPA V1.00

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 18	19	20	21	22	23	24	25	26	27	28	29	30	1
07 AUG03	[redacted]	VS per routine	06	[redacted]													
			18														
07	[redacted]	Act: BR	06														
			18														
07	[redacted]	Regular diet	06														
			18														
12 AUG03	[redacted]	PT to do ROM & LLE	10														
05 SEP03	[redacted]	Pin care q day (betadine)	10														
10 SEP03	[redacted]	Toe touch weight	06														
		bearing	18														
		(b)(6) -2															

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW, ex fix (L) LEG S/P WASHOUT

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

b(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 09 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
18	[redacted]	AP/LAT (L) Femur in Ahn	18 [redacted]	800	0830	[redacted]
24 SEP03	[redacted]	D/C to EPW camp 25SEP03	25 SEP03		(b)(6)-2	
24	[redacted]	F/U in 3 weeks for X-ray	24	NOTED		[redacted]
24	[redacted]	Provide pt supplies for pin care, ensure pt can do it himself				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
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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. 08 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 2	22	23	24	25	26	27	28	29	30	31	1	2	3
7Aug	[redacted]	VS q8 per routine	5	[redacted]													
			19														
7Aug	[redacted]	Activity Bedrest	5	[redacted]													
			19														
7	[redacted]	~~Diet~~ Regular diet	5	[redacted]													
			19														
12Aug	[redacted]	W→D NSS dsg to B calf + dry isolation packing gauze to thigh BID	8	[redacted]													
			20														
12Aug	[redacted]	Pt to do ROM ≥ lle	20	[redacted]													

(b)(6) - 2

ALLERGIES: ☐ YES ☐ NO — NKDA

PRIMARY DIAGNOSIS: S/P ex fix L leg S/P wound

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

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 08 Yr 2003

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
22 AUG03	[redacted]	XR - Femur AP & LAT	22 AUG03	1630	1630	[redacted]
8/24	[redacted]	NPO - To OR in AM	24 Aug	2400		
25	[redacted]	~~Benadryl 50mg PRN I now~~	~~25th~~	~~2200~~		[redacted]
26		Resume prev. orders	26th		noted	
31	[redacted]	Send UA w/ next ord	31 pm			[redacted]
				(6)	(6)	(2)

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

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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. 09 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 3	4	5	6	7	8	9	10	11	12	13	14	15	16
10 Aug	[redacted]	Lovenox 70mg SQ BID	08	[redacted]													
			20														
01Sep	[redacted]	Cipro 500mg po BID	10														
			22														
09 Sep 03	[redacted]	Naprosyn 500mg BID	10														
			22														
10 Sep 03	[redacted]	Motrin 800 mg	08														
		P.O TID	16														
			24														

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW extix Dleg S/P washout

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO. 1

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)					Mo. 09 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials	
12 Aug	[redacted]	P					
		b(6)-2 All					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
10 Aug	[redacted]	Percocet 1-11 tabs PO Q 4-6hr prn pain	3Sep 0700	3Sep 1230	3Sep 1630	3Sep 2035	4Sep 0040	4Sep 0415	4Sep 1120	4Sep 2225	05Sep 0925	05Sep 1340	05Sep 1800	5Sep 2245	6Sep 0330	6Sep 0755
			9mg	11	11	11	11	11	11	11	11	11	11	11	11	11
			[redacted]													
8 Aug	[redacted]	Tylenol 650mg P.O Q4-6hr PRN	D/T	5Sep 0420			(b)(6)-2									
			D/I	11 AH												
10 AUG 03	[redacted]	Percocet T-11 tabs PO q 4-6° pm pain	D/T	06Sep 1353	6Sep 1830	6Sep 2245	7Sep 0418	7Sep 1330	7Sep 2345	8Sep 2255	9Sep 0845	9Sep 0605	10Sep 0118	10Sep 0900	10Sep 1635	10Sep 2120
			D/I	11	11	11	11	11	11	11	11	11	2	11	11	11
			[redacted]													
		Percocet 1-11 tabs PO	D/T	11Sep 0340	11Sep 0603	11Sep 1100	11Sep 1600	11Sep 2230	12Sep 1303	12Sep 1700	12Sep 2130	13Sep 0035	13Sep 1822	13Sep 2300	14Sep 0515	14Sep 0600
		Q4-6hr PRN	D/I	11	11	11	11	11 AH	11	11	11	11	11	11	11	11
10 AUG 03	[redacted]	Percocet 1-11 tabs PO q 4-6° pm	D/T	15Sep 0620	15Sep 1510	15Sep 1905	15Sep 2315	15Sep 0318	16Sep 0740	16Sep 1155	16Sep 1755	16Sep 2210	16Aug 0505			
			D/I	11	11	11	11	11	11	11	11	11	11			
9/15	[redacted]	Restoril 10mg PO QHS prn night pain, insomnia		[illegible]	[illegible]	9/15										

USAPA V1.00

b(6)-2 A 11

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 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]	IV LR @ 200cc/hr	6	/													
			14	/													
			21														
7 Aug	[redacted]	Ancef 1 gm IV q 8°	6	[redacted]													
			14														
			22														
7 Aug	[redacted]	D5 1/2 NS c̄ 20 meq KCL	6	/													
		@ 100cc/hr (A/L)	14	/													
			21														
7 Aug	[redacted]	Lovenox 70mg SQ	08	/													
		q bid	20														
10 Aug	[redacted]	IVF D5 1/2 NS c̄	05	/													
		20 mEq KCL @ 100cc/hr	13	/													
			21														
16 Aug	[redacted]	Keflex 500mg PO QIV	06											/			
			12														
			18														
			24														
		Cipro 500mg PO BID	10	/	/	/	/	/	/	/	/	/	/				
			22	/	/	/	/	/	/	/	/	/	/				

Dc'd 7 Aug 03

7 Aug 0650

See below

(b)(6)-2

Dc'd 7 Aug 0650

See other page

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: EGW (L) thigh (L) lower fx (L) tib fib fx s/p ex fix (L) leg s/p wash out (L) leg

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION: EGW # [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

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	7	8	8	9	10	10	10		1			
		PRN MEDS	DATE DISPENSED												
7 Aug	[redacted]	MSO4 2-6mg IVP q 2° prn pain		0139 5mg IVP	0329 3mg IVP	0415 3mg 4mg	0824 6mg ABS	2015 4mg	0800 5mg IVP	1600 10mg	2397 10mg 5mg	11Aug 1000 5mg	12Aug 0539 5mg	13Aug 2030 5mg	14Aug 2000 5mg
				[redacted]											
7 Aug	[redacted]	Phenergan 12.5mg IVP q 4-6° prn													
8 Aug	[redacted]	Tylenol 650mg PO q 4-6° PRN		7Aug 0500 PO	10Aug 0525	11Aug 0700	12Aug 0100	12Aug 1400	12Aug 2300	13Aug 1630					
				[redacted]			[redacted]			[redacted]					
10 Aug	[redacted]	Immodium 1 tab po prn diarrhea		10Aug 1600											
				[redacted]											
10 Aug	[redacted]	Percocet 1-2 tabs PO q 4-6° prn pain		10Aug 1700	10Aug 2115	11Aug 0050	11Aug 1200	11Aug 1700	11Aug	12Aug 0555	12Aug 1000	12Aug 2300	13Aug	13Aug
				[redacted]		[redacted]								
12	[redacted]	Colace 100mg PO BID PRN constipation												
10 Aug	[redacted]	Percocet 1-2 tabs PO q 4-6° prn pain		13Aug 1600	13Aug 2000	14Aug	14Aug 1515	14Aug 1930	14Aug 2300	15Aug	15Aug 0600	15Aug 1000		
				[redacted]		[redacted]		[redacted]		[redacted]				
10 Aug	[redacted]	Percocet 1-2 tabs PO q 4-6° prn pain		15Aug 1700	16Aug 0150	16Aug 0320	16Aug 0830	16Aug 1100	16Aug 2300	17Aug 0220	17Aug 0655	17Aug 1930	17Aug 2330	17Aug 0330	19Aug 0600
				[redacted]			[redacted]				[redacted]				[redacted]
7 Aug	[redacted]	MSO4 2-6mg IVP q 2° prn - pain breakthrough		15Aug 1730 5mg IVP	16Aug 1035 5mg IV										
				[redacted]		[redacted]									

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (b)(6) - 2 all

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

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. 9 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 17	18	19	20	21	22	23	24		1				
10 AUG03	[redacted]	Lovenox 70mg SQ BID	10	[redacted]													
			22														
01 SEP03	[redacted]	Cipro 500mg po BID	10														
			22														
10 SEP03	[redacted]	Motrin 800mg po	08														
		TID	16														
			24														
		(b)(6)-2 all															

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P Washout GSW Ex Fix L leg

ADDITIONAL PAGES IN USE: ☑ YES ☐ NO

PAGE NO. 2

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

b(6)-2 All

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. Sept Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
/	/	/	/	/	/	/
24 Sep 03	[redacted]	DIC meds: motrin 800mg po TID pm Cipro 500mg po BID	24	NOT EXD		[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
9/15 9/18	[redacted]	Restoril 30mg	D/T	26Sep 2210	17Sep 2215	22Sep 0045	20Sep 2345								
		p.o. Q HS prn	D/I	[redacted]											
		night pain,	/												
		insomnia	/												
10/04/03	[redacted]	Percocet T-II tabs po q 4-6° pm	D/T	17Sep 0800	17Sep 1100	17Sep 2215	18Sep 0450	18Sep 1000	18Sep 1740	18Sep 2310	04Sep 0450	19Sep 1244	19Sep 1540	19Sep 2045	2358 2011
			D/I	[redacted]											
09/04/03	[redacted]	Tylenol 650mg po q 4-6° pm	D/T	20Sep 1000	20Sep 17	21Sep 0630									
			D/I	[redacted]											
10/04/03	[redacted]	Percocet T-II tabs po q 4-6° pm	D/T	23Sep 0715	23Sep 1525	23Sep 2120	24Sep 1705								
			D/I	[redacted]											
		(b)(6)-2	all												

USAPA V1.00

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. 08 YR. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 20	21	22	23	24	25	26	27	28	29	30	31	1	2
7 Aug	[redacted]	Lovenox 70mg SQ Q BID	08	[redacted]													
			20														
6 Aug	[redacted]	Keflex 500mg PO QID	06	[redacted]													
			12														
			18														
			24														
26 Aug	[redacted]	IV LR @ 125cc/hr	06														
		HL when TOL. PO well	18														
		(HL locked)															
01 Sept	[redacted]	Cipro 500mg PO BID	10														
			22														

(b)(6)-2 all

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: GSW ex fix ⓡ leg S/P washout ⓡ leg

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

PKIN MEDICATIONS

7 Aug	Pm	MSO4 2-6 mg IVP Q2° PRN pain	23 Aug 0300 6mg [redacted]	24 Aug 0658 6mg IM [redacted]	24 Aug 0300 6mg SQ [redacted]	29 AUG 1130 6mg IM											
Aug	Pm	Phenergan 12.5 mg IVP Q4-6 PRN															
Aug	Pm	Tylenol 650 mg PO Q4-6° PRN	20 Aug 0800 [redacted]	27 Aug 03 0700 60ch [redacted]	30 AUG 1040 KAS	2 Sep 1300 12mg 2 tabs.											
Aug	Pm	Percocet 1-2 tabs PO Q4-6° PRN pain	20 Aug 2030	21 Aug 03 0820	21 AUG 1600	21 Aug 2300 2	22 Aug 0400 2	22 AUG 1040	22 AUG 1650	22 AUG 0102 2	23 AUG 0935	23 AUG 1700	[redacted]				
Aug	Pm	Colace 100mg PO BID PRN constipation															
Aug	7A	Percocet 1-2 tabs PO q4-6° PRN PAIN	24 Aug 0250 2	24 AUG 0853	24 Aug 1535	24 Aug 2030 2	25 Aug 0936	25 AUG 1637	25 Aug 2030	25 Aug 0055	26 Aug 0100	[redacted]					
12 Aug	BR	Percocet 1-2 PO Q4-6 PRN PAIN	28 Aug 2100	29 Aug 0100	29 Aug 0500	28 Aug 0630	28 Aug 1700	28 2100	29 0210	29 AUG 0805	29 AUG 1310	29 AUG 1745	29 AUG 2300	[redacted]			
Percocet 1-2 PO Q4-6 PRN			30 AUG 0630	30 AUG 1150	30 AUG 1700	30 AUG 2003	30 AUG 0430	31 AUG 1030	31 AUG 1556	1 Sept 0720	1 Sep 1503	1 Sep 1050	[redacted]				
Percocet 1-2 PO Q4-6° PRN PAIN		2 SEP 2 tabs 0840 12mg	2 Sep 1616	2 Sep 2305	[redacted]												

(b)(26) - 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. 08 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED														

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS:

GSW (R) thigh, (L) femur fx, (L) tib/fib fx

s/p ex fix (L) leg, washout

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

Elw [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

PRN Meds

Percocet 5/325 takes 9q4-6 PO PRN PAIN	19 Aug 2015 [redacted]

(b)(6) - 2

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
	.....					
	.....					
	.....					
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	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....	(b)(6) - 2 all				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
10 Aug	[redacted]	Percocet 1-II tabs PO q 4-6 hrs prn	18 Aug 0700	18 Aug 1100	18 Aug 2000	19 Aug 0600	25 1900	25 0200	25 Aug 2130							
			II PO	II PO	[redacted]	II PO	II	II	II							
.....	.....															
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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 03
Time In: 1742
Allergies: NKDA
Pre-op V/S: 109/65 HR107
Procedures: 1+ DD leg, Ex Fix Femur

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1100cc Colloid
OR Output: UOP 225cc EBL 200cc
Meds/Times: 2mg Versed 480mcg Fent 10mg MSO4 Abx prophylaxis x1

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds History

Time	1740	1750	1755	1810	1830	1900	1930	2000
SaO2	99	97	100	98	97	97	96	95
FiO2	100	100	10	6	4	RA	2	RA
Methods	SF	SF	SF	NC	NC		NC	
240								
220								
200								
180								
160								
140								✓
	138	✓	✓	✓	✓	✓	✓	
120		•	•		•	•	•	•
100								
80	80	^	^	^		^	^	^
					^			
60								
40								
20								
RR	10	13	10	18	12	10	18	22
T	98.3				98.6			

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	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

Time	
Pain (0-10)	
LOS	

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

(Continue on reverse)

PREPARED BY (Signature & Title): (b)(6)-2 [redacted] AN

DEPARTMENT/SERVICE/CLINIC: ICU #2

DATE: 7 AUG 03

PATIENT [redacted] (Typed or written entries give: Name – last, first, middle [redacted] or medical facility)

[redacted]

(b)(6)-4

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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(L)	Ø	+	DP	BR	COOL	NL
15'	(L)	TOES	+	DP	BR	COOL	NL
30'	(L)	TOES	+	DP	BR	COOL	NL
45'	(L)	TOES	+	DP	BR	COOL	NL
60'	(L)	TOES	+	DP	BR	COOL	NL
90'							
D/C	(L)	TOES	+	DP	BR	COOL	NL

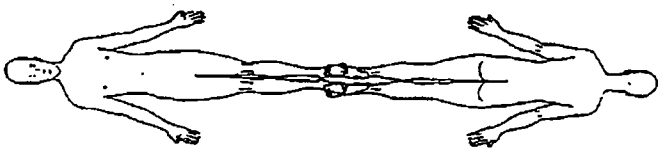
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

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 & EXTX	Sm to Mod
30'	(L) LEG	BULKY & EXTX	~~Sm to Mod~~ SANGUINEOUS
60'	(L) LEG	BULKY & EXTX	~~Sm~~ CHANGED
D/C	(L) LEG	"	"



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

NURSING NOTES

Received from PACU @ 1749. Pt arousable to verbal stimulus NKB @ 10L to wean to RA before transfer. IV to LFA ~~to LR~~ @ KVO during PACU Recovery BS ↓ to ↑ Quads. FTR c̄ straw color urine. Skin Intact. ⊗ Fx to LLE on upper thigh. Pulses palpable DP 2+ - 3+. Monitor and continue to wean off O2 for transfer. [redacted] LT RN

Pt c̄ mod sanguinous drainage from (L) upper thigh portion. Will monitor for Δ in bleeding. [redacted] LT RN

Pt placed on RA @ [redacted] SaO2 ↓ to 89-91 on RA placed on 2L NC @ 1930. Will monitor. [redacted] LT RN

(b)(6)-2 a4

(b)(6)-2 a4

Discharge Criteria:
Date: 7 AUG 03 **Time:** 2000 **PARS:** 9
BP: 138/88 **T:** 98.8 **HR:** 112 **RR:** 22 **SaO2:** 95
Pain Level at D/C (0-10): Ø
Intake: 30cc PO H2O **Output:** 100cc
Additional Data: Ø
Transferred To: IMW 2
Report Given To: LT [redacted]
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: LT [redacted]
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: [redacted]

WAMC OP 173-E

135/94 HR 117

A Surg

5min OR time

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: 0800 15 min
Allergies: NKDA
Pre-op V/S: 135/94 (117)
Procedures: HO LLE
Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid ∅ Colloid ∅
OR Output: UOP ∅ EBL minimal
Meds/Times: 40 Fent 25 Phenergan

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

Pre Op Meds History

Time	0000	0053	0100	0105	0110	0130	0145	0200	0215
SaO2	99	100	100	100	100	100	93	92	93
FiO2	RA	RA	RA	RA	RA	RA	RA	RA	RA
Methods	NC	NC	NC	NC	NC	NC	/	/	/
240									
	134/82								
220		114/91	128/71	108/74	115/77	117/44	123/78	119/88	128/80
200									
180									
160									
140									
120									
100									
80									
60									
40									
20									
RR	23	18	18	18	18	18	20	16	18
T	99.4			99.4			99.4		
Time									
Pain (0-10)	9		0		8		8		
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	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	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	10	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): [redacted]

DEPARTMENT/SERVICE/CLINIC: 1412

DATE: 10/8/03

PATIENT'S IDENTIFICATION (For typed or written entries give: Name – last, first, middle; grade; date; hospital or medical facility) (b)(6)-2

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

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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	LLE	UTA/+	+	+	<3sec	C	Brown
15'	LLE	UTA/+					
30'	LLE						
45'	LLE						
60'	LLE						
90'	LLE						
D/C	LLE	UTA/+	+	+	<3sec	C	Brown

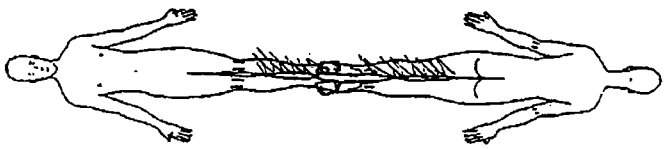
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	LLE	ACE/Xtra	Ø
30'			
60'			
D/C	LLE	ACE/Xtra	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

Pt had uneventful recovery. Required 7mg Ø Ldi at beginning of recovery ↓ to 4L. Then ↑ed to RA, Ø desatted in high 80's when fell back to sleep. Pt easily arousable and SpO2 ≥93% c deep breaths. Pt moves spont. and denies pain @ this time. — CPT [redacted]

(b)(6)-2

(b)(6)-2 all

Discharge Criteria:
Date: 10/8/03 **Time:** 0215 **PARS:** 12
BP: 128/80 **T:** 99.4 **HR:** 104 **RR:** 18 **Sa02:** 93% RA
Pain Level at D/C (0-10):
Intake: Ø **Output:** Ø
Additional Data: Ø
Transferred To: Ward 2
Report Given To: SCT [redacted]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: CPT [redacted]
Cleared IAW Recovery Room SOP B-3 [redacted]
Charge Nurse Signature: CPT [redacted]

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-68; the proponent agency is the Office of The Surgeon General.

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

OTSG APPROVED (Date)

Date: 26 Aug 03
Time In: 1835
Allergies:
Pre-op V/S: 110/60 AR P20
Procedures: Amputation femur

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1000 Colloid
OR Output: UOP EBL
Meds/Times: see DA 7389

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

Pre Op Meds / History

Time	1835	1840	1845	1850	1855
SaO2	96	98	99	99	96
FiO2					
Methods	RA	RA	RA	RA	RA
240					
220					
200					
180					
160					
140					
120					
100					
80					
60					
40					
20					
RR	22	17	18	16	22
T	98.3				

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	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	2	2	2
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

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

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 26 Aug 03

b)(6)-2

PATIENT'S IDENTIFICATION (Typed or written em... first, middle; grade; date; hospital or medical facility) [redacted]

Name — last,

(b)(6)-4

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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(L) leg	limited	(+)	P	<3	warm	P
15'							
30'							
45'							
60'							
90'							
D/C	(L) leg	Full ROM	(+)	P	<3	warm	P

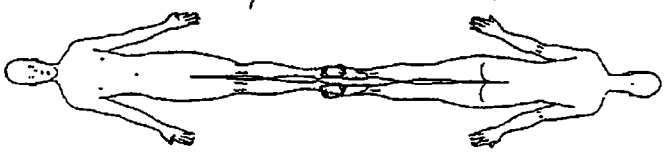
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) leg	Gauze ace wrap	
30'	"	"	"
60'			
D/C	(L) leg	Gauze ace wrap pins / no dressing	



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1835	SR	no	∅

WAMC OP 173-E

NURSING NOTES

1835 - Pt received from OR via gurney; accompanied by OR staff. monitors placed VSS. O_2 sats > 93% RA. Awake denies pain. Dressing around pins CDI. no oozing. will cont to monitor [redacted]

1915 - Pt meets dc criteria VSS. no issues this tim [redacted]

(b)(6) - 2

(b)(6) - 2 all

Discharge Criteria:
Date: [illegible] **Time:** 1915 **PARS:** 10
BP: 115/66 **T:** **HR:** 104 **RR:** 18 **SaO2:** 94
Pain Level at D/C (0-10): ∅
Intake: 200 **Output:** ∅
Additional Data: ∅
Transferred To: ICW 1
Report Given To: CT
Transferred Via: W/C Litter Gurney Ambulan[redacted]
Transferred By: CPT [redacted]
Cleared IAW Recovery Room SOP B-3 [redacted]
Charge Nurse Signature [redacted]

1. DATE AND TIME OF CAPTURE	2. SERIAL NO.
27 July 03 1530	[redacted] A
3. NAME [redacted]	4. DATE OF BIRTH 1957
5. RANK (b)(6)-4	6. SERVICE NO.
7. UNIT OF EPW	8. CAPTURING UNIT [redacted]
9. LOCATION OF CAPTURE (Grid coordinates) [redacted] ← (b)(2)-2	
10. CIRCUMSTANCES OF CAPTURE CAR THEFT	11. PHYSICAL CONDITION OF EPW SUNSHINE
	12. WEAPONS, EQUIPMENT, DOCUMENTS

DD FORM 1 JUL 73 600

REPLACES EDITION OF 1 OCT 51 WHICH MAY BE USED

PATIENT'S BAGGAGE TAG (DO NOT DETACH)	NO A [redacted]
ORIGINATING CARRIER	
PA[redacted]me-Middle initial) #1	
GRADE	SSN (b)(6)-4
[redacted]	
ORIG[redacted]ING TERMINAL	
THRU	
IC[redacted]#1	
TO	
DESTINATION HOSPITAL	TERMINAL

2nd PRIORI MODERATE [redacted]

[redacted]

DECEASED

Mass Casualty Incident Tag
©Eastern PA EMS Council - 1997

TIME	7:22	SEX	M
AGE			
LUNGS	Clear		
PULSE	138		
RESP.	20		
B.P.	104/74		
A	V	P	U

(A) (P)

GSW
Poss Femur fx
Entry/exit

atient Name (if known)

Notes/Treatment Left: MSO Poss Femur fx
(L) leg GSW entry/exit distal (L) knee.
(R) leg GSW entry/exit thigh
(R) groin pulse good cap refill

To be given to:
TRANSPORTATION OFFICER

Priority #	[redacted]	2		D
Primary Injury/Illness				
E.M.S. Unit				
Depart Time				
Hospital				

T A# G [redacted]

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

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
	46y	Z	9	unk

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
NA	Z	2010	NA

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Q	ICW 2	unk

NAME AND LOCATION OF MEDICAL TREATMENT	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
[redacted] (b)(2)-2	unk

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
unk

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
50		030825

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
AEAA		030807

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

GSW (L) FEMUR FX.

T: 1
Inj: 450

Dx: 82110, 8910, 71906, 5059, E9912

PR: 7965, 7905, 2309, 8191, 8604, 7915, 7845

891.0, 821.10, 719.06, 525.8, E991.2

78.15, 79.05, 86.28 X2, 81.91, 23.09

ADMITTING OFFICER [redacted]

DR. [redacted]

SIGNATURE OF ADMITTING CLERK [redacted]

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)(6)-4		3. GRADE EPW	ADMISSION REMARKS
4. SEX M	5. AGE 19	6. RACE —	7. RELIGION (b)(6)-4	8. LENGTH OF SVC —
9. ETS —	10. PREVIOUS ADMISSION NO	11. EMP 99	12. SSN [redacted]	13. ORGANIZATION —
14. WARD —	15. FLYING STATUS —	16. RATING/DSG —	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 1401	23. CLINIC SERVICE A EAA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK	25. TYPE DISPOSITION ~~50~~ 24	26. DATE OF DISPOSITION 13 ~~12~~ Aug 03		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK	27b. TELEPHONE NO. UNK	28. DATE OF THIS ADMISSION 8 Aug 03	ADMITTING OFFICER DR [redacted] (b)(6)-2	
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 [redacted]

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: ~~GSW to Abn~~ old GSW to abdomen with Colostomy appliance problem

569.62
E878.3

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	4	4

36. Total Days All Facilities (b)(6)-2

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

SIGNATURE OF ATTENDING [redacted] SIGNATURE OF MEDICAL RECORDS OFFICER

Dr [redacted]

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

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

1 yo Iraqi EPW
GSW to abd 12 days ago (shot by Iraq police)
RC @ Iraqi hospital. Transfer to EPW
Camp c̄ abdomen and colostomy. Unable to keep
colostomy appliance on.
Meds NKDA
Ø

PSHX
- GSW abd 12 days ago s/p ex lap
- Ex lap s/p explosion 6 yrs ago

PMHX
Ø

PHYSICAL EXAMINATION

Gen: well appearing ♂ NAD
PERLA
neck supple trachea
lungs clear
CV RRR s m
abd soft NTND colostomy

Ext: tender R/L foot
NV intact bilat
strength/motor grossly
needs crutches to ambulate

PROGRESS (Enter date of discharge and final diagnosis)

[redacted] Colostomy appliance problem
to RCW

(b)(6)-2

SIGNA[redacted]	DATE	IDENTIFICATION NO.	ORGANIZATION
	[redacted]		

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

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

539-106

[redacted]

AUTHORIZED FOR LOCAL REPRODUCTION

b(6)-2 A

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
9AUG03 1355	VS-111/63, P76, T99.0, R21 — [redacted] Pt is an EPW who is S/P GSW and colostomy. Pt presents to the 28th CSH c̄ c/o not being able to keep the colostomy bag on due to the heat. The medics who brought him in report that they have tried tape, tape and benzione tincture c̄ success. General Surgery notified. — [redacted]
1420	New colostomy bag placed on pt. Pt to be admitted to ward. — [redacted]
9AUG03 1530	Admitted from EMT to ICW2 @1500. VSS. Denies any pain @ this time. Lung sounds clear bilat. BSX4. Colostomy clean pink, and intact. Will continue to monitor. — [redacted]
10Aug03 0140	Pt care assumed @2100. VSS, A+OX3, no c/o pain. Lung sounds CTA, pulses palpable x4, DSD. Colostomy site intact, no production. Will continue to monitor. [redacted]
10Aug03	0700 Assume pt care @ 0500. Asleep easy to awake. VSS. HR reg Lungs CTA Abd midline stitches intact. Colostomy bag intact to LUQ. BSx3. (R) hip/femur pain c̄ ambulation. No pain @ this time. Will continue to monitor — [redacted]

(b)(6)-2 all

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 USAPA V2.00

AUTHORIZED FOR LOCAL REPRODUCTION

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

10AUG03 1430: Assumed care @ 1300. VSS. Lung sounds clear. c/o pain. Tylenol 650mg PO given. Relief acceptable. Colostomy bag intact, draining scant amt liquid stool. Will continue to [redacted] monitor.

2304 Pt. care assumed @ 2100. VSS. HR Reg, lungs CTA, BS ⊕ X4. Colostomy intact. Ostomy pink. MC ABD incision c̄ sutures OTA. ⊘ s/s infection. Will cont. to monitor. [redacted]

11Aug03 0622 Assume pt care @ 0500. Asleep easy to awake. No c/o pain or discomfort. VSS. Colostomy intact. Ostomy pink BSx4. Midline Abd sutures intact - no s/s infection. Will continue to monit: [redacted]

11AUG03 1430: Assumed care @ 1300. VSS. Lung sounds clear bilat. Colostomy intact, pink. Smant. stool out. No c/o pain or discomfort. Will continue to monitor. [redacted]

2219 Pt. care assumed @ 2100. VSS - HR Reg, lungs CTA, BS⊕X4, MC ABD incision c̄ sutures CDI, OTA, ⊘ s/s infection. Ostomy pink, passing scant amt. soft formed brown stool. Colostomy bag intact. Will cont. to monitor. [redacted]

12Aug03 0548 Assume pt care @ 0500. VSS. HR reg. (b)(6)-2 lungs CTA Abd soft non tender midline incision c̄ sutures intact free of infection. Colostomy intact c̄ brown soft stool. (cont.)

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 USAPA V2.00

MEDICAL RECORD	PROGRESS NOTES
DATE	
12Aug03	0548 (cont.) No c/o pain @ this time. Plan to have pt ambulate this am. Will cont to monit. [redacted] 3/LWM6
12AUG03	1340: Assumed care @ 1300. VSS. ½ pain in (R) leg. Medicated c̄ Tylenol 650mg PO. Relief acceptable. Colostomy bag intact. Colostomy pink, draining sm. amt soft brown stool. Will continue to monitor. [redacted]
12 Aug03 2330	Assumed care @ 2100. VSS, qrox3, no complaints. Lungs CTA, pulses+x4, ~~no c~~ SS bsf. Assessment WNL. Colostomy c̄ moderate output. Pt has p/c orders and summary, continue to monitor. [redacted] alumo
13Aug03	0733 Assume pt care @ 0500. VSS Alert ~~x4~~ [redacted]. Colostomy intact. Will place new bag before pt leaves today. Will cont. to monitor [redacted] (b)(6)-2 all

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY: 9

POST- DAY

MONTH-YEAR Aug 2003 | DAY: 10 11 12 13

19 | HOUR

PULSE (O) | TEMP. F (°)

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

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

TEMP. C: 40.6° 40.0° 39.4° 38.9° 38.3° 37.8° 37.2° 37.0° 36.7° 36.1° 35.6° 35.0°

(Centigrade Equivalents, for Reference only)

Dc'd 12 Aug 03 1600 [redacted]

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

VITAL SIGNS RECORDS

Medical Record

MEDCOM - 16359

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

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

8/9/03 Ward 19 @

Admit to R ~~[illegible]~~

Conduct sfp obsv to all

(+) Colorly @ Iraqi Hospital

VS q 8°

Diet Regular

Colorly Irrigation AND bag

to Colorly site

noted [redacted] 9AUG03

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

Tylenol 650 PO q4° PRN

[redacted]

Please send

plan film of

(R) Hip and [redacted]

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

24°VS | 0140

10 Aug 03 [redacted]

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

DATE OF ORDER | TIME OF ORDER | HOURS

8/12/03

Return to Camp

[redacted]

[redacted]

[redacted]

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

[redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

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

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

ORDER DATE	CLERK/ NURSE	~~RECURRING~~ PRN MEDICATIONS, DOSE, FREQUENCY
9AUG03	[redacted]	Tylenol 650mg PO q 4° PRN
		(b)(6)-2

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

HR	DATE DISPENSED														
	10AUG03 1400 II PO [redacted]			10Aug 1800 II PO [redacted]			11Aug 1845 II PO [redacted]		12Aug 1300 II PO [redacted]		12Aug 1800 II PO [redacted]		DC 12Aug03		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P GSW to Abd/Colostomy

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.* ____ *Yr.* ____

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED													

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P GSW to Abd./Colostomy

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

b(6)-7

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (~~MEDICATIONS~~ Actions) 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	Single Actions ~~RECURRING MEDICATIONS~~, DOSE, FREQUENCY	HR	DATE DISPENSED: Date Done	Initials
9AUG03	[redacted]	Admit to ward		9AUG03	[redacted]
		Condition s/p GSW to			
		Abd.			
9AUG03	[redacted]	Please send for plain film of (R) hip & femur		9AUG03 1730	[redacted]

D/C'd 1600 12Aug03 [redacted]

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: s/p GSW to Abd./Colostomy

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

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING ~~MEDICATIONS~~ actions DOSE, FREQUENCY	HR	DATE DISPENSED 9	10	11	12
9AUG03	[redacted]	V.S. q 8°	05	/	[redacted]		
			13	[redacted]			
			21	[redacted]			
9AUG07	[redacted]	Diet Regular	07	/	[redacted]		
			11	/	[redacted]		
			17	[redacted]			
9AUG03	[redacted]	Colostomy water & bag to Colostomy site	05	/	[redacted]		
			13	[redacted]			
			21	[redacted]			

Dcd 12 Aug 03 1600

[redacted]

(b)(6)-2 all

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: 5/8 GSW to Abd./Colostomy

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

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]	EPW # [redacted] (b)(6)-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
[redacted]	[redacted]	Z	Z	UNK

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
	(b)(6)-4	9 9	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	Z	1401	—

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
6		UNK

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] (b)(2)-2

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: UNK

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
5 ~~8~~ 05		0 3 0 8 1 ~~2~~ 3

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

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

FOR LOCAL USE

Dx: Gswto Abn

Dx: V535 PR: 9729

[redacted] (b)(6)-2

SIGNATURE OF ADMITTING CLERK: [redacted] (b)(6)-2

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)(6)-4			3. GRADE EPW	ADMISSION REMARKS
4. SEX M	5. AGE 20	6. RACE UNK	7. RELIGION UNK	8. LENGTH OF SVC —	9. ETS —	10. PREVIOUS ADMISSION N	
11. FMP 20 ~~04~~		12. SSN [redacted]		13. ORGANIZATION (b)(6)-4		14. WARD ICU 2	
15. FLYING STATUS —	16. RATING/DSG —	17. DEPT./BEN KMB	18. BRANCH/CORPS —	19. UIC/ZIP —		20. TYPE CASE WIA	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION direct from ER				22. HOURS OF ADMISSION 1200	23. CLINIC SERVICE ABAA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK				25. TYPE DISPOSITION d/c to Camp	26. DATE OF DISPOSITION 17 Aug 03		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK				27b. TELEPHONE NO. UNK	28. DATE OF THIS ADMISSION 11 Aug 03		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] (b)(2)-2					30. DATE OF INTIAL 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

GSW · soft tissue ⓒ LE

Dx 891.0, 780.6, E991.2

Px 83.09, 88.27

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	6	6

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
	[redacted]	(b)(6)-2	[redacted]		

SIGNATURE OF ATTENDING MED [redacted] BDL GUT

SIGNATURE OF DA[redacted] [redacted]

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
11 Aug 03 1415	PT admitted to Ward #2 via gurney. PT is ambulatory c̄ assistance and has Dx of soft tissue injury to LLE. VS 122/73-26-20-99.8-97% SpO_2 on RA. PT Alert, verbal in Arabic, NAD, lungs CTA(B), resp even and non-labored, (+) cough, CV-S1,S2, NSR c̄ extra pulses +3 in 4 extremities, 18g c̄ IV NS TKO, GI-ABD, ND, NT, BS x 4, GU-PT bids 450 cc clear yellow urine, PT's skin warm, dry and his color is normal for race. PT has movement and sensation in all extremities. PT is restrained. [redacted] SPC [redacted] (b)(6)-2
11 AUG 1900	VS 78 133/83 20 @ 99% RA ALERT AND ORIENTED. PERRL CTA B/L c̄ NON PRODUCTIVE COUGH. S1,S2 (+) 3+ PERIPHERAL PULSES THROUGHOUT CAPREFILL BRISK. GI BS (+) TOLERATING 50% REGULAR DIET. GU VOIDING LS LIGHT YELLOW URINE TO FECAL ISOLE c̄ DIFFICULTY. PIV 18G TO (L) HAND c̄ NS @ KVO RATE. RECEIVES ANTIBIOTICS PER ROUTINE. SKIN INTACT c̄ GSW TO LLE WRAPPED. GOOD ROM ABLE TO WIGGLE TOES (+) SENSATION. BID DSG CHANGE. WILL CONTINUE TO MONITOR.
(b)(6)-2 [redacted]	
1910	PT RECEIVED PERCOCET II TABS FOR PAIN TO LLE. WILL MONITOR [redacted]
12 Aug 03 0715	AE AtO x 3, VSS, Afebrile. HR 90, B/P 128/88, RR 18, SaO_2 98 [redacted] T. 97.3. Heart Sounds S^1, S^2 Present c̄ Murmur. Lung Sounds CTA bilaterally. + BS x 4 quadrants. UOP. Voiding spontaneously, 1475 cc clear/yellow this [redacted] (b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S [redacted] (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.

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

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
12 Aug 03 Continued	am. IV site (L) wrist infusing NS @ KVO, site ∃ S/S of infection or infiltration. Peripheral pulses 3+ throughout. Drsg to LLE C/D/I. Will Δ this am. Pt on IV Abx Tx per md orders. Tolerating Reg. diet ∃ complaint. Will continue to monitor. [redacted] LRA
0830	Drsg Δ done. Pt given 2mg MSO4 per Dr [redacted] orders c̄ Drsg Δ. Tolerated well. Will continue to monitor. [redacted]
1635	Pt c/o Pain. Given Ī percocet, will monitor for relie[redacted]
2100	Nursing Note: Pt. A+O, lungs clear. Hyp active BS x 4 quad. Pt. walking ∃ difficulty. IV to (L) arm c̄ NS @ TKO. Pt. remains on IV antibiotics. Well to dry drsg Δ done. ∅ signs of infection. Pt. medicated for Dsg Δ procedure. cap refill < 3 secs x 4 extremities; cold pulses x4. will continue to monitor — [redacted] (b)(6) - 2 All

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

NSN 7540-00-634-4176

HEALTH RECORD | Progress ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~ | 600-10

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
13Aug03	1200 - Pt received from ICU-II via wheelchair. VSS, lungs CTA, HR reg, BS⊕x4, pulses ⊕ & strong to ↑ & ↓ extremities, skin warm to touch, cap refill <3 secs. PERRLA. IV NS KVO to (L) forearm. Ø s/s of infx. Wound to (D) ankle wet-dry dsg DS. Ace wrap CDI. Voiding Ø complaints at this time. Will cont. to monitor (b)(6)-2 [redacted] 24hrs
13Aug03 1350	assumed pt care @ 1300. VSS. lungs CTA, abd soft nontender BS⊕x4. RLE c̄ full ROM⊕ pulses, (D) ankle c̄ ace wrap, dressing CDI, ⊕pulse. BUE c̄ full ROM ⊕ pulse. IV (L)FA infusing 3 diff. (D) complaints voiced @ this time. Will cont to monitor [redacted] 91WMD (b)(6)-2
13Aug03 22:30	Rec'd c/o pt @ 21:00. Restraints x2 (B) wrist/ankle. VS WNL per FS. Awake and alert in bed. Skin W/D/I. PERRLA⊕ WNL. LCA(B) BS⊕ WNL. Abd soft/non-tender. ⊕PP(B). (D)LE bandage C/D/I. c/o pain x1 to LLE → Percocet given. Will cont. to mon [redacted] 2LT/AN (b)(6)-2
14Aug03	NURSING ASSESSMENT: Assumed pt care. AAOx3. Airway intact, breathing even and unlabored LS CTA(B). Abd soft, nontender, ē distention. BS⊕x4. Voids spontaneously. Afebrile and neurovascularly intact to (B)UE and (B)LE. LLE limited ROM to ankle 2° pain but neurovascularly intact. Dsg to (L)calf, Kerlix wrap, CDI. IV to (L)FA ē s/s infection/infiltration [redacted] (b)(6)-2

PATIENT'S IDENTIFICATION (Use this space for Mechanical Print)

EPW

[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

~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

P

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)*
1 Aug 03 1430	Pt care assumed @ 1300. Pt awake et alert VSS lungs CTA to all fields abd soft nontender BS(+) x4. RLE c̄ full ROM strong (+) pulse. LLE c̄ limited ROM (+) pulse. drsng to LLE Kerlix CDI. BUE c̄ full ROM HLO IV site to LFA infusing NS @ KVO c̄ diff. (-) s/sx of infiltration noted. (-) complaints voiced @ this time. Will cont to monitor — [redacted] 91WM6 (b)(6)-2
170530 Aug 03	Nursing Assessment: Assumed pt care. Airway intact, breathing easy, unlabored, LS CTA @ 4/10.3, Abd soft, nontender, BS(+)x4, c̄ distention. Void spontaneously. FROM and neurovascularly intact to all extremities. (-) lower leg has Kerlix dsg that is CDI — Pain to Dorsiflexion limited by pain. IV to (L) FA flushes well c̄ s/s infiltration or infiltration. — [redacted] (b)(6)-2

STANDARD FORM 600 BACK (REV. 5-84)

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

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
8 Aug 03	20 ♂ c̄ c̄ bullet in (L) ankle 5 days ago. Very painful, Hurts to walk on or stand on this leg
	O) Pt has an avulsion injury medial aspect (L) leg ¼ proximal ankle to knee. Injury ~6 cm long X 4 cm wide. Appears to be made by large caliber rifle. Wound is from just anterior to tibia and travels in a medial to lateral direction, ~1.5 cm deep. This travels through medial muscle bellys. X ray – shows soft tissues avulsed & NO periosteal disruption
	A) GSW (L) low leg
	P) Cleaned wound c̄ betadine, scrubbing softly c̄ 4X4 dressings. Anesthesia c̄ Xylocaine 1%, 9cc used. – Area bandaged c̄ folded 4X4 dressing c̄ antibiotic ointment, 2nd 4X4 & covered c̄ Kling dressing. – Keflex 500 mg po QID X 7 days given [redacted] 2LT, SP
	(b)(6)-2
7 Aug 03	Cleaned site w/ sterile H_2O. (+) bloody discharge. (-) smell (+) inflammation (+) redness T 104.2 core temp. Applied wet → dry DSG b/c wound not healing properly w/ above care. Consulted Cpt [redacted]

SPITAL OR MEDICAL FACILITY | STA[redacted] | ART./SERVICE | CORDS MAINTAINED AT

NSOR'S NAME | (b)(6)-2 | SSN/[redacted] b(2)-2 | RELATIONSHIP TO SPONSOR

ENT'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.

Meds: ∅

Allergies: NKA

PMH: ain surgery yrs. ago.

PW

[redacted]

b(a)-4

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

US[redacted]

b(a)-2

gshot wound to

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
9 Aug 03	20 yo ♂
T-103.2	Pt was returned to w/ fever in Tenny.
P-112	Infected wound Lt leg
R-16	Started on PO Keflex but temp 103.2 today
BP-124/78	Tongue moist
SpO2-98%	Pt is alert & well oriented
	Chest clear
	CVS: S1 S2+ RRR
	ABD: Soft Nontender
	(A) Infected wound Lt LE
	(P) keep in holding
	IV fluids + IV antibiotics. b(6)-2
	Dr. [redacted] may
	C&B 100 q 6h Asmag
9 Aug 03 1820	400mg Cipro placed in 400cc LR
1823	1g Tylenol PO
1920	Continued LR IV (Bag #2)
2042	Continued LR IV (Bag #3)
2106	Continued LR IV (Bag #4)
2337	Continued LR IV (Bag #5)
0200	Continued LR IV (Bag #6)
0306	Pt c/o headache - gave 1B 800 mg PO

(b)(6)-2 [redacted]

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
0700	continued LR IV [redacted]
0720 10 Aug 03	Dsg change completed. Wound healing well. Plus or drainage & red streaking noted. Granulation noted. Wound cleansed on outside c̄ Betadine + Wet to dry sterile dsg applied [redacted] (b)(6) - 2
10 Aug 03	Pt Capt [illegible] with VS Apl. [illegible] 1-80 Lungs [illegible] Cost CA Abd - 20W wound - [illegible] injury - opened good healing wet-dry dressing A - granulated wound - so infected P Cont Cipro [illegible] [redacted] b(6) - 2
11 Aug 03	T: 98.4 P: 76 R: 24 B/P: 122/68 Persistent fever - to 103 for the past 5 days On hold at ASOR for 3 days on IV antibiotics Transfer to CASH for evaluation - ? osteomyelitis ? Endocarditis → Dr [redacted] minor b(6) - 2 CO B [redacted] Atrous

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

(b)(2) - 2

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
11 Aug 03 0845	Seen On Aug 8th for GSW Lt ankle 5 days prior to that date
	Temp was 101.7
	Had "Pravin surgery" 4 yrs ago
	X Ray on the 8th showed no significant periosteal elevation or osteolytic fragment removal.
	Her was started on keflex
	Temp spiked to 104.2 on 8th Aug 03 and was sent back to [redacted] (b)(2)-2
	Switched to IV Cipro
	However continuing to spike to 103 daily in spite of antibiotics.
	Has no cardiac murmur.
	Wound looks improved.
(A) PERSISTENT FEBRILE ILLNESS	Since the patient has been in holding at AGMC for >48 Hrs with resumed temp spikes of >103 will transfer to CASH for further workup -
	? osteomyelitis ? Endocarditis ? Unrelated other infection (viral syndrome / malaria).
(P)	- Transfer to CASH.
	- Routine - Ambulatory
	(b)(6)-2 Dr [redacted] MAJ MC

HOSPITAL OR MEDICAL FACILITY

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

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

≥ PW - [redacted]

L [redacted] -

b(a)-4

REGISTER NO.	WARD NO.

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

USAPA V2.00

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11Aug03	0900 Change IV site from (R) Ant. cubital [redacted] area to (L) forearm (b)(6)-2

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

MEDICAL RECORD

DATE	CHRONOLOGICAL RECORD OF MEDICAL CARE — SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
11 Aug 03 1330	Ortho Consult 20 y/o ♂ EPW ~ 8 d s/p GSW (3 Aug) c/o fevers @ EPW camp. transfer here. PM: ? Brain surgery '98 MCL CTPW NKDA PE: T 98.7 P 91 BP 128/76 A: O + III LLE: Distal 1/3 medial LE ~ 10 cm wound granulation thigh out (+) necrotic edges ∅ obvious purulence 2+ DP/PT LTZ ∅ pain ± pitting edema / crepitus comp soft / NT Xr: (-) A: Soft-tissue wound LLE P: I&D, w/ D/C Abx (b)(6)2 [redacted] (MA) [redacted]

6.7 / 40 × 13 / 254

131 | 100 | 5
9.2 | 21 | 0.6 (5)

ESR 79

'AL OR MEDICAL FACILITY			
'R'S NAME	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT OIZ Tito
'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)	SSN/ID NO.	RELATIONSHIP TO SPONSOR (b)(6)2 [redacted]	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

USAPA V2.00

NSN 7540-00-634-4176

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

600-10

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
14 Aug 03 22:32	Rec'd c/o pt @ 21:00. VS WDL. per F.S. Awake and alert. Restraints x 2 (B) wrist/ankle. Skin WD/I. PERRLA (+) ICAB. HPRS, S2. BS (+) x4. ABD soft/non-tender. (+) PPB. Kerlix dsg to LLE C/D/I. (+) ROM to digits and ankle. (+) <3 sec cap refill (+) sensation to (D) digits. Ø c/o pain @ this time. Will cont. to mon [redacted] DTS/AW
15 Aug 03	1200 - pt alert & oriented (b)(6)-2 OOB x 2. VSS, lungs CTA, BS (+), pulses (+) x4. Dsg ∆'d to (L) ankle CDI. (+) ROM. Ø complaints at this time. NS @ TKO into (L) arm → patent. Will cont to monitor [redacted] 2 hour
15 Aug 03 1340	(b)(6)-2 pt. lying in bed awake & alert. VSS. assessment findings WNL. (L) ankle dressing CDI, (+) pulse (+) movement (+) sensation. Ø complaints voiced @ this time. Will cont to monitor [redacted] 9/WMC
15 Aug 03 22:21	(b)(6)-2 Rec'd c/o pt @ 21:00 Restraints x 2 (B) ankle/wrist. VSWD per flowsheet. Lungs (B) insp + exp. wheezing. HPRS, S2. BS (+) x4. (+) PPB. (D) 2F C kerlix dsg applied C/D/I. (+) ROM to (D) foot digits and ankle. <3 sec cap refill (+) sensation. Will cont to mon & c/o pain @ this time. PIV (L) wrist intact and patent. [redacted] DTS/AW
0155	Old PIV (R) F/A leaking @ insertion site. New IV initiated above old IV site. Attempts x 2. Patent, flushed easily. [redacted] DTS/AW

PATIENT'S IDENTIFICATION (Use this space for Mechanical Print)

[redacted] (b)(6)-4

RECORDS MAINTAINED AT:

PATIENT'S NAME (Last, First, Middle initial) [redacted] (b)(6)-2

RELATIONSHIP TO SPONSOR | STATUS | SEX

SPONSOR'S NAME | RANK/GRADE

DEPART./SERVICE | SSN/IDENTIFICATION NO. | ORGANIZATION | 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)*
6 Aug 03	1010 · Pt alert & oriented ODB x1 this Am. VSS, lungs CTA, HR reg, BS⊕, pulses ⊕x4. Dsg Did to ⊕ foot. NS @ TKO into ⊕ forearm. Voicing Ø complaints. Will cont to monitor [redacted] Dea
6 Aug 03 1330	assumed pt care @ 1300. Pt awake et alert. lungs CTA, abd soft, nontender, non distented BS⊕x4. dressing to LLE CDI, LLE c̄ ⊕ movement, ⊕ ~~sensation~~ LO sensation ⊕ pulse. RLE c̄ full ROM ⊕ pulse. BUE c̄ full ROM strong ⊕ pulses. IV to ⊕ FA infusing NS @ TKO 5 diff, ⊕ S/SX of infiltration. ⊕ complaints voiced. Will cont to monitor [redacted] 9/WMC (b)(6)-2
16 Aug 03 22:11	Rec'd c/o pt. @ 21:00. Restraints x 2 ⊕ wrist/Ankle. VS WNL Per flow sheet. Skin W/D. PERRLA⊕ WNL. LCA⊕ BS⊕x4. HRRSS2. ⊕ PP⊕ Kerlix dsg to ⊕ LE C/D/I ⊕ Pedal pulse ⊕ sensation ⊕ <3sec cap refill. ∅ c/o pain @ this time. Will cont. to mon [redacted] 2ND/AN (b)(6)-2
17 Aug 03 1345	pt care assumed @ 1350. pt awake et alert. VSS. assessment findings WNL. LLE c̄ kerlix dressing CDI ⊕ movement, ⊕ sensation, ⊕ pulse. HL to ⊕ FA ⊕ S/SX of infection noted. ⊕ complaints voiced. Will cont to monitor [redacted] 9/WMC (b)(6)-2
17 Aug 03 22:15	Rec'd c/o pt @ 21:00. Restraints x 2 ⊕ wrist/Ankle. VS WNL Per flow sheet. Awake and alert in bed. PERRLA⊕ WNL. LCA⊕ HRR S1S2 WNL. BS⊕x4. ABD soft/non-tender. Kerlix dsg ⊕ LE. ∅ c/o pain @ this time. From Ankle and digits to ⊕ LE. ⊕ sensation ⊕ Pedal pulse ⊕ <3sec cap refill. Will cont to mon [redacted] 2ND/AN. [redacted] (b)(6)-2

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

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
13Aug86 0840	pt A10x3. pupils perla. lungs CTA. S1S2 Auscultated NSR. BS present bilateral. Abdomen soft Not Distended. +3 pulses Hquads. IV D5W/ NS @ KVO. Pt resting. Continue to monitor — [redacted] LPN —
13Aug86 0830	Δ Dressing no SIS infection. pt expressed Δ dressing as painful. Medicated pt c̄ 2 percs. 45 minutes prior and 2mc morphine prior to dressing Δ. — [redacted] LPN
13Aug86 1115	VSS. pt transferred to ICW 2 — [redacted] LPN

(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.)*

EPW # [redacted]

(b)(6)-4

REGISTER NO.	WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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

NSN 7540-00-634-4176

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 Aug 01	(1) (L summary)
1700	20 y/o ♂ s/p I&D at ~ 2 wk
	old soft tissue tissue (L) calf.
	On Dcl 2 1/2 str ⇒ D dressing
	Δ's c̄ good response
	Plan cont dry Δ's until wound
	granulates
	[redacted]
	MAJ [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.

[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)
190330 Aug 03	NURSING NOTE: Assumed pt care. AAO x3. Airway intact, breathing even and unlabored, LS CTA @. Abd soft, nontender, ± distended. BS @ x4. Void. spontaneously. Flow and neurovascularly intact to all extremities. Dsg to @ calf is CDI. Sure Foam intact to @ ankle 2° pain. IV to @ FA flushes well and is ± s/s infiltration or infiltration. [redacted] (b)(6)-2

NSN 7540-01-075-3786

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

STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 11 AUG 03 | TIME: 1055

TRANSPORTATION TO FACILITY: MEDEVAC

DUTY/LOCAL PHONE	
AREA CODE	NUMBER
HOME PHONE	
AREA CODE	NUMBER

M

20

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

ALLERGIES

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

EMERGENCY ROOM VISIT	
DATE LAST VISIT	24 HOUR RETURN ☐ YES ☐ NO
TETANUS	
DATE LAST SHOT: 11 Aug 03	COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: consultation

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☒ NON-URGENT

TIME: 1055

INITIALS: [redacted] b(4)-2

VITAL SIGNS

TIME	1055				
BP	128/76				
PULSE	91				
RESP	16				
TEMP	98.7				
WT					

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

X-RAY ORDERS

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

✓ PULSE OX 95%

ORDERS

☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1150	x-ray left tib/fib	[redacted]			
12:05	MSO4 IV 2g		b(4)-2		
12:05	Td booster IM (R) delt				
12:05	Nafcillin 2g IV				

DISPOSITION: ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

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

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATE

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

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]

EPW (b)(6)-4

NSN 7540-01-075-3786

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

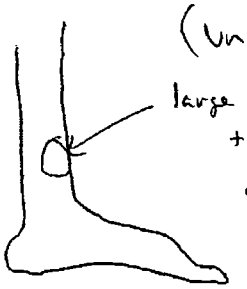
CH-99

TEST RESULTS

6.7 / 13.2/40 / 254	SMAC	131 / 4.2	100 / 21	5 / 105 / 0.6	ABG/PULSE OX		RADIOLOGY — Check if read by radiologist ☐
					SUP 02 / PH / PO2		RESULTS: ESR - 79
					PCO2 / SAT / OTHER		
					U/A: DIP		EKG INTERPRETATION
	BHCG	ETOH	GLU		U/A: MICRO		

PROVIDER HISTORY/PHYSICAL 20y/o EPW s/p GSW to lower left leg from 3 days. Here for evaluation of wound + fevers.

O:



(Unable to ambulate

large defect, oozing, ⊕ dead tissue + granulating tissue + tenderness edges but not grossly warm or fluctuant

Able to dorsiflex foot/ankle ∓ pain + 5/5 strength.

Distal pulses DP/PT - 2+

Head - RRR ∓ ⊖ m/r, ∓ ⊖ rub,

(Able to wiggle toes)

⊖ medial leg

X-ray ⊖ lower leg
↓
⊖ fx
⊖ osteomyelitis

P:
Debride
wet/dry
IV abx
Pain control
Ortho consult.

CONSULT WITH	TIME	ACTION

RESIDENT [redacted] AL STUDENT SIGNATURE AND STAMP (b)(6)-2

PRO[redacted] AND STAMP MAJ/MC FP/Sports Med

DIAGNOSIS

A: GSW ... recurrent fevers...

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

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

9 Aug 03
1815

1. Transfer to holding
2. Dx Infected wound LA leg
3. Condition Fair
4. VS Q 15min Q 2° Q 4-6° Immediate, delay, minimal, expectant
   Per Routine
   Call physician if BP>160/90 < 90/60
   P >120 < 50
   R >25 < 10
5. Activity: ___ Bed Rest X Bathroom Privileges ___ Ambulate TID
   ___ With Assistance
6. Nursing: X Dressing Changes QD or more PRN
   ___ Cold Pack PRN
   ___ ECG PRN for S & S of CV problems
7. Diet: ___ NPO ___ Clear Liquids X Advance diet as tolerated
   ___ Regular diet
8. IV Fluids ___ LR- Wide open until pt. Stable
   ___ LR – TKO
   X LR - @ 500 cc/hr X 2 Hrs then 200 cc [redacted] (b)(6)-2
9. Allergies
10. Pain Control
   ___ Morphine Sulfate
   ___ a. 10 mg IV/IM/SQ of 2-4° PRN pain
   ___ b. or follow bolus by infusion of 0.05-0.1 mg/kg/hr
   ___ c. or 10-30 mg PO q 4° PRN pain
   ___ Tylenol 3 1-2 tabs PO q 4-6° PRN pain
   ___ Ibuprofen 800 mg TID PRN pain/fever
   X Tylenol 325 – 650 mg Q 4-6° PRN pain/fever
11. Ship Out: ___ Immediate
   Hold: ___ Till further notice ___ on next available transport
   ___ for ___ hours monitor vital signs
12. Meds
   • Ciprofloxacin 400mg IV BID

13. Labs /X-Ray

14. PRN Meds:
   a. Benadryl 30 mg Q 4-6° PRN insomnia
   b. MOM or Mylanta PRN for GI
   c. O_2 2 liters per mask for S & S of respiratory difficulty

[redacted] b(6)-4

Dr. [redacted] (b)(6)-2
CoR [redacted]

(b)(2)(2)

b(6)-2 [redacted]

CLINICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
8-10-03		1200	500 cc fluid infused. Another 500 cc hours [redacted]
		1430	Pt urinating well per ~~the~~ urinal. [redacted]
			(b)(6)-2

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

Continue on reverse side

REGISTER NO.

WARD NO.

[redacted]

b(6)-2

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

AUTHORIZED FOR LOCAL REPRODUCTION

CONSULTATION SHEET

REQUEST

TO: [redacted]

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

DATE OF REQUEST 11 Aug 03

REASON FOR REQUEST (Complaints and findings) Persist and febrile illness

PROVISIONAL DIAGNOSIS Rlo osteomyelitis vs Endocarditis vs malaria

DOCTOR'S SIGNATURE [redacted] Maj MC

APPROVED

PLACE OF CONSULTATION ☐ BEDSIDE ☐ ON CALL

☐ ROUTINE ☐ 72 HOURS ☐ TODAY ☐ EMERGENCY

RECORD REVIEWED ☐ YES ☐ NO (b)(6)-2 all

CONSULTATION REPORT

PATIENT EXAMINED ☐ YES ☐ NO

TELEMEDICINE ☐ YES ☐ NO

TURE AND TITLE

(Continue on reverse side)

AL OR MEDICAL FACILITY

RECORDS MAINTAINED AT

DATE

ON TO SPONSOR

SPONSOR'S NAME (Last, first, middle)

DEPARTMENT/SERVICE OF PATIENT

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

SPONSOR'S ID NUMBER (SSN or Other)

REGISTER NO.

WARD NO.

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

.19

MEDICAL RECORD

VITAL SIGNS RECORD

NSN 7540-00-634-412

HOSPITAL DAY

POST-

DAY

MONTH-YEAR

19

DAY 13 14 15 16 17 18 19

HOUR

PULSE (O)

TEMP. F (•)

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

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

TEMP. C

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

EPW

[redacted]

(b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY																	
POST-OP DAY																	
MONTH-YEAR	DAY	9AUG03		10AUG03		10Aug03											
19	HOUR	2000		0700	1330	1700	2130	2330									
PULSE (O)	TEMP. F (●)																
180	105°																
170	104°																
160	103°																
150	102°																
140	101°																
130	100°																
120	99°																
110	98.6°																
100	98°																
90	97°																
80	96°																
70	95°																
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		110/72		110/68													
HEIGHT:	WEIGHT→																
SPO2		97		98													

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)-2

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

Ward/Section:

REQUESTING PHYSICIAN:

LAST, FIRST, MI.

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

DATE | TIME | SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52% 37-47%	
Sed Rate	79		
Other			

Coagulation Studies

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

i-STAT CREA

Pt: [redacted] ← (b)(6)-4

Pt Name:_____

Crea_____0.7 mg/dL

Sample Type_:

11AUG03 11:46

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

i-STAT 6+

Pt: [redacted] -> Pt:

Pt Name:_____

Glu_____102 mg/dL
BUN_____5 mg/dL
Na_____136 mmol/L
K_____3.9 mmol/L
Cl_____106 mmol/L
Hct_____39 %PCV
Hb*_____13 g/dL
*via Hct

Sample Type_:

11AUG03 11:47

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

REMARKS:

REPORTED BY: [redacted] **DATE:** 11Aug03 **LAB II**

(b)(6)-2

SW

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted] (b)(6)-2		CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. EPW #[redacted] (b)(6)-4	DATE 11AUG03	TIME 1100	SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl

======= PICCOLO =======
11/08/03 11:47
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOI #: (b)(6)-2 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted] (b)(6)-4

GLU	105	73-118	MG/DL
BUN	5*	7-22	MG/DL
CRE	0.6	0.6-1.2	MG/DL
CK	99	39-380	U/L
NA+	131	128-145	MMOL/L
K+	4.2	3.3-4.7	MMOL/L
CL-	100	98-108	MMOL/L
tCO2	21	18-33	MMOL/L

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

REMARKS:

REPORTED BY: [redacted] (b)(6)-2	DATE: 11Aug03	LAB ID NO.:

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER / HOURS	LIST TIME ORDER NOTED AND SIGN
Admit	ICU #2	
DX	SOB - Rule out	(C)
Vital	routine	
Activity	BR	
Diet	regular	
IVF	KVO	
meds	Ancef 1 g IV q 6	11Aug03 [redacted]
	Gent 100 mg IV q 6	1440
	Tylenol 650 mg PO q 6	PRN
	Percocet 1-2 PO q 4	PRN
	IV → D B2D 4 + 4 s in	
	1/2 strength Dakins Solution	
	[redacted]	[redacted] (b)(6)-2

PATIENT IDENTIFICATION

EPW [redacted]

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER / HOURS	
11Aug03	1445	
(1) INF NS @ KVO		
WO Dr [redacted]		
DAILY 0800 MSO4 2 mg IV for ds		(b)(6)-2
[redacted] 12Aug03	[redacted]	(b)(6)-2

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER / HOURS	
12AUG03	2000	
GIVE 4mg IVP		
MSO4 now		[redacted]
		[redacted]
		2000
		DAILY
24 / done	[redacted]	

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHI[redacted]

(b)(6)-2

U.S. GOVERNMENT PRINTING OFFICE: 1996—409-924

"USE BALL POINT PEN—PRESS FIRMLY. NO CARBON PAPER REQUIRED"

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-68; the proponent agency is OTSG

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

PATIENT IDENTIFICATION

b(6)-4

EPW [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 12 AUG | TIME OF ORDER: 2205 | HOURS | LIST TIME ORDER NOTED AND SIGN

Darkness Wing po QHS prn

[redacted]

b(6)-2

Noted CPT [redacted] 2205 12 AUG

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 13 Aug 03 | TIME OF ORDER: 0945 | HOURS

Transfer IW 2 c/o [redacted]

13 Aug 03 1145 [redacted]

Results on all prior [redacted]

24°/Cont [redacted] b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 16 Aug 03 | 1425 | HOURS

V.O.

HL IV Fluids

Dr [redacted] 9/wm6 [redacted]

b(6)-2

9/wm6 16 Aug 03 1426

PATIENT IDENTIFICATION

b(6)-4

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 17 Aug 03 | TIME OF ORDER: 1300 | HOURS

- D/C p EPW Camp

- B2D w → D D5 Δ

- Ceftriax 500 mg po Q2D

- Flu c 20 mg po 10-14 d

noted [redacted] 9/wm6 17 Aug 03 1517

24°/Cont [redacted]

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH [redacted]

U.S. GOVERNMENT PRINTING OFFICE: 1986—403-924

"USE BALL POINT PEN—PRESS FIRMLY. NO CARBON PAPER REQUIRED"

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 11	12	13	14	15	16	17	18
11 Aug 03	[redacted]	IVF: NS @ KVO & HL	05	[redacted]							
			11								
11 Aug	[redacted]	Ancef 1 gm IV q 6°	06								
			12								
			18								
			24								
11 Aug	[redacted]	Gentamycin 100mg IV q 6°	04								
			10								
			16								
			22								
17 Aug	[redacted]	Keflex 500mg po QID	04							[redacted]	
			10								
			16						[redacted]		
			22						[redacted]		

DC'd 17 Aug 03

DC'd 17 Aug 03

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Soft Tissue wound (L) lower leg

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(4)-2 A11

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo._____ Yr._____
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
[redacted]	[redacted]	MSO 4mg & NW Ambien 10mg po qHS		[redacted]		

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
11Aug	[redacted]	Tylenol 650mg PO	17A 650mg po 0935 CS													
		q6° prn														
11Aug	[redacted]	Percocet 1-2 PO q4°	11AUG 1900 [redacted]	11 AUG 2300 [redacted]	12Aug 0700 [redacted]	12Aug 1635 [redacted]	12 Aug 2335 [redacted]	13Aug 0700 [redacted]	13Aug 0938 PO	14Aug 1935 [redacted]						
		prn	[redacted]			[redacted]										
12Aug	[redacted]	MSO 4 2mg IV for DCED Ing Chelsea	0830 12Aug 2mg	0900 2mg	2mg 8/14											
12Aug	[redacted]	Ambien 10mg PO qHS prn	12Aug 2010 [redacted]		IV 1015 [redacted]											
			10mg PO [redacted]													

USAPA V1.00

b(a) -2 b(a) -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 13	14	15	16	17	18
13 Aug	[redacted]	Vitals: routine	05	✓	[redacted]				
			13	[redacted]					
			21	[redacted]					
13 Aug	[redacted]	Act: BR	05	✓	[redacted]				
			13	[redacted]					
			21	[redacted]					
13 Aug	[redacted]	Diet: Regular	06	✓	[redacted]				
			12	[redacted]					
			17	[redacted]					
13 Aug	[redacted]	W→D dsg BIO 4*4 in 1/2 Strength Dakins solution	08	✓	[redacted]				
			20	[redacted]					

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Soft tissue wound (L) LE

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

GW [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 4677, 1 OCT 78

EDITION OF 1 DEC 77 MAY BE USED.

USAPA V1.00

b(4)-2

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
17Aug [redacted]		D/C to EPW camp	28 Aug - 07 Sept			
17Aug [redacted]		F/U c̄ 28th 10-19 days				
	.....					
	.....					
	.....					
	.....					
	.....					
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	.....					
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	.....					
	.....					
	.....					

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

Mo. 8 Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 11	12	13
11 Aug	[redacted]	Vitals - routine	05	[redacted]		
			17			
11 Aug	[redacted]	Activity: BR	05			
			17			
11 Aug	[redacted]	Diet: Regular	06			
			11			
			17			
11 Aug	[redacted]	W→D drsg BID	05			
		4*4 in 1/2 strength	17			
		Dakins solution				

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Soft Tissue wound (L) lower leg

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

[redacted]

2nd PRIORITY **MODERATE** [redacted]

[redacted]

DECEASED [redacted]

Mass Casualty Incident Tag
©Eastern PA EMS Council - 1997

(A) (P)

TIME	1310		
AGE	20	SEX	M
LUNGS	clear		
PULSE	92		
RESP.	~~[illegible]~~ 96		
B.P.	120/72		
A	V	P	U

Patient Name (if known)
L14145

Notes/Treatment IRAQI has GSW (L) Lower Leg for 5 days

To be given to:
TRANSPORTATION OFFICER

TAG# [redacted]

Priority #		**2**		**D**
Primary Injury/Illness				
E.M.S. Unit				
Depart Time				
Hospital				

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

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19 20 21 22 23 24 25 26: Z Z Z Z Z Z Z Z	27 28 29: 2 0 Y	30: X	31: 9	UNK

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—	46: Z	1200	—

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49: —	50 51 52: K 7 8	53 54 55 56 57 58 59 60 61: —

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
62 63: —	64 65 66 67 68 69 70: —	71: 1	YEAR: ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: 0 b(2)-2	ICU2	UNK

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

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
73 74: 5 0	75 76 77 78 79 80:	81 82 83 84 85 86: 0 3 0 8 1 7

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
87 88 89 90: A B A A	91 92 93 94 95 96:	97 98 99 100 101 102: 0 3 0 8 1 1

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

FOR LOCAL USE

GSW - Soft tissue ① LE

TI	DX	PROC
1 450	8910	8604
	E9912	

b(2)-2 [redacted]

ADMITTING OFFICER (Signature as required)	SIGNATURE OF CLERK
[redacted]	[redacted]

DA FORM 3985 MAR 89

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(6)-4				3. GRADE EPW	ADMISSION REMARKS
4. SEX M / AGE 29	6. RACE UNK	7. RELIGION UNK	8. LENGTH OF SVC —	9. ETS —	10. PREVIOUS ADMISSION N	
11. FMC 20 / 99	12. SSN [redacted]		13. ORGANIZATION —		14. WARD ICU3	
15. FLYING STATUS —	16. RATING/DSG —	17. DEPT./BEN K78	18. BRANCH/CORPS —	19. UIC/ZIP —	20. TYPE CASE NBI	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: direct from ER			22. HOURS OF ADMISSION	23. CLINIC SERVICE AEAA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: UNK			25. TYPE DISPOSITION A 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 11 Aug 03		ADMITTING OFFICER
29. NAME [redacted] b(2)-2				30. DATE OF INITIAL ADMISSION		32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

31. SELECTED [redacted]

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Cellulitis Dx: 891.1, 682.6, 995.90, E995

Px: 88.27 (x2), 99.21, 77.17

Trauma: 9

Inj: 649

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	8	8

36. Total Days All Facilites

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

SIGNATURE OF ATTENDIN[redacted] b(6)-2 [redacted] RDS OFFICER

DA FORM 36 [redacted] JSAPPC V1.10

9 Aug 03
15 25

1. Transfer to holding
2. Dx Cellulitis
3. Condition Fair \Immediate, delay, minimal, expectant
4. VS Q 15min Q 2° Q 4-6°
   Per Routine
   Call physician if BP >160/90 < 90/60
   P >120 < 50
   R >25 < 10
5. Activity: ___ Bed Rest X Bathroom Privileges ___ Ambulate TID
   ___ With Assistance
6. Nursing:
   ___ Dressing Changes QD or more PRN
   ___ Cold Pack PRN
   ___ ECG PRN for S & S of CV problems
7. Diet: ___ NPO ___ Clear Liquids X Advance diet as tolerated
   ___ Regular diet
8. IV Fluids ___ LR- Wide open until pt. Stable
   ___ LR – TKO
   0.9% OR LR - @ 500 cc/hr x 2 hrs then 200 cc/hr
9. Allergies
10. Pain Control Acetaminophen + Oxycodone 2 po now
    ___ Morphine Sulfate
    ___ a. 10 mg IV/IM/SQ of 2-4° PRN pain
    ___ b. or follow bolus by infusion of 0.05-0.1 mg/kg/hr
    ___ c. or 10-30 mg PO q 4° PRN pain
    ___ Tylenol 3 1-2 tabs PO q 4-6° PRN pain
    X Ibuprofen 800 mg TID PRN pain/fever
    ___ Tylenol 325 – 650 mg Q 4-6° PRN pain/fever
11. Ship Out: ___ Immediate ___ on next available transport
    Hold: ___ Till further notice ___ for ___ hours monitor vital signs
12. Meds
    - Roceptin 1gm IVPB qd starting 10/8/03

13. Labs /X-Ray WBC
    X-Ray Lt leg (Tibia / Fibula)

14. PRN Meds:
    a. Benadryl 30 mg Q 4-6° PRN insomnia
    b. MOM or Mylanta PRN for GI
    c. O_2 2 liters per mask for S & S of respiratory difficulty

b(6)-2

Dr [redacted]

[redacted] b(6)-4

EPW

[redacted] b(2)-2

b(2)-2

b(6)-2

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

TIME: 1530 SIGN [redacted]

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature warm to touch 102.7

Color: Pale / Cyanotic / Jaundiced appropriate for race

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc: Alert / Lethargic / Unresponsive non compliant

Oriented / Disoriented Pupils: 3mm brisk perrla

Extremity Movement: Full / Limited / None (R) LE d/t pain

CARDIOVASCULAR

Pulse (0 - 4): +2 Radials +2 --- Pedals +2

Capillary Refill <3 Edema (R) LE Homan's Sign ∅

Jugular Venous Distension ∅ Edema

Heart Sounds S1 S2

Rhythm NSR-ST PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			[redacted]	
Site			Dorsal	
Saline			LR KVO	

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical even and labored

Respiration / No Dyspnea / SOB / Labored / Use of Access. Muscles

Breathing Patterns: even and labored

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor ∅

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes --- Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior Location	Posterior Location
Crackles		
Wheezes	CTA	B
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings:

NG Tube: Clamped/Intermittent Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate:

Stool: Character ∅

Drains:

GENITOURINARY

Urine Color: clear straw/amber sediment

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

TIME: 0 SIGNATURE: [redacted] b(6)-2

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature WDCM

Color: Pale / Cyanotic / Jaundiced AFR

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc: Alert / Lethargic / Unresponsive A+O x3

Oriented / Disoriented Pupils: 3mm

Extremity Movement: Full / Limited / None (R) LE

CARDIOVASCULAR

Pulse (0 - 4): +2 Radials +2 Pedals +2

Capillary Refill: <3s Seconds +2 RLE Homan's Sign

Jugular Venous Distension Edema

Heart Sounds S1 S2

Rhythm NSR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			[redacted]	
Site			L Wrist	
Saline			LR KVO	

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Dyspnea / SOB / Labored / Use of Access. Muscles

Breathing Patterns: Unlabored

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor ∅

Chest Drainage System Gravity: Suction cm:

Air Leak NO Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior Location	Posterior Location
Crackles		
Wheezes	CTA	B
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings:

NG Tube: Clamped/Intermittent Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character ∅

Drains:

GENITOURINARY

Urine Color: Clear Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

EPW [redacted] b(6)-4

ICU Flowsheet **Patient Name:** **Date:** 8 / 4 / 2003

Vitital Signs	24	01	02	03	04	05	06	07	08	09	10	11		12	13	14	15	16	17	18	19	20	21	22	23	
Temperature															~~102.7~~		102.7		102.9					98.6		
Pulse															~~113~~		113			84				77		
B/P² A-Line																										
MAP																										
B/P² Cuff															~~89/76~~		137/76							135/60		
Respirations															~~26~~		26									
SaO2															~~99~~		99							16		
mode															~~84~~		99			100				168		
Intake	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
IVF:																										
PO Intake															~~60~~		60	100				100				
O.RR. IN																										
Totals																										
Output	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
Urine Hourly															~~[illegible]~~		~~[illegible]~~ 925			~~[illegible]~~ 1400		~~[illegible]~~ 2050		~~[illegible]~~	~~[illegible]~~	
NG Tube																								2700	3600	
Drains #1																										
#2																										
#3																										
Emesis																										
Stool																										
O.RR. OUT																										
Totals																										

24 hour input	
24 hour output	
24 hour balance	

MEDCOM - 16403

C&B [redacted] b(2)-2

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9 Aug 03	24 yo ♂ in mild distress due to stab around to bil legs. Ø N/V or abd cramps
Oral - 103.6	
Rectal - 104.4	erythema, swelling, and drainage on ⓛ leg. ⓡ leg tender ⊕ swelling. Scabs cover both wounds. febrile @ 104.4 rectal Lungs CTA Heart RRR ABD soft NT ND Ø organomegaly.
	1500 1g tylenol PO Lab: WBC ↑ @
	1503 1g Rocephin IV 14,400
	A: 1) Sepsis
	2) Infected wounds - cellulitis
	P: IV Rocephin q 8°
	Patient held
	[redacted] HLT SP b(w)-2
1600	500 ml LR (Bag #2) [redacted]
1642	500 ml LR (Bag #3) [redacted]
1941	500 ML LR (BAG #4) [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	MAINTAINED AT
2000 ARS 1000ML LR	(Bag #5)		
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	
0530 ML LR	Bag #6		

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(w)-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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2000	Pt c/o of slight headache - rec VALIUM. OK per Dr [redacted] 5mg VALIUM PO. b(6)-2
2227	Continued LR IV 500ml — [redacted]
0500	Pt c/o headache - temp taken = 104.2°. 800 mg IBP Given
0615	Cleaned wounds on both shins, changed dressings.
10 Apr 03	[illegible]
	S. T- 102 [illegible] P- 80 R-18
WBC.	14,400 [illegible]
	A - [illegible]
	P - [illegible]
	[redacted] b(6)-7

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

CLINICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M	HOUR P.M	OBSERVATIONS Include medication and treatment when indicated
			b(w)-2
8-10-03	0930		Dr's [redacted] in to examine pt. Wounds cleansed on bilat lower legs. Wound on (R) leg dressed c̄ Kerlex and Telfa. Pulses palpable bilat. +1 edema noted in (R) lower leg. (R) leg tender to touch on all of lower leg. (R) leg tender around area of wound. [redacted]
	1330	1330	500cc fluid infused. Another 500cc hung. Pt c/o pain in (R) leg + requests Valium. Dr [redacted] informed. He states to use Motrin for pain + release Valium. b(w)-2 [redacted]
		1430	Pt urinating well still c/o heat + some dizziness [redacted]
		1800	Changed IV Bag 500ml LR [redacted] 60pc b(w)-2

Continue on reverse side

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

b(w)-4 [redacted]

[redacted] b(2)-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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19 Aug 03 0900.	Was admitted on 9 Aug 03 for cellulitis Rt Leg — Had sted swell to both legs
	Temp 103 at that time. (Rectal 104°)
	WBC 14,400
	Was started on IV Rocephin
	Rt leg still quite painful & swollen
	Temp somewhat 101 daily despite of
	IV Rocephin + Motrin + Tylenol.
	Has been in Acute for 5 4 days.
	Transfer to CASH for further evaluation & recommendation
	Routine Ambulatory
	for [redacted] may be b(4)-4 [redacted] b(2)-2

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

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* [redacted] b(2)-2

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8-11-03/1500	Assumed pt care from LT. At time of pt VSS ~~x~~ temp 100.7 → Given tylenol, Pt in no apparent distress @ time of sign, CR infusing @ KVO, @ this Pt verbalized pain @ rated 2 percocet PO denies N/V @ this time, Pt currently resting quietly in bed. will cont to monitor [redacted] CTRN
8-11-03/1800	Rpt recieved, physical assessment completed, Pt c/o pain but recieved pain med 3hrs ago will continue to monitor, Pt set up c̄ food. [redacted] CPT/AN
8-12-03/0300	Pt c/o leg pain Percocet II PO given, Pt voided 350 clear yellow urine [redacted] CPT/AN b(w)-2
8-12-03/0500	Pt c/o Headache Tylenol 650 mg Given CPT/AN
8-12/0630	Assumed pt care from LT Frazier. Pt resting comfortably in bed @ in no apparent distress, LR @ KVO [redacted]
8-12/0700	N a/o cooperative, appropriate c̄ staff Jaundice perrla, bright. Moves all extremity, hesitent in moving (R) LE d/t pain. CV NSR S edema, S1 S2 +2 radial & pedal pulses bilat. (R) LE red & warm to touch +2 edema, cap refill <3secs bilat UE & LEs. Resp even & unlabored breathing, CTA (B), denies SOB, Spo2 98-99% on RA, ∅ cough GI hypo BS, denies N/V/D. abdomen soft/ ~~distended~~ nontender GU clear straw colored urine uses urinal @ bedside cont. . . .

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(w)-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

b(4)-2A11

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
8.12/0100	cont.... Lungs (C) auscs PIV patent ¢/D/I, no other issues
	@ this time [redacted]
8.12/0800	VS, 98.5F° Spo2 100%, on RA RR 16 HR 76 BP 129/68 [redacted]
1048	Output @ 0930 - 800cc; Output for 1040 - 850 cc.
	intake 240cc. Ø complaints voiced. Will monitor.
	[redacted]
8.12/1400	u/o 700cc intake 900cc [redacted] KTRN
8.12/1600	u/o 950 cc intake 1100 cc [redacted] KTRN
8.12/1630	Dressing change done, pt premedicated c̄ 2 percocet, iodoform
	packed in (R) LE & reinforced c̄ gauze dressing & ace wrap
	pt tolerated procedure well, pt remains [redacted] 99% @ 1600
	will cont to monitor [redacted] KTRN
12 Aug 03	Received report from ongoing shift. Pt in bed awake &
1800	any complaints. IV LR @ tko (L) forearm. (R) LE dressing
T 99.6	wrapped c̄ ace wrap. Pulses palpable, (R) foot slightly swollen.
1900	Medicated c̄ Percocet II tabs p.o. for c/o pain.
(OW) V: 800	dressing changed to the (R) LE & small cut on the (L) leg
	c̄ iodoform gauze [redacted] /AN
2130	Up to have a bedbath, changed clothing. Had a
(OW) V: 800	snack milk + chips. Medicated for pain. Pt. back
	in bed to rest. T 99.2, VSS [redacted] Mg/BN
[redacted]2400	Up to void @ bedside. Pain controlled from Percocet
no V: 800	earlier. (R) LE ↑ on a pillow [redacted] Mg/BN
0130	c/o being hot. Took T 97.5, pt was covered
	c̄ wool blanket including the face. Vent closed
	earlier per pt request. Gave cold water.
0300	VS 97.6 - 59 - 20 - 122/62, pt up want snack + milk.
	Otherwise no other complaints [redacted] Mg/BN

STANDARD FORM 600 (REV. 6-97) BACK

USAPA V2.00

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)*
11 Aug 03	Ortho Consult
1430	24 y/o ♂ EPW c̄ reports of "stab wounds"
	BLE ? time ago, now c̄ cellulitis
	RLE & T up to 104. c̄ other c/o.
	∅ pm/PS/neu/LN Rocephin IV
	(PE) 99.1 92 128/62
14	A · O × ⅢⅢ NAD
14.0 377 43	LLE post. cut fib ~ ¼ cm superficial
	wound, sm. amount pus c̄ ∅ local
	extension ∅ erythema ∅ TTP ∅ pain
139/108/5 97	NVI throughout
3.9 441 1.0	RLE erythema med-calf → ankle
	area ~ 5 cm in center, fluctuant
ESR 81	compartments soft NT, NVI throughout
	∅ pain ankle/knee ROM
	(XR) (−)
	(A) cellulitis & soft-tissue abscess
	(P) 2 c̄ D, Dsg Δs, Abx
	b(6)-2 [redacted] MAJ [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERV[redacted]	RECORDS[redacted]
		Ortho	
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	[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. b(2)-2 WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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

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)*
19 Apr 03	DC Summary
	24 yo ♂ admitted 11 Apr for cellulitis & RUE soft tissue abscess. Abscess I&D, placed on IV Abx & dsg Δs. Responded well & Δ to po Abx & cont good result
	Plan BID w → D Dsg Δ until wounds granulated
	Cipro BID 500 mg until wounds healed
	[redacted]
	MAJ [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.

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

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Patient)*	NUMBER [redacted] b(2)-2 RECORDS MAIN [redacted]

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS: EPW # [redacted] b(6)-4

CITY | STATE | ZIP CODE

SEX: M

AGE

DUTY/LOCAL PHONE	
AREA CODE	NUMBER
HOME PHONE	
AREA CODE	NUMBER

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

ARRIVAL

DATE *(Day, Month, Year)*: 11 AUG 03 | TIME: 1055

TRANSPORTATION TO FACILITY: MEDEVAC

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

CURRENT MEDICATIONS

ALLERGIES

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

EMERGENCY ROOM VISIT	
DATE LAST VISIT	24 HOUR RETURN ☐ YES ☐ NO
TETANUS	
DATE LAST SHOT	COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: Cellulitis (R) leg

CATEGORY OF TREATMENT

☐ EMERGENT
☐ URGENT
☒ NON-URGENT

TIME: 1059

INITIALS: [redacted]

VITAL SIGNS

TIME	1057	1550			
BP	128/62				
PULSE	92				
RESP	18	20			
TEMP	99.5	102.1			
WT					

LAB ORDERS

X	CBC/DIFF	ABG	PT/PTT
	URINE C&S	UA MSCC/CATH	
	BLOOD C&S X	X	

BHCG/URINE/BLOOD/QUANT
X CHEM: MET B
SED RATE ESR

X-RAY ORDERS

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

b(6)-3

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	COMPLETED BY	TIME	PATIENT'S RESPONSE
1200	Nebulizer for IV	[redacted]		
11:45	Tylenol Breath			
1200	Mag for IV			
1459	3 Tylenol			

DISPOSITION: ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

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

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATE

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

[redacted] b(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

NSN 7540-01-075-3786

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

TEST RESULTS

WBC 14	SMAC	139 / 108 / 5.7	ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
H/H 12.7/43		3.9 / 44 / 1.0	SUP 02	PH	PO2	RESULTS ESR: 87	
PLT 577			PCO2	SAT	OTHER		
			U/A DIP			EKG INTERPRETATION	
	BHCG	ETOH / GLU	MICRO				

PROVIDER HISTORY/PHYSICAL

S: 24 yo ♂ c̄ recent stab wounds bilat lower legs. Developed cellulitis & not improving. Also spiking fevers. Sent to R/o deep soft tissue infection vs. osteomyelitis

O: afebrile, non-toxic

(L) ant. proximal shin c̄ 2 cm rim draining wound. ⊖ fluctuance ⊖ tibial tenderness.

(R) lower leg diffuse c̄ ↑ warmth, redness, fluctuant bead of tissue just proximal to ankle ⊖ pain c̄ stretch (passive) of ant. tendons.

X-rays:

(L) tibia - ⊖ fx ⊖ osteo

(R) LE - ⊖ fx ⊖ osteo.

P: Nafcillin 2 gm IV now
Tetanus booster
MSSA 2 mg

CONSULT WITH	TIME	ACTION	RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP
			[redacted] b(6)-2

DIAGNOSIS

A: cellulitis (R) LE ... possible osteomyelitis.

CODES b(2)-2

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

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

[redacted] b(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13 Aug 03 0320	Up awake c/o pain. Medicated c̄ Percocet 2T p.o. @ this time. T97.6 VSS. [redacted] b(6)-7
0500	Slows pain when awaken VS: 120/61-61-20-97.4.
13 Aug 03 0830	Received report on pt around 0615. Pt resting in bed c̄ HOB ↑. No complaints. Pt ate 100% of breakfast independently. See DA Form 4700 for assessment data. Pt stood @ bedside for moment. Stable on feet. No c/o pain c̄ standing. IV abx given. Infusing S. saline. Pt cooperative. Dressings in place. [redacted]
13 Aug 2003 @ 1015	Pt given 2T percocet @ 0900 for premedication ā dressing Δ. Dressing Δ to RLE & LLE. RLE wound iodoform packing c̄ 4x4 & ace wrap. LLE iodoform on wound c̄ 4x4 & ace wrap. Slightly painful during dressing Δ. Pt tolerated well. [redacted]
13 Aug 2003 @ 1115	Pt c/o HA. Only been 2° since last pain meds. Layed pt's head back to help get some sleep. [redacted]
13 Aug 2003 @ 1300	Pt. fell asleep for approx an hour. Pt now sitting up in bed eating lunch. Pt will stand @ bedside to urinate. [redacted]
~~13 Aug 2003 @ 161~~	
13 Aug 2003 @ 1615	Pt slept for a while. Had a snack. Has been talking to pt next to him. No change in condition. [redacted]
13 Aug 2003 @ 1800	Pt did well through shift. C/O pain in head & RLE x 2. Pain

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

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

EPW [redacted]

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

b(6)-2 A 11

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
cont.	relieved by meds. Pt sitting in bed eating dinner. No Δ throughout shift. b(6)-2 [redacted] AN
8-14/0630	Assumed pt care from LT Frazier. Pt resting quietly in bed in no apparent distress. LR infusing @ KVO. Pt voided 625cc @ 0600. Pt ate 75% of breakfast. b(6)-2 [redacted] LT RN
14 AUG 0600 LATE ENTRY	Patient slept throughout night ∅ complaint. Awoke c̄ pain at 0530, given Percocet 2 tabs @ 0545, will monitor pain to (R) leg. Patient resting in bed c̄ HOB↑. Report given to RN. b(6)-2 [redacted] LT/AN
8-14/1500	Dressing Δ done to (R) LE, redness & swelling continue to decrease. Scant wound c̄ serosanguinous drainage. Pt premedicated c̄ 2 Percocet, pt tolerated dressing well. [redacted] RN
1830.	Report received from LT [redacted]. Pt resting in bed quietly. b(6)-2 [redacted]
1950.	Drsg Δ'd to (B) cellulitis wounds. Wounds appear red. Packed c̄ iodoform gauze and rewrapped c̄ ace wrap. [redacted]
2240	Percocet 2 tab PO given for pt c/o pain.
0200.	Pt resting in bed c̄ eyes closed. [redacted]
0330.	Pt c/o pain to (R) LE. Percocet 2 tabs PO given. [redacted]
8-15/0600	Assumed pt care from LT [redacted] resting quietly in ∅ no apparent distress. b(6)-2 [redacted] LT RN
8-15/1400	Dressing change to bilat LE wounds. (R) LE wound red & slightly swollen, scant purulent drainage noted rest of wound beefy red & bled easily. Removed iodoform packing removed. (L) LE bled slightly when iodoform removed no purulent drainage, redness or swelling noted. Both wounds packed c̄ iodoform & covered c̄ 4x4 & ace wrap. Pt tolerated dressing change well. [redacted] LT RN

STANDARD FORM 600 (REV. 6-97) BACK

USAPA V2.00

b(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE** b(6)-2 All

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
15 Aug 03 1500	Pt resting quietly in bed throughout night c̄ complaints. Pt denied any pain other than during dressings. Pt at risk of lung decics N/V/D. Ambulated to dirty utility room w/ c̄ assist. No other issues noted — [redacted]
15 Aug 03 @ 1835	pt report recieved from Lt [redacted] pt in bed c̄ complaints @ this time will continue to monitor — [redacted]
@0800	pt resting quietly in bed @ this time pt c/o of pain early medicated w/ percocet No problems since will continue to monitor — [redacted]
16 Aug 03 0000	Received report from previous shift. Pt resting c̄ eyes closed. Ø needs expressed @ this time. Drsgs D+I. — [redacted]
Ø730	Pt ate ≈ 40% breakfast. Ø% pain/discomfort. UO 575cc. Will cont. care. — [redacted]
Ø845	Premedicated pt c̄ percocet II tabs for drsg Δ. Will cont. care — [redacted]
Ø910	Completed drsg Δ. Dried blood and serous fluid noted. Wet to dry drsg c̄ iodoform done to open wound on BLE. Pt tol well. Used spandag to hold drsgs in place. Will cont. care. [redacted]
1240	Pt sitting in bed reading magazine. Ø% pain @ this time. Will cont. care. — [redacted]
1540	Δ'd drsg IV (L) wrist. LR infusing @ 30cc/h [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS

SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR

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

CPW [redacted] b(6)-4

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

USAPA V2.00

b(6)-2 A11

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
14 Aug 03 1435	Pt c/o pain (L) LE. Gave percocet ii tabs IAW cont to assess pain level. — [redacted]
1830	Report recieved from SPC [redacted]. Pt VSS no changes in condition — [redacted]
2145	pt awake VSS, afebrile — [redacted]
2400	Drsg Δ done @ this time — [redacted]
15 Aug 03 0027	Received report from SPC [redacted] Pt. sitting in bed s distress. Consumed 100% of breakfast. IV access to (R) AC s redden or swelling noted to site. Bandage noted to (R) leg s drainage noted @ present time + pulse to feet & radial. -o complaints voiced @ present time. VS; B/P 130/64 RR 12 HR 72 Temp 96.3 SpO2 98% on RA. Will continue to monitor for [redacted] distress.
0850	DBG Δ completed @ present time. [redacted] tab ii PO for c/o pain. Will cont[redacted] monitor.
1034	Resting in bed c eyes closed. -o complaints voiced. -o distress noted. Will cont[redacted] monitor.
1322	Resting c eyes closed Ø distress noted [redacted] will monitor.
1412	c/o pain. [redacted] tab ii p.o. given for [redacted]
1621	Resting in bed c eyes opened. Ø complaints voiced. Will cont. to monitor.

STANDARD FORM 600 (REV. 6-92) BACK

USAPA V2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE** b(6)-2 A11

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 Aug 03 @ 1920	pt report recieved @ 1900 from Sgt [redacted] pt sitting quietly in bed ~ c/o problems no acute signs of distress noted @ present will continue to monitor throughout night — [redacted]
@2000	VSS → HR- 90 BP- 138/64 RR- 12 SPO2- 97% T- 97.4 no problems noted @ present will continue to monitor — [redacted]
@2210	pt medicated for pain prior to dressing Δ, dressing Δ complete ~ problems pt sitting up in bed no signs of acute distress noted @ present will continue to monitor — [redacted]
@2340	pt voided 2200cc so far tonight no problem or complaints @ this time will continue to monitor — [redacted]
18 Aug 03 1225	VSS, pt c/o abdominal cramps in (R) lower, abdominal quadrant. Pt attempted to have BM ~ success. ØN/V. Pt also c/o pain BLE. Given Percocet 2 tabs PO @ 1200. Voiding ~ difficulty. LR infusing @ TKO. Ø s/s of infection @ IV site. — [redacted]
18 Aug 03 1235	Nursing: Dr. [redacted] notified of abdominal cramps. Pt given 30cc Milk of Magnesia. Will continue to monitor — [redacted]
18 Aug 03 1730	Nursing: Dressing Δ completed, small amount of purulent drainage noted from wound on LLE. Wound in HE ~ drainage or s/s of infection. Wound packed iodoform gauze. Premedicated c̄ Percocet. Tolerated procedure.

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

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

EPW
[redacted]
b(6)-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18 Aug 03 1830	Report recieved from dayshift. VSS — [redacted]
19 Aug 03 0200	Drsg Δ's done — [redacted]
0620	Report given to dayshift — [redacted]
0620	Received report + assumed care of [redacted] VSS, Pt stable. Pt Lying in bed sleeping + appears to be resting comfortably @ this time. Will monitor. [redacted]
	b(6)-2 A11

STANDARD FORM 600 (REV. 6-97) BACK

USAPA V2.0

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD Progress [redacted]

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19 Aug 03	1230 - Pt alert & oriented transfer from IIW 3 via ambulatory. Dsg to (R) leg CDI. IV D'Cd Voicing Ø complaints, Will cont to monitor b(6)-2 [redacted] Dorm
1545	Pt alert and oriented. Stable. Discharged to EPW camp c meds, xray and discharge instructions. Ambulatory at time of discharge. Escorted by MP. [redacted] RN/DN 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.

EPW
[redacted]
b(6)-4

[redacted]

Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CONSULTATION SHEET

b(6)-2

REQUEST b(6)-2

TO:	FROM: *(Requesting physician or activity)*	DATE OF REQUEST
[redacted] (ORTHO	DR- [redacted] maj	11 Aug 03

REASON FOR REQUEST *(Complaints and findings)*

Temp spikes to 101 despite of IV antibiotics
Persistant cellulitis ~~[illegible]~~ following SFAB wound.
Please evaluate and advise regarding management.

PROVISIONAL DIAGNOSIS

Rule Osteomyelitis ?, DVT.

b(6)-2

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

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO 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(2)-2		

[redacted] b(6)-4

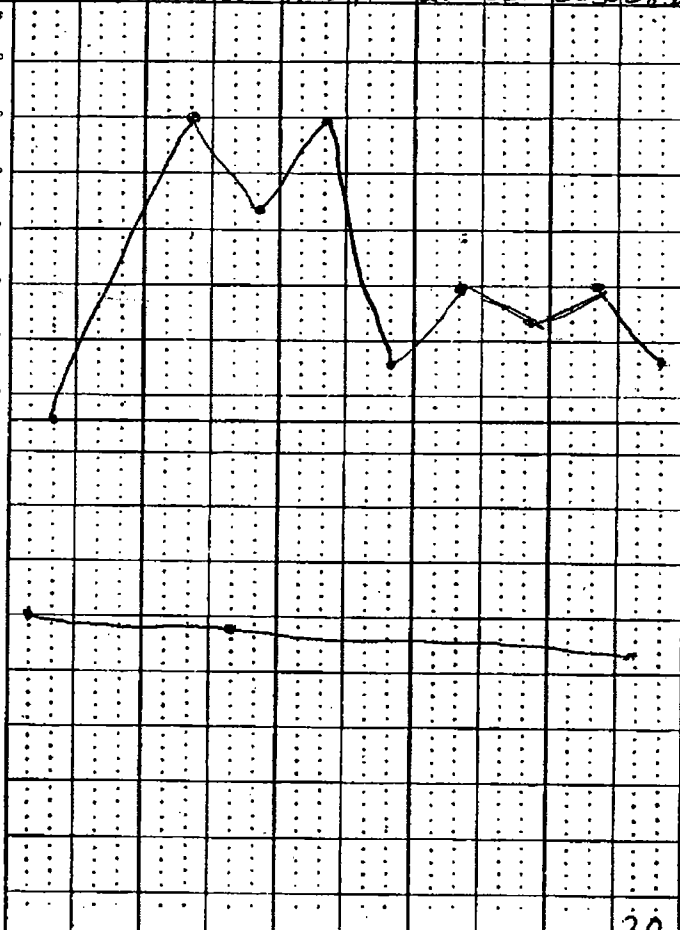
CONSULTATION SHEET
Medical Record

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

MEDICAL RECORD | VITAL SIGNS RECORD

HOSPITAL DAY																
POST-	DAY															
MONTH-YEAR	DAY	9AUG03		10AUG03						11AUG03						
19	HOUR	2000		0500	0800	1400	1700	2115	2330	0530	0830					

PULSE (O) — TEMP. F (●)



TEMP. C (Centigrade Equivalents, for Reference only): 40.6°, 40.0°, 39.4°, 38.9°, 38.3°, 37.8°, 37.2°, 37.0°, 36.7°, 36.1°, 35.6°, 35.0°

RESPIRATION RECORD														
										20				
BLOOD PRESSURE	120/60		120/60							118/74				
HEIGHT: / WEIGHT→														
SpO2	96		SpO2 94							97				

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)

[redacted] b(u)-4

REGISTER NO.

WARD NO.

511-112

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

EPW

Cellular

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted] b(6)-2	CH MIST (Subject to
LAST, FIRST, M: EPW # [redacted] b(6)-4	DATE: 11AUG03 TIME: 1115	SSN

(i-STAT) TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
		mmol/L
		mmol/L
		45
		mmHg (art)
		mmHg (ven)
		mmHg (art)
		mol/L (art)
		mol/L (ven)
		mol/L (art)
		mol/L (ven)
		+3)
		mmol/L
		32 mmol/L
		g/dl
		mg/dl
		mg/dl
		PCV
		/dl

(Piccolo) Chemistry 12 TEST	RESULT	REF. RANGE
GLU		
BUN		
CA++		
CRE		
NA+		
K+		
CL-		
tCO2		

(Piccolo) TEST	RESULT	REF. RANGE
ALB		
ALP		
ALT		
AMY		
AST		
TBIL		
GGT		
TP		

(Piccolo) TEST	RESULT
NA+	
K+	
CL-	
tCO2	

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

======= PICCOLO =======
11/08/03 11:30
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8 b(6)-4
DISC LOT #: 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	102	73-118	MG/DL
BUN	♦♦♦	7-22	MG/DL
CRE	♦♦♦	0.6-1.2	MG/DL
CK	49	39-380	U/L
NA+	♦♦♦	128-145	MMOL/L
~~K+~~	~~4.6~~	~~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

ID# 000570 11-08-03
NB 11:26

			Patient Limits	
WBC	14.1 H	x10^3/uL	4.5	10.5
RBC	4.47	x10^6/uL	4.00	6.00
Hgb	13.7	g/dL	11.0	18.0
Hct	42.8	%	35.0	60.0
MCV	95.7	fL	80.0	99.9
MCH	30.6	pg	27.0	31.0
MCHC	32.1 L	g/dL	33.0	37.0
Plt	377.	x10^3/uL	150.	450.
LY%	9.7 * L	%	20.5	51.1
LY#	1.4 *	x10^3/uL	1.2	3.4

i-STAT 6+
Pt: [redacted]
Pt Name:_____

Glu_____97 mg/dL
BUN_____5 mg/dL
Na_____139 mmol/L
K_____3.9 mmol/L
Cl_____108 mmol/L
Hct_____44 %PCV
Hb*_____15 g/dL
*via Hct

Sample Type_:
11AUG03

i-STAT CREA
Pt: 0570
Pt Name:_____

Crea_____1.0 mg/dL

Sample Type_:
11AUG03 11:26

Oper: [redacted]
Physician:_____
Ser# [redacted]
Ver: JAM5046A
CLEW A93

REMARKS: b(6)-2

REPORTED BY: [redacted] **DATE:** 11Aug03 **LAB ID NO.:**

Ward/Section:	REQUESTING PHYSICIAN: [redacted] b(a)-7	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: b(a)-4 [redacted]	DATE	TIME	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^3
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	81		
Other			

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS: b(a)-2

REPORTED BY: [redacted]	DATE: 11 Aug 03	LAB ID NO.:

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

NURSING UNIT: ICU3 | ROOM NO. | BED NO.

DATE OF ORDER: 11 Aug 03 | TIME OF ORDER: 1430 HOURS | LIST TIME ORDER NOTED AND SIGN: 1450

A Sunrise Ortho
D/C cellulitis RLE
w/ fels routine
Activity BR
Diet regular
IVF KVO
Meds Tylenol 650 mg po q 6 PRN
Percocet 1-2 HOURS PO q 4 PRN
Cipro 400 mg IV BID
BID Dry Δ BLE c Iodoform gauze b(6)-2

[redacted]

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

NURSING UNIT: ICU3 | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: Chart val 8/18/03 @ 0936 [redacted] CPT/MN

14 Aug 03 1630 1635
c/ Δ Cipro to 500 mg po BID
b(6)-2 [redacted] (MN)

[redacted] b(6)-4

NURSING UNIT: 24 Chart check: Linda Kenni Maj/AN 2300 | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: [redacted]

DATE OF ORDER: 18 Aug 03 | TIME OF ORDER: 1234 HOURS | [redacted] 18 Aug 03

Milk of Magnesia 30cc PO x 1
v.o. Dr [redacted] 99/MN
b(6)-2

[redacted] 1235 18 Aug 03 99/MN

NURSING UNIT | ROOM NO. | BED NO.

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1996—409-828

"USE BALL POINT PEN—PRESS FIRMLY. NO CARBON PAPER REQUIRED"

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

EW [redacted]

b(a)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW #2		

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
19 Aug 03	0915 HOURS	
✓ (1) Transfer to ICW 2 [redacted]		
✓ (2) Dx: cellulitis		b(a)-2
✓ (3) Cond good		19 Aug 1230
✓ (4) VS q 4 hr		
✓ (5) Diet: BSC		[redacted]
✓ (6) NKDA		
✓ (7) Dvt: legs		

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
	HOURS	
✓ (8) IVF: KVO		
✓ (9) Ceftriaxone 500 mg PO BID		
✓ (10) BID dressing D & (8) VC c iodoform gauze		
(11) prn Percocet 1-2 PO q4° PRN		
(12) XR - (D) HAND R/O Fx		
[redacted]		

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
	HOURS	b(a)-2
DR (V)		19 Aug A11 1230
[redacted]		[redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
	HOURS	

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1996—409-924

"USE BALL POI[illegible] [illegible]ON PAPER REQUIRED"

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 8/9	8/10	8/11
8/9/03	[redacted]	Rocephin 1gm IV q24	1500	[redacted]		
8/9/03	[redacted]	Ibuprofen 800mg po	08	X		
			15			
		b(4) -2 A11	22			

See PRN's

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

PATIENT IDENTIFICATION:

[redacted]

EPW 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

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
8/9/03	[redacted]	Acetaminiphen + Oxycodine 2 PO	8/9/03	1600	1600	DS
8/9/03	[redacted]	VALIUM 5mG PO	8/9/03	2000	2000	[redacted]
8/9/03	[redacted]	IBP 800mG PO	10 AUG 03	0500	0500	[redacted]
		b(w)-2 A11				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
8/10	[redacted]	Ibuprofin 800mg PO q6-8hr PRN Fever or Pain	8-10 1830 CS	8-10 2100 [illegible]												
8/10	[redacted]	Tylenol 325mg ÷ - ii PO q4-6 PRN Fever or Pain	8-10 1330 CS	8-10 1940 [illegible]	8-11 0530 [illegible]											

☆ U.S.G.P.O.: 1986 - 491-003/43119

b(6)-2

CLINICAL RE

THERAPEUTIC DOCUMENTATION CA PLAN (NON-MEDICATION)

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

Mo. ____ Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 11	12	13	14	15	16	17	18	19	20				
8-11	[redacted]	Vitals: Routine.	06	[redacted]													
			18														
8/11	[redacted]	Activ: BR	06														
			18														
8/11	[redacted]	Diet: Regular	06														
			18														
8-11	[redacted]	BID Dressing Δ BLE	06														
		c Iodoform gauze	18														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Cellulitis RLE

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

CLINICAL RECORD

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

Mo. ___ Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 19	20	21	22	23
19 Aug	[redacted]	VS QS	05					
			13					
			21					
19 Aug	[redacted]	Act BSC	05					
			13					
			21					
19 Aug	[redacted]	Diet regular	07					
			12					
			17					
19 Aug	[redacted]	DSSA to (B) LE c	10					
		iodiform gauze	22					

D/C [redacted] 19 Aug 03

b(6)-2

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: Cellulitis

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

b(a) - 2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo	Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
Reg [redacted]		Transfer to ICW 2, Cond: Stable	—	done		[redacted]	
Reg [redacted]		X-Ray ⊙ hand R/O Fx	—	done		[redacted]	

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

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. ____ *Yr.* ____

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED													
				11	12	13	14	15	16	17	18	19	20				
8.11	[redacted]	Cipro 400mg IV BID	08	[redacted]													
	------	b(6)-2	20	[redacted]					14	14	Aug	[redacted]		18 3V			
8.11	------	IVF KVO	06	[redacted]													
	------		18	[redacted]													
14 Aug	[redacted]	Δ Cipro to 500mg PO BID	10	[redacted]													
	------	b(6)-2	22	[redacted]													

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: RLE cellulitis

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. Aug Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
18Aug03	[redacted]	Milk of Magnesia 30cc PO x 1	18Aug03		1235	[redacted]

	-----	D(4)-2 A11				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
8-11	[redacted]	Percocet 1-2 po q4°	8-11 1510	8-11	8-11	8-12 0830	8-12 1100	8-12 1530	8/12 1900	8/12 2300	8/13 0900	8/13/03 1420	8-14		8-14 1230	14Aug03 0 total
-----	-----	prn		[redacted]					[redacted]							[redacted]
8-11	[redacted]	Tylenol 650mg po q6°	8-11 1510	8-12	8-12	8-15										
-----	-----	prn		[redacted]												
8-11	[redacted]	Percocet 1-2 PO q4°	15Aug03 2100 0800	15Aug03	15Aug03	16 Aug 1226	16Aug 1635	16 Aug 1854	16Aug 2307	17Aug 0546	17Aug 1413	17Aug 2128	17Aug 238 1200			
-----	-----	PRN	[redacted]													
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
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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.* ____ *Yr.* ____

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 19	20	21	22	23	24
19 Aug	[redacted]	Cipro 500mg PO	10	[redacted]	D/C [redacted] aug03				
		BID	22						

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: Cellulitis

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

PRN Meds

9 aug	pm	Percocet I-II PO Q4° PRN	D/C [redacted] 19aug03

...DICAL RECORD-SUPPLEMENTAL MEDIC/

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA APPR 08MAR89

b(6)-2

INITIAL SHIFT ASSESSMENT

		Time: 0800 Initals: [redacted]	Time: 1830 Initals: [redacted]
NEURO	Pupils	PERRL 3mm, Alert, obeys command	PERRL 3mm Alert, cooperative
	Sensorium	to understanding. Sensation all extremities	Able to move extremities
	LOC / GCS	(R) gag reflex, (R) grip > (L) grip moderate	BUE strength equal, BLE strength
		Moves all extremities.	equal but weak
CARDIAC	Cardiac Rhythm	Regular HR, Capillary Refill < 3sec.	SR
	PRI: / QRS:	Radial pulses 3+. Pedal pulses 2+.	
	Pulse Strength	(-) reg. JVD. 2+ edema around wounds	Pulses +2 x 4 extremities
	Cap Refil / JVD	(R) foot 2+ edema. Ø C/O CP.	Cap Refill < 3 sec
	Edema		Ø ∓ around wound LE
	Chest Pain		Ø/Denies
RESP	Respiratory Pattern	Regular, even, unlabored	RRR
	Breath Sounds	Clear all lung fields. Ø cough.	CTA (B)
	Secretions	RA sats 98%.	RA
	Cough		
SKIN	Color	WNL ∓ to (R) foot has a red tint	Normal for colar ∓ (R) foot
	Integrity	color to it. Skin Dry warm.	∓ reddened color.
	Backside	(R) foot > (L) foot in warmth. Dressings to	Drsg CDI BLE
		(R) mid lower extremity & (L) LE under knee	
IV	Access Devices	18g. SL to KVO ∓ LR to (L) FA.	18g (L) FA, LR @ KVO
	Location	Ø Redness or swelling. Ø pain.	C/I S S/S infection
	Condition	Intact.	intact
GI	Abdomen	Soft, pain x4 quadrants ∓ palpation.	Soft, Flat, ∓ Pain on palpation
	Bowel Sounds	ABS x4. Ø stool this AM. Eats reg.	BS (+) x 4 quadrants. Reg diet.
	Stoma/Ostomy	diet independently. Adequate po.	
		Intake	
GU	Device	Urinal @ bedside.	Voiding spontaneously
	Color / Clarity		Clear, Yellow Urine

(Continue on reverse)

PREPARED BY: [redacted] LT/AN b(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU 3 [redacted] (b)(2)-2

DATE: 13 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

DA FORM 4700, MAY 78

USAPPC V2.00

ICU3

Patients Name: [redacted] b(6)-4 Date: 13 Aug 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	123/61		124/59									122/69				120/70										
TEMP	97.4	9	97.5									97.9				97.2										
HR	60		68									77				66										
RR	20		14									16				14										
SaO2	97		98									98				98										
FiO2	RA		RA									RA				RA										
Source																										
MAP																										

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Tota
IVF	20	20	20	—	—	20	20	20	20	20	20	20	200	20	20	20	20	20	20	20	20	20	20	20	20	240
IVPB				100	100								200					100								100
NGT																										
PO		120		240	120	120		360	240	360	360		1920					240								240
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	
URINE	250	700		700	625	825	760	525			640	425	5500		550			400			300				800	
NGT																										
STOOL																										
DRAIN																										
Total													5600													2050
																										1450

MEDCOM - 16437

DICAL RECORD-SUPPLEMENTAL MEDIC

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA APPR 08MAR89

INITIAL SHIFT ASSESSMENT

b(6)-2

		Time: 0630 Initals: [redacted]	Time: 1830. Initals: [redacted]
NEURO	Pupils	Perrla 3mm a/o follows	PERRLA 3mm. Pt follows simple
	Sensorium	commands, appropriate c staff	commands. Pt is responsive
	LOC / GCS	GCS 15 moves all extremities x5	to verbal stimuli. Moves extremities
		directed to pt (R)LE d/t pain	x 4.
CARDIAC	Cardiac Rhythm	Regular NSR S1 S2	S1-S2. Regul[redacted] rate, rhythm.
	PRI: / QRS:		(+)2 (B) radial pulses, (+)1 (B)
	Pulse Strength	+2 radial, +1 pedal (R)LE warm	pedal pulse. <2sec cap
	Cap Refil / JVD	to touch (L)LE cold to touch	refill.
	Edema	+1 non pitting edema	
	Chest Pain	denies	
RESP	Respiratory Pattern	even and unlabored	Even and unlabored. Rate
	Breath Sounds	CTA (B)	12-16/min. Breath sounds
	Secretions	Ø	clear bilat. No cough
	Cough	Ø	noted.
SKIN	Color	appropriate for race	Normal for race. Darker
	Integrity	see progress note.	skin noted to @ankle just
	Backside	no breakdown	below wound.
IV	Access Devices	(L) wrist PIV	(L) FA 18 PIV. Dsg intact.
	Location	(L) wrist 18 ga	No redness or drng noted.
	Condition	patent	
GI	Abdomen	soft nontender	Abd soft and nontender BS x 4.
	Bowel Sounds	x4	Last BM unknown.
	Stoma/Ostomy	Ø	
GU	Device	Ø	~~Foley~~ Voiding per urinal.
	Color / Clarity	amber-clear	Voiding clear yellow urine.

(Continue on reverse)

PREPARED BY (Signature & Title): [redacted] /LCPN b(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU 3, [redacted] b(2)-2

DATE: 8-14-03.

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

EPW [redacted] b(6)-4

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

DA FORM 4700, MAY 78

USAPPC V2.00

ICU3

Patients Name: [redacted] 6(2)-4

Date: 8-14-03.

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP			124/85												125/85											
TEMP			98°												97											
HR			72												65											
RR			16												14											
SaO2			98												98%											
FiO2																										
Source			RA												RA											
MAP																										

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Tota
IVF																										
IVPB			200																							
NGT																										
PO			450					600																		
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	
URINE	625								725						700			550						60		
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 16439

JICAL RECORD-SUPPLEMENTAL MEDICA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA APPR 08MAR89

INITIAL SHIFT ASSESSMENT b(6)-2

		Time: 0700 Initials: [redacted]	Time: 1900 Initials: [redacted]
NEURO	Pupils	Perrl, 3mm brisk	PERRL brisk
	Sensorium	c/o follows commands, appropriate	A&O x3
	LOC / GCS	T staff GCS 15. A&O x3 follows	pt follows commands @ movement
		extremities well except (R)LE d/t pain	to all extremities
CARDIAC	Cardiac Rhythm	Regular rhythm	NSR HR-55 BP-
	PRI: / QRS:		
	Pulse Strength	+2 radial, +1 pedal pulses	@2 Radial @2 Pedal
	Cap Refil / JVD	<3sec ø JVD	≤3sec. ø JVD
	Edema	+1 non pitting edema (R)LE	+1 RLE
	Chest Pain	denies	ø chest Pain @ Present
RESP	Respiratory Pattern	even unlabored RR 16-18	RR-18 unlabored SpO2 98% on RA
	Breath Sounds	CTA (B)	CTA (B)
	Secretions	ø	ø secretions
	Cough	ø	ø cough
		SpO2 98-99% @ RA.	
SKIN	Color	appropriate for race.	Normal for Race
	Integrity	See progress note	wounds to (R)LE
	Backside	intact no breakdown	no breakdown noted
IV	Access Devices	PIV 18G.	IV in (L) Arm TKO
	Location	(D)orsal	
	Condition	patent	patent no s/s of infection/infiltration
GI	Abdomen	soft nontender.	soft flat non tender non distended
	Bowel Sounds	x4 quads	Normoactive X4
	Stoma/Ostomy	ø	ø ostomy ø stoma
		denies N/V/D. Ate 75% breakfast	
GU	Device	urinal @ bedside.	urinal @ bedside
	Color / Clarity	amber clear ++.	clear yellow
		denies pain while urinating	

(Continue on reverse)

PREPARED BY (Signature & Title): [redacted] 1800 — Nights 1800-0600 b(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU 3, [redacted] (b)(6)-2

DATE: 8·15·03

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

EPW [redacted]

b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

USAPPC V2.00