AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
05 Oct 03	assumed care at 0615, WNL A+O, all care caught pt ambulated to BR, pin care complete with H_2O_2 and sterile water, wounds around pins - reddish pink with minimal drainage after ambulating, pins open to air, pt ambulated w/ difficulty, pt sat in chair [redacted]
05 Oct 03 1330	I concur w/ above assessment. Tolerating crutch ambulation well. Pt w/ 2 pt restraints to compromise to skin integrity & circulation b(6)-2 [redacted]
05 Oct 03 2035	VSS. Ambulated to bath with help for 50 min and tolerated well. Performed own pin care w/ difficulty. No s/s infection to pin sites. Healing light crusts, wipe quantity sufficient. [redacted] b(6)-2
06 Oct 03 0700	ORTHO Pain eval AF/SS Stiff knee - 0-30° to OR tomorrow, manipulation w/ anesthesia. [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			[redacted] 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.

[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
06OCT03 0522	Pt Awake A&O. LS CTA(B) ~~2N~~ S1, S2, present, (+) BS X4 quad. Ex Fix on (R) L.E. CTA. (+) [redacted] in all [redacted] tremities. PT NPO p̄ midnight. On call to OR Tom[redacted]w. Will cont to Monitor. b(6)-2 [redacted] Spc 91Wm t
06OCT03	2100=VSS, Ø c/o pain @ present time, A&OX3, pt. did pin care on his own after setting up supplies for him, ex fix in place c̄ small exudate from pin insertion sites. (-) LE ↑, edema noted. Neurovascular intact 2+ pedal pulse (-) foot. IV Hr to (R) FA flushed & patent, continuing Ancef around the clock, will be NPO p̄ MN & initiating maintenance fluids @ that time (LR@100cc/h). Ø other remarkable findings. X2 restraints when in bed, continue to monitor. [redacted] 91W/AN
07OCT03 0810	Pt Returned from OR via litter. P/O Ex Fix adjustment. Gauze Dry c̄ small ~~[illegible]~~ Bloody show on middle pin. Pt c/o Pain controlled c̄ ~~[illegible]~~ (R) L.E Elevated. Will continue to monitor. [redacted] 91WM
8OCT03 0118	VSS. Performed ~~self~~ pin care and wrapped pins. Ø s/s of infection. Cont c̄ AB p̄ and voiding light yellow urine quantity sufficient. [redacted] b(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

PROGRESS NOTES

DATE	NOTES
070403	ORTHO
0811	preop DX: stiff (L) knee s/p Fem fx.
	postop DX: same
	manipulation under anesthesia, clean pin sites.
	preop ROM 0-30, postop ROM 0-50°
	Dressing
	Q comp
	to RR stable
	[redacted]
	b(6)-2

RELATIONSHIP TO SPONSOR

SPONSOR'S NAME: LAST | FIRST | MI

SPONSOR'S ID NUMBER (SSN or Other)

RANK/SERVICE

HOSPITAL OR MEDICAL FACILITY

RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

USAPA V1.00

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

5 OCTOBER 1000 Received pt resting in bed, VSS, tol PO, HL in (R) fa, patent, flushes easily. Amb w/ crutches showered this am. SWS. Self care of perineum w/ H2O2 half strength, minimal serous drainage on old dressings. amb independently w/ crutches. X ray request for AP & LAT of (L) femur. Ex fix to (L) femur intact. IV to (L) hand (8g d/c'd. ∅ other remarkable assessments @ this time. Restraints per GPW protocol, ∅ skin breakdown noted. Will cont to monitor pt. [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

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

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
080CT03	D/C Summary
	This is a 35 y.o. Iraqi male s/p GSW (L) femur with open femur fracture. Wound is closed w/ ETD & external fixator in place. Pin sites are clean and X-ray demonstrates callous formation at fracture. Pt is ambulatory with crutches. Pin sites should be cleaned twice a day and oral antibiotics twice a day can be taken by mouth (Keflex 500mg BID). Routine follow up for X-ray in 2 weeks & Dr [redacted] b(6)-2
	[redacted]
	b(6)-2

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

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

TIENT'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

b(2)-2

NSN 7540-01-075-3786

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

PATIENT'S HOME ADDRESS OR DUTY STATION			ARRIVAL	
STREET ADDRESS EPW			DATE *(Day, Month, Year)* 11 Sep 03	TIME 1221
CITY	STATE	ZIP CODE	TRANSPORTATION TO FACILITY N/A	

SEX	DUTY/LOCAL PHONE		MILITARY STATUS				THIRD PARTY INSURANCE		
M	AREA CODE	NUMBER	ITEM	YES	NO	N/A	ITEM	YES	NO
			PRP				ADDITIONAL INSURANCE		
AGE 35	HOME PHONE		FLYING STATUS				DD 2568 IN CHART		
	AREA CODE	NUMBER	MEDICAL HISTORY OBTAINED FROM				NAME OF INSURANCE COMPANY		

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

CHIEF COMPLAINT SIP GSW

CATEGORY OF TREATMENT		VITAL SIGNS					
☐ EMERGENT	TIME 1220	TIME	1220				
☒ URGENT		BP	113/63				
	INITIALS [redacted] b(4)-2	PULSE	101				
		RESP	16				
☐ NON-URGENT		TEMP	101.6				
		WT					

LAB ORDERS					X-RAY ORDERS		
Ø CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT		CXR PA & LAT/PORTABLE		C-SPINE
URINE C&S	UA MSCC/CATH		CHEM: ~~Met 8~~		ACUTE ABDOMEN		LS SPINE
BLOOD C&S X		PTS			SINUS		HEAD CT
					ANKLE R/L		

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
	CXR, Ø Tylenol				

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

CONDITION UPON RELEASE	ADMIT TO UNIT/SERVICE	REFERRED ▶	TO	WHEN
☐ IMPROVED ☐ UNCHANGED				
☐ DETERIORATED	TIME OF RELEASE	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]

b(4)-4

NSN 7540-01-075-3786

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	RESULTS	
	H/H					PCO2	SAT	OTHER		
	PLT									
PT					U/A	DIP			EKG INTERPRETATION	
APTT		BHCG	ETOH	GLU		MICRO				

PROVIDER HISTORY/PHYSICAL

See Admission Paperwork

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

DIAGNOSIS

CODES

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

[redacted] b(6)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

510-112

Top.

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
2145 10SEP03			PT CARE TRANSFERRED => PH VIA LITTER.
			I+D @ (R) TIBIA/EXFIX @ (R) FEMUR FX.
-VS @ 2145-			A+O×3 PER TRANSLATOR. Ø SOB Ø NAUSEA
B/P 126/68			NTD. SMALL AMT. BLOODY DRAINAGE NTD
PR 75			@ EXFIX SITE / TIBIA DRSG. Ø ODOR NTD
RR 18			CURRENTLY RESTING SUPINE NAD. IV @
PO2 97% ON RA			(R) ~~FA~~ INFUSING LR @ 120cc/hr SITE Ø EEE
TMP 98.8° FORAL			[redacted] b(6)-2
			[redacted] SGT [redacted] EPW
VS @ 0145-		1030	2mg (MSO4) IVP ≈ 5cc LR FLUSH [redacted] EPW
B/P 130/72			* MED NOTE => ANCEF Q 8 × 6 DOSES
P 77			1ST DOSE @ 1730L [redacted] b(6)-2 EPW
RR 16			
PO2 97% ON RA			
TMP 99.1° FORAL			
11SEP03	0130	~~0130~~ AAA	ANCEF 1g IVPB [redacted] EPW
	0200		VOID => 510cc CLR. YEL. URINE Ø DYSURIA
VS @ 0545-			NTD. Ø LROSS BLD. NTD b(6)-2 [redacted] EPW
B/P 130/73			
P 73	0230		2mg (MSO4) IVP ≈ 5cc LR FLUSH [redacted]
RR 18			
PO2 98% ON RA	0230		PT ASLEEP NAD [redacted]
TMP 101.3° FORAL	0310		VOID #2 => 800cc CLR. YEL. URINE Ø DYSURIA b(6)-2 [redacted]
	0440		VOID #3 => 650cc CLR. YEL. URINE Ø DYSURIA NTD [redacted]
	0545		PT FEBRILE @ 101.3° FORAL III 325mg (TYL) PO
			[redacted] SGT. [redacted] LAW
	0600		~~DRSG~~ SMALL AMT. BLOODY DRAINAGE NTD b(6)-2
			@ EXFIX SITE. [redacted] EPW
	0600		BAL # 1L LR @ 120cc/hr. SITE Ø EEE [redacted]
	0745		PT DENIES BREAKTHROUGH PAIN [redacted]

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

[redacted]

IRAQI EPW

b(6)-4

(Continue on reverse side)

REGISTER NO.

WARD NO.

BACK

NURSING NOTES

Medical Record

MEDCOM - 19048

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

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
11 SEP 03		0830	VOID => CLR. YEL. URINE 900cc Ø DYSURIA
			Ø BLOOD NTD [redacted] CPN
		0845	2mg ~~MSO4~~ IVP c̄ SCC NS FLUSH [redacted] CPN
		0930	1g ANCEF IVPB. * AWAITING GROUND EVAC
			=> [redacted] [redacted] CPN b(2)-2
			b(2)-2

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: 35

HEIGHT:

WEIGHT: 61 Kg

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

3. PREVIOUS SURGERY [ ] NO [X] YES (type):
Ex. Fix (L) femur

4. PROPOSED SURGICAL PROCEDURE:
I&D (R) tibia, I&D (L) femur, Adjust Ex Fix

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition WNL
Tobacco (Y) ppd X___ yrs. Body Piercing Ø Diabetes (Y) (N) ROM ↓ ASA/Motrin w/72 hrs (Y) (N)
ETOH (N) Implants Ex Fix L Femur Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures Ø Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS: MS04

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

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

EPW # [redacted] b/w-4

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

6. PATIENT PROBLEMS AND NEEDS	PATIENT GOALS AND EXPECTED OUTCOMES	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 wraps. If none, check with doctor. ✓ 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 f transfer. ✓ Insure proper body alignment. ✓ Allow patient to lie in position of comfort while waiting for surgery. ✓ Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated 2) W/O Glasses F.2. ✓ Potential for decreased communication due to: 1) Diminished Hearing ✓ 2) Language Barrier Arabic F.3. Potential injury due to dentures: 1) Upper 4) Caps 2) Lower 5) Crowns 3) Bridges	✓ Pt. will be made aware of surroundings prior to anesthesia induction. ✓ Pt. will be transferred safely to OR table. ✓ Pt. will be able to understand instructions. ✓ Minimize danger of injury during intraop period.	✓ Introduce self. Keep pt. informed where he/she is and what is happenin ✓ Inform pt. in which direction to m and assist if necessary. ✓ Speak clearly and slowly. ✓ Address pt. from either side. ✓ Validate pt.'s understanding of ve 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.

[redacted] b(6)-2 AN 11 SEP 03 DATE

11. POSTOPERATIVE EVALUATION: SKIN INTEGRITY: Bovie Pad Site: ☒ Clean and Dry ☐ Red ☐ N/A DRESSING DRY & (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. PREOP[redacted] EVALUATION (Signature and [redacted] PREPARED BY

DATE: 11 Sep 03 TIME: 1520

13. POSTOPERA[redacted] PARED BY (Signature and Titl[redacted]

DATE: 11 Sep 03 TIME: 1745

REVERSE OF FORM 5179, JUN 91 MEDCOM - 19051 USAPA V1.0

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

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 ATLS

2. PATIENT IDENTIFIED, RECORD [illegible] PROCEDURE
VERIFIED BY Spc [redacted] b(6)-2

3. DATE 10 Sept 03 TIME PATIENT ARRIVED IN SUITE 1810 HRS

4. PATIENT IN ROOM
TIME 1810 HR NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

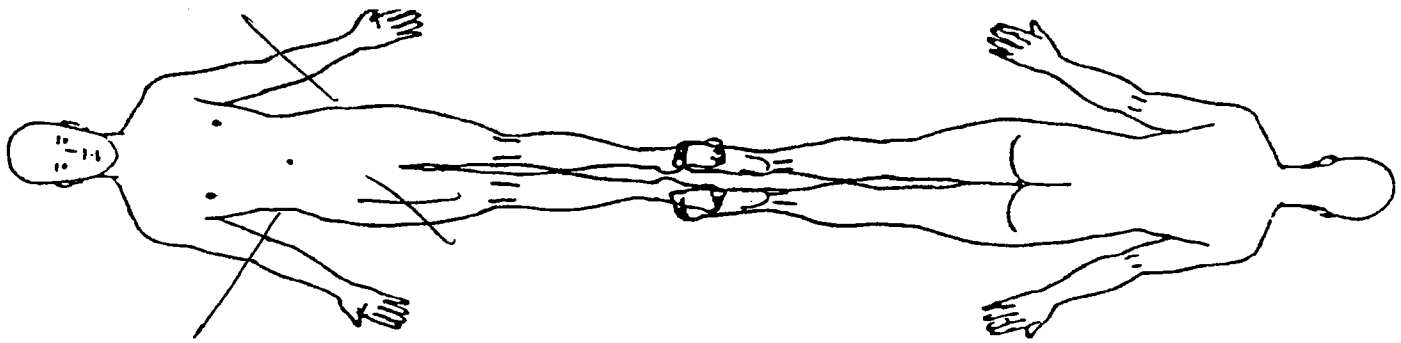
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine / Betadine b(6)-2
SITE: LLE BY WHOM: Spc [redacted]
SITE: RLE BY WHOM: Dr [redacted]

COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap - - - Tourniquet

10. COUNTS

C – Correct I – Incorrect

		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No	5K	10	10	Spc [redacted] b(6)-2	Spc [redacted]
Needle Sharp	☐ Yes ☐ No	8	8	8		
Instrument Blade	☐ Yes ☐ No	2	2	2		
Other Raytex	☐ Yes ☐ No	9	9	9		

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

LOG# [redacted]
SSAN# Iraqi Cy EPW b(6)-4
NAME:

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

☐ ESU NO: Cut to / Coag to
GROUND PAD: BRAND
LOT NO:

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

RE Lt femur external fixator

Cat No. [redacted] i-150
Ultra X External Fixator
NSN [redacted]
LOT CODE: [redacted]

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):
1000cc NS

OTHER ORDERS	TIME	CARRIED OUT BY

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

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. Lg Penrose	2.	3.
SITE	1. RLE	2.	3.

18. DRESSING/IMMOBILIZATION (Specify)
RLE Kerlix Roll & Ace wrap Dressing
LLE Kerlix Roll & Ace wrap Dressing

19. ADDITIONAL INFORMATION

Assisted by Dr [redacted] b(6)-2
Attempted foley placement per myself and Dr [redacted] made + place due to resistance.

IN 1810 HRS
CUT 1845 HRS
CLOSE 1718 HRS
OUT 1945

Bovie Tip 1 | First Cart 1 | Last Cart 1

b(6)-4
LOG # [redacted]
SSAN# Imaging & EPN
NAME:

20. OPERATION(S) PERFORMED
I + D to GSW + RLE
External fixator placement to Lt femur fx

21. PATIENT TRANSFERRED TO ICU b(6)-2 | TIME 1945 | METHOD Litter

22. REGISTERED NURSE SIGNATURE Sp[redacted]GIC

REVERSE OF DA FORM 5179-1, OCT 87

USAPA V1.01

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY Anesthesia

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

3. DATE 11 Sep 03 TIME PATIENT ARRIVED IN SUITE 1540

4. PATIENT IN ROOM TIME 1540 NUMBER 2-5

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies:
NKDA, NPO p MN

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify) Pt. supine on padded OR table

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

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL [X] YES [ ] NO Dr. [redacted]
DONE BY: [X] OR [ ] NURSING UNIT
METHOD: [ ] DEPILATORY [X] RAZOR
[ ] CLIP (R) calf

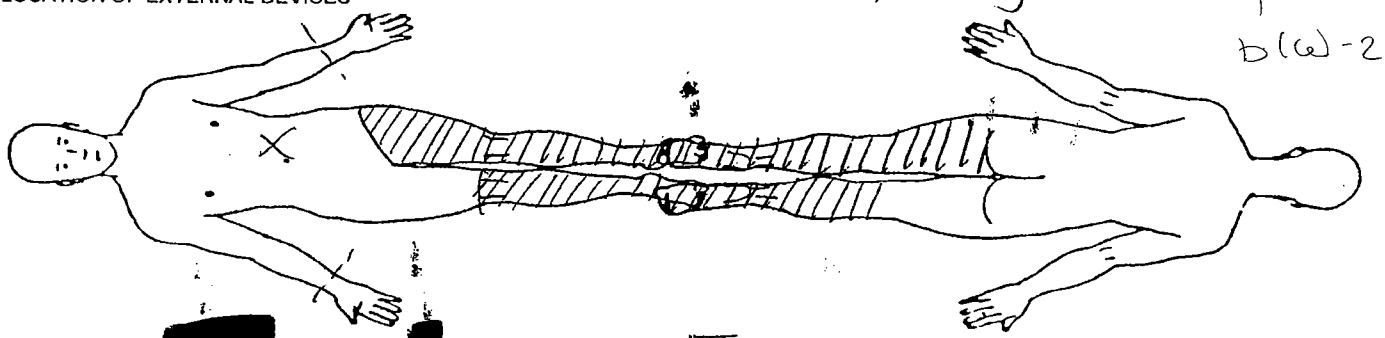
COMMENTS: No nicks or cuts noted

PREP SOLUTION (Specify) Betadine / Betadine
SITE: Left leg BY WHOM: ILT [redacted]
SITE: Right leg BY WHOM: CPT [redacted]

COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES

b(6)-2



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

initial: SPC SSGS
ILT Malachi

10. COUNTS

C = Correct I = Incorrect

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

EPW # [redacted] b(6)-4

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

[X] ESU NO: VL Force 40
GROUND PAD: BRAND VL REM Polyhesive II
LOT NO: 1089310 Exp 2005-03

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

[ ] BIPOLAR NO:

MEDCOM - 19054

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

Hoffman II Ex Fix
Lead # 0425101

5023-5-150 x1
5018-6-180 x2
4920-1-010 x5
4920-2-020 x2

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

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 [X] YES [ ] NO, TYPE(S):
0.9% NaCl - Q.S.

OTHER ORDERS	TIME	CARRIED OUT BY
N/A [redacted]		

PHYSICIAN'S SIGNATURE [redacted] MD CPT [redacted]

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

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 [X] NO [ ]

TYPE/SIZE	1. 3/8" Penrose	2.	3.
SITE	1. (R) leg x (L) thigh	2.	3.

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

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

Bovie Pad site intact pre-op ✓; post-op_____ Bovie Settings: Coag/Cut 30/30, 45/45.
Tourniquet Site intact pre-op N/A; post-op_____
Tourniquet Time: Up____ Down N/A

b(6)-2 All

DA 5179 initiated.

20. OPERATION(S) PERFORMED
I&D (R) tibia
I&D (L) femur
Modification Ex Fix (L) femur

1. PATIENT TRANSFERRED TO PACU | TIME See DA 7389 | METHOD Liter c O2

REGISTERED NURSE SIGNATURE [redacted] RN [redacted] CPT/AN

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

b(u)-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 MAJ [redacted] MAJ [redacted]

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PRE[redacted]ED BY MAJ [redacted]

3. DATE 14 Sept 03 TIME PATIENT ARRIVED IN SUITE [redacted] 1232

[redacted]ATIENT IN ROOM TIME 1232 NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: PCN NKA
SD

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] b(u)-2	RELIEF SCRUB	1310 SPC [redacted] b(u)-2
ASSIGNED CIRCULATOR	MAJ [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

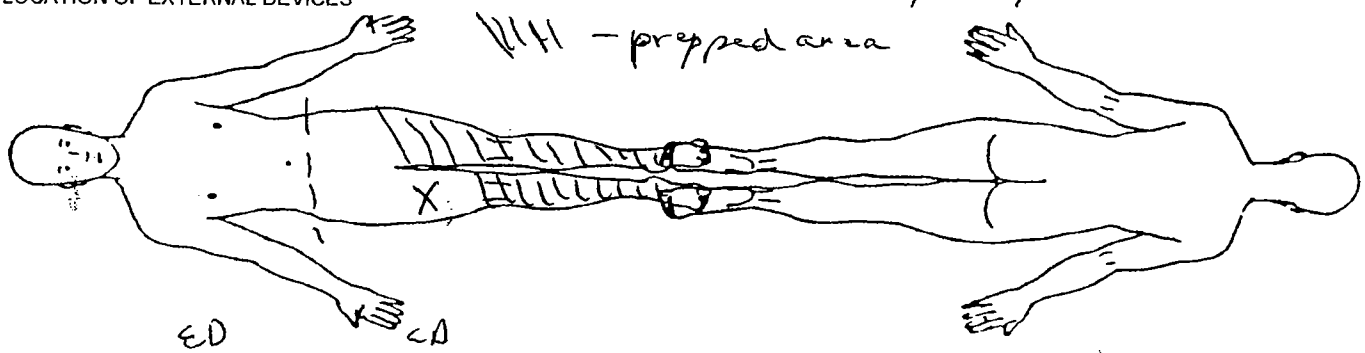
HAIR REMOVAL ☐ YES ☑ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine scrub + solution
SITE: Left leg BY WHOM: MAJ [redacted]
SITE: Right leg BY WHOM: CPT [redacted]

COMMENTS: No pooling of solution b(u)-2

9. LOCATION OF EXTERNAL DEVICES



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

b(u)-2

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes	☐ No		C	C		
Needle Sharp	☑ Yes	☐ No		C	C		
Instrument	☐ Yes	☑ No				SPC [redacted] SPC	MAJ [redacted] MAJ
Other	☐ Yes	☑ No					

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

EP
#[redacted] b(u)-4

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

☑ ESU NO: R8B 102395
GROUND PAD: BRAND Valleylab
LOT NO: 68245 Exp 2005-02

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

MEDCOM - 19056

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): NS.

OTHER ORDERS	TIME	CARRIED OUT BY
[redacted]		

PHYSICIAN'S SIG[redacted] b(4)-2

15. X-RAY IN OPE[redacted] IF YES, SITE

YES ☐ NO ☑

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☑

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

18. DRESSING/IMMOBILIZATION *(Specify)*

Lt thigh ABD 4x8 Kerlix

Rt calf 4x8's Kerlix

19. ADDITIONAL INFORMATION

WC

Surgeons: [redacted] b(4)-2 Anesthesia: MAJ [redacted] Anesthesia Type: Gen

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

Tourniquet Site intact pre-op NA: post-op_____

Tourniquet Time: Up NA Down_____

20. OPERATION(S) PERFORMED

I&D Rt ~~thigh~~ calf, I&D Left thigh & adjustment of ex fix

21. PATIENT TRANSFERRED TO	TIME	METHOD
PACU	1350	Litter

22. [redacted] MAJ AN 14 Sep 03

REVERSE OF DA FORM 5179-1, OCT 87

b(4)-2

MEDICAL RECORD — **INTRAOPERA DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA letter BY anesthesia

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

3. DATE 70CT03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 0745 NUMBER 1-1 (1)

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:
pt not english speaker.

6. NURSING PERSONNEL

ASSIGNED SCRUB	SS6 [redacted] 91D b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted], 06E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

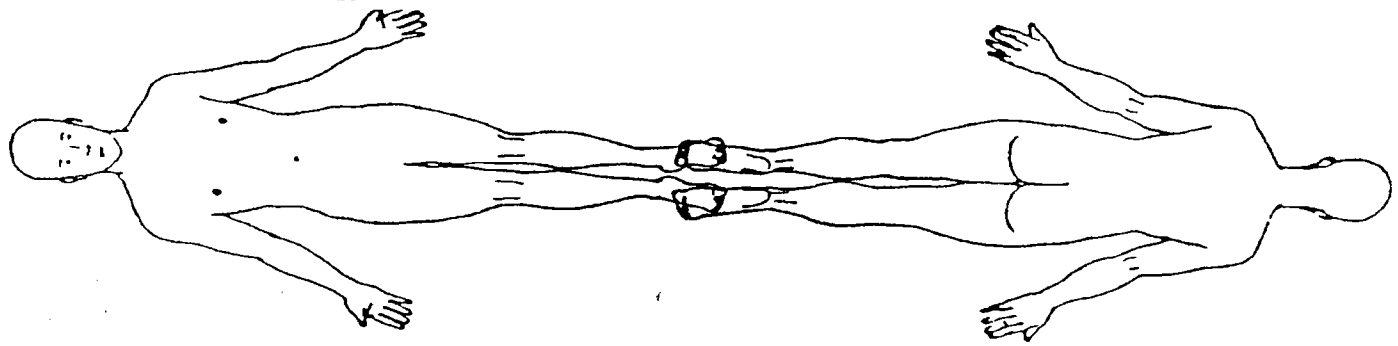
8. SKIN PREPARATION

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

COMMENTS:

PREP SOLUTION *(Specify)*
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	☐ 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

70CT23

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

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☐ YES ☒ NO, TYPE(S):

OTHER ORDERS	TIME	CARRIED OUT BY

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

15. X-RAY [redacted] IF YES, SITE

YES ☐ [redacted]

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)*

Herlix around pins.

19. ADDITIONAL INFORMATION

20. OPERATION(S) PERFORMED

(h) knee exam under anesthesia

21. PATIENT TRANSFERRED TO ICW b(6)-2 TIME 0820 METHOD gurney

22. REGISTERED NURSE SIGNATURE [redacted] CPT/AN

REVERSE OF DA FORM 5179-1, OCT 8

USAPA V1.00

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ____ HOURS TO ____ HOURS | TOTAL HOURS COVERED | DATE 11Sep03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1Sep 3-00 2100	120 H20		120
			14Sep

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
?	1000	NS@100			
	1800-0600				
800	1000	LR@100			950

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

[redacted] b(6)-4

OUTPUT

URINE

	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
Sep	2100	400	400cc			
	2300	150	550cc			
	0500	600	1150cc			
	0570	300	1450cc			
Sep 400cc 00-0100		400cc				
	2030	100	500cc			
300	dyu	420	920cc			
200	dyu	600	1320			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL
14th Sep 0800	700cc	urine med yellow	700
14th	Sep	1800-0600	
2300	400	dkd. yellow	400
0200	800		1200
0530	400	(dyu)	1600

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

[redacted]

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

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

#[redacted]

b(4)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 792, JAN 74

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY: 1

POST- DAY

MONTH-YEAR Sep 03 DAY: 11Sep/12 12Sep03 13Sep03 14Sept 15Sep03 16Sept 17Sep

19 HOUR

PULSE (O) — TEMP. F (°) — TEMP. C

105° 40.6°

180 104° 40.0°

170 103° 39.4°

160 102° 38.9°

150 101° 38.3°

140 100° 37.8°

130 99° 37.2°

98.6° 37.0°

120 98° 36.7°

110 97° 36.1°

100 96° 35.6°

90 95° 35.0°

80

70

60

50

40

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. TCW #1

#[redacted] b(6)-4

#[redacted]

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	18 Sept	19 Sept	20 Sep	21 Sep	22 Sept	23 Sept	23 Sept		
19	HOUR	0 1	8 1	0220 1	0230	1830	0830	1845		

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° / 98.6°	37.2° / 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

	18 Sept	19 Sept	20 Sep	21 Sep	22 Sept	23 Sept	23 Sept
BLOOD PRESSURE	120/85	138/51	133/48	124/77 115/57	111/56	110/58	122/44
	103°	122/70	99	83	101	121	79
	98.1		98°	97.4	98.9	100%	15
HEIGHT: WEIGHT →			100%	99%		R-B	12
02 SAT	94%	97/(RA)	RA	98% RA		98.7	99%
		97% (RA)					RA

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7-95) BACK

[redacted]

b(4)-4

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY
POST- DAY
MONTH-YEAR DAY
19 HOUR

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

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

[redacted]

b(4)-4

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

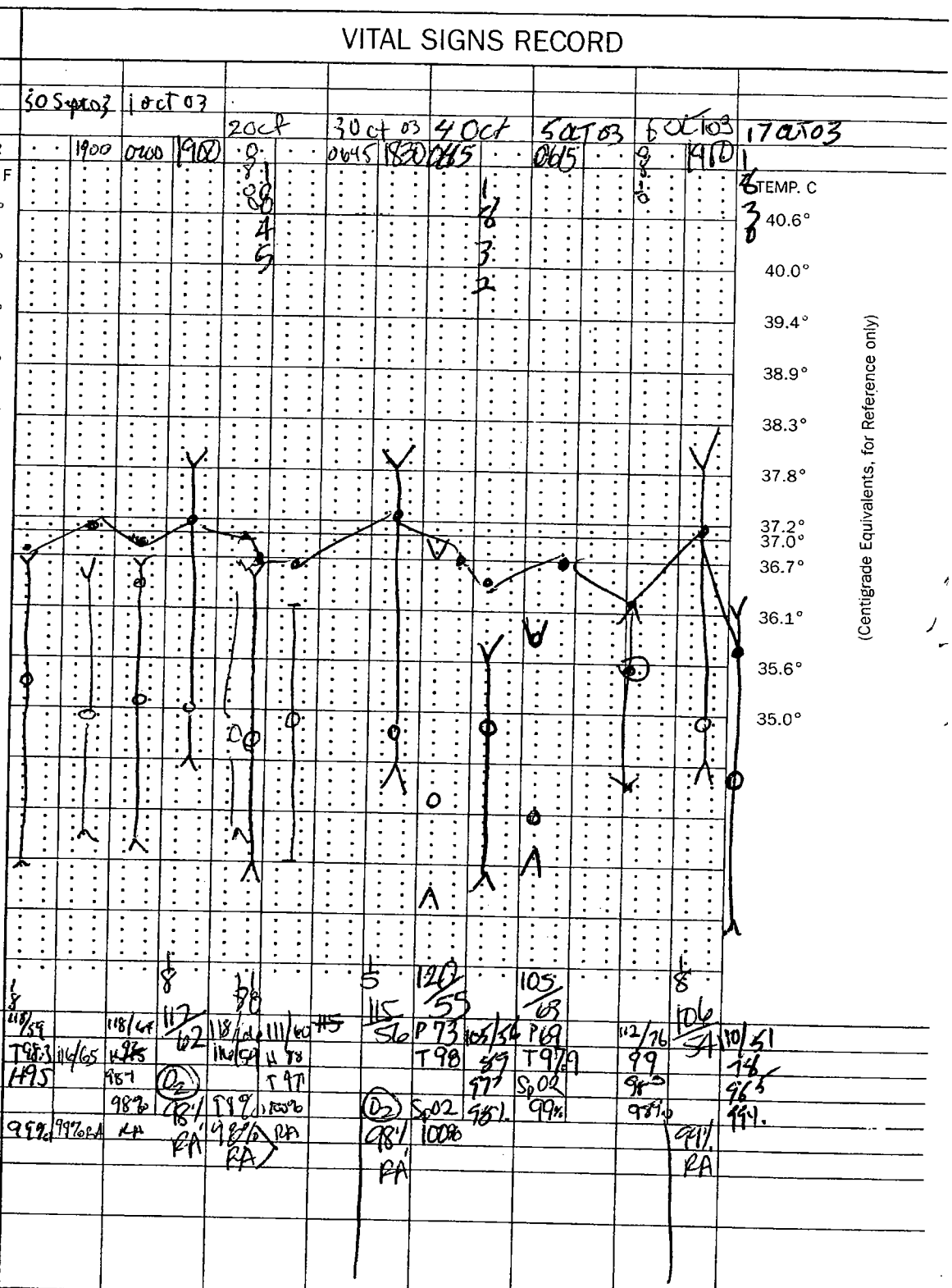
MONTH-YEAR | DAY

19 | HOUR

PULSE (O) | TEMP. F (•)

TEMP. C

(Centigrade Equivalents, for Reference only)



RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

Ø [redacted] b(4)-4

b(4)-2

Ward/Section:	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST [redacted]	DATE 11 Sept 03 / TIME 1230	SSN/PSEUDO SSN: [redacted]

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

[redacted]ology) CBC

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

Mis[redacted]

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

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	DATE: 11 Sep 03	LAB ID NO.:

b(4)-2

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

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

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 17

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~~

======= PICCOLO =======
11/09/03 13:07
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
BASIC METABOLIC
DISC LOT #: 3145AA4
OPER #: [redacted] -2 DR #: 000
SERIAL #: b(6) [redacted]

GLU	101	73-118	MG/DL
BUN	10	7-22	MG/DL
CA++	8.3	8.0-10.3	MG/DL
CRE	1.0	0.6-1.2	MG/DL
NA+	136	128-145	MMOL/L
K+	4.2	3.3-4.7	MMOL/L
CL-	95*	98-108	MMOL/L
tCO2	24	18-33	MMOL/L

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

GSW to leg

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

Age 35 **DAYS MOS YRS** **Sex** (✓) **MALE** ( ) **FEMALE**

PROPOSED PROCEDURE: adjust ex-fix/washout
SURGICAL SERVICE: ORTHO
NPO SINCE: 10 Sept 03

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

HABITS:
TOBACCO: +
ETOH: 0
DRUGS: 0

CURRENT MEDICATIONS:
( ) = ordered as premed

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

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

LABORATORY STUDIES:
HB/HCT: 13.6/42 PS 10/34 1.0/01
U/A: ____
OTHER: ____

11 Sept 03
4.6 / 11.0 / 33.8 / 258

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	
Angina	N	Y	
MI	N	Y	
CVA	N	Y	
Other	N	Y	
Pulmonary System:			
Asthma	N	Y	
Bronchitis/URI	N	Y	
COPD	N	Y	
Other	N	Y	
Renal System:			
Acute/Chronic RF	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	
Hiatal Hernia	N	Y	
PUD/GERD	N	Y	
Endocrine System:			
Diabetes	N	Y	
Steriods	N	Y	
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	
Other	N	Y	
Gynecological :			
Pregnancy	N	Y	
Other Significant Hx:			
	N	Y	
	N	Y	
Familial HX	N	Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC

N/A

PHYSICAL EXAMINATION
BP 163/100 HR ____ R ____ T ____
Pain Scale 0-10 ____
HEENT - Teeth Intact
Trachea midline
TMJ/Neck FROM
Oropharnyx Cl. 2, 3/6 Tm
Nares ____
CHEST: BBS+/CTA
CARDIAC: S1 S2 S0
EXTREMITIES: ____
IV Access: (L) A/C #18 (R) A/C #18
Ulnar Filling: OK
BACK: OK
OTHER: ____

NPO Since 10 Sept

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. used translator

The patient/legal guardian [redacted]stand and agrees. Questions answered.
Signed: [redacted] **Date:** 11 Sept 03 **Time:** 1400 **Hrs**

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

Signed: ____ **Date:** ____ **Time:** ____ **Hrs**

SEDATION KEY:

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

Patient Identification: (Ward) ____

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

ICW 1

NKDA

Procedure/site verified

MEDICAL RECORD - ANESTHESIA

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

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

DRUG (Units)								TOTALS
fentanyl (UG)	250		250					500
lidocaine (MG)	40							40
propofol (MG)	150							150
(SUX) Vec (MG)	(10)	10	10		2			32
( )								
VOLAT AGENT % del	150	1.7	1.7	1.7	1.5	1.5	1.5	
% e.t.								
AIR L/Min								
N20 L/Min								
O2 L/Min	6	2	2	2	2	2	2	2-6

TOTAL EBL: Min

TOTAL URINE: —

FLUIDS SUMMARY
CRYSTALLOID- NS-1500
COLLOID-
BLOOD-

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

FLUIDS
LINE site 18 (L) A/C ☑ Warmed — NS
☐ Warmed
☐ Warmed
☐ Warmed

LOSSES: EST BLOOD LOSS; URINE -

REMARKS
Code drugs with numbers, events with letters
1530-Meta 10 cc IV place, Chart V/d heap done
1545-In room monitors on Induction Ancef 1 gm IV
1730-Reversal 5 mg Neostig/.8 mg Glycopyrrolate
1745-Marcaine 20 cc
Opened eyes Spont resp Extubated

Smoker

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

BODY WEIGHT: 61 (KG)

HEMATOCRIT:

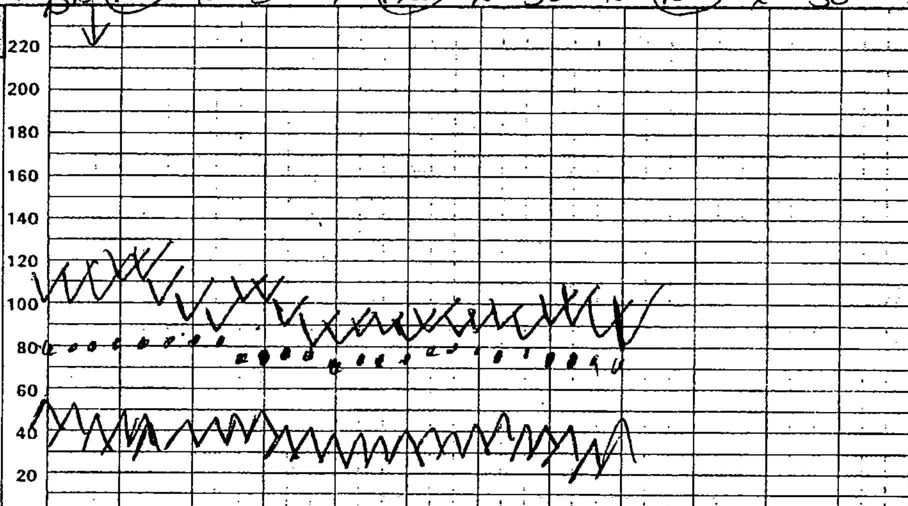
INITIAL DATA:
BP- 115/63
HR- 90s

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? (Y)
TIME- 1530

TIME → 1515 (1600) x 30 x (1700) x 30 x (1800) x 30 x

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



VENTIL

VT - ml		860	840	760	770	770	720	400
f - breaths/min		10	10	8	8	8	8	4
Peak inf pres / PEEP		20	20	21	21	21	21	
MODE - S(pon), A(ssist), C(on)	SV	CV	CV	CV	CV	CV	CV	SV

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)		31	31	40	35	35	36	<30
BP/oth	FIO2 (Frac or %)	.96	.96	.96	.94	.85	.85	.85	.85
ART line	SpO2 (%)	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	NS	NS	NS	NS	NS	NS	NS	NS
Gas analyzer	TEMP-site	skin		35	35	35	35	35	
O2	N-M Block (T/4)		4/4	0/4	0/4	0/4	0/4	1/4	4/4 ST
Warming blkt	blanket/sheets →								
Conv warmer									

Mark with letters & symbols, explain under REMARKS EVENTS Position → arms <90° abducted/padded

RECOVERY AT 98.6
(PACU) ICU (Specify)
OTHER Stable
CONDITION:
RESP- 26 SpO2- 99%
BP- HR- 120

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1530	1545	1745

	Ready	Begin	End
PROC	1555	1611	1735

PROCEDURES and CPT Codes: Washout - D&D - Adjust Ex-fix (L) femur

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GETA-#3 MAC, taped 22 cm teeth, Eyes taped, retain. Soft bite block. CO2 ↑ ↓ c (+)

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* Preox, DL x1, Gr 2 view, ETT easily passed, BS = bilat, Atraumatic. Teeth OK

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*
ICW 1 b(6)-4
[redacted]

SURGEONS: [redacted] b(6)-7

[redacted]

PROCEDURE LOCATION: 22

DATE: 11 Sept 03

PAGE 1 OF

MEDCOM - 19069

– Agree c̄ previous anesthesia (pre-op) 11Sept03

Tobacco

NKDA

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)	
Phenergan	(mg)	25
MSO4	(mg)	4 <6> <5> <5> <5>
Ketorolac	(mg)	100
Propofol	(mg)	200 20
	(mg)	
	( )	
VOLAT AGENT	% del	2.0 2.0 2.0 2.5%
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	10 2 2 2 10

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML. "|"=CONSTANT INFUSION

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

TOTALS	
15	
70	
100	

TOTAL BLD: <50

TOTAL URINE: Ø

FLUIDS – SUMMARY

CRYSTALLOID– 500

COLLOID– Ø

BLOOD– Ø

FLUIDS		
LINE site 18G-L/A	☐ Warmed	D/C'd
18G-L/A	☐ Warmed	CCH1
	☐ Warmed	
	☐ Warmed	

LOSSES: EST BLOOD LOSS / URINE –

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 61 (KG) LB

HEMATOCRIT: —

INITIAL DATA: BP – 106/56 HR– 96

SONIP CHECK: OK?– (Y) N

PATIENT RECHECK: OK for PROCEDURE? Y TIME– 1130

TIME → 1130 . 1300 . 30 . 1400

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

220 200 180 160 140 120 100 80 60 40 20

	VT – ml	400 380 670-400 400
	f – breaths/min	24 22 20 DS 25
	Peak inf pres / PEEP	— — —
	MODE– S(pon), A(ssist), C(on)	S~CS S S S S
BP/Auto Cuff	ET CO2 (torr)	40 40 49 52
BP / oth	FIO2 (Frac or %)	.82 .82 .82 .79 .78 .78
ART line	SpO2 (%)	100 100 100 100 100 100
Steth- PC/ES	ECG	SR SR SR SR SR SR
Gas analyzer	TEMP- site(s)	
	N-M Block (T/4)	
Warming blkt	X 1 WOD Blanket →	
Conv warmer		

Mark with letters & symbols, explain under REMARKS. EVENTS (1) (2) (3) (4) Position → O–I

REMARKS– Code drugs with numbers, events with letters

(1) Pre-op assessm Phenergan + MSO4 IV. NPO verifie
(2) Room, monitor O2 induced eyelids taped clos 18G PIV started (L) arm. PIV D/C'd
(3) Head tilt, chi lift OA + NP 30FR tube placed (R) nare.
(4) OA + NP tube removed, responsive to PACU. Report to RN
(5) Demerol 10mg IV for P.O. Shivering.

RECOVERY AT 1350

(PACU) ICU ____ (Specify) OTHER T-101.4

CONDITION: Stable, responsive

RESP– 20 SpO2– 100 BP– 108 HR– 106

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	1215	1225	1402
	Ready	Begin	End
PROC	1235	1255	1336

PROCEDURES and CPT Codes: I + D (L) femur; (R) calf wounds

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GMA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: LMA #4 reinforced – not sealed. Mask easily 90mm OA placed + BBS + Sust ETCO2

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

EPW # [redacted] b(6)-4

SURGEONS: [redacted] b(6)-2

ANESTHE[redacted] CRNA

[redacted] MAJ MED[redacted] ESTHESIA

PROCEDURE LOCATION 2(2)

DATE 14 Sept 03

PAGE 1 OF 1

WAMC OP 376 REVISED Jan 99

MEDCOM - 19070

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

MEDICAL RECORD — ANESTHESIA

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

DRUG	Units					
Versed	( )	2	2	2	2	2
Ulsby	( )	3	2	2		
	( )					
	( )					
	( )					
	( )					

VOLAT AGENT: % del / % e.t.

AIR /Min

N2O /Min

O2 2 LC /Min — 3 — 3

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

FLUIDS — LINE site: LR — ☐ Warmed / ☐ Warmed / ☐ Warmed / ☐ Warmed — 1 / 2

LOSSES — EST BLOOD LOSS — 100; URINE –

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 70 KG LB

HEMATOCRIT:

INITIAL DATA: BP 124 / 59; HR – 119

GROUP CHECK: OK? – Y N

PATIENT RECHECK: OK for PROCEDURE? TIME – 1800

TIME → 1800, 30, 1900, 30, 2000

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

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

VT – ml					
f – breaths/min	22	16	16	16	16
Peak inf pres / PEEP					
MODE – S(pon), A(ssist), C(on)	S	S	S	S	S
BP/Auto Cuff					
BP / oth					
ART line					
Steth – PC/ES					
Gas analyzer					
Warming blkt					
Conv warmer					
ET CO2 (torr)					
FIO2 (Frac or %)					
SpO2 (%)	98	100	100	100	100
ECG	SR	SR	SR	SR	SR
TEMP – site Skin	37	37	37	36	36
N-M Block (T/I)					

TOTALS: TO 6 mg — TOTAL FLUID 100 — TOTAL URINE 0

FLUIDS – SUMMARY: CRYSTALLOID – 800; COLLOID – 0; BLOOD – 0

REMARKS – Code drugs with numbers, events with letters

35 yo ♂ GSW (R) LE

NKDA

Ato ✓ 3

PMH: 0

SAB: sitting, midline L3-4 BPx3, local 2cc 1% lidocaine 18G introducer, 24G spinal BPx1, free flow CSF, Heme, ⊙ 10cm anesthesia, 12 mg 0.75% marcaine ≈ 8.6% glucose.

EVENTS — Position: ⟶

PROCEDURES and CPT Codes: Debridement, GSW (R) LE. Application External Fixator (L) Femur.

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: SAB ≈ IVS

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: b(6)-2

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

[redacted]

b(6)-4

[redacted] May / CRNA

DELIVERY AT: PACU / ICU (Specify)

OTHER:

CONDITION:

RESP – 24 SpO2 – 98% RA

BP – 124/61 HR – 72

PACU	Start	Room	End
	1800	1810	1825
PROC	Ready	Begin	End
	1825	1845	1935

PROCEDURE: GSW FST

LOCATION: Ward

DATE: 19 Sep 03

PAGE: 1 OF 1

WAMC OP 376 REVISED Jan 99

MEDCOM - 19071

ASA II 70b.
NKA
61 kg

Hx Rx Fx L [illegible] MPCII 3FB m→H on UscTA [redacted]
Dr [redacted] Ma. [illegible] Hondy Anes. GETA . is: Kefal [redacted] 10/7/03

MEDICAL RECORD - ANESTHESIA

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

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

DRUG (Units)																	
Propofol (mg)	200	100															
Lidocaine ( )	100																
VERSED ( )	2.5																
FENTANYL ( )	100	150															
Succinylcholine ( )	80																
Narcan (mg)			.04	.04													
VOLAT AGENT: FORANE % del	20	X	X														
% e.t.																	
AIR L/Min																	
N2O L/Min																	
O2 L/Min	8	8	8														
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS	(1)(2)(3)																

FLUIDS

LINE site																	
18g (2) wrist	☐ Warmed	LR	—														
	☐ Warmed																
	☐ Warmed																
	☐ Warmed																

LOSSES

EST BLOOD LOSS																	
URINE -																	

TOTALS: 300 — **TOTAL EBL**: min

TOTAL URINE: 2.5 — Ø

FLUIDS - SUMMARY
CRYSTALLOID- 700
COLLOID- Ø
BLOOD- Ø

REMARKS
Code drugs with numbers, events with lettters
(1) PT ID IN
(2) RM-O2-MON.
(3) IND/INT.
(4) PT ∈ purposful mvmt - ext-sen
(5) OOR TO RR
(6) RPT

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 61 KG LB

HEMATOCRIT: /

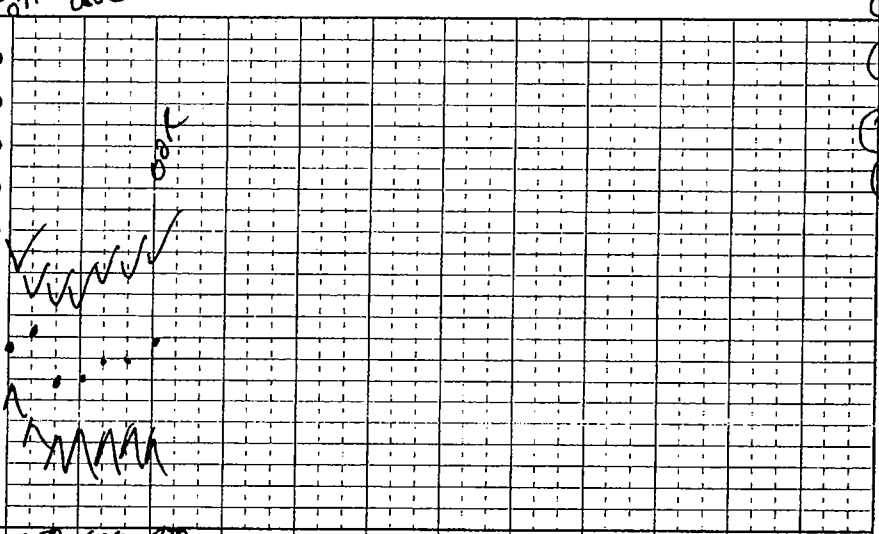
INITIAL DATA:
BP- 110 / 56
HR- 98

EQUIP CHECK
OK?- (Y) N

PATIENT RECHECK
OK for PROCEDURE? ✓
TIME- 0741

TIME → 0745 0800

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



VENTIL

VT - ml	800	800	800
f - breaths/min	6	6	14
Peak inf pres / PEEP	/	/	
MODE - S(pon), A(ssist), C(on)	SV-CV	CV	SV

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	52	51	62
BP/oth	FIO2 (Frac or %)	.73	.73	.73
ART line	SpO2 (%)	100	100	100
Steth- PC/ES	ECG	SR	SR	SR
Gas analyzer	TEMP-site	Axil		
	N-M Block (T/4)	4/4	4/4	
Warming blkt				
Conv warmer				

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

RECOVERY AT 0820
PACU ICU _____ (Specify)
OTHER _____
CONDITION: 95%
RESP- 16 SpO2- 100
BP- HR- 99

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0730	0735 0740	0826
	Ready	Begin	End
PROC	0742	0745	0756

PROCEDURES and CPT Codes:
EUA

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

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*
[redacted] Ward 13B
[redacted] b(6)-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* RSI/c DLX1 grade I view #8.0 ETT to 23 lip #90A in — TOTS

SURGEONS: [redacted] b(6)-2

ANESTHETIST: [redacted] CPT CRNA

PROCEDURE LOCATION: 1-1
DATE: 7 OCT 03
PAGE 1 OF

Doctor's Orders—Post-OP

126th OP 4256

Nurse Complete	Dr.'s Select	DATE: TIME:
☐	☑	1. Admit to: ☐ OR ☑ PACU ☐ ICW ☐ Patient Holding
☐	☑	2. Diagnosis: [illegible]
☐	☑	3. Condition: ☐ Critical ☐ Guarded ☑ Stable ☐ VSI ☐ SI
☐	☑	4. Allergies: See SF 558
☐	☑	5. Vitals: ☑ Unit SOP ☐ Notify Dr. for SBP < ___ or > ___, DBP < ___ or > ___, HR < ___ or > ___, RR < ___ or > ___, or Temp > ___
☐	☑	6. Activities: ☑ Bed Rest, ☐ BRP, ☐ OOB ASAP w/ assist, ☐ Sit up and dangle when stable ☐ Other:
		7. NRSG:
☐	☑	a. Propaq monitor w/ Pulse-ox
☐	☑	b. O_2 to maintain SAT's above 94%
☐	☐	c. ~~Maintain Vent~~ settings at MODE=_____ Vt=_____ RR=_____ PEEP= FIO$_2$=
☐	☐	d. ☑ Reinforce or ☐ Change dressing for bleed-through X1 then notify Dr.
☐	☐	e. ~~Ps & O's~~
☐	☐	c. ~~Suction NT ETT PRN~~
☐	☐	d. ~~CT to~~ ☐ ~~H_2O seal~~ or ☐ Suction at
☐	☐	8. Diet: ☐ NPO ☑ Clear fluids as tolerated ☒ Other: ADAT
☐	☐	9. IV: ☐ NS or ☑ LR TRA ~~125~~ cc/hr until to 1 pm ☐ DEXTRAN or ☐ Hespan X 500 cc bolus titrated then _____ cc/hr ☐ Albumin 100cc X ____ TRA _____ cc/hr ☐ When tolerating PO fluids, complete current fluid then SL.
☐	☐	10. ~~BLOOD~~: ☐ T&S or ☐ T&C _____ units ☐ Transfuse _____ units ☐ PRBCs or ☐ Whole Blood
		11. Medications:
☐	☐	a. ~~Tobramycin 300mg~~ IV Q12hrs X ☐ e ☐ Ceftriaxone 750 mg IV
☐	☐	b. ~~Clindamycin 600mg~~ IV ☐ f ☐ PEN G 2 million Units IV
☐	☑	c. Cefazolin 1 gram IV q 8hrs x 6 doses 1st dose @ 1730 hrs
☐	☐	d. Phenergan 12-25mg Titrate ☑ IV ☐ IM Q4hrs PRN nausea/vomiting
☐	☐	g. Droperidol 1mg ☐ IV ☐ IM X 1 PRN Nausea/Vomiting
☐	☐	h. MSO_4 1-3mg Titrate ☑ IV ☐ IM Q10min PRN Pain
☐	☐	i. Robinul 0.1mg IV X 1
☐	☐	j. ~~Zantac 50 mg~~ ☐ IV or ☐ IM or ☐ 6.25mg/hr infusion
☐	☐	k. Tetanus Immune Globulin
☐	☐	~~l. Toradol ☐ IV 30mg or ☐ IM 60 mg~~
☐	☐	m. Maintain sedation/paralysis w/ Rocuronium and MSO_4 PER SOP
☐	☐	12. LABS:
		a. iSTAT ☐ Glucose ☐ ABG ☐ BMP ☐ CMP
		13. Additional:
		Normal Saline [redacted] 10mg IV @ 10am pm pa [redacted] 10mg
		[redacted]
		Signature:

LOG# PT NAME: PT SSAN# b(6)-2

10JAN03

MEDCOM - 19073

1 mg IV & EPN

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT: b(6)-4 | ROOM NO. | BED NO.

DATE OF ORDER: 11 Sept 03 | TIME OF ORDER: 1840 HOURS | LIST TIME ORDER NOTED AND SIGN

Demaral 12.5 IM
X 2 pm Shivering

MSO4 1-2 pm pain
up to 20 IM b(6)-2

[redacted]

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT: b(6)-4 | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT: b(6)-4 | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

PATIENT IDENTIFICATION

[redacted]

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
#[redacted] b(6)-4				11 Sept 83	HOURS	
				(1) Admit to ICW 1		
				(2) Dx: GSW (B) LE		
				(3) Condition - stable		
				(4) Vitals - per floor routine		
				(5) Allergies NKDA		
NURSING UNIT	ROOM NO.	BED NO.				
ICW						

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
				(6) Activity - Bedrest		
				(7) Nursing notify MD for [redacted] b(6)-4 temp > 100.4, BP > 160/90 or < 90/50 RR > 25 or < 10 HR > 130 or < 50		
NURSING UNIT	ROOM NO.	BED NO.				

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
				(8) Diet - NPO		
				(9) IVF - 125cc/hr LR		
				(10) CABG φ		
NURSING UNIT	ROOM NO.	BED NO.		(11) Meds - MSO4 2-4mg IVP q 3-4 hr prn		

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					[redacted] HOURS	
					b(6)-2	
NURSING UNIT	ROOM NO.	BED NO.				

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION b(u)-4

SPN

[redacted]

notified transport 1180B 2102

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

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

Adm to Floor / Hygate / ortho

Slip I/D (R) leg, I/D (L) Fem + ext fix

Stat

Vitals pt Eo's Rontin

NKDA

ADAT to Reg.

LL @ 100cc/° until tol po

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER (HOURS)

MSO4 1-3g iv 20 min pr

Percocet I-II po q4° pr

Tylenol 650 mg po PR q6° pr

Phenergan 12.5 mg iv q6° pr

Lovenox 30 mg SQ BID start AM 9/12

Acet. Keflex 1g iv q8° x 6 doses postop. — 8 hr

Zantac 150 mg po bid

PT consult: WBAT (R) LE

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | ~~TIME OF ORDER~~

LLE

Rom (L) knee

Rontin call orders. b(u)-2

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

b(u)-2

JPO Urent [redacted] U/AN 1180B 2102

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER (HOURS)

13SEP03 0700

OK OOB to chair BID at least.

D/C Zantac

b(u)-2 [redacted]

b(u)-2 Noted [redacted]

NURSING UNIT [redacted] 13SEP03 1450 | BED NO.

JPO 2135 13SEP03 [redacted]

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

DATE OF ORDER: 14 Sept 03 | TIME OF ORDER: HOURS | LIST TIME ORDER NOTED AND SIGN

[redacted]

NPO

LR @ 100cc/

plan OR today for [redacted] I/P.

[redacted] b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: b(6)-2 [redacted]

DATE OF ORDER: 16 Sept 03 | TIME OF ORDER: HOURS

- Readmit to Floor S/P repeat I/O.
- Resume prep orders

ADAT to Reg

LR @ 100cc/0 mn/ tx po

AP/LAT (L) Femur [redacted]

b(6)-2

NURSING UNIT | ROOM | BED

PATIENT IDENTIFICATION

DATE OF ORDER: 9-14-03 | TIME OF OR[redacted] | 1400 HOURS

(1) Demerol 10mg IV PRN [redacted]

post-op shivering max dose 25mg IV

[redacted] CRNA/MAT ?

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

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

DATE OF ORDER: 15 Sept 03 0830 | TIME OF ORDER: HOURS

~~NPO p MN for OR tomorrow~~ even

~~LR @ 100cc/0 p MN~~ even

Kef 2gl IV q8° x3 [redacted] [redacted]

[redacted] b(6)-2

Vitals q shift

D/C I/O's

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER (HOURS)	LIST TIME ORDER NOTED AND SIGN
	17Sep03 1918	pin care BID c ½ str H2O2 - may leave pins & dressing. b(6)-2	[redacted]
		V/O Dr [redacted]	[redacted]
NURSING UNIT: 24V / ROOM NO.: 0030 / BED NO.: 17Sep03		may leave @ ankle actu[redacted] OTA. [redacted]	0000. 17Sep [redacted]

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER (HOURS)	
b(6)-4 # [redacted]	21Sep03 0842	~~[illegible]~~ Colace 1 po bid.	[redacted] 4/21/ 0843
NURSING UNIT: ICW / ROOM NO.: / BED NO.: 24 Charlie		~~PDIL~~ [redacted]	

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER (HOURS)	
b(6)-4 [redacted]	25Sep03 0925	D/c lovenox. b(6)-2	[redacted]
NURSING UNIT: ICW / ROOM NO.: 24 Charlie / BED NO.: 2345 [redacted]			

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER (HOURS)	
	27Sep03 0930	Keflex 1g iv q8	[redacted]
		b(6)-2	
NURSING UNIT: Not [redacted] / ROOM: [redacted] / BED NO.: 27Sep03 0925		[redacted]	9/29/03

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	29 Sep 03 0922	HOURS	
	AP/LAT (L) Femur today. [redacted] b(6)-2		[redacted] 9/29/03 0923
NURSING UNIT: 1CW 24° ✓ 30 Sep 03 @ 2245	ROOM NO.	BED NO.	

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
Noted + transcribed 6 Oct 03 1910 [redacted] b(6)-2	6 Oct 03	HOURS	
	- NPO p MN		
	- LR @ 100cc/' p MN.		
	- plan OR tomorrow for manipulation knee		
	b(6)-2 [redacted]		
NURSING UNIT: 24° ✓	ROOM NO. [redacted]	BED NO. [redacted]	6 Oct 03 1910

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
	10-8-03	1000 HOURS	[redacted]
	- XR AP + LAT (L) femur		
	- DC pt to EPW comp. b(6)-2		
b(6)-2 Noted [redacted] 8 Oct 03 1000	[redacted]		SOC
NURSING UNIT	ROOM NO.	BED NO.	

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

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] b(6)-4				07 OCT 03	HOURS	
				0800	Readmit to Floor	
					Regular diet	
					LR @ 100cc/hr until tolpo	
					Resume prep orders/meds	
				XRAYS	AP/LAT (L) Femur today [redacted]	
NURSING UNIT	ROOM NO.	BED NO.			b(6)-2 [redacted]	
PATIENT IDENTIFICATION				DATE OF ORDER	HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

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

b(4)-2 All

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 9 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 11	12	13	14	15	16	17	18	19	20	21	22	23	24
9/11	[redacted]	Vitals per P/R	06	[redacted]													
		Routine	18														
9/11	[redacted]	Activity - Bedrest	06														
			18														
9/11	[redacted]	Nursing: notify MD	06														
		for temp >100.4	18														
		B/P >160/90 or <90/50															
		RR >25 or <~~20~~ 10															
9/11	[redacted]	Diet NPO	06														
			18														
9/11	[redacted]	Nursing: notify MD	06														
		for temp >100.4	18														
		B/P >160/90 or <90/50															
		RR >25 or <10															
		HR >130 or <50															
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]													
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]													
13 Sep 03	[redacted]	OOB to chair BID &	06														
		least	18														
14	[redacted]	~~NPO~~ ADAT to	06														
		NOS	18														
9/15	[redacted]	Vitals q shift	06														
			15														
			06														

DC'd per P/R

See rewritten order below

DC 9/15

DC

Rewritten

ALLERGIES: ☐ YES ☒ NO — NKDA

PRIMARY DIAGNOSIS: GSW BLE S/P I&D

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

b(6)-4

[redacted]

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

b(6)-2 A11

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo Sept Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
9/11	[redacted]	Admit to ICU 1, Stable	9/11	—	[redacted]	
9/11	[redacted]	Labs ✓	9/11	noted	[redacted]	
11Sep	[redacted]	Admit to floor/Hugate/Ortho	11Sep03	—	[redacted]	
11Sep	[redacted]	Stable	11Sep03	—	[redacted]	
11Sep	[redacted]	PT consult: WBAT @ LE,	11Sep03	—	[redacted]	
	-----	FFNWB LLE, ROM @ knee				
11Sep	[redacted]	Routine call orders	11Sep03	—	[redacted]	
14	[redacted]	Plan OR today for repeat I+D				
14	[redacted]	NPO				
14	[redacted]	Read mt to floor, resume prop				
	[redacted]	orders, ADAT to regular				
14	[redacted]	AP/LAT @ bedside in AM	PSO Physiot		[redacted]	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
-----	-----															
-----	-----															
-----	-----															
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-----	-----															
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b(u)-2 All

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 9 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 18	19	20	21	22	23	24	25	26	27	28	29	30	1
13Sep	[redacted]	OOB to chair BID	06	[redacted]													
		@ least.	18														
14Sep	[redacted]	Regular diet	06	[redacted]													
			18														
15Sep	[redacted]	VS q shift	06	[redacted]													
			18														
17Sep	[redacted]	pin care BID c 1/2	10	[redacted]													
		sterile H2O, may leave	22														
		pins 5 drsg./may	/														
		leave (R) ankle sutures	/														
		open to air.	/														

ALLERGIES: ☐ YES ☑ NO

PRIMARY DIAGNOSIS: GSW (B)LE — O/P I+D (L) thigh ex-fix.

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

#[redacted] b.(u)-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 A11

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
4/09	[redacted]	AP = LAT (L) Femur	[redacted]			

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

USAPA V1.00

b(6)-2 All

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/ 0 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 2	3	4	5	6	7	8	9
13 Sep	[redacted]	OOB to chair BID	06	[redacted]							
		(at least) (recopied)	18	[redacted]							
14 Sep	[redacted]	Reg diet	06	[redacted]							
		(recopied)	18	[redacted]							
15 Sep	[redacted]	VS q shift	06	[redacted]							
		(recopied)	18	[redacted]							
17 Sep	[redacted]	pin care BID c.	10	[redacted]							
		1/2 sterile H2O2. May		[redacted]							
		leave pins c dsg.									
		May leave (R) ankle									
		sutures open to air									
		(recopied)									

ALLERGIES: ☐ YES ☑ NO
NKDA

PRIMARY DIAGNOSIS:
GSW (B) LE S/P I&D (L) thigh ex fix

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

b(6) - 2 A11

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo ____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
6Oct	[redacted]	NPO p MN	7Oct03	0001		[redacted]
6Oct	[redacted]	Plan OR tomorrow for manipulation	7Oct03			
	----	of knee				
08 Oct03	[redacted]	XR AP & LAT of femur	08 Oct03			
08	[redacted]	D/C pt to EPW camp				

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

b(6)-2 A11

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (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	11	12	13	14	15	16	17	18	19	20	21	22	23	24
9/11	[redacted]	LR@100cc until	6	X	[redacted]												
		~~TOL PO~~ tol PO	18	[redacted]													D/C
11sep	[redacted]	Lovenox 30mg SQ	10	X	[redacted]												
		BID (start 9/12)	22	X	[redacted]												
11sep	[redacted]	Zantac 150mg	10	X	[redacted]	DIC 13SEP03											
		PO BID.	22	[redacted]													
11sep	[redacted]	Kefzol (Ancef) 1gm	08	X	[redacted]												
		IVQ8X6 doses	16	[redacted]													
		post-op.	24	[redacted]													
15Sept	[redacted]	Kefzol (ancef) 1gm	08				[redacted]										
		q 8° x3 doses	16				[redacted]										
			24				[redacted]										
9/21	[redacted]	Colace I po bid	10												[redacted]		
			22												[redacted]		
9/11	[redacted]	HL when tol PO	9/6-18														
			18-06												[redacted]		

ALLERGIES: ☐ YES ☒ NO — NKDA

PRIMARY DIAGNOSIS: GSW (B) LE S/P IXD

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)-2

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

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
13 SEP03	[redacted]	PC Zantac	13 SEP03	—	—	[redacted]
		b(6)-2 All				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
11 Sep03	[redacted]	MSO4 1-3 mg IV q20min PRN	D/T	11Sep 2030	11Sep 2130	11Sep 2300	12Sep 0030	12Sep 0400	12Sep 0440	12Sep 0905	12Sep 2215	13 0045	13 0530		
				2mg	2mg	2mg	2.5	2.5	3mg	3mg	3mg	3mg	3mg		
				[redacted]											
11 Sep	[redacted]	Percocet 1-2 tablets PO Q4 PRN	D/T	13Sep 1510	13Sep 2315	16Sep 1115	16Sep 1545	16Sep 2140	17Sep 0830	17Sep 2200	18Sep 1010	18Sep 1933	19Sep 0500	19Sep 1030	19Sep 1635	19 2320
			D/T	✓ KPS	✓ ✓	✓	✓	✓	✓	✓	✓	2	2	✓	✓	✓
				[redacted]												
11 Sep	[redacted]	Tylenol 650mg PO/PR q6 PRN	12Sep 000	12Sep 1905												
			650	✓												
			[redacted]													
11 Sep03	[redacted]	Phenergan 12.5mg IV q6 PRN														
11 Sep	[redacted]	Percocet 1-2 PO Q4 PRN	D/T	21Sep 0530	21/22 1300	21Sep 2200	22 0210	9/22 1040	9/22 1605	9/22/03 2030	23Sep 0915	23Sep 1235	23Sep 1945	23Sep 2005	24Sep 1005
			D/T	✓ BR	2mg ✓	BR ✓	BR ✓	9P ✓	9P ✓	PD ✓	KPS ✓	KPS ✓	✓ PD		✓ KPS
11 Sep	[redacted]	Percocet 1-2 PO Q4 PRN	D/T	24 0530											
			D/T	✓	[redacted]										

USAPA V1.00

b(6)-2 All

CLINICAL RECORD

Th. .PEUTIC DOCUMENTATION CARE PLA.. (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 25	26	27	28	29	30	1	2	3	4	5	6	7	8
11 SEP03	[redacted]	Lovenox 30mg SQ BID	10	02	<	D/C'd	25	Sept	03								
		(start 9/12)	22														
21 SEP03	[redacted]	Colace 1 po BID	10	[redacted]													
			22														
11 SEP03	[redacted]	HL when td po	06	[redacted]													
		(flush q shift)	18														
27 SEP03	[redacted]	Kefzol 1gm IV q8°	06														
			14														
			22														
6 OCT03	[redacted]	LR @ 100cc/° p MN	06														
			18														

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: GSW (B) LE S/P I/D

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

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
		b(u)-2 All				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED														
11SEP03	[redacted]	MSO4 1-3mg IV q20 min prn	D/T	7OCT 0920													
			D/I	3mg SJS													
11SEP03	[redacted]	Percocet 1-II po q4° prn	D/T	25SEP 1615	25SEP 1515	25SEP 2110	26SEP 1915	27SEP 1655	28SEP 2009	29SEP 2330	1OCT 0220	1OCT03 2230	2OCT03 2200	3OCT03 2202	5OCT 0224		
			D/I	II KPB	II	II	II	2	2	II	II	II	II	II	2		
11SEP03	[redacted]	Tylenol 650mg PO/PR q6° prn	D/T	25SEP 1000	27SEP 1055												
			D/I	650mg SJS	[redacted]												
11SEP03	[redacted]	Phenergan 12.5mg IV q 6° prn	D/T	7OCT 12.5mg 0920													
			D/I	SJS													
11SEP03	[redacted]	Percocet 1-II po q4° PRN	D/T	7OCT 0920													
			D/I	II	[redacted]												

USAPA V1.00

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 9/11
Time In: 1750
Allergies: NKDA
Pre-op V/S: 115/63 90
Procedures: Ex fix to left femur

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1500 NS Colloid
OR Output: UOP Ø EBL MIN
Meds/Times: Ancef 1gm 1545

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds History

Time	1750	1750	1800	1815
SaO2	99	98	99	95
FiO2	RA			
Methods	GW	RA	RA	RA
240				
220				
200				
180				
160				
140		✓	✓	
			✓	
120	•	•		
100	✓			
		•	•	•
80				
			∧	∧
60		∧		
40	∧			
20				
RR	21	20	20	14
T	96.4			

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
1830	NAcLR	400	LFA		

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
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

[redacted] b(4)-2 21220

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 11 Sep 03

PAT[redacted]e: Name – last, first, middle; grade; date; hospital or medical facility)

[redacted] b(4)-4

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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1800	—	Demerol 12.5	IV	—	—	[redacted]

NEUROVASCULAR

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

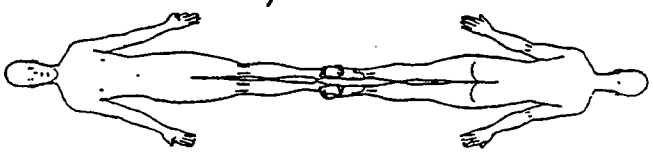
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	ex fix left leg	Kerlex	MIN
30'	ex fix R leg	Kerlex	MIW
60'			
D/C	ex fix R leg	Kerlex	MIW



PACU OUTPUT

Time	Source	Color/Appearance	Amount
Ø			

CARDIAC RHYTHM

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

WAMC OP 173-E

NURSING NOTES

Received pt from OR. Sats 69%. Put pt on 10L FM sats ↑ 100%. Took pt off of O_2. Pt sats 98% RA. 12.5mg Demerol given for Shivering

b(w)-2 A11

Discharge Criteria:
Date: 1 Sep 03 **Time:** 1820 **PARS:** 10
BP: 134 **T:** **HR:** 86 **RR:** 14 **Sa02:** 94
Pain Level at D/C (0-10):
Intake: _____ **Output:** Ø
Additional Data: _____
Transferred To: ICW #1
Report Given To: _____
Transferred Via: W/C Litter (Gurney) Ambulance
Transferred By: SGT [redacted]
Cleared IAW Recovery Ro [redacted]
Charge Nurse Signatur [redacted]

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: _____ Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block

Time In: 1353

Allergies: NKDA OR Intake: Crystalloid 600 Colloid _____

Pre-op V/S: 106/74, 96 OR Output: UOP 0 EBL 150

Procedures: JOD (R) LE Meds/Times: Phenergan / Ancef

Gen Mask Air

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

Pre Op Meds History

Time	1355	1400	1405	1415	1425	1430	1440
SaO2	98	100	100	100	100	97	99
FiO2	2L	2L	2L	2L	NR	NR	NR
Methods	NC	NC	NC	NC			
240							
220							
200							
180							
160							
140							
120							
100							
80							
60							
40							
20							
RR	40	24	12	10	8	12	14
T	101						

Time	1355							
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	1	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	1	1	
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	7	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

PREPARED BY [redacted] b(6)-2

DEPARTMENT/SERVICE/CLINIC: PACU/ICU

DATE: 14 Sep 03

PATIENT'S IDENTIFICATION (For typed or written entri[redacted] first, middle; grade; date; hospital or medical facility) Name – last,

[redacted] b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete

USAPPC V2.00

MEDICATIONS

Allergies: NKDA

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1400	—	10% Dextrose	IV	—	—	[redacted]

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	Bilat	—	+	P	<3	L	Pk
15'							
30'							
45'							
60'							
90'							
D/C							

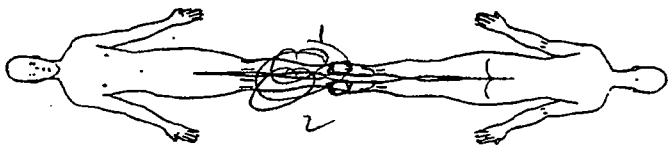
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) Leg/Ankle	Gauze	Ø
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

(B) LE TCD w/ (+) 3+ pulses to (D) extremities. Cap (R). Given demerol 1mg x 2 for hx of shakes. [redacted] 1420

[redacted] 1420: Pt continues to be hemodynamically stable, VSS. Sats 95-100 on room air. Will continue monitor. Needs to take a deep breath. [redacted] 1440

Pt [redacted] 1440: Pain unbearable. Follows commands on deep breathing/coughing in I.C. Transfer on 1400

b (u)-2 All

Discharge Criteria:
Date: 9/1/02 **Time:** 1440 **PARS:** 9
BP: 109/62 **T:** 101.2 **HR:** 95 **RR:** 12 **Sa02:** 95
Pain Level at D/C (0-10):
Intake: 100 cc **Output:** Ø
Additional Data:
Transferred To: ICW2
Report Given To: GMM
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: [redacted] 1470

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 OCT 03
Time In: 0820
Allergies: NKDA
Pre-op V/S: 116/80 98
Procedures: Knee manipulation

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 700 Colloid
OR Output: UOP 0 EBL 0
Meds/Times: Fentanyl ; versed (MARCAIN)

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

Pre Op Meds History

Time	0820	0830	0840	0845
SaO2	100	100	120	
FiO2				
Methods	RA	RA	RA	
240				
220				
200				
180				
160				
140				
120				
	V	V	V	V
100				
80	•	•	•	•
			^	^
60	^	^		
40				
20				
RR	17	17	13	17
T	95			
Time				
Pain (0-10)				
LOS				

Pacu Intake

Time	Solution	Amount	Site	By	Infused
0820	LR	700	L hand	OR	800

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	1	1	1
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C,	8	9	9

Codes

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

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

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

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

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

(Continue on reverse)

PREPARED BY: [redacted] b(6)-2 LPN

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 7 Oct 03

PATIENT [redacted] (If 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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

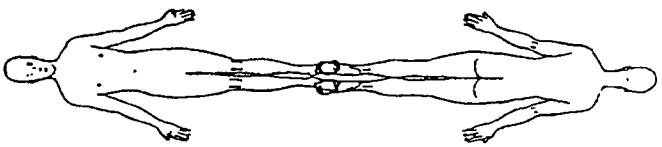
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) leg	lkt fix	-0
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0820	SR	-0	-0

NURSING NOTES

Pt to recovery room from OR via litter s/p (L) knee manipulation. Ext fix intact. IV of LR infusing into (L) hand. D s/s of redness at dwelling. VS. will continue to monitor [redacted] Pt to ICW#1 — [redacted]

b(a)-2 All

Discharge Criteria:
Date: 7 OCT Time: 0845 PARS: 9
BP: 113/60 T: 95.7 HR: 93 RR: 17 Sa02: 100
Pain Level at D/C (0-10):
Intake: 100 Output: -0
Additional Data:
Transferred To: ICW#1
Report Given To: SPC [redacted]
Transferred Via: W/C [redacted] ney Ambulance
Transferred By: SPC [redacted]
Cleared IAW Recovery Room SOP B-3
[redacted] se Signature: [redacted]

WAMC OP 173-E

[redacted]

1. DATE AND TIME OF CAPTURE	2. SERIAL NO. [redacted]	A
10 Sept 03 1700		
3. NAME [redacted]		4. DATE OF BIRTH b(6)-4
5. RANK	6. SERVICE NO.	
7. UNIT OF EPW	8. CAPTURING UNIT C [redacted]	
9. LOCATION OF CAPTURE (Grid coordinates) [redacted] b(2)-2		
10. CIRCUMSTANCES OF CAPTURE	11. PHYSICAL CONDITION OF EPW	12. WEAPONS, EQUIPMENT, DOCUMENTS

DD FORM 2745, MAY 96 REPLACES DA FORM 5976, JAN 91, USABLE UNTIL EXHAUSTED.

1. DATE AND TIME OF CAPTURE	2. SERIAL NO. [redacted]	B
10 Sept 03 1700		
3. NAME [redacted]		4. DATE OF BIRTH b(6)-2
5. RANK	6. SERVICE NO.	
7. UNIT OF EPW	8. CAPTURING UNIT C [redacted]	
9. LOCATION OF CAPTURE (Grid coordinates) [redacted] b(2)-2		
10. CIRCUMSTANCES OF CAPTURE	11. PHYSICAL CONDITION OF EPW	12. WEAPONS, EQUIPMENT, DOCUMENTS

DD FORM 2745, MAY 96 REPLACES DA FORM 5976, JAN 91, USABLE UNTIL EXHAUSTED.

1. DATE AND TIME OF CAPTURE	2. [redacted]	C
10 Sept 03 1700		
3. NAME [redacted]		4. DATE OF BIRTH b(6)-2
5. RANK	6. SERVICE NO.	
7. UNIT OF EPW	8. CAPTURING UNIT C [redacted]	
9. LOCATION OF CAPTURE (Grid coordinates) [redacted] b(2)-2		
10. [redacted]		

DD FORM 2745, MAY 96 REPLACES DA FORM 5976, JAN 91, USABLE UNTIL EXHAUSTED

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	Z Z	[redacted]	[redacted] b(6)-2	EPW	M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
Z	32 Y	X	9	MUSLIM

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
Z	Z	~~9 9~~ 30	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	Z	1410	b(6)-4

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø	ICW1	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	[redacted] b(2)-2	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

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

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

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

FOR LOCAL USE

DX: (1) GSW (B) LE

(2) S/P I+D (L) THIGH EX-FIX (open (L) Femur fx)

[redacted] b(6)-2

ADMITTING OFFICER (Signature)	SIGNATURE OF ADMITTING CLERK
[redacted] CPT	[redacted]

DA FORM [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 [redacted] b(6)-2			3. GRADE CIV	ADMISSION REMARKS
4. SEX m	5. AGE 40Y	6. RACE X	7. RELIGION UNK	8. LENGTH OF SVC —	9. ETS —
10. PREVIOUS ADMISSION no					
11. FMP 99	12. SSN [redacted]	13. ORGANIZATION b(6)-2		14. WARD ICW2	
15. FLYING STATUS —	16. RATING/ DSG —	17. DEPT./ BEN —	18. BRANCH/CORPS —	19. UIC/ZIP —	20. TYPE CASE NB1
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct (ER)			22. HOURS OF ADMISSION 0824	23. CLINIC SERVICE general surgery	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION O/C HOME	26. DATE OF DISPOSITION 19Sept03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)			27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION 15 Sept 03	ADMITTING OFFICER [redacted]
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted]				30. DATE OF INTIAL ADMISSION 15 Sept 03	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMIN [redacted] b(2)-2

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

grade II liver laceration

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	5	5

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0 [redacted]	0 b(6)-2	0	0	5	5

SIGNATURE OF ATTE [redacted] SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER [redacted] b(6)-2

MEDCOM - 19099

DA FORM 3647 [illegible] EDITION OF 1 AUG 76 IS OBSOLETE US

PATIENT'S CLEARANCE RECORD

For use of this form, see AR 40-2; the proponent agency is OTSG

[redacted] b(6)-4

PATIENT'S IDENTIFICATION

DATE OF DISCHARGE	TIME OF DISCHARGE
19 Sep 03	1000

SIGNATURE OF WARD OFFICER

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

ACTIVITY CLEARANCE

(The final activity with which the patient must clear will be the disposition office.)

Military	INITIALS*	Non-military	INITIALS*
1. Patient's Trust Fund		1. Patient's Trust Fund	[redacted] b(6)-2
2. Medical Services Account Officer		2. Medical Services Account Officer	
3. Clothing and Baggage		3. Clothing and Baggage	
4. Medical Holding Unit		4. Postal Service	
a. Supply		5. Change of Address	
b. Pay Section		6. Other *(Specify)*	
c. Service Records		7.	
d. Insurance and Allotments		8.	
5. Postal Service		9.	
6. Change of Address		10.	
7. Other *(Specify)*		11.	
8.		12.	
9.		13.	

REMARKS

DATE	SIGNATURE OF PATIENT ADMINISTRATOR
19 Sep 03	[redacted] b(6)-2

* INITIALS OF PERSON AUTHORIZING CLEARANCE.

DA FORM 4029, MAR 73 REPLACES DA FORM 6-258, 1 DEC 59, WHICH WILL BE USED USAPPC V1.00

15 Aug 1315

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

40 y/o Iraqi civilian struck by frag from IED ~ 15M away ~ 0700, brought to EMT, rec'd tox ER
Mental status SH
PMH:

PHYSICAL EXAMINATION

PE: 120/70 90 afeb R 20
HEENT (-), poor dentition
chest - clear bil co RRR s/(R)
abd - generally soft by tense rectus c̄ resp'n, c/o pain c̄ palpation RUQ
BS+
back - slight (R) CVA tenderness
pelvis - stable
extr - moves all

PROGRESS (Enter date of discharge and final diagnosis)

Hct 47 WBC 19 | 130 | 104 / 3.7 | 26 glu 129 cr 1.2 alb 3.3 ~~ALT 83 (10-42)~~ AST 77
amyl 98
plt 205
U/A 1030 SG
trace blood

CXR - frag (R) thoracoabd
CT - tract from entry wound, thru (R) lobe liv, into SQ post. Bilateral abdwall, ō evidence hemo, ō free air or fluid in abd, admit for obs + ABX's

SIGNATURE	DATE	IDENTIFICATION NO.	ORGANIZATION
b(6)-2 [redacted] MC	15 Aug		

PATIENT'S IDENTIFICATION	(For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)	REGISTER NO.	WARD NO.
# [redacted] b(6)-4			

[redacted] b(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

19 Sep '03 Discharge Note

Admit 18 Sep - Disch 19 Sep

Dx - grade III liver lac (R) lobe liver

Follow-up 1 week 26 Sep EMT

Pt a 40 y/o M injured ~0700 15 Sep arrival EMT 1300. Exam revealed stable pt c̄ wound Anterior Axillary line (R) side ~ 7th IS. Pt had moderate pain in (R) lower anterior chest and (R) UQ

CXR (-) Hct 47 WBC 19 lytes + pH T's normal

CT abdomen revealed a posterior point of fragment from anterior thru lateral (R) lobe into soft tissues - subcutaneous - posteriorly (not able to palpate frag)

Pt received gent 400 mg daily + Ancef 1gm q8h x 48h then switched to po cipro 500 mg po q12h. His WBC progressively decreased to 9.1 - 9.2 by 3rd day. He has remained afebrile throughout his course.

His bilirubin increased to 3 on the 16th and has remained there but his GGT remains normal, ALT ~ 58-60. A repeat CT on the evening of the 16th revealed ō change in tract - there was ~~not~~ no extracapsular blood, no free blood in abdominal cavity. The patient is eating well and has minimal pain and →

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	ambulatory. He is discharged to be followed up in 1 week, and will continue ciprofloxacin 500 mg po q12h for 6 more days - total 10 days AB's
	[redacted] MD LTC
	[redacted] LTC
	b(a)-2

STANDARD FORM 509 (REV. 5/1998) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
15Sept03 @0825	pt arrived via Medevac, ? injury / incident per interpreter. Arrived Axox3, grunting & holding (R) side. Pt c small ½ inch shrapnel wound to (R) rib area, lungs CTA 4L O_2 placed immediately & on full monitor pt stable, see TSS for VS. [redacted]
@0830	labs drawn & sent. pt to have [redacted] done. Fast exam - limited (-). No other injuries noted. 50mg fentanyl given for pain.
@0900	pt calm, lying flat, talking c interpreter. Anaf 16m ~~complet~~ administered. Td shot given IM on (R) deltoid. waiting for CT [redacted] SCAN [redacted]
@0910	pt transferred to CT Scan, O2 [redacted] pt 97% RA, appear in no apparent distress [redacted]
@1000	pt back from CT Scan, tolerated [redacted]
@1145	pt waiting for transfer to Iraqi hosp [redacted] arranged by PAG. pt grunting & holding (R) side, 50mg fentanyl given [redacted]
@1205	pt lying flat in NAD, VSS [redacted]
@1205	Iraqi ambulance here for transfer [redacted]

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

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

[redacted] b(4)-4

Iraqi Civilian

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

b(4)-2
All

b(2)-2

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
@1405	pt arrived back @ [redacted] p Iraqi hospital refused patient. Am pt placed back in EMT, pt alert, VSS ~ see 558. 1200cc clear, yellow urin in foley. 2, 18g IV still in place in each AC. PAD not fed, admission [redacted] initiated —

[redacted] b(6)-2

STANDARD FORM 600 (REV. 6-97) BACK

☆ U.S. GPO:1998-432-786/75236

PREVIOUS EDITION IS USABLE

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
15 Sep 03	S) 40 year old male Iraqi civilian s/p IED injury to (B) lower anterior chest wall w/ complaint of localized abd pain. Mild (B) scapular pain
ΦIMMV	
ΦPMV	O) Mild pain, A O x 3 BP 122/70, HR 80, 99% RA, 18
NIDDA	MMM
ΦMCS	Φ carotids, midline
	CTAB. (B) BS
	RRR Φ murmurs
	Soft, NT, ND, NTP w/ hyperactive bowel
	Φ Back injury
	M Gu.
	small abrasion (B) RA CVA. Φ IRAIR
	ΦPTV
	~~Φ hemothorax~~
	AP (1) RUQ penetrating injury
	Blood dripping thru L
	wound 3 hr
	normal cranial & abdomen
	PO CVA.
	[redacted] b(6)-2
	[redacted] MMJ, MC

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

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

[redacted]

[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	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
15 Aug '03	0900
	40 y/o ♂ c̄ IED in ~2 hr ago, brought to EMT, c/o
	pain (R) lower ant chest/(R) upper ant abd
	Med ō all ō PMH (-)
	PE: 122/70 80 97%
	HEENT (-), poor dentition
	neck (-)
	chest - bil BS
	cv - c̄ (n)
	abd - generally soft, tender rectus c̄ rep'n
	extreme worst ~ 6th IS AAL
	pelv - stable
	extr - move all
	CXR - (R) lower thorax abd
	P - c̄ [redacted] b(6)-2
18 Aug 1000	
	Frag entered ~ 7th IS, AAL, passed thru (R) lobe liver + is
	lodged in posterior SQ; ō free fluid or free air; atelectatic
	bases bilateral
	Hct 15 WBC 19.4 a. 1.2 amylase 98
	130/104 BR 1.5 ALT 83 (10-47)
	3.7/26 ALP 49 nl
	alb 3.3
	A - gr II liver lac b(6)-2
	P - transfer to Iraqi Hosp for cont'd abx antibiotics [redacted] MD LTC

STANDARD FORM 600 (REV. 6-97) BACK

[redacted] b(6)-4

PREVIOUS EDITION IS USABLE

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
15SEP03	SURGERY
0750	40 y/o ♂ c̄ hx of Improvised Explosive Device shrapnel
	injury to RUQ abdomen / (R) low chest. Pt. c/o pain
	RUQ. No dyspnea / SOB. No other injuries to 2° survey.
	CXR obtained (upright AP) s̄ evidence of HTX / PTX,
	SpO_2 98% ORA, phonating, mentating well.
	SBP 120-130, HR 88.
	Local wound exploration @ bedside shows ½ cm
	entrance wound @ 8 cm inferior to (R) nipple.
	Foley placed. DRE (-). 8 quage IV x 2.
A:	RUQ penetrating abdominal wound.
	Pt's VS stable for transport.
P:	Transfer to CSH, possible ex lap.
	[redacted] b(6)-2
	CPT MC M.D.

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

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

[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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
16 Sep	0700
	S- ↓ pain
	O- afeb
	BS clear
	abd (+) BS
	ten tender RUQ
	hct 44 WBC 12.6 plt 200 132/100 44/22 Gl 12
	CXR-nl
	A- stable
	P- reg diet DC foley if stable disch c̄ AD's 17 Sep
16 Sep 1930	[redacted]
	IV DC'd, switch to po ATB's
	Tolerated diet well [redacted]
17 Sep	b(6)-2 A11
	1100
	chest clear, 1+/4 pain RUQ, abd soft
	WBC 9.3 Hb 14.5 plt 188
	BR 3.0 GGT 18 amyl 175 ALT 68 ALPS,
	A- likely resolving hematoma c̄ sl GGT, but c̄ lo grade
	temp p̄ being afeb, will watch 24 hr [redacted]

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 Sep	2100
	CT ō ⚠, ō air in bowel, ō fluid in Morrison's pouch, minimal (R) pleural effusion
	P- cont obs, re-eval [redacted] b(6)-2
18 Sep	0630
	S- feels better
	O- BS present bil, slightly ↓ (R) base, tender afeb, abd soft, minimal RUQ pain, drill ok
	Hct 48 WBC 9.1 plt 211 cr 1.2 BR 3.5↑ AST 26 ALT 58↓ ALP 51 GGT 20
	A- stable
	P- obs x 48hr + [redacted] b(6)-2

STANDARD FORM 600 (REV. 6-97) BACK

☆ U.S. GPO:1998-432-786/75236

b(2)-2

NSN 7540-01-075-3786

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

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS: IRAQI CIV

CITY: | STATE: | ZIP CODE:

ARRIVAL

DATE *(Day, Month, Year)*: 15 Sep 03 | TIME: 0824

TRANSPORTATION TO FACILITY: MEDEVAC

SEX: M

AGE: 40

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

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

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

CURRENT MEDICATIONS: 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 INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: Shrapnel (R) chest

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☐ NON-URGENT

TIME: 0824

IN [redacted] b(2)-2

VITAL SIGNS

TIME	0824	0842	0935	1200	1155	1400
BP	124/77	125/59	110/57	114/55	120/55	112/69
PULSE	79	77	74	76	75	80
RESP	18	22	18	20	18	20
TEMP	97.8 (A)					
~~WT~~	98%	97%	98%	97% RA	98%	94%

LAB ORDERS

X CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT
URINE C&S	UA MSCC/CATH		X CHEM: 12 E/lytes
X BLOOD C&S X ~~2 units~~ T&S			

X-RAY ORDERS

CXR PA & LAT/PORTABLE	C-SPINE
ACUTE ABDOMEN	LS SPINE
SINUS	HEAD CT
ANKLE R/L	~~X~~ ~~HAS~~ cancel
	~~X~~ CT Scan – Abdomen

ORDERS

☒ PULSE OX 94% ☒ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
	50mcg Fentanyl IV	[redacted]	@0840		75mcg Fentanyl IVPRE 1145 for pain
	1gm Ancef	↑@0836			
	12 IMS		0858		
	50mg Fentanyl IV		[redacted] @1012		

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)*

IRAQI CIV

[redacted] b(2)-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

LFTs - mild ↑

CBC		SMAC				ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
WBC 19		130	104	16		SUP O2	PH	PO2	RESULTS CXR - ⊖ PTX or HTX	
H/H 15/47		3.7	26	129	1.2	PCO2	SAT	OTHER		
PLT 205										
PT						UA: DIP (2)			EKG INTERPRETATION CTAbd - Grade 2 liver laceration	
APTT		BHCG	ETOH	GLU		MICRO				

PROVIDER HISTORY/PHYSICAL

S: pt arrived 4x0x3 per interpreter, c/o (R) rib / abdominal pain. ? sharp to (R) rib, no other injuries noted. pt arrived c̄ foley in place, 2189 IVS in (L)/(R) AC c̄ 1500cc fluid in. Lungs CTAB

O: Abd, NAD, GSC = 15

HEENT - ⊖ apparent injuries.

Neck ⊖ injuries

Lungs - CTAB

Abd - soft, non-distended, min. tender

Chest (R) shaped wound ≈ 3-4mm ant. axilly line @ T7 (R) side

Back ⊖ injury Back ⊖ exit wound.

FAST exam - limited; unable to visualize (R) kidney well; (L) side ⊖ fluid/injury.

P: Transfer to Drogi hospital for observation

CONSULT WITH	TIME	ACTION

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

MAJ, MC

AND STAMP FNP/Specialist [redacted] (b)(2)-2

DIAGNOSIS

A: stripped wound as detailed above pt. stable

CODES

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

[redacted] IRAQI CIV

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

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 15 Sept 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 03 | HOSPITAL DAY: 1

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time 1455 To ICW#2 From EMT ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☒ STRETCHER

Total ER/RR/PACU time 4.5 hrs Physician _____ Anesthesia (Specify): _____

Procedure/Diagnosis Liver lac (level II) B/P 112/69 P 80 R 20 T 97.9

LOC AAOx3. No English Neurovascular checks 98% RA

Dressing/cast RUQ entrance wound. Tubes IV, Foley

Intake (IV, po): _____ Output (EBL, other) _____ Voided ☒ No ☐ Yes Amount: N/A

Medication Fentanyl early AM.

Other S/P TED explosion. Labs OK. Tetanus

Report From CPT [redacted] 15 Sept b(6)-2 Received By LT [redacted] b(6)-2

VITAL SIGNS

TIME:	1600	2000	0400													
BP ARTERIAL LINE																
BP CUFF	100/60	116/64	118/68													
TEMPERATURE	99.5	97.9	99.0													
PULSE	68	100	76													
RESPIRATORY RATE	18	18	16													
OXYGEN (L/%)																
PULSE OXIMETER	98%	96	96													
O2 METHOD	RA	RA														

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	1500	2000	2230					
PAIN INTENSITY (10 / 5 / 0)			X					
MED ADMINISTERED (Y/N)	N		Y					
RELIEF ACCEPTABLE (Y/N)			Y					
MSO4 5mg			5mg					

OTHER

TIME:	1500							
FINGER STICK GLUCOSE	N/A							
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:	1500	2230
*Skin breakdown prevention	N/A	NA
*Falls prevention protocol		
*Restraint protocol		
*Seizure precautions		
*Isolation precautions		

YESTERDAY'S WEIGHT: NA

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT
	NA													

PATIENT IDENTIFICATION

[redacted] b(6)-4

DIAGNOSIS: Liver lac

DRG: _____ ADMISSION DATE: 15 Sept 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (Specify): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column. D(e)-2

	TIME: 1500 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑	☑	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑ ~~x~~ TTP @ liver lac site.	☐ pain c̄ palpation @ liver lac site	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☐ Foley to gravity c̄ clear yellow urine.	☐ Foley to gravity c̄ clear yellow urine	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ GOB c̄ assist	☐ OOB c̄ assist 2° to pain	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☑ ~~x~~ liver lac.	☑ Dsg to (R) UQ CD1 to liver lac puncture site	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☐ 5/10 pain MSO4 for pain	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☐

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 1500 INITIALS: [redacted]	TIME: 2230 INITIALS: AW	TIME: INITIALS:
IV patency ✓ q 5 hr: PRN	IV patency ✓ q 8 hr:	IV patency ✓ q hr:
IV site care provided: assessed	IV site care provided: assessed	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (R) AC / OK	IV Site #1: (R) AC / OK	IV Site #1:
IV Site #2:	IV Site #2: (L) AC / OK	IV Site #2:
Comments: LR @ 100 cc/hr.	Comments: LR @ 100 cc/hr to (R) AC; (L) AC HL	Comments:

[redacted]

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: +30 TIME:	1500	2230				
COLOR	NA	NA				
CAPILLARY REFILL	↓	↓				
TEMPERATURE	↓	↓				
EDEMA	↓	↓				
SENSATION	↓	↓				
MOTION	↓	↓				
PASSIVE FLEXION	↓	↓				
PERIPHERAL PULSE	↓	↓				

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	E	2230	
ID band visible/legible	DB	AW	
Orient to environment prn	DB	AW	
Side rails (2/4) up	NA	NA	
Bed position low	↓	↓	
Call light within reach	↓	↓	

OTHER

Review & post lab results	DB	AW	
Notify MD abnormal labs	DB	AW	
Incontinent urine/stool	NA	NA	
Linen change prn	↓	↓	
Turn/reposition q2h	↓	↓	
ROM q2h if immobile	↓	↓	
Antiembolic hose	↓	↓	

DIET

BREAKFAST	LUNCH	DINNER
TYPE:	TYPE:	TYPE: CL
PERCENT CONSUMED:	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED:
☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☒ ASSIST # TIMES/SHIFT	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☒ ASSIST # TIMES/SHIFT

TEACHING

TIME: INITIALS:	TIME: INITIALS:	TIME: 2230 INITIALS [redacted]
CONTENT:	CONTENT:	CONTENT: - Pain management - Fluids via IV - Encourage PO fluids
☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
CIV [redacted] b(6)-4	[redacted]	[redacted] /OT/AW	F
		[redacted] AW/AN	22-06

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1400	(R) upper flank over lac	Dsg CDI	Dsng Δd 2° Blood soaked bandage
	2230	(R) UQ	Dsg CDI	assessed

SECTION IV - NOTES

1500: Pt. tx to ward from EMT via litter c̄ unknown allergies. IV to (R) AC c̄ LR @ 100cc/hr. IV to (L) AC HL. Foley to gravity draining clear yellow urine. Pt. stable. Will cont. to monitor [redacted]

15 Sep 03 2230 Pt sleeping, easily arousable c̄ verbal stimuli. C/O pain to abd (R) LQ/(R) UQ c̄ palpation. Given MSO4 for pain. Will cont to monitor [redacted]

b(6)-2 All

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 16Sep03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: Ø | HOSPITAL DAY: 2

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From [redacted] Received By _____

VITAL SIGNS

TIME:	1000	1650	2000	0400												
BP ARTERIAL LINE	/	/		/												
BP CUFF	107/87	114/60	110/80	123/60												
TEMPERATURE	97.9	99.4	98.9	99.5												
PULSE	71	67	83	71												
RESPIRATORY RATE	16	16	16	18												
OXYGEN (L/%)	/	/		/												
PULSE OXIMETER	96	98	98%	95												
O_2 METHOD	RA	RA	RA													

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	1600	2000	2230					
PAIN INTENSITY (10 / 5 / 0)	0	A	X					
MED ADMINISTERED (Y/N)	N		N					
RELIEF ACCEPTABLE (Y/N)	N/A		NA					

OTHER

TIME:	1600	2230						
FINGER STICK GLUCOSE	N/A	NA						
INSULIN (Y/N)	/	/						

SPECIAL NEEDS

TIME:	900	1600	2230
*Skin breakdown prevention	Q	N/A	[redacted]
*Falls prevention protocol	NO		
*Restraint protocol	NO		
*Seizure precautions	NO		
*Isolation precautions	NO		

YESTERDAY'S WEIGHT: N/

TODAY'S WEIGHT: NO

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

Civ [redacted] b(w)-2

DIAGNOSIS: Liver lac

DRG: _____ ADMISSION DATE: 15Sep03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

ARE MANAGER: _____

ISOLATION REQUIRED (S...

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

b(6)-2

	TIME: INITIALS:	TIME: 1600 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☐	☑	☑
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☐	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☐	☑	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☐ upper LQ bowel sounds dwe to liver location slight tender	☐ RUQ TTP, drsng from liver lac CDI	☐ Pt rebound pain to RUQ & LQ palpation
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☐ Foley D/C.	☑	☑ Foley D/C voiding to urinal
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐	☑	☑
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐	☐ ☒ RUQ liver lac, drsng CDI	☐ Drsg to RUQ puncture site CDI
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐	☑	☑
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☐	☑	☑

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 800 INITIALS: [redacted]	TIME: 1600 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
IV patency ✓ q ___ hr:	IV patency ✓ q 5 hr: PRN	IV patency ✓ q 8 hr:
IV site care provided: [illegible]	IV site care provided: assessed	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: [illegible]	IV Site #1: LUE / OK	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments:	Comments: IVF @ 75cc/hr	Comments: ∅ IV access

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:	1800	1600	2230			
COLOR	N	N/A	NA			
CAPILLARY REFILL	1					
TEMPERATURE	W					
EDEMA	0					
SENSATION	S					
MOTION	R					
PASSIVE FLEXION	0					
PERIPHERAL PULSE	2					

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	[redacted]	E	2230
ID band visible/legible	[redacted]	[redacted]	[redacted]
Orient to environment prn	[redacted]	[redacted]	[redacted]
Side rails (2/4) up	[redacted]	[redacted]	[redacted]
Bed position low	[redacted]	[redacted]	[redacted]
Call light within reach	[redacted]	[redacted]	[redacted]

OTHER

Review & post lab results			[redacted]
Notify MD abnormal labs			[redacted]
Incontinent urine/stool	[redacted]		[redacted]
Linen change prn	[redacted]		
Turn/reposition q2h	[redacted]		
ROM q2h if immobile	[redacted]		
Antiembolic hose	[redacted]		

DIET

BREAKFAST	LUNCH	DINNER
TYPE:	TYPE: CLEAR FLUIDS	TYPE:
PERCENT CONSUMED:	PERCENT CONSUMED: 80%	PERCENT CONSUMED:
HOW TOLERATED:	HOW TOLERATED: WELL	HOW TOLERATED:
☐ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☐ COMPLETE ☐ ASSIST ☒ TOTAL	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☒ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☒ ASSIST; # TIMES/SHIFT

TEACHING

TIME: INITIALS:	TIME: 1800 INITIALS: [redacted]	TIME: 2230 INITIALS [redacted]
CONTENT: TO EST [redacted] TO ASK FOR PAIN MED IF NEEDED	CONTENT: - pain management - ambulate c assist	CONTENT: - Pain management - ambulate c assist - call for assistance
☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

Civ[redacted] b(6)-4

INITIALS	SIGNATURE	SHIFT
[redacted]	b(6)-2	1-2
[redacted]	UT/AN	E
[redacted]	UT/AN	2-06

SECTION III - INTERVENTIONS & TEACHING (Co

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
		PPC BELOW STOMIC CONTIN		PSC WET DRY
	1600	RUQ	Drsng CDI	assessed
	2230	RUQ	Dsg CDI	assessed

SECTION IV - NOTES

1 AM Pt advised to ambulate. Pt had foley D/C. IV removed PSCW. Pt encouraged to eat & assess tolerance for food. Pt ambulating w/ tolerating PO fluids. Pt BLR. Discussed Pt plan of care by MD. -BJ 9 Nov 06

13 AM Pt ate clear liquid diet, tolerated diet well. BJ Pt asleep most of the time. Pt voided x1 and BJ Pt ambulates to bathroom — [redacted] b(6)-2 A11

16Sep03 2230 Pt awake and alert. VS C/D [redacted] except T. palpation to RUQ & RLQ. Tolera[redacted]g clear liquids. Will do labs in am and continue to monitor — [redacted] IU/AN

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 17 Sep 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: Ø | HOSPITAL DAY: 3

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (Specify): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0400	0800	1200	2000	0400											
BP ARTERIAL LINE	/	/														
BP CUFF	123/60	/	114/69	125/76	111/68											
TEMPERATURE	99.5	99.6	98.5	97.9	98.8											
PULSE	71	/	79	92	74											
RESPIRATORY RATE	18	/	16	18	16											
OXYGEN (L/%)	Ø	/		–												
PULSE OXIMETER	95	/	96%	96	96											
O2 METHOD	RA	/	RA	RA												

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	0600	2000	2030					
PAIN INTENSITY (10 / 5 / 0)								
MED ADMINISTERED (Y/N)	N		X N					
RELIEF ACCEPTABLE (Y/N)	N/A		NA					

OTHER

TIME:	0600	1500	2230					
FINGER STICK GLUCOSE	N/A	N/A	NA					
INSULIN (Y/N)	N/A							

SPECIAL NEEDS

	TIME: 0600	1500	2230
*Skin breakdown prevention	N/A	N/A	NA
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

Civ # [redacted] b(6)-4

DIAGNOSIS: grade II liver lac

DRG: _____ ADMISSION DATE: 15 Sep 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

CARE MANAGER: _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME 0600 INITIALS [redacted]	TIME [redacted]	TIME: 2220 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑ language barrier	☑	☑ b(6)-2 All
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑ RUQ dsg CDI	☐ RUQ puncture to liver	☐ Dsg to (R) UQ puncture site
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☑
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☑	☑	☑
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☑	☑	☐ (R) UQ puncture site affecting liver, dsg CDI
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ C/o sm amt of pain to liver puncture	☐ wound to RUQ 2° shrapnel	☐ C/o pain c palpation and ambulation
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: _____ INITIALS: _____	TIME: _____ INITIALS: _____	TIME: _____ INITIALS: _____
IV patency ✓ q ___ hr: _____	IV patency ✓ q ___ hr: _____	IV patency ✓ q ___ hr: _____
IV site care provided: _____	IV site care provided: _____	IV site care provided: _____
IV tubing changed: _____	IV tubing changed: _____	IV tubing changed: _____
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: _____	IV Site #1: _____	IV Site #1: ~~Ø access~~
IV Site #2: _____	IV Site #2: _____	IV Site #2: _____
Comments:	Comments:	Comments:

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:						
COLOR						
CAPILLARY REFILL						
TEMPERATURE						
EDEMA						
SENSATION						
MOTION						
PASSIVE FLEXION						
PERIPHERAL PULSE						

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY / OTHER

TIME:	0600	E	2230
ID band visible/legible	[redacted]		
Orient to environment pm			
Side rails (2/4) up		[redacted]	NA
Bed position low			
Call light within reach			
Review & post lab results			[redacted]
Notify MD abnormal labs			[redacted]
Incontinent urine/stool			NA
Linen change pm			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Reg	TYPE:	TYPE:
PERCENT CONSUMED:	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED:
☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: 0600 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
CONTENT: — Call for assist	CONTENT:	CONTENT: - Call for assistance - Ambulate c assist
☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

Civ # [redacted] b(6)-4

INITIALS	b(6)-2 SIGNATURE	SHIFT
[redacted]	[redacted]	D
[redacted]	[redacted] CT/AN	E
	[redacted] CT/AN	N

SECTION III - INTERVENTIONS & TEACHING (cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	0845	RUQ	Sm wound dry-no drainage	Dsg Δ
	1400	RUQ	Drsng CDI	assessed
	2230	(R) UQ	Dsg CDI	assessed

SECTION IV - NOTES

17Sept03 0855 Dr. [redacted] into see pt this am. Labs reviewed BIL elevated. pt encouraged to ambulate and eat. Labs to be drawn tomorrow. — [redacted]
17Sept03 2230 Pt sleeping, easily arousable to verbal stimuli. Ø c/o pain. Will monitor [redacted]

b(6)-2

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 18 Sep 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: Ø | HOSPITAL DAY: 4

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (Specify): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0800	1500	1900	1200	1,00	2000	2400	0400	0400							
BP ARTERIAL LINE	—			—												
BP CUFF	—	1[illegible] / 76		—	110/70	—			106/61							
TEMPERATURE	97.9			98.8	99.1	99.5	98	100.4/61	100.0							
PULSE	—			—	92	—			71							
RESPIRATORY RATE	—			16	16	18		20	20							
OXYGEN (L/%)	—			—		—										
PULSE OXIMETER	—			—	96%	—			97%							
O_2 METHOD	—			—	RA	—			4							

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	1400	2000	0100					
PAIN INTENSITY (10 / 5 / 0)	X	X	X					
MED ADMINISTERED (Y/N)	N		N					
RELIEF ACCEPTABLE (Y/N)	Y		N/A					

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:	0800	1400	0100
*Skin breakdown prevention	[redacted]	NA	N/A
*Falls prevention protocol	NA		
*Restraint protocol	NA		
*Seizure precautions	NA		
*Isolation precautions	NA		

YESTERDAY'S WEIGHT: NA

TODAY'S WEIGHT: NA

WEIGHT CHANGE: NA

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

CIV# [redacted] b(a)-4

DIAGNOSIS: Grade II liver lac

DRG: _____ ADMISSION DATE: 15 Sep 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

[illegible]E MANAGER: [redacted] b(a)-2

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a bri explanation of abnormal findings will be noted in the appropriate column.

	TIME: 0500 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: 0100 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑	☑	☑
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☐ PO DSG DONE SITE closed. SLIGHT ABD DISCOMFORT.	☐ Drg to (R) flank/UQ is CDI wound has no drainage noted.	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☑
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☑	☑	☑
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☑	☐ & able wound	☐ (R) flank/UQ wound - dsg CDI
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ SLIGHT PAIN FROM SID SHRAPNEL WOUND	☐ See pg 1	☑
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 1200 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: ____ INITIALS: ____
IV patency ✓ q ___ hr:	IV patency ✓ q 8 hr:	IV patency ✓ q ___ hr:
IV site care provided:	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: No IV.	IV Site #1:	IV Site #1:
IV Site #2:	IV Site #2: No Access	IV Site #2:
Comments: PO or PO MSDS.	Comments:	Comments:

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:	0700	1				
COLOR	N					
CAPILLARY REFILL	1					
TEMPERATURE	W					
EDEMA	0					
SENSATION	S					
MOTION (R) BIDO	P					
PASSIVE FLEXION	0					
PERIPHERAL PULSE	2					

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	0700	1400	2100
ID band visible/legible			
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			

OTHER

Review & post lab results		MA	
Notify MD abnormal labs			
Incontinent urine/stool			
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Regular	TYPE: Regular	TYPE: Regular
PERCENT CONSUMED: 75 %	PERCENT CONSUMED: 50 %	PERCENT CONSUMED: 75%
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED: OK
☒ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☒ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR ☒ SELF ☐ ASSIST # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR ☒ SELF ☐ ASSIST # TIMES/SHIFT

TEACHING

TIME: INITIALS:	TIME: 1400 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: 1. ENCOURAGE TO AMBULATE SELF 2. ENCOURAGE TO AMBULATE - TOWARDS REWARDS	CONTENT: - Staff orientation - Call for help - Pain management	CONTENT:
☐ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

Civ # [redacted]

b(6)-4

INITIALS	b(6)-2 SIGNATURE	SHIFT
[redacted]		
[redacted]	19.AN	14-22
[redacted]	MATHAN	BNS

SECTION III - INTERVENTIONS & TEACHING (Cont.)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	2300	(R) side	~~ESCHAR~~ SCAB.	DRESSING APPLIED - 3
	01 00	(R) Side	covered	dsg CDL

SECTION IV - NOTES

Pt wound area at (R) side of upper abdomen Area 2x2cm scab. edges closed and site maintained clean. Pt able to tolerate food, encourage more PO fluids and [redacted] Pt on Rx meds. [redacted]

1400 → Assumed pt care. [redacted]

b(6)-2 A11

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

DATE: ~~18~~ 19Sept03

SECTION I - PATIENT ASSESSMENT

PATIENT ACUITY LEVEL: III

POST-OP DAY: Ø

HOSPITAL DAY: 5

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____

Procedure/Diagnosis _____ Anesthesia (Specify): _____

LOC _____ B/P _____ P _____ R _____ T _____

Dressing/cast _____ Neurovascular checks _____

Intake (IV, po) _____ Tubes _____

Medication _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0400	0800															
BP ARTERIAL LINE		—															
BP CUFF	106/61	—															
TEMPERATURE	100.0	98.9															
PULSE	71	—															
RESPIRATORY RATE	20	—															
OXYGEN (L/%)	Ø	—															
PULSE OXIMETER	97%	—															
O2 METHOD	RA	—															

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	0400								
PAIN INTENSITY (10 / 5 / 0)									
MED ADMINISTERED (Y/N)	N								
RELIEF ACCEPTABLE (Y/N)	N/A								

DOT

TIME:	0400								
FINGER STICK GLUCOSE	N/A								
INSULIN (Y/N)	—								

SPECIAL NEEDS

	TIME: 0400			
*Skin breakdown prevention	N/A			
*Falls prevention protocol				
*Restraint protocol				
*Seizure precautions				
*Isolation precautions				

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: N/A

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2													

TOTAL IN | Urine | Stool | TOTAL OUT

PATIENT IDENTIFICATION

Civ [redacted]

b(6)-2

DIAGNOSIS: Grade II liver lac.

DRG: _____

LOS: _____ ADMISSION DATE: 15Sept03

CASE MANAGER: _____ EXPECTED RELEASE: _____

PRIMARY CARE MANAGER: [redacted] b(6)-4

Specify): _____

SECTION II - PATIENT ASSESSMENT

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column. b(2)-2

	TIME: 0600 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑ lang barrier	☐	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☐	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☐	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☐	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☐	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☑	☐	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Sm wound RUQ	☐	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☐	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☐	☐

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: ____ INITIALS: ____	TIME: ____ INITIALS: ____	TIME: ____ INITIALS: ____
IV patency ✓ q ___ hr: ____	IV patency ✓ q ___ hr: ____	IV patency ✓ q ___ hr: ____
IV site care provided: ____	IV site care provided: ____	IV site care provided: ____
IV tubing changed: ____	IV tubing changed: ____	IV tubing changed: ____
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: ____ / ____	IV Site #1: ____ / ____	IV Site #1: ____ / ____
IV Site #2: ____ / ____	IV Site #2: ____ / ____	IV Site #2: ____ / ____
Comments:	Comments:	Comments:

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE:	TIME: 0600					
COLOR						
CAPILLARY REFILL						
TEMPERATURE						
EDEMA						
SENSATION						
MOTION						
PASSIVE FLEXION						
PERIPHERAL PULSE						

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

	TIME: 0600		
ID band visible/legible	[redacted]		
Orient to environment pm	[redacted]		
Side rails (2/4) up			
Bed position low			
Call light within reach			

LABS

Review & post lab results	[redacted]		
Notify MD abnormal labs	[redacted]		

OTHER

Incontinent urine/stool			
Linen change pm			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Reg	TYPE:	TYPE:
PERCENT CONSUMED: 75%	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED: well	HOW TOLERATED:	HOW TOLERATED:
☑ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☑ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: 0600 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
CONTENT: - Dsg Δ - pain management - Discharge teaching by MD	CONTENT:	CONTENT:
☑ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

INITIALS	SIGNATURE	SHIFT
KW	b(6)-2 [redacted] r/Name	D

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	0100	RUQ	Sm wound healing well	DSG A

SECTION IV - NOTES

19Sept03 0945 Pt being Discharged th. am.
T Cipro. Follow up + 1 week [redacted]

b(6)-2 A11

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR Sep 15 DAY 15 16 17 18 19

2003 HOUR

PULSE (0) | TEMP. F (°) | TEMP. C

105° 40.6°

180 104° 40.0°

170 103° 39.4°

160 102° 38.9°

150 101° 38.3°

140 100° 37.8°

130 99° 37.2°

98.6° 37.0°

120 98° 36.7°

110 97° 36.1°

100 96° 35.6°

90 95° 35.0°

80

70

60

50

40

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: 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. 1CW2

C [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

b(6)-2

Ward/Section: EMT	REQUESTING PHYSICIAN [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. b(6)-2 [redacted]	DATE 15 Sep 03	TIME 0837	SSN/PSEUDO SSN: [redacted] b(6)-2

(Hematology) CBC

TEST	RESULT	REF. RANGE
[redacted]		
ID: [redacted]		15-09-03
WB		08:51
		Patient Limits
WBC	19.4 H	x10^3/uL 4.5 10.5
RBC	5.18	x10^6/uL 4.00 6.00
Hgb	15.1	g/dL 11.0 18.0
Hct	47.4	% 35.0 60.0
MCV	91.5	fL 80.0 99.9
MCH	29.1	pg 27.0 31.0
MCHC	31.8 L	g/dL 33.0 37.0
Plt	205.	x10^3/uL 150. 450.
LY%	9.4 *	% 20.5 51.1
LY#	1.8 *	x10^3/uL 1.2 3.4
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	yellow	N/A
App	Hazy	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	neg	Negative
SG	1.030	N/A
Bld	Trace	Negative
pH	5.0	N/A
Prot	1+	Negative
Urob	0.2	0.2-1.0
Nit	neg	Negative
Leuk	neg	Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

RBC - 0-3 Calcium oxalate
WBC - 0-1 Urates - many
EPI - 0-2 SSA - Trace

CSF

Cell Count	
Directigen	Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	DATE: 9-15-03	LAB ID NO.:

b(6)-2

ENT

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

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

LAST, FIRST, MI. H [redacted] b(6)-2

DATE 15 Sep 03 TIME 0840

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

(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.

======= PICCOLO =======
15/09/03 08:48
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-2 [redacted]

ALB	3.3	3.3-5.5	G/DL
ALP	49	26-84	U/L
ALT	83*	10-47	U/L
AMY	98*	14-97	U/L
AST	77*	11-38	U/L
TBIL	1.5	0.2-1.6	MG/DL
BUN	15	7-22	MG/DL
CA++	8.7	8.0-10.3	MG/DL
CHOL	179	100-200	MG/DL
CRE	1.2	0.6-1.2	MG/DL
GLU	137*	73-118	MG/DL
TP	7.0	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

======= PICCOLO =======
15/09/03 08:48
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-2 [redacted]

GLU	129*	73-118	MG/DL
BUN	16	7-22	MG/DL
CRE	1.2	0.6-1.2	MG/DL
CK	120	39-380	U/L
NA+	130	128-145	MMOL/L
K+	3.7	3.3-4.7	MMOL/L
CL-	104	98-108	MMOL/L
tCO2	26	18-33	MMOL/L

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

REMARKS:

b(6)-2

REPORTED BY: [redacted]

DATE: 9-15-03

LAB ID NO.:

Ward/Section: ICW2	REQUESTING PHYSICAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST FIRST MI [redacted] b(6)-4	DATE 15Sep03	TIME 1800	SSN/PEEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
ID [redacted]		15-09-03
WB		18:31
		Patient Limits
WBC	16.2 H	x10^3/uL 4.5 10.5
RBC	5.09	x10^6/uL 4.00 6.00
Hgb	15.1	g/dL 11.0 18.0
Hct	46.8	% 35.0 60.0
MCV	91.9	fL 80.0 99.9
MCH	29.6	pg 27.0 31.0
MCHC	32.2 L	g/dL 33.0 37.0
Plt	207.	x10^3/uL 150. 450.
LY%	10.4 *L	% 20.5 51.1
LY#	1.7 *	x10^3/uL 1.2 3.4

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Macroscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	DATE: 15Sep03	LAB ID NO.:

b(6)-2

Ward/Section: 1CW2	REQUESTING PHYSICAN: [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: CW [redacted] b(6)-4	DATE: 18Sep	TIME: 0500	SSN/PEEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
ID: [redacted] WB		16-09-03 04:59 Patient Limits
WBC	12.6 H	x10^3/uL 4.5 10.5
RBC	4.86	x10^6/uL 4.00 6.00
Hgb	14.1	g/dL 11.0 18.0
Hct	44.4	% 35.0 60.0
MCV	91.4	fL 80.0 99.9
MCH	29.1	pg 27.0 31.0
MCHC	31.9 L	g/dL 33.0 37.0
Plt	200.	x10^3/uL 150. 450.
LY%	15.5 *L	% 20.5 51.1
LY#	1.9 *	x10^3/uL 1.2 3.4
Segs		
Mono		
Bands		
Eos		
Lymph		
Baso		
Atyp		
Imm		
RBC Morph		
Spun Hematocrit		42-52%(M) 37-47%(F)
Set Rate		
Other		

Urinalysis

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

CSF

Cell Count	
Directigen	Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Macroscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS: CBC, Met Panel, LFT's

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section:	REQUESTING PHYSICAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
ICW2	[redacted] b(6)-2	

LAST, FIRST	DATE	TIME	SSN/PEEUDO SSN:
CIV [redacted] b(6)-4		1500	

(i-STAT)

TEST	RESULT	REF. RA
Na		138-146 mm
K		3.5-4.9 mm
CI		98-109 mm
pH		7.31-7.45
PCO2		35-45 mm 41-51 mm
PO2		80-105 mm N/A (ven)
TCO2		23-27 mm 24-29 mm
HCO3		22-26 mm 23-28 mm
SO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mm
Ca		1.12-1.32
BUN		8-26 mg/
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-I		
Drug of Abuse		

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA+		128-145 mmol/dl
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
GLU		73-118 mg/d
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 /l (M 30-190 /l (F
NA+		128-145 mm
K+		3.3-4.7 mm
CL-		98-108 mm
tCO2		18-33 mm

======= PICCOLO =======
16/09/03 04:57
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: b(6)-2 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	100	73-118	MG/DL
BUN	10	7-22	MG/DL
CRE	1.2	0.6-1.2	MG/DL
CK	112	39-380	U/L
NA+	132	128-145	MMOL/L
K+	4.4	3.3-4.7	MMOL/L
CL-	100	98-108	MMOL/L
tCO2	22	18-33	MMOL/L

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

======= PICCOLO =======
16/09/03 04:57
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
LIVER PANEL PLUS
DISC LOT #: 3154AA7
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-[redacted]

ALB	3.3	3.3-5.5	G/DL
ALP	49	26-84	U/L
ALT	81*	10-47	U/L
AMY	63	14-97	U/L
AST	58*	11-38	U/L
TBIL	3.1*	0.2-1.6	MG/DL
GGT	17	5-65	U/L
TP	6.5	6.4-8.1	G/DL

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section:	REQUESTING PHYSICAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
1CW2	[redacted] b(6)-2	

LAST, FIRST, MI.	DATE	TIME	SSN/PEEUDO SSN:
Civilian # [redacted] b(6)-4	17 Sep	0500	

(Hematology) CBC

TEST	RESULT	REF. RANGE
WI		
RI		
H		
H		
M		
I		
I		
Segs		
Bands		
Lymph		
Atyp		
RBC Morph		
Spun Hematocrit		42-52%(M) 37-47%(F)
Set Rate		
Other		

ID [redacted]
WB

.0 108 x10
17-09-03
05:01

			Patient Limits	
WBC	9.3 *	x10^3/uL	4.5	10.5
RBC	4.99	x10^6/uL	4.00	6.00
Hgb	14.5	g/dL	11.0	18.0
Hct	45.3	%	35.0	60.0
MCV	90.9	fL	80.0	99.9
MCH	29.1	pg	27.0	31.0
MCHC	32.0 L	g/dL	33.0	37.0
Plt	188.	x10^3/uL	150.	450.
LY%	23.1 *	%	20.5	51.1
LY#	2.2 *	x10^3/uL	1.2	3.4

Urinalysis

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Macroscopic Urinalysis

CSF

Cell Count			
Directigen		Negative	

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS: CBC & LFT's

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section:	REQUESTING PHYSICAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
1CW2	[redacted] b(6)-2	

LAST, FIRST MI		DATE	TIME	SSN/PEEUDO SSN:
Cw [redacted] b(6)-4		17 Sep	0500	

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
CI		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (art)
SO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-1		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		
CA^{++}		
CHOL		
CRE		
GLU		
TP		

(Piccolo) Metly

TEST	RESULT	REF. RANGE
GLU		7
BUN		7-
CRE		0.6-
CK		39-3 30-1
NA^+		128-1
K^+		3.3-4.7
CL^-		98-108
tCO2		18-33 mn

(Piccolo) Metabolic Panel

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

Panel Plus

		REF. RANGE
		3.3-5.5 g/dl
		26-84 u/l
		10-47 u/l
		4-97 u/l
		38 u/l
		1.6 mg/dl
		u/l
		g/dl
		NGE
		ol/l
		/l

======= PICCOLO =======
17/09/03 05:10
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
LIVER PANEL PLUS
DISC LOT #: 3154AA7
OPER #: [redacted] DR #: 000
SERIAL #: b(6) [redacted]

ALB	3.4	3.3-5.5	G/DL
ALP	51	26-84	U/L
ALT	68*	10-47	U/L
AMY	55	14-97	U/L
AST	43*	11-38	U/L
TBIL	3.0*	0.2-1.6	MG/DL
GGT	18	5-65	U/L
TP	6.8	6.4-8.1	G/DL

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

REMARKS: CBC & LFT's

REPORTED BY:	DATE:	LAB ID NC

Ward/Section:	REQUESTING PHYSICAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
ICW2	[redacted] b(6)-2	

LAST, FIRST MI		DATE	TIME		SSN/PEEUDO SSN:
CIV [redacted] b(6)-4		18 Sep	0500		

(i-STAT)

ID: [redacted]
WB
18-09-03
05:22

			Patient Limits	
WBC	9.1	x10^3/uL	4.5	10.5
RBC	5.21	x10^6/uL	4.00	6.00
Hgb	15.5	g/dL	11.0	18.0
Hct	47.8	%	35.0	60.0
MCV	91.8	fL	80.0	99.9
MCH	29.8	pg	27.0	31.0
MCHC	32.4 L	g/dL	33.0	37.0
Plt	211.	x10^3/uL	150.	450.
LY%	24.0	%	20.5	51.1
LY#	2.2	x10^3/uL	1.2	3.4

		REF. RANGE
HCO3		22-26 mmol/L (23-28 mmol/L (
SO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-1		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l

======= PICCOLO =======
18/09/03 05:17
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
BASIC METABOLIC
DISC LOT #: b(6)-2 3145AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	94	73-118	MG/DL
BUN	14	7-22	MG/DL
CA++	8.9	8.0-10.3	MG/DL
CRE	1.2	0.6-1.2	MG/DL
NA+	137	128-145	MMOL/L
K+	3.9	3.3-4.7	MMOL/L
CL-	103	98-108	MMOL/L
tCO2	25	18-33	MMOL/L

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
[illegible]		7-22 mg/dl

======= PICCOLO =======
18/09/03 05:36
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
LIVER PANEL PLUS
DISC LOT #: 3154AA7
OPER #: [redacted] DR #: 000
SERIAL #: b(6) [redacted]

ALB	3.5	3.3-5.5	G/DL
ALP	51	26-84	U/L
ALT	58*	10-47	U/L
AMY	58	14-97	U/L
AST	26	11-38	U/L
TBIL	3.3*	0.2-1.6	MG/DL
GGT	20	5-65	U/L
TP	7.4	6.4-8.1	G/DL

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

REMARKS:
CBC, LFT's, lytes

REPORTED BY:	DATE:	LAB ID NO.:

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN *(Sponsor)*	WARD/CLINIC	REGISTER NO.
CT abdomen					
	FILM NO.				PREGNANT ☐ YES ☑ NO
	REQUESTED BY *(Print)* [redacted] b(6)-2				TELEPHONE/PAGE NO.
	S[redacted]ESTOR				DATE REQUESTED 15 Jul 03

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

Shrapnel RUQ. Please include lower lobes of (R) lung field.

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

RADIOLOGIC REPORT

1) Laceration Liver AP
2) bullet fragment (R) post soft tissue back
3) [illegible]
4) (B) Lateral AT 6X

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

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

RADIOLOGIC CONSULTATION REQUEST/REPORT
3 — RADIOLOGY

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

7540-01-165-7294

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED ABD CT	AGE / SEX: M	SSN (Sponsor): CIV # [redacted] b(4)-4	WARD/CLINIC: ICW#2
	FILM NO.		REGISTER NO.
	REQUESTED BY (Pri[redacted] Dr		PREGNANT ☐ YES ☐ NO
	SIGNATURE OF REQUESTOR b(4)-2		TELEPHONE/PAGE NO.
			DATE REQUESTED 9-17-03

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

Liver lac

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

RADIOLOGIC REPORT

(1) No sig A (R) liver lac.

(2) Small (R) SS ATLX

(3) Small (R) effusion

b(4)-2

[redacted]

b(2)-2

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

CIV # [redacted]

b(4)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
1 — MEDICAL RECORD

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

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sp[redacted]	WARD/CLINIC	REGISTER NO.
Portable CXR	40	M	C[redacted]	1CW2	
	FILM NO. b(6)-4				PREGNANT ☐ YES ☐ NO
	REQUESTED [redacted] b(6)-2				TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR A Walker				DATE REQUESTED 16 Sep

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

liver laceration

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

RADIOLOGIC REPORT

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

RADIOLOGIC CONSULTATION REQUEST/REPORT
1 — MEDICAL RECORD

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

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

15 Sep 1330

Admit EPW ward [redacted]

Cool fain

Diet - clear liq

Act - OOB 1310 may ambulate c̄ assist

VS - q 4h

Dx - grade II liver lac 2° IED

PATIENT IDENTIFICATION

b(6)-4 [redacted]

NURSING UNIT	ROOM	ED NO

DATE OF ORDER | TIME OF ORDER | HOURS

IV LR 1000 at 150 cc/h

Ancef 1gm IVPB q 8h

Dextr 400 cc IV q am

CBC at 0800 today

CBC lytes am 16 Sep also LFT's

portable CXR 16 Sep

MS 2-6 mg IV q 1-2h prn pain

PATIENT IDENTIFICATION

[redacted]

b(6)-4

DATE OF ORDER | TIME OF ORDER

July to gravity drain [redacted]

hold MD if UO < 60cc

for any 2 consecutive hr [redacted]

b(6)-2

remove filled IV's, + place Lpan IV

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
15 Sep 03	0-50	[redacted]

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

16 Sep 0700

DC foley

Reg diet

ambulate, hall

↓ IV to 75 cc/hr [redacted]

b(6)-2

16 Sep 03 0710 [redacted]

b(6)-2

NURSING UNIT	ROOM NO.	BED NO.

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

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

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

PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
# b(6)-4 [redacted] b(6)-2 [redacted] 9-16-03 2000	16 Sep 1930 HOURS (1) DC IV + IV ABs (2) ciprofloxacin 500 mg po q 12h (3) CBC, LFT's am 17 Sep [redacted] b(6)-2	
NURSING UNIT: 17Sep03 0030 [redacted]	ROOM NO.:	BED NO.:
PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER	
# b(6)-4 [redacted]	17 Sep 0830 HOURS (1) CBC, LFT's am 18 Sep (2) ambulate bell [redacted] b(6)-2	Noted 17Sep03 0835 [redacted] MAJ/AN b(6)-2
NURSING UNIT:	ROOM NO.:	BED NO.:
PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER	
# b(6)-4 [redacted]	17Aug03 0830 HOURS Dressing Δ q day Vitals routine c̄ temp q 4° VO Dr [redacted] MAJ/AN b(6)-2 [redacted]	
NURSING UNIT:	ROOM NO.:	BED NO.:
PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER	
# b(6)-4 [redacted] b(6)-2 [redacted]	17 Sep 1730 HOURS Abd CT - reevaluate [redacted]	b(6)-2
NURSING UNIT:	ROOM NO.:	BED NO.:

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

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

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

PATIENT IDENTIFICATION

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

NURSING UNIT	ROOM NO.	BED NO.
18SEP03 [redacted]	b(6)-2	[redacted]

DATE OF ORDER 17 Sep 2045 TIME OF ORDER _____ HOURS

(1) add 'lytes to am 18 Sep labs

(2) Percocet 1-2 po q 4 prn pain

[redacted]

340 Chest V

[redacted]

PATIENT IDENTIFICATION

CIV [redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW2	7	A 240 [redacted]

DATE OF ORDER 18 Sep 0700 TIME OF ORDER _____ HOURS

(1) Temp q 4h b(6)-2

(2) BP, pulse 1X/24 hrs

(3) encourage fluids

(4) CBC, H&H, 'lytes 19 Sep a

[redacted]

PATIENT IDENTIFICATION

CIV [redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 19 Sep 0915 TIME OF ORDER _____ HOURS

(1) diet pt

(2) follow-up 1 week MONDAY 26 Sep in EMT

[redacted] b(6)-2

Noted 19Sep0940 [redacted] b(6)-7

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.

b(6)-2 A11

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 9 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 15	16	17											
9-15	[redacted]	LR 1000cc @ 150	D	X	[redacted]												
		cc/hr	E	[redacted]													
9-16		↓IV to 75cc/hr	N														
9-15	[redacted]																
		Ancef 1gm IVPB	08	[redacted]													
		q8h	16														
			24														
9-15	[redacted]	Gent 400 mg IV	0	[redacted]													
		Q am.															
9-16	[redacted]	Cipro 500mg PO	10	X	X	[redacted]											
		Q 12h	22	X	[redacted]												
		A.S															

D/C'd

D/C 1600

ALLERGIES: ☐ YES ☐ NO	PRIMARY DIAGNOSIS: Grade IV liver lac 2° TEN	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO PAGE NO.

PATIENT IDENTIFICATION:

CIV # [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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				Mo. 9 Yr. 03
Order Date	**Clerk/ Nurse**	**SINGLE ORDER, PRE-OPERATIVES**	**Date to be Given**	**Time to be Given**	**Time Given**	**Initials**

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED													
9.15 9.18	[redacted]	MS 2-6mg IV	1540 0300	1650 [redacted]												
-----	-----	Q 1-2h prn pain	5mg PM	5mg [redacted]												
-----	-----															
9.17	[redacted]	Percocet 1-2 PO	9.17. 2117													
-----	-----	Q4° PRN	" PO													
-----	-----		[redacted]													
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															

b(6)-2 A11

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 15	16	17
9-15	[redacted]	CL Diet	7	/	N	
			11	/		
			17	[redacted]		D/C 16Sep03
9-15	[redacted]	Act: OOB BID,	08	X	[redacted]	
		may ambulate	20	[redacted]		
		assist				
9-16		Ambulate in hall	D		[redacted]	
9-15	[redacted]	VS Q4°	00	X	[redacted]	
			04	X		
			08	X		
			12	X		D/C 16Sep03 [redacted]
			16	[redacted]		
			20	[redacted]		
9-15	[redacted]	Foley to gravity	D	X	D	
		drain	E	[redacted]		D/C 16Sep03
			N	[redacted]		[redacted]
9-16		Regular Diet	08	/	[redacted]	
			12	/		
			18	/	[redacted]	
9-17		Ambulate in halls	D	/	/	[redacted]
			E	/	/	
			N	/	/	
9-17		Dressing Δ q day	10	/	/	[redacted]
9-17		Vitals routine c̄	D	/	/	
		temp q 4°	E	/	/	
			N	/	/	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Grade II liver lac 2° IED

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

Civ # [redacted]

b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

b(6)-2 A1

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo ____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
9-15	[redacted]	Admit to FPW ward	9-15	1500	1500	[redacted]
	----	cond. fair				
9-15	[redacted]	CBC @ 1800 today	9-15	1800		
9-15	[redacted]	CBC, lytes, LFTS 16 Sept AM	9/16	0400		
9-15	[redacted]	Portable CXR 16 Sep	9/16			
9-15	[redacted]	Remove field IVs and place	DONE			
	----	Inew				
9-16	[redacted]	D/C foley	9/16	9/16.	7:30	[redacted]
	----	Due to void 6° p D/C foley	9/16	9/16	7 [redacted]	[redacted]
9-16	[redacted]	CBC, LFTS am 17 Sept.	9/17	0400	0430	[redacted]
9-17	[redacted]	CBC, LFTS in am 18 Sep	9/18	0400	0500	[redacted]
9-17	[redacted]	CT ABD	9-17	ASAP		[redacted]
9-17	[redacted]	Add lytes to a.m. Sept 18 labs	9-18	0400	0500	[redacted]
9/18	[redacted]	DRAW CBC, LFT's, LYTES. 9/19/03	9/19.	0400		

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
9-15	[redacted]	Call MD if UO														
----	----	<60 cc for any														
----	----	2 consecutive														
----	----	hrs.														
----	----															
----	----															
----	----															
----	----															
----	----															
----	----															

USAPA V1.00

b(6)-2 All

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 7 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 18	19	20	21	22	23							
16 Sep	[redacted]	Regular diet	08	[redacted]												
			12													
			18													
16 Sep	[redacted]	Ambulate in halls	D													
			E													
			N													
16 Sep	[redacted]	Drg Δ Qday	10													
16 Sep	[redacted]	VS QS ± temp	D	[redacted]												
		Q4	E													
			N													
16 Sep	[redacted]	Encourage PO fluids	D	[redacted]												
			E													
			N													
18	[redacted]	BP, pulse QD 04	04	[redacted]												
		Temps Q4 08	~~06~~													
		12	~~10~~													
		16	~~14~~													
			~~18~~													
			20													
			24													

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Grade II Lower LAC

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

Civ # [redacted] b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

b(6)-2 A11

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo ____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
18 Sep	[redacted]	CBC, LFT's, Lytes in AM	19 Sep	0430	0500	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
16 Sep	[redacted]	Call MD if UO														
----	----	<60cc for any														
----	----	consecutive 2 hrs														
----	----															
----	----															
----	----															
----	----															
----	----															
----	----															
----	----															

USAPA V1.00

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

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
	40 Y	X	9	

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	Z	0824	b(6)-4

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K 7 6	

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

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

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME [redacted] TELEPHONE NUMBER OF EMERGENCY ADDRESSEE b(2)-2

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
05		030919

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
ABAA		030915

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

grade II liver laceration 2° IED

Dx: 864.15

E991.9

88.19
87.44
88.01
99.29

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

DA FORM 3985 MAR 89

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) [redacted] b(4)-4			3. GRADE CIV	ADMISSION REMARKS
4. SEX M	5. AGE 22y	6. RACE X	7. RELIGION MUSLIM	8. LENGTH OF SVC —	9. ETS —
10. PREVIOUS ADMISSION NO	11. FMP ~~99~~ 20	12. SSN [redacted]	13. ORGANIZATION b(4)-4	14. WARD ICW2	
15. FLYING STATUS —	16. DSG	17. DEPT./BEN ~~K76~~ K78	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE DNBI

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct From ER.

22. HOURS OF ADMISSION: 1228

23. CLINIC SERVICE: Opthomology

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: UNK

25. TYPE DISPOSITION: D/C HOME

26. DATE OF DISPOSITION: 29 Sep 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK

27b. TELEPHONE NO.:

28. DATE OF THIS ADMISSION: 15 Sep 03

ADMITTING OFFICER

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY

30. DATE OF INITIAL ADMISSION

32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: (1) ~~Retinal Hemorrhage OS~~ / RUPTURED GLOBE OS
(2) ENDOPHTHALMITIS OS
(3) ZMC FRACTURE (L)
(4) MULTIPLE FACIAL LACERATIONS

Px: 76.71, 86.09, 87.44, 88.27, 88.22, 87.03

Dx: 871.0, 360.00, 802.4, 873.40, 823.30, E991.9

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	15	15

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

a. ABSENT SICK DAYS	b. OTHER DAYS	c. [redacted]	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	[redacted]	[redacted]	15	15

SIGNATURE OF ATTENDING MEDICAL OFF[redacted]

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

22 yo Kurdish soldier involved in car bomb explosion ~10 Sep 03. Pt seen @ Kurdish hospital & transferred to [redacted] to R/O orbital floor fx. Pt was dx'd c̄ retinal hemorrhage and (L) 2MC fx. Pt sent to the [redacted] for CT scan. Eval by OPHTHALMology & ORIF of (L) 2mc fx.

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

PMH: ϕ
PSH: ϕ
All: NKDA
Meds:

VS: BP 144/66
P 101
@1111 R 18
T 99.5

HT 165 cm
WT 78 kg.

PHYSICAL EXAMINATION WD Kurdish male in NAD

Heent: NC - multiple facial lacs closed @ Kurdish hospital wounds poorly cared for
(B) Periorbital Ecchymosis
edema
OU c̄ subconjunctival hematoma
OS pupil oval & NR c̄ chemosis
OD pupil reactive + slow
EOM - limited upgaze - IR
(+) Pain on palpation of face
Left ear TM perforation + Pinna wound c̄ dried Blood
(B) TM clear
Maxilla & mandible stable c̄ repeatable occlusion
nasal bones stable

CV: RRR
Lungs: CTA (B)
Abd: SOFT NT/ND (+) BS
Chest: Sup. shrapnel wounds

mult lacs
dried crusted blood + silk suture

Left: R forearm c̄ lacs sutured
3rd digit c̄ injury
legs c̄ superficial shrapnel wounds

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

+/P S/P car bombing ~5 days ago. Pt sent to Kurdish Hos. & 21st CSH and no apparent wound care given. Suspected (L) 2mc fx c̄ entrapment of IR.
) CT scan face (2) OPHTHAL consult (3) ORIF (L) 2mc (4) ORTHO Eval

SIGNATURE	DATE	IDENTIFICATION NO.	ORGANIZATION
b(6)-2 [redacted]	15 Sep 03		

PATIENT IDENTIFICATION *(For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)*	REGISTER NO.	WARD NO
[redacted] b(6)-2		

[redacted]
b(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
#769	Kurdish soldier (b)(2)-2
	saved vs soldiers p carbomb.
	sent to [redacted] x 5 days c̄ ZMC fx
	seen by optom – rehna fleet, entraped + force duchins
	Evac to [redacted] limbal entrance @ 7 o'clock c̄
	ins encarceation. — repair 9/15
9/17	repair ZMC fx – assisted OMF removing eye from fx site
	pending → PPVit IOFB removal b(2)-2
	[redacted] 6014 LTC,

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

OMS Brief OP NOTE

17 Sep 03 @1256 Pre OP dx: Left 2mc fx
non healing facial wounds
Post op dx: Same
Procedure: ORIF (L) 2mc fx, foreign body remo
Orbital floor exploration
wl+D + closure of facial wound
Surg: [redacted]
Assist: [redacted]
Anesth: GETA
EBL: 100 cc
U/O 300 cc
fluids 2000 cc LR
Comp: Ø
findings: comminuted (L) 2mc fx
foreign body in (L) side of nasal bone
lateral orbital foreign body.
Poorly closed facial wounds Ø hematoma
Cond: Stable extubated & transferred to
recovery Serent. [redacted] MAJ/MC

plates + screws

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.

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
9/18/03	
#769.	Ophth Note
	POD #1 s/p 2 MC c̄ entrapment repair
	Va - HM
	signif chemosis, ↓ STS periorbital
	EOM improved c̄ sig. pain
	DFE: signif heme, vitreous
	Imp retained IOFB
	Plan CPM add Med 60mg po qD ↓ Zantac 150 bid [redacted] b(a) - 2
18Sep03	OMFS POD #1 Ancy #3
	S/P (L) 2mc. Ex ORIF c̄ Orbital floor exploration.
	Pt c̄ clo pain this am controlled c̄ pain meds.
	(L) eye. Periorbital edema c̄ chemosis present

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

[redacted]

b(a) - 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
	facial wounds closed 1° c̄ no active bleeding, granulating Right chin and left ear wounds. no signs of infx.
	intraoral wounds closed 1°.
	A/P S/P c/R of (L) 2mc fx.
	(1) continue current wound care
	(2) OPHTH tx per Dr [redacted]
	b(u)-2
19 Sep 03	OMS POD#2 Ancy #19
@0905	Pt sitting in chair c̄ c/o pain facial edema + Left eye edema ↓ing. wounds closed 1° c̄ no s/s of infx and bleeding.
	A/P S/P c/R of (L) 2mc fx
	(1) awaiting eval c̄ Ophtho [redacted]
	b(u)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
9/19/03	Optho Svc
10/8	
	S: pt to clinic c̄ c/o headache
	O: Va - CF→LP
	Ext: extensive STS - improved from yesterday able to spont open eye
	SLE: Conj: sig chemosis cornea clear Tc ~ 1+/cell & flare iris dilated lens cl. vit: ⊕ blood/cells poor view
	B SCAN: layed blood in retrocus retina flat
	Imp: s/p ruptured globe, 3mc fx repair
	Plan: CAM, steroids initiated; awaiting retina eval. [redacted]

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

b(6)-2

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

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

[redacted]
b(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

OMFS PN POD #7

14 Sep 03 @0900 Pt S/P ORIF Ob (L) 2mc pt doing well this am. wounds healing well and closed 1°. Abrasions well granulated. will remove remaining sutures. Continue Bacitracin to face. Awaiting appt c Iraqi OPHTH.

b(4)-2

[redacted]

25 Sep 03 @0840 OMFS PN POD #8

pt doing well - wounds healing well ⊘ S/S infect. Continue bacitracin awaiting appt c iraqi OPHTH. [redacted] b(4)-2

27 Sept Pt seen in conjunction c Iraqi retinal specialist agreed c current mgmt. pt to be sent to Iraqi hospital for vitrectomy. coordination already started [redacted] b(4)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME: LAST [redacted] MI	SPONSOR'S ID NUMBER (SSN or Other)
DEPART./SERVICE	HOSPITAL OR MEDICAL FAC[redacted]	RECORDS MAINTAINED AT [redacted]

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

[redacted]

b(4)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

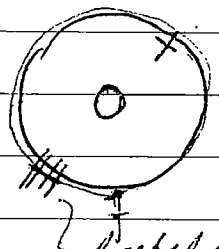
STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9/15/03 1920	Ophth Op Note

pre-op dx: ruptured globe c̄ IOFB, globe entrapment
postop dx SAA
proc. repair of limbal rupture site OS
globe exploration OS
forced duction test OS
findings



limbal rupture c̄ uvs incarceration

compl ∅
EBL min
anes: GETA
fluids: 1400 cc

[redacted] b(6)-2

[redacted] 60 ft LTC

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

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

[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)*
9-15-03	0740
	22 y/o Kurdish male involved in car bombing 5 days ago sustaining multiple soft tissue wounds. XR reports r/o demonstrable no fx's. (R)UE has volar forearm lacs sutured c̄ silk. (R)MF c̄ open wound volar aspect PE. No evidence of infection. P/S ant/post flexors FDS/FDP, ax sensory loss. 2+ pulses. (R)UE AT. (B)LE c̄ no joint effusion. FROM c̄ 2+DP/PT. Superficial shrapnel wounds (R) & (L) knee, ant tibia (R) leg.
	Imp: Multiple soft tissue wounds (R)UE (B)LE c̄ no clinical evidence of infection. NV compromise. no fx.
	Plan: Local wound care. b(6)-2 [redacted]
	(b)(2)-0
9/15/03 1340	22 y/o Kurdish male involved in a car bombing 5 days ago, eval c̄ [redacted] sent here for eye exam to clear eye & repair of zygomatic fracture.
	V/a - unobtainable - can't communicate c̄ pt.
	ROS: restricted in all directions of gaze P 4/6 +2 hr DNPD

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

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

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	SLE: 4L swollen, ? small healing lac center @ lid right above lashes Cnj: sig chemosis inf limbus Cornea clear x̄ ? small rupture ~1-2mm @ limbus 70 clock A/C 1+ cell iris ~3/4 dilated @ mmt (trau)
	DFE: poor view 2° to vit heme
	B scan: vitreous ? IOFB metallic inf retina
	CT scan @ IOFB inf retina s ? sub conj f-b nasal conj anterior to globe
	Imp ① comminuted zmc fx c̄ ? entrapment ② ? globe limbus intrana wound @ 70 cl. OS ③ sig CT metallic f-b adj to globe inf. nasal ④ per CT metallic IOFB inf. retina OS
	Plan ① will discuss c̄ OMF plan ds globe exploration to determine status of limbus @ 70 clock s to explore to insure f-b infranasal not into globe then determine timecourse for fx repair. ② metallic IOFB - will need to coordinate c̄ Ocu curbside for removal - ASAP.
	b(6)-2 [redacted]

[redacted] (REV. 6-97) BACK

[redacted]

MEDCOM - 19165

b(2)-2

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

PATIENT'S HOME ADDRESS OR DUTY STATION

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

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 15 SEPT 03 | TIME: 1111

TRANSPORTATION TO FACILITY: BIRD

SEX: M

AGE: 22

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

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

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

CURRENT MEDICATIONS: ~~NKDA~~ PO Benier

ALLERGIES: NKDA

INJURY OR OCCUPATIONAL ILLNESS			
ITEM	YES	NO	WHEN *(Date)*: 09/10/03
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: Here for optharmology evaluation

CATEGORY OF TREATMENT

☐ EMERGENT

☑ URGENT

☐ NON-URGENT

TIME: 1111

INITIALS: [redacted] b(6)-2

VITAL SIGNS

TIME	1111	1138				
BP	144/66	124/60				
PULSE	101	100				
RESP	18	18				
TEMP	99.5	[illegible]				
WT						

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

☑ PULSE OX 98 ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE

DISPOSITION: ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

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

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

[redacted] b(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

NSN 7540-01-075-3786

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

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

Seen by Dr. [redacted] / Dr [redacted]
For pneumo.
See opthalmology / oral surg note

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

[redacted] b(4)-2

DIAGNOSIS
1) Orbital fx (2) orbit
OS retinal hemorrhage

CODES

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

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 15 Sept 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: Ø | HOSPITAL DAY: 1

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time 1250 To ICW2 From EMT ☐ AMBULATORY ☐ CRUTCHES ☑ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician Dr [redacted] Anesthesia (Specify): _____

Procedure/Diagnosis Retinal bleed, maxillar fx, shrapnel Rt knee B/P 144/66 P 101 R 18 T 99.5

LOC A+O x3, speaks Kurdish Neurovascular checks N/A

Dressing/cast dressing ® leg + ® arm Tubes NS @ AC

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☑ No ☐ Yes Amount: _____

Medication _____

Other car bomb, saved americans CT → Dr [redacted] → ICW2, Transfer from [redacted] b(2)-2

Report From LT Fiske Received By MAJ [redacted]

VITAL SIGNS

TIME:	2000	0400													
BP ARTERIAL LINE															
BP CUFF	120/52	119/58													
TEMPERATURE	98.9	99.7													
PULSE	94	71													
RESPIRATORY RATE	19	20													
OXYGEN (L/%)															
PULSE OXIMETER	100	100%													
O2 METHOD	RA														

7 hole curved plate (1.5)
7 hole curved plate c (1.5)
Six screws
4 hole straight plate (2.0) under eye

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	1445	2030						
PAIN INTENSITY (10 / 5 / 0)								
MED ADMINISTERED (Y/N)	N	Y						
RELIEF ACCEPTABLE (Y/N)	N	Y						
morphine		4 mg						
percocet		IV						

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:	1445	2300
*Skin breakdown prevention	NA	NA
*Falls prevention protocol		
*Restraint protocol		
*Seizure precautions		
*Isolation precautions		

YESTERDAY'S WEIGHT: NA

TODAY'S WEIGHT:

WEIGHT CHANGE:

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

Civ [redacted]

Kurdish

DIAGNOSIS: Retinal bleed, maxilla fx, shrapnel (R) knee

DRG: _____ ADMISSION DATE: 15 Sept 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (Specify): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column. D(ce)-2

	TIME: 1445 INITIALS: [redacted]	TIME: 2300 INITIALS: [redacted]	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☐ (R) eye WNL. (L) eye swollen shut. When opened ~~manually~~, sclera reddened & conjunctiva extremely swollen.	☐ (L) eye covered (R) eye swollen lids	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☐ NPO for OR	☐ tol. regular diet - small amount	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☐ Void	☐	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ Maxillary fx & (R)/(L) knee wounds. Swelling noted to (L) side of face.	☐	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Multiple abrasions & sutures to face (primarily (L) side). Mouth dry at this time. Drsgs to	☐ multiple abrasions to (L) side of face, IV sites x2	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ c/o pain. Anxiety med orders	☐ See pg 1	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑ speaks no English. Understands some arabic	☐ understands some arabic no english	☐

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: (R) 1445 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]	TIME: INITIALS:
IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr:	IV patency ✓ q hr:
IV site care provided:	IV site care provided: Flushed	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (L) AC / OK	IV Site #1: (L) AC / OK	IV Site #1:
IV Site #2:	IV Site #2: (R) FA / OK	IV Site #2:
Comments: NS@75ml/hr	Comments: SLIdx2	Comments:

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: ~~1445~~ [redacted] TIME:	1445					
COLOR	P					
CAPILLARY REFILL	1					
TEMPERATURE	W					
EDEMA	1					
SENSATION	S					
MOTION	M					
PASSIVE FLEXION	0					
PERIPHERAL PULSE	2					

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY / OTHER

	TIME: 1445	2300	
ID band visible/legible	[redacted]	[redacted]	
Orient to environment prn	[redacted]	[redacted]	
Side rails (2/4) up	[redacted]	N/A	
Bed position low	[redacted]		
Call light within reach	[redacted]		
Review & post lab results	[redacted]		
Notify MD abnormal labs			
Incontinent urine/stool			
Linen change prn		[redacted]	
Turn/reposition q2h		[redacted]	
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE:	~~TYPE:~~	TYPE: NPO
PERCENT CONSUMED:	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED:
☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☑ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT	(BEDREST) AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT	(BEDREST) AMBULATE BSC BRP CHAIR ☐ SELF ☒ ASSIST # TIMES/SHIFT

TEACHING

TIME: 1445 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
CONTENT: -Staff orientation -Call for help -On call to OR	CONTENT:	CONTENT:
☑ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

[redacted]
b(6)-4

INITIALS	SIGNATURE	SHIFT
[redacted]	[redacted]	14-22
	[redacted]	N
	b(6)-2	

MEDCOM FORM 689-R (TEST) (MCHO) MAR 99

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	0233 00	dsg to (L) eye	covered	CDL

SECTION IV - NOTES

~~1400~~ → arrival at 1445 → Pt arrived via ~~litter~~ wheel chair to ward. Ambulated from w/c to bed & assisted. IV @ TKO. NKDA. NPO for OR. [redacted]

1530 → Pt to OR via litter & anesthesia. [redacted]

2000 → Pt returned from OR via litter. Pt ambulating from litter to bed & [redacted]

2005 → Pt has large pressure dsg to OS. Ø drng noted. Pt's nausea [redacted] bed. Pt fell asleep almost instantly. IV Fluids continue. Pt is due to void. [redacted]

b(6)-2
A11

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 16Sep03 | PATIENT ACUITY LEVEL: II | POST-OP DAY: Ø | HOSPITAL DAY: 2

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (Specify): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1200	2000	0400													
BP ARTERIAL LINE	—	—														
BP CUFF	112/53	110/52	111/96													
TEMPERATURE	98.3	98.5	99.3													
PULSE	72	76	72													
RESPIRATORY RATE	18	16	20													
OXYGEN (L/%)	a	—														
PULSE OXIMETER	99%	100%	99%													
O_2 METHOD	RA	RA	RA													

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	0645	8	8	2300	2400	0400		
PAIN INTENSITY (10 / 5 / 0)	X	X			YES			
MED ADMINISTERED (Y/N)	Y	Y Y	N	N	Y	N		
RELIEF ACCEPTABLE (Y/N)	N	N Y	NA	NA	Y	NA		
percocet					IV			

OTHER

TIME:	1500							
FINGER STICK GLUCOSE	NA							
INSULIN (Y/N)	↓							

SPECIAL NEEDS

TIME:	1500	2300	
*Skin breakdown prevention	N/A	N/A	
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			
		↓	

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

CIV [redacted] b(6)-4

Kordish

DIAGNOSIS: retinal bleed, maxilla fx, Schrapnel R&L knee

DRG: _____ ADMISSION DATE: 15Sep03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

RE MANAGER: _____

ISOLATION REQUIRED (Specify): _____

MEDCOM - 19172

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

b(6) - 2 - A11

	TIME: 1300 INITIALS: [redacted]	TIME: 1500 INITIALS: AB3	TIME: 2300 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑ (E) eye covered c̄ DRSG -> CDI (B) PERRLA/EOMI ↓ 40 HA;	☐ OS edematous, erythema to sclera, pupil reactive to light -language barrier.	☐ (L) eye covered c̄ dsg
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☑
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☑	☑	☑
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ multiple scars	☐ Sutures to OS lid, multiple abrasions to neck, face, chest, RUE.	☐ multiple abrasions on face, neck (B) arm
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ medicated c̄ percocet (MSX) (+) effect	☑	☑
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 1300 INITIALS: [redacted]	TIME: 1500 INITIALS: [redacted]	TIME: 2300 INITIALS: [redacted]
IV patency ✓ q ___ hr:	IV patency ✓ q 5 hr: PRN	IV patency ✓ q 8 hr:
IV site care provided:	IV site care provided: flushed.	IV site care provided: assessed
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (L) FA / OK	IV Site #1: (L) FA / OK	IV Site #1: (L) FA / OK
IV Site #2:	IV Site #2:	IV Site #2:
Comments: HL	Comments: HL	Comments: SLd

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:						
COLOR						
CAPILLARY REFILL						
TEMPERATURE						
EDEMA						
SENSATION						
MOTION						
PASSIVE FLEXION						
PERIPHERAL PULSE						

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	1300	E	2300
ID band visible/legible	[redacted]		
Orient to environment prn			
Side rails (2/4) up	✓	NA	NA
Bed position low	✓	↓	↓
Call light within reach	✓	↓	↓
Review & post lab results	✓	↓	↓
Notify MD abnormal labs	✓	↓	↓
Incontinent urine/stool	✓	↓	↓
Linen change prn	[redacted]	↓	[redacted]
Turn/reposition q2h		↓	[redacted]
ROM q2h if immobile		↓	↓
Antiembolic hose		↓	↓

DIET

BREAKFAST	LUNCH	DINNER
TYPE: ETHNIC / ROG	TYPE: B. ETHNIC	TYPE:
PERCENT CONSUMED: 20%	PERCENT CONSUMED: 50%	PERCENT CONSUMED:
HOW TOLERATED: well	HOW TOLERATED: well	HOW TOLERATED:
☐ SELF ☐ ASSIST ☐ COMPLETE	☑ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☑ SELF ☑ ASSIST ☐ COMPLETE ☐ TOTAL	☒ SELF ☐ ASSIST ☐ COMPLETE ☐ TOTAL	☒ SELF ☐ ASSIST ☐ COMPLETE ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☑ SELF ☑ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☒ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: 1300 INITIALS: [redacted]	TIME: 1500 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: OOB c̄ shoes for safety and c̄ asst. pain control	CONTENT: - pain control	CONTENT:
☑ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

C1V [redacted] b(6)-d

b(6)-2 [redacted]

SIGNATURE	SHIFT
[redacted]	
[redacted] LUTAN	E
[redacted] ATAN	N

SECTION III - INTERVENTIONS & TEACHING

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1500	(1) OS (2) RUE	(1) Sutures CDI, OTA, edema, tearing (2) Drsng CDI	(1) assessed. chsng Δ's (2) Drsng reinforced
	23 00	(1) OS (2) RUE	(1) Covered (2) Covered	(1) CDI (2) CDI

b(6)-2

SECTION IV - NOTES

1500: IV to (R) hand ø patent and D/c'd — [redacted] TAN

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 17Sept03 | PATIENT ACUITY LEVEL: II | POST-OP DAY: Ø | HOSPITAL DAY: 3

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (Specify): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1400	2000	0400														
BP ARTERIAL LINE																	
BP CUFF	126/56	130/58	121/58														
TEMPERATURE	98	99.8	98.7														
PULSE	90	79	78														
RESPIRATORY RATE	16	16	20														
OXYGEN (L/%)		—	—														
PULSE OXIMETER	98%	99%	94%														
O2 METHOD		RA															

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	1600	2000	2400					
PAIN INTENSITY (10 / 5 / 0)	Ø	X						
MED ADMINISTERED (Y/N)	Y		Y					
RELIEF ACCEPTABLE (Y/N)	Y		Y					

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:	1400	1600	2400
*Skin breakdown prevention	Ø	NA	NA
*Falls prevention protocol	NA		
*Restraint protocol	NA		
*Seizure precautions	NA		
*Isolation precautions	NA		

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

CIV [redacted] b(6)-4

kurdish soldier

[redacted]

DIAGNOSIS: retinal bleed, maxilla fx, schrapnel R/L knee

DRG: #20MF OF LT FAC Fx. class 3 Lac ADMISSION DATE: 15Sept03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____ b(6)-2

E MANAGER: [redacted]

ISOLATION REQUIRED (Specify):

MEDCOM - 19176

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: INITIALS:	TIME: 1600 INITIALS: [redacted]	TIME: 2400 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑ (L) EYE. PATINKY CLOSED DUE TO TRAUMA, S/P SURGERY	☐ OS swollen shut, No ↓ function to OD noted,	☐ OS swollen shut
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☐	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☐	☑	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☐ Has Foley from OR. to be D/C	☑ Foley D/C'd	☑
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ KNEE	☑	☑
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ (R) HAND	☐ Sutures to (R) orbital area, (R) face (L) forehead intact. wounds to (R) chin (L) eyebrow, chest & (R) arm, Dsg (R) arm D & I	☐ Sutures to (R) area under eye. Sutures to (L) side of forehead. abrasions to chin. (R) arm draining CDI
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ NO PAIN AT THIS TIME.	☐ Screaming in agony upon return from OR, crying. MSO4 4mg IVP given	☐ C/O pain @ 2230 given ii percocet
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 800 INITIALS: [redacted]	TIME: 1600 INITIALS: [redacted]	TIME: 2400 INITIALS: [redacted]
IV patency ✓ q ___ hr: 1JC	IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr:
IV site care provided: CR	IV site care provided:	IV site care provided:
IV tubing changed: 00 IV (L) ARM	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (L) ARM. Good	IV Site #1: (L) FA OK	IV Site #1: (L) FA OK
IV Site #2:	IV Site #2:	IV Site #2:
Comments: OT RETURN FROM OR. S/P ORIF OF LEFT 2MC FRACTURE, CLOSURE OF LACERATION.	Comments:	Comments: HL'd

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:	1400					
COLOR	N					
CAPILLARY REFILL	1					
TEMPERATURE	W					
EDEMA (2) SIDS FAC (1) RAS.	2 / 1					
SENSATION	S					
MOTION	P					
PASSIVE FLEXION	P					
PERIPHERAL PULSE	2					

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	0900	1600	2100
ID band visible/legible	[redacted]		
Orient to environment prn	[redacted]		
Side rails (2/4) up	ND	NA	
Bed position low	[redacted]		
Call light within reach	ND		

OTHER

Review & post lab results			
Notify MD abnormal labs			
Incontinent urine/stool	No		
Linen change prn	[redacted]		
Turn/reposition q2h	NA	NA	
ROM q2h if immobile	NA		
Antiembolic hose	ND		

DIET

BREAKFAST	LUNCH	DINNER
TYPE: MNO	TYPE:	TYPE: CI lig
PERCENT CONSUMED: Ø	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED:
☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☑ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR ☒ SELF ☐ ASSIST # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT

TEACHING

TIME: INITIALS:	TIME: 1600 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: (1) NOT TO BEND DOWN FROM THE WAIST (2) NO STRAINING (3) NO TOUCHING OF (4) EYE & BARE HANDS	CONTENT: Plan of Care Pain control	CONTENT:
☐ Patient/Family Verbalizes Understanding	☑ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

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

INITIALS	SIGNATURE	SHIFT
[redacted]		6-2
[redacted]	[redacted] LT, AN	2
[redacted]	[redacted] Quinn	N

b(6)-2

SECTION III - INTERVENTIONS & TEACHING

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
		(L) EYE	EDEMATOUS	EYE DROPS
		(L) SIDE OF FACE	RED.	OPEN, SUTURED
		(R) ARM	SLIGHTLY EDEMATOUS	DRESSING
	2100	(L) eye (R) eye (R) arm	OS swollen shut - sutures under eye OD c bruising to eye lid Rarm drsng CDI	assessed
				to (ue) - 2 All

SECTION IV - NOTES

0800 PT had complete bath, oral care and meds given as ordered. PT prep for OR — [redacted]

1400 PT returned from [redacted] PACU. PT has foley and IV fluids. Chest wounds cleaned and (2) tubes attended to by surgeons. PT transferred to bed. PT resting comfortably. Left in strict foley to be removed — [redacted]

1600: Awake and alert. c/o pain in OS. 4mg of MSO4 IVP given. Cleaned face & applied bacitracin. Will continue to monitor [redacted]

18 Sep 03 0030 pt c/o tightness to face, bacitracin applied as ordered. WLO cont to monitor — [redacted] Allwrng

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 18 Sept 03 | PATIENT ACUITY LEVEL: II | POST-OP DAY: 1 | HOSPITAL DAY: 4

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (Specify): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1900	2000	0400													
BP ARTERIAL LINE																
BP CUFF	104/60	104/60	115/56													
TEMPERATURE	98.8	100	97.2													
PULSE	79	84	100													
RESPIRATORY RATE	16	18	22													
OXYGEN (L/%)																
PULSE OXIMETER	99%	98%	100%													
O2 METHOD	RA	RA														

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	2300	830	930	1400	2000			
PAIN INTENSITY (10 / 5 / 0)								
MED ADMINISTERED (Y/N)	Y	Y	Y	N				
RELIEF ACCEPTABLE (Y/N)	Y	Y	Y	Y				

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:	0700	1400	2300
*Skin breakdown prevention			
*Falls prevention protocol			
*Restraint protocol	NA		
*Seizure precautions	NA		
*Isolation precautions	NA		

YESTERDAY'S WEIGHT: NA

TODAY'S WEIGHT: NA

WEIGHT CHANGE: NA

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

Civ [redacted] to (u) - 4

[redacted]

Kurdish Soldier

DIAGNOSIS: retinal bleed, maxilla fx, soft tissue Rt knee

DRG: _____ ADMISSION DATE: 15 Sept 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

CARE MANAGER: _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brie explanation of abnormal findings will be noted in the appropriate column.

	TIME: INITIALS:	TIME: 1400 INITIALS: [redacted]	TIME: 2300 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☐ (L) GCS-IMPAIRED SIP SURGERY.	☐ (L) eye is extremely edematous. Ø vision noted for that eye. Only opens by manual manipulation, & significant pain. (R) WNL	☐ OS Swollen Shut, opens only forced.
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☐	☑	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☑
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ (R) ARM TRAUMATIZED, HAS DRESSING DUE TO SIGNIFICANCE.	☐ (R) arm bandaged. Neurovascularly intact & no c/o pain. Dry CDI.	☐ (R) forearm & dressing CDI
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ HAS WOUND FROM MINOR FRAGMENTS	☐ Abrasions & sutures to face, especially (R) side,	☐ Sutured under OD intact OTA, sutures to (R) side of forehead, bacitracin applied to face
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ REQUESTED PAIN MED IV FOR COMFORT.	☐ see pg 1	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 0700 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: 2300 INITIALS: [redacted]
IV patency ✓ q ___ hr: 12	IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr:
IV site care provided:	IV site care provided:	IV site care provided: flushed
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (L) hand	IV Site #1: (L) hand / OK	IV Site #1: (L) hand / OK
IV Site #2:	IV Site #2:	IV Site #2:
Comments:	Comments: HL (flushed well)	Comments: HL'd

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: (2) EYES. TIME:	1200	1400				
COLOR	W					
CAPILLARY REFILL	2					
TEMPERATURE	W					
EDEMA	2					
SENSATION	S					
MOTION	P					
PASSIVE FLEXION	P/D					
PERIPHERAL PULSE	2					

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	0800	1400	2300
ID band visible/legible	[redacted]		
Orient to environment prn	[redacted]		
Side rails (2/4) up	[redacted]		
Bed position low	[redacted]		
Call light within reach	[redacted]		

OTHER

Review & post lab results		[redacted]	
Notify MD abnormal labs			
Incontinent urine/stool	[redacted]		
Linen change prn	[redacted]		
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Regular	TYPE:	TYPE: Regular
PERCENT CONSUMED: 75%	PERCENT CONSUMED:	PERCENT CONSUMED: 50%
HOW TOLERATED: well	HOW TOLERATED:	HOW TOLERATED: ok
☒ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	(BEDREST) AMBULATE BSC BRP CHAIR ☒ SELF ☐ ASSIST # TIMES/SHIFT	(BEDREST) AMBULATE BSC BRP CHAIR ☒ SELF ☐ ASSIST # TIMES/SHIFT	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT

TEACHING

TIME: INITIALS:	TIME: 1400 INITIALS: [redacted]	TIME: 2300 INITIALS [redacted]
CONTENT: 1. NO TO BEND FROM WAIST. 2. NO SUDDEN TURNING OF HEAD	CONTENT: - Staff orientation - Call for help - Pain management	CONTENT: pain management call for help
☐ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

INITIALS	b(6)-2 SIGNATURE	SHIFT
[redacted]		6-2
[redacted]	[redacted] LGAN	14-22
[redacted]	[redacted] Pillumle	N

SECTION III - INTERVENTIONS & TEACHING (cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	8	(R) EYE	PALE, EDEMATOUS	1. EYE DROPS
	8	(R) SIDE OF FACE		2. CLEANSED [illegible] AND BACITRACIN APPLIED
		(L) HAND	NORMAL, SMALL CUTS	3 DRESSING
	2300	DS (R)		

SECTION IV - NOTES

Pt medicated for pain IV and given AB therapy via IV and orthol. Pt in (R) wheelchair, advised. [redacted] Pt to perform ADLs, (R) hand cleansed and dressing applied. Pt encouraged with PO fluids, and rest advised — [redacted] 91 WMS

1400 → Pt are assumed [redacted]

[redacted] AN

b(u)-2

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 19 Sept 03 | PATIENT ACUITY LEVEL: II | POST-OP DAY: 2 | HOSPITAL DAY: 5

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0400	1200	2000
BP ARTERIAL LINE			
BP CUFF	125/56	127/61	103/41
TEMPERATURE	97.2	98.6	97.5
PULSE	100	77	67
RESPIRATORY RATE	22	20	16
OXYGEN (L/%)	Ø		
PULSE OXIMETER	100%	98	100
O2 METHOD	RA		RA

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	0600	1400	2000	2200
PAIN INTENSITY (10 / 5 / 0)			X	X
MED ADMINISTERED (Y/N)	Y	N		N
RELIEF ACCEPTABLE (Y/N)	Y	Y		NA

OTHER

TIME:	0600
FINGER STICK GLUCOSE	N/A
INSULIN (Y/N)	N/A

SPECIAL NEEDS

TIME:	0600	1400	2200
*Skin breakdown prevention	N/A	NA	NA
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: N

TODAY'S WEIGHT: _____

WEIGHT CHANGE: A

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

Civ [redacted] b (ce) - 4

[redacted]

Kurdish Soldier

DIAGNOSIS: retinal bleed, Maxillofx, Schrapnel R/L Knee

DRG: _____ ADMISSION DATE: 15 Sept 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (*Specify*): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

b(6)-2

	TIME: 0600 INITIALS: KW	TIME: 1400 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑ Language barrier	☐ (L) eye extremely swollen. Can be opened by pt however. No visual Δs to (R) eye	☐ (L) eye edematous and echymotic Pt can open own eye
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☑
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☑	☑	☑
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ RUE c̄ multiple sharpnel wounds. Facial wounds	☐ Multiple lacerations to face and (R) UE dry. RUE COC. Facial lacs covered c̄ bacitracin. Some serosang & purulent drainage	☐ multiple lacs to face and (R) UE. Bacitracin to face, O drainage to (R) UE
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ 5/10 percced sharp	☐ See pg 1 dang notify MD asap	☑
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 0600 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
IV patency ✓ q 5 hr:	IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr:
IV site care provided: assess/flush	IV site care provided:	IV site care provided:
IV tubing changed: /	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (L) FA / OK	IV Site #1: (L) FA / OK	IV Site #1: (L) FA / OK
IV Site #2:	IV Site #2:	IV Site #2:
Comments: HL'd	Comments: HL (flushed)	Comments: HL

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: RUE	TIME: 0600	1400	2200			
COLOR	P		P			
CAPILLARY REFILL	2		2			
TEMPERATURE	W		W			
EDEMA	0		0			
SENSATION	S		S			
MOTION	M		M			
PASSIVE FLEXION	0		0			
PERIPHERAL PULSE	2		2P			

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY / OTHER

	TIME: 0600	1400	2200
ID band visible/legible	[redacted]		
Orient to environment prn	[redacted]		
Side rails (2/4) up	[redacted]		
Bed position low	[redacted]		
Call light within reach	[redacted]		
Review & post lab results	[redacted]		
Notify MD abnormal labs			
Incontinent urine/stool			
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Reg	TYPE: Regular	TYPE: Regular
PERCENT CONSUMED: 50%	PERCENT CONSUMED:	PERCENT CONSUMED: 50%
HOW TOLERATED: well	HOW TOLERATED: ok	HOW TOLERATED: OK
☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: 0600 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
CONTENT: - Encourage pt to ambulate - call for assist - pain management	CONTENT: - Staff orientation - Call for help - Ambulation	CONTENT: - Call for assistance - Encouraged ambulation - Reflexotto
☒ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

Civ [redacted]
Kurdish Soldier

INITIALS	SIGNATURE	SHIFT
[redacted]	b(6)-2	D
[redacted]	UTAN	14-22
[redacted]	UT/MN	22-06

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	0400	RUE	multiple shrapnel wounds sm in size no drainage	cleaned wounds c̄ sterile water - dsg of Keflex
	0400	(L) ~~side of~~ face, eye	sutures intact	Cleaned and bacitracin applied
	2230	(L) eye, face	sutures intact, shrapnel wound OT	bacitracin applied
			bacitracin	

SECTION IV - NOTES

19Sept03 0900 pt going to appointment c̄ Dr. [redacted] SPC/9/WM

1400 → Assumed pt. care. [redacted] WM

1820 New IV started by order of LT Vanfossen 20 ga to back of (L) wrist. PRN Adapter in place. PFC [redacted] 9/W10

19 Sep 03 2230 (1) Coprim. Pupils reactive to light (L) pupil sluggish. Eye edematous and erythematous but improved from yesterday. Gtts to eye. Will monitor [redacted] WM

b(6)-2 A11

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 20Sep03 | PATIENT ACUITY LEVEL: II | POST-OP DAY: 3 | HOSPITAL DAY: 6

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (Specify): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0400	1200	2000	21Sep03 0400												
BP ARTERIAL LINE	/		/	/												
BP CUFF	111/60	116/56	115/76	111/68												
TEMPERATURE	99.1	97.9	97.9	97.6												
PULSE	79	62	80	68												
RESPIRATORY RATE	18	18	16	16												
OXYGEN (L/%)	/	/	/													
PULSE OXIMETER	99	99	96	99												
O2 METHOD		RA	RA													

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	1400	2000	2230					
PAIN INTENSITY (10 / 5 / 0)								
MED ADMINISTERED (Y/N)	N		N					
RELIEF ACCEPTABLE (Y/N)	Y		NA					

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:	0	1400	2000
*Skin breakdown prevention	Y	NA	NA
*Falls prevention protocol	NA		
*Restraint protocol	NA		
*Seizure precautions	NA		
*Isolation precautions	NA		

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: NA

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

Civ[redacted] to (w)-2

[redacted]

Murdish Dolder

DIAGNOSIS: retinal bleed, maxilla fx, Shrapnel [illegible]

DRG: _____ ADMISSION DATE: 15Sep03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: [redacted]

EQUIRED (Specify): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

b(4)=2

	TIME: INITIALS:	TIME: 1400 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☐ (2) eye injury ACTION FOREIGN 1300	☐ (L) eye swelling markedly ↓ from yesterday. Pt concerned about eye swelling. No good assessment at site available 2° language barrier	☐ (L) eye edema stable ↓ ecchymotic stable to periorbital (L) pupil responding slowly, not completely round pupil @ (L) edge
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☐	☐ ✓	☐ ✓
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☐	☐ ✓	☐ ✓
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☐	☐ ✓	☐ ✓
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☐	☐ ✓	☐ ✓
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐	☐ ✓	☐ ✓
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ SIDE OF (2) FACE SUTURED	☐ Sutures to (L) side of face c abrasions contd. Jaw/trach sutures	☐ sutures to (L) side of face intact abrasions c bacitracin
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐	☐ ✓	☐ ✓
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☐	☐ ✓	☐ ✓

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 08 ON	TIME: 1400	TIME: 2230
INITIALS: [redacted]	INITIALS: [redacted]	INITIALS: [redacted]
IV patency ✓ q ___ hr: 12	IV patency ✓ q 8 hr:	IV patency ✓ q ___ hr:
IV site care provided:	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1:	IV Site #1: (R) hand / OK	IV Site #1: (R) hand / OK
IV Site #2:	IV Site #2:	IV Site #2:
Comments: RE CHECK	Comments: HL (flushed)	Comments: heplocked
ON CSR IV		

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: (1) Knee	TIME: 0700	1400				
COLOR	N					
CAPILLARY REFILL	1					
TEMPERATURE	W					
EDEMA	2					
SENSATION	S					
MOTION	P					
PASSIVE FLEXION	D					
PERIPHERAL PULSE	2					

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY / OTHER

	TIME: 0700	1400	2230
ID band visible/legible	[redacted]		
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			
Review & post lab results		[redacted]	
Notify MD abnormal labs			
Incontinent urine/stool	[redacted]		
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Menus	TYPE: Menus	TYPE: Regular
PERCENT CONSUMED: 30%	PERCENT CONSUMED: 100%	PERCENT CONSUMED: 75%
HOW TOLERATED:	HOW TOLERATED: well	HOW TOLERATED: ok
☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☒ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME:	INITIALS:	TIME: 1400	INITIALS: [redacted]	TIME: 2230	INITIALS: [redacted]
CONTENT: 1. To report changes in mental status. 2. Ask for pain meds.		CONTENT: - Staff orientation - Call for assistance - Pain management - Encouraged Ambulation		CONTENT: Staff orientation Call for assistance Pain management	
☐ Patient/Family Verbalizes Understanding		☒ Patient/Family Verbalizes Understanding		☒ Patient/Family Verbalizes Understanding	

PATIENT IDENTIFICATION

Civ [redacted] b(4)-4
Kurdish Soldier

INITIALS	SIGNATURE	SHIFT
[redacted]	b(4)-2	6-2
[redacted]	[illegible]	14-22

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
		(L) EYE.	SWOLLEN, RED	EYE DROPS
		(L) SIDE OF FACE	SWOLLEN MOD SHARPLY	BACITRACIN
	2230	(L) eye	Sclera reddened, swollen, edematous	gtts 930
		(L) side of face	Swollen, sutures intact	bacitracin to sutures

SECTION IV - NOTES

[illegible] Pt alert and oriented. Mobile [illegible] level of light. Pt concern about his eye. Care given, face cleaned with water and hydrogen peroxide mixture. Eye drops given then bacitracin applied to sutures site. [illegible]

1400 Pt ate lunch. Pt deeply concern about when he is going home. Pt seen by MD and Pt condition explained. Pt his strength interpreter that he has to undergo more surgery before he is stabilized. Pt resting quietly in bed. Able to open (L) eye [redacted] PCM

1400 → Assumed pt care. [redacted]

20Sep03 2230 Pt awake and alert, Ø c/o pain. Pt able to open (L) eye on his own although still reddened and edematous. Unable to assess visual A's to eye due to language barrier. Will continue to administer gtts and monitor, pain management [redacted]

b(6)-2 All.

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 21 Sep 03 | PATIENT ACUITY LEVEL: II | POST-OP DAY: 4 | HOSPITAL DAY: 7

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ 22 Sep 03 Received By _____

VITAL SIGNS

TIME:	0400	1200	2000	0400												
BP ARTERIAL LINE																
BP CUFF	111/49	124/64	113/63	117/60												
TEMPERATURE	97.6	97.7	97.5	97.6												
PULSE	69	71	80	81												
RESPIRATORY RATE	16	16	16	16												
OXYGEN (L/%)	Ø	/	/	/												
PULSE OXIMETER	99	98%	98%	99												
O2 METHOD	RA	RA	RA	RA												

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	0600	1400	2000	2230				
PAIN INTENSITY (10 / 5 / 0)								
MED ADMINISTERED (Y/N)	N	N	NA	N				
RELIEF ACCEPTABLE (Y/N)	N/A	Y		NA				

OTHER

TIME:	0600							
FINGER STICK GLUCOSE	N/A							
INSULIN (Y/N)	N/A							

SPECIAL NEEDS

TIME:	0600	1400	2230
*Skin breakdown prevention	N/A	NA	NA
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: N/A

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

CIV [redacted] b(4)-4

[redacted]

Kurdish Soldier

DIAGNOSIS: retinal bleed, maxilla fx, shrapnel ®

DRG: _____ ADMISSION DATE: 15 Sep 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: b(4)-2

PRIMARY CARE MANAGER: [redacted]

MEDCOM - 19192 IUIRED (*Specify*): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

b(6)-2

	TIME: 0600 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑ (L) pupil slow reaction to light & round. Sclera red	☐ (L) pupil appears clear but non-reactive. Slight distortion to circle at 7-o'clock position. Sclera to (R) pupil eye reddened but no active bleed	☐ OD Sclera red OS reactive to light.
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☑
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☑	☑	☑
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ wounds to face & drainage	☐ wounds to the L eye w/ no drainage. Bacitracin applied. Also, IV site	☐ Sutures to (L) side of face intact OTA
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☑	☑
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 0600 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
IV patency ✓ q 5 hr:	IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr:
IV site care provided: Assess/flush	IV site care provided:	IV site care provided:
IV tubing changed: (L) FA OK (LOCATION / CONDITION)	IV tubing changed:	IV tubing changed:
IV Site #1:	IV Site #1: (L) wrist OK	IV Site #1: (L) wrist OK
IV Site #2:	IV Site #2:	IV Site #2:
Comments: HL'd	Comments: HL (flushed)	Comments: HL'd

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:						
COLOR						
CAPILLARY REFILL						
TEMPERATURE						
EDEMA						
SENSATION						
MOTION						
PASSIVE FLEXION						
PERIPHERAL PULSE						

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	0600	1400	2230
ID band visible/legible	[redacted]		
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			

OTHER

Review & post lab results		[redacted]	
Notify MD abnormal labs			
Incontinent urine/stool			
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

	BREAKFAST	LUNCH	DINNER
TYPE:	Reg	Reg	Regular
PERCENT CONSUMED:	50%	50%	50%
HOW TOLERATED:	Well	well	OK
	☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: 0600 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: 2230 INITIALS [redacted]
CONTENT: - call for assist - inform nurse of dizziness, nausea	CONTENT: - Staff orientation - Call for help - pain management	CONTENT: pain management call for assistance
☒ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

Civ [redacted] b(6)-4

[redacted]

Kurdish soldier

INITIALS	b(6)-2 SIGNATURE	SHIFT
[redacted]	SPC/9mm	D
[redacted]		14-22
[redacted]	9mm	N

MEDCOM - 19194

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	0600	wounds to face	sutures OTA, intact no drainage	bacitracin applied

SECTION IV - NOTES

21 Sept 03 0830 pt up to shower $\bar{S}$ difficulty. Wounds cleaned bacitracin applied. Pt resting at this time

1400 → Assumed pt care. [redacted] PC/SWM

1415 → Pt ambulatory to opthmology clinic [redacted] SAW

1435 → Pt returned from opthmology clinic $\bar{S}$ difficulty [redacted] SAW

b(6)-2

MEDCOM FORM 689-R (TEST) (MCHO) MAR 99

Page 4 of 4 pages

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 22 Sept 03 | PATIENT ACUITY LEVEL: II | POST-OP DAY: 5 | HOSPITAL DAY: 8

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (Specify): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ 23 Sep _____ Received By _____

VITAL SIGNS

TIME:		1200	2000	0400												
BP ARTERIAL LINE		—	—	—												
BP CUFF	114/55	119/46	110/61	114/[illegible]												
TEMPERATURE	97.7	98.6	98.4	96.4												
PULSE	66	83	81	69												
RESPIRATORY RATE	20	18	18	16												
OXYGEN (L/%)		—	—	—												
PULSE OXIMETER	99	100	99%	98												
O2 METHOD	RA	RA	RA													

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	1200	1400	2000	2230	0200			
PAIN INTENSITY (10 / 5 / 0)	X	X	X	X	X			
MED ADMINISTERED (Y/N)		Y	NA	N	Y			
RELIEF ACCEPTABLE (Y/N)		Y		NA	Y			
Percocet		7						

SPECIAL NEEDS

TIME:	0800	1400	2230
*Skin breakdown prevention	G	NA	NA
*Falls prevention protocol	NS		
*Restraint protocol	NS		
*Seizure precautions	NS		
*Isolation precautions	NS		

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: NA

WEIGHT CHANGE: _____

*Per hospital policy.

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

[redacted] b(4)-21

[redacted]

Kurdish soldier

DIAGNOSIS: Retinal bleed, maxilla fx, shrapnel (R) knee

DRG: _____ ADMISSION DATE: 15 Sept 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: [redacted]

 QUIRED (Specify): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: INITIALS:	TIME: 1400 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☐	☐ (L) eye pupil @ 5mm. Non reactive. Tends to remain position ~~[illegible]~~ somewhat distorted. Pt states that loses light & see shadows.	☐ (L) eye pupil at 5mm, responds slightly and sluggish to light. Pt vision blurry to (L) eye
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☑
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☑	☐ Pt c/o (R) shoulder pain, Percocet given for pain	☑
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐	☐ IV site & sutures in place. MD says sutures will come out tomorrow	☐ Multi shrapnel wounds to chest and bilat UE.
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐	☐ See pg 1	☑
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 0800 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
IV patency ✓ q ___ hr:	IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr: prn
IV site care provided:	IV site care provided:	IV site care provided: site d'd
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1:	IV Site #1: (L) hand / OK	IV Site #1: (L) hand / I
IV Site #2:	IV Site #2:	IV Site #2: (R) wrist / OK
Comments: PO on IV	Comments: HL (flushed)	Comments: HL between meds
PO 17 B 0556		

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: (L) Eye [illegible] TIME:	1200					
COLOR	P					
CAPILLARY REFILL	1					
TEMPERATURE	W					
EDEMA	0					
SENSATION	S					
MOTION	P					
PASSIVE FLEXION	P					
PERIPHERAL PULSE	2					

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

	TIME: 1200	1400	2230
ID band visible/legible	[redacted]		
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			

OTHER

Review & post lab results		[redacted]	
Notify MD abnormal labs			
Incontinent urine/stool	[redacted]		
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

	BREAKFAST	LUNCH	DINNER
TYPE:	Regular		Regular
PERCENT CONSUMED:	75%		~~OK~~ 75%
HOW TOLERATED:	well		OK
	☒ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: INITIALS:	TIME: 1400 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
CONTENT: 1. not to touch eye with fingers 2. not to bend from waist	CONTENT: - Staff introduction - Call for help - Pain management	CONTENT: Staff orientation Call for assistance Pain management Eye gets
☐ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

Civ [redacted] b(6)-d

INITIALS	SIGNATURE	SHIFT
[redacted]	b(6)-2	6-2
[redacted]	19 AM	14-22
[redacted]	10 PM	22-06

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
		(L) EYE, CHEEK	PINK, SWOLLEN x 1	EYE DROPS SUTURES INTACT. BACITRACIN
	2230	(L) eye & cheek	(L) eye reddened, swollen (L) cheek swollen, sutures intact	eye gtts q20° Bacitracin to face

SECTION IV - NOTES

1100 Patient alert and oriented x3. able to voice wants. Pt had eye drops and IV meds. Had visit from DOD rep. Pt passed American liver. Pt in no distress. resting quietly [redacted]

1400 → Assumed pt care. [redacted]

22 Sep 03 2230 Pt awake and alert, Ø C/O pain. Gtts continue to (L) eye, bacitracin to (L) cheek. New IV to (R) wrist. [redacted] b(4)-2

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 23 Sep 03 | PATIENT ACUITY LEVEL: II | POST-OP DAY: 6 | HOSPITAL DAY: 9

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1100	2000	0400													
BP ARTERIAL LINE																
BP CUFF	118/66	109/70	109/61													
TEMPERATURE	97.5	97.8	97.3													
PULSE	84	78	76													
RESPIRATORY RATE	20	18	16													
OXYGEN (L/%)																
PULSE OXIMETER	99	99%	99													
O_2 METHOD	RA	RA														

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	1600	2000						
PAIN INTENSITY (10 / 5 / 0)	6	1						
MED ADMINISTERED (Y/N)	Y							
RELIEF ACCEPTABLE (Y/N)								

OTHER

TIME:	1600							
FINGER STICK GLUCOSE	N/A							
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:	0600	1600	2000
*Skin breakdown prevention	[redacted]	NA	NA
*Falls prevention protocol	NA		
*Restraint protocol	NA		
*Seizure precautions	NA		
*Isolation precautions	NA		

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: NA

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

Cio [redacted] 5(a)-2

[redacted]

Kurdish Soldier

DIAGNOSIS: retinal bleed, maxilla fx, shrapnel (R) knee

DRG: _____ ADMISSION DATE: 15 Sep 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (*Specify*): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

b(w)-2

	TIME: 800 INITIALS: [redacted]	TIME: 1600 INITIALS: [redacted]	TIME: 2200 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☐ (L) EYE SWELLING POOR VISION CAPABILITY.	☐ OS BV, erythema Pupil ⊘ reactive to light.	☐ OS swollen erythema to OU ⊘ reaction to light
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☑
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☑	☑	☑
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ (L) FACE LACE - SUTURED SITE.	☐ Laceration (L) cheek sutures OTA	☐ (L) cheek c̄ sutures intact
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☑	☑ ⊘ c/o pain. asked for Ambien 10mg Ambien given 2230
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑ WORRIED ABOUT FAMILY	☑	☐

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 800 INITIALS: [redacted]	TIME: 1600 INITIALS: [redacted]	TIME: 2200 INITIALS: [redacted]
IV patency ✓ q ___ hr: HL	IV patency ✓ q 8 hr: PRN	IV patency ✓ q 8 hr:
IV site care provided:	IV site care provided: assessed	IV site care provided: flushed
IV tubing changed:	IV tubing changed: flushed	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1:	IV Site #1: (R) FA / OK	IV Site #1: (R) FA / OK
IV Site #2:	IV Site #2:	IV Site #2:
Comments: RO IN HL IV? B MDS	Comments: HL	Comments: HL

CW [redacted] b(w)-4

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: (L) EXT (R) FOOT TIME:	1600	E				
COLOR	N	NA				
CAPILLARY REFILL	1					
TEMPERATURE	W					
EDEMA	2					
SENSATION	S					
MOTION & HEAD	M					
PASSIVE FLEXION & HEAD	D					
PERIPHERAL PULSE	2					

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY / OTHER

TIME:	1600	E	N
ID band visible/legible	[redacted]		
Orient to environment prn	[redacted]		
Side rails (2/4) up	[redacted]		
Bed position low	[redacted]		
Call light within reach	[redacted]		
Review & post lab results			
Notify MD abnormal labs			
Incontinent urine/stool	[redacted]		
Linen change prn	[redacted]		
Turn/reposition q2h	[redacted]		
ROM q2h if immobile	[redacted]		
Antiembolic hose	[redacted]		

DIET

BREAKFAST	LUNCH	DINNER
TYPE: REGULAR	TYPE: REGULAR	TYPE: REG
PERCENT CONSUMED: 60%	PERCENT CONSUMED: 80%	PERCENT CONSUMED:
HOW TOLERATED: WELL	HOW TOLERATED: WELL	HOW TOLERATED:
☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: INITIALS:	TIME: 1600 INITIALS: [redacted]	TIME: 2200 INITIALS: [redacted]
CONTENT: 1. HOW TO COMMUNICATE USING SIGN BY GESTURES. 2. TO MONITOR AND REPORT CHANGE IN V/S.	CONTENT: Pain management	CONTENT: Pain management call for assistance
☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
CIV [redacted] b(6)-4 [redacted] Kurdish Soldier	[redacted] b(6)-2		6-2
		[redacted] AZAN	E
		[redacted] Gilmore	N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
		(R) EYE	SWOLLEN - REDNESS	EYE BAND
		(R) SIDE OF FACE	SWOLLEN	SUTURES
		(L) eye	Swollen, erythema	eye drops
		(L) side face	sutures CDI	
	2200	OS	Swollen erythema	assessed
		(L) Cheek	Sutures CDI	

SECTION IV - NOTES

0800 PT in bed, aware of treatment plan. That is need for eye drops and keep area around eye and facial laceration site clean. PT had visit from DOD personnel. PT called & phone family. [redacted] 91WM6

1000 PT feels more comfortable on unit & bonding with other persons including Iraqi friends and patients. PT prefers Kurdish food. Eye drops applied to (R) eye, pt showing more outgoing. PT 91WM6.

PT also drinks 100% [redacted] b(6)-2

MEDCOM FORM 689-R (TEST) (MCHO) MAR 99

Page 4 of 4 pages

CIV [redacted] b(6)-4

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 24 Sept 03 | PATIENT ACUITY LEVEL: II | POST-OP DAY: 7 | HOSPITAL DAY: 10

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (Specify): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ 25Sep _____ Received By _____

VITAL SIGNS

TIME:	0955	2000	0400													
BP ARTERIAL LINE																
BP CUFF	117/59	140/56	102/[illegible]													
TEMPERATURE	97.1	97.3	97.3													
PULSE	72	98	68													
RESPIRATORY RATE	20	20	16													
OXYGEN (L/%)																
PULSE OXIMETER	98	98	99													
O2 METHOD	RA	RA														

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	1540	2000	0230	0530				
PAIN INTENSITY (10 / 5 / 0)								
MED ADMINISTERED (Y/N)	Y		N	Y				
RELIEF ACCEPTABLE (Y/N)	Y		NA	Y				

SPECIAL NEEDS

	TIME: 0900	1540	0230
*Skin breakdown prevention	[redacted]		
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

[redacted]

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

CIV [redacted] b(6)-4

[redacted]

Kurdish soldier

DIAGNOSIS: Retina O Bleed, maxilla fx, traumatic (R) knee

DRG: _____ ADMISSION DATE: 15 Sept 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: b(6)-2

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (Specify): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

b(4)-2

	TIME: 0700 INITIALS: [redacted]	TIME: 1540 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☐ (L) EYE = IMPAIRED VISION, PUPIL 5MM (R) EYE PUPIL 3 M.	☐ ↓ vision to OS, pain to OU.	☐ ↓ vision to (L) eye
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☑
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☑	☑	☑
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ (L) SIDE OF FACE LAC, SUTURES INTACT.	☐ Lacerations to (L) face sutures intact. Bacitracin applied.	☐ lacerations to (L) side of face sutures removed.. CDI. Bacitracin applied
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☐ c/o pain in OU & (R) shoulder. Percocet ii PO given.	☐ Percocet for pain to face
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 0630 INITIALS: [redacted]	TIME: 1540 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
IV patency ✓ q ___ hr: KL	IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr:
IV site care provided:	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1:	IV Site #1: (R) FA / OK	IV Site #1: (R) FA / 1
IV Site #2:	IV Site #2:	IV Site #2: (L) wrist / OK
Comments: KL RE FO IWPB MODS	Comments:	Comments: (R) FA IV removed, new IV placed to (L) wrist

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:	0700					
COLOR	N					
CAPILLARY REFILL Blanch	1					
TEMPERATURE	W					
EDEMA	2					
SENSATION	S					
MOTION & HEAD	P					
PASSIVE FLEXION & HEAD	D					
PERIPHERAL PULSE	2					

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	0700	1540	2230
ID band visible/legible	[redacted]		
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach		✓	

OTHER

Review & post lab results		[redacted]	
Notify MD abnormal labs			
Incontinent urine/stool	[redacted]		
Linen change prn			
Turn/reposition q2h	NA	NA	
ROM q2h if immobile	NA		
Antiembolic hose	NA	✓	

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Regular	TYPE:	TYPE:
PERCENT CONSUMED: Week	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED: 20%	HOW TOLERATED:	HOW TOLERATED:
☒ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☑ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☑ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☑ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☑ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: INITIALS:	TIME: 1540 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
CONTENT: 1. TO KEEP ARTICLES & CLOTHES AWAY FROM (L) EYE. 2. TO REST (L) EYE	CONTENT: Plan of care.	CONTENT: Call for assistance, Pain management, Gtts to (L) eye, New IV
☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
C [redacted] b(6)-4	[redacted]	[redacted]	6 2
		[redacted] MT/PN	2
		[redacted] LVT/RN	22-06
		b(6)-2	

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1.	(L) EYES.	SWELLING +2, PINKISH-RED.	EYE DROPS "
	2.	(L) SIDE OF FACE	BACKGROUND DIN.	SUTURES.
	1540	(L) face	sutures intact	bacitracin applied.
	2220	(L) eye (L) side of face	Sclera red, eyelids still swollen Sutures removed, CDI	gtts q2° Bacitracin applied

SECTION IV - NOTES

0900 PT performs ADLs, face cleansed and eye drops administered, scabs and sutures dabbed with bacitracin. MD removed sutures from face, PT tolerated procedure well. PT (R) eye pupil 3MM, (L) eye pupil 5MM. PT said, "I have see." [redacted]

1100. PT seen by MD [redacted] for pain in (R) scapula. x-rays orders completed - no bone defects noted. [redacted]

1540: Alert. % pain in OU + (R) shoulder. Percocet II PO given. Will continue to monitor. [redacted] 20th

24 Sep 03 2220 Pt awake and alert, ∅ C/O pain at this time. Sutures removed from (L) side of face, wound healing well, edges well approximated. Bacitracin applied. Gtts continue to eye. [redacted] (LPN)

b(6)-2 A11

MEDCOM FORM 689-R (TEST) (MCHO) MAR 99

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 25 Sep 03 | PATIENT ACUITY LEVEL: II | POST-OP DAY: 8 | HOSPITAL DAY: 11

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (Specify): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1200	2000	0400													
BP ARTERIAL LINE	—															
BP CUFF	122/60	100/60	121/52													
TEMPERATURE	97.6	99.1	98.2													
PULSE	79	84	91													
RESPIRATORY RATE	18	18														
OXYGEN (L/%)	—															
PULSE OXIMETER	100	99	100													
O2 METHOD	RA	RA														

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	8	1200	1400	2200				
PAIN INTENSITY (10 / 5 / 0)	X	X	X	X				
MED ADMINISTERED (Y/N)	Y	Y	N	Y				
RELIEF ACCEPTABLE (Y/N)	N		Y					

SPECIAL NEEDS

	TIME:		
*Skin breakdown prevention			
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

[redacted] b(6)-4

[redacted]

Kurdish Soldier

DIAGNOSIS: Retinal bleed, Maxillofacial, Shrapnel Knee

DRG: _____ ADMISSION DATE: 15 Sep 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: [redacted] b(6)-2

ISOLATION REQUIRED (Specify): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

b(6)-2

	TIME: 0830 INITIALS [redacted]	TIME: 1460 INITIALS [redacted]	TIME: 2300 INITIALS [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☐ sclera reddened OU (R) eye 4-5mm (L) eye 3 mm ↓ c/o HA, dizziness, ↓ vision in OU	☐ (R) eye sclera continues to be reddened. (R) eye PERLA. (L) eye does not constrict.	☐ Sclera OU red
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☐ ✓	☐ ✓	☐ ✓
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☐ ✓	☐ ✓	☐ ✓
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☐ ✓	☐ ✓	☐ ✓
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☐ ✓	☐ ✓	☐ ✓
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ ✓	☐ ✓	☐ ✓
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ multiple scars to face bacitracin ointment applied	☐ multiple lacerations & abrasions to face. Treated + bacitracin	☐ Several abrasions to face
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ MEDICATION ~~provided~~ Percocet providing (+) effect	☐ see pg 1	☐ ✓
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☐ ✓	☐ ✓	☐ ✓

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 0830 INITIALS: [redacted]	TIME: 1460 INITIALS: [redacted]	TIME: 2300 INITIALS: [redacted]
IV patency ✓ q ___ hr:	IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr:
IV site care provided:	IV site care provided:	IV site care provided: flushed
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (L) RA / OK	IV Site #1: (L) FA / OK	IV Site #1: (L) FA / OK
IV Site #2:	IV Site #2:	IV Site #2:
Comments: HL	Comments: HL (flushed)	Comments: HL

Civ [redacted] b(6)-4

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:						
COLOR						
CAPILLARY REFILL						
TEMPERATURE						
EDEMA						
SENSATION						
MOTION						
PASSIVE FLEXION						
PERIPHERAL PULSE						

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY / OTHER

TIME:	0830	1400	2300
ID band visible/legible	[redacted]	[redacted]	[redacted]
Orient to environment prn	[redacted]	[redacted]	[redacted]
Side rails (2/4) up	—	[redacted]	
Bed position low	—		
Call light within reach	—		
Review & post lab results	—	[redacted]	
Notify MD abnormal labs	—		
Incontinent urine/stool	—		
Linen change prn	[redacted]		
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

b(6)-2

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Reg	TYPE:	TYPE: Regular
PERCENT CONSUMED: 50%	PERCENT CONSUMED:	PERCENT CONSUMED: 75%
HOW TOLERATED: well	HOW TOLERATED:	HOW TOLERATED: ok
☑ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☑ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☑ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☑ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: 0830 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: 2300 INITIALS: [redacted]
CONTENT: Pain Control, Translator and lib	CONTENT: -Call for help, -Pain management, -Staff orientation	CONTENT: Pain management
☑ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding	☐ P[redacted] Verbalizes Understanding

b(6)-2

PATIENT IDENTIFICATION	INITIALS		SHIFT
Civ [redacted] b(6)-2 [redacted] Kurdish soldier	[redacted]	[redacted]	1
		[redacted]	14-22
		[redacted]	N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE

SECTION IV - NOTES

1400 → Assumed pt care. [redacted] b(6)-2

MEDCOM FORM 689-R (TEST) (MCHO) MAR 99

Page 4 of 4 pages

Civ [redacted] b(6)-4

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 26 Sep 03 | PATIENT ACUITY LEVEL: II | POST-OP DAY: 9 | HOSPITAL DAY: 12

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0400	1200	2000	0400												
BP ARTERIAL LINE																
BP CUFF	121/52	117/48	104/57	110/53												
TEMPERATURE	98.2	98.3	96.5	97.3												
PULSE	91	82	72	86												
RESPIRATORY RATE	16	18	16	16												
OXYGEN (L/%)	0	—	—													
PULSE OXIMETER	100	100	100%	98												
O_2 METHOD	RA	RA	RA													

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	0700	1200	1600	2000	2230			
PAIN INTENSITY (10 / 5 / 0)			X					
MED ADMINISTERED (Y/N)	N		Y	N/A	N			
RELIEF ACCEPTABLE (Y/N)	N/A		Y		NA			
Percocet			II					

SPECIAL NEEDS

TIME:	0700	1400	2230
*Skin breakdown prevention	[redacted]		
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: N/A

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

OTHER

TIME:	0700							
FINGER STICK GLUCOSE	N/A							
INSULIN (Y/N)	N/A							

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

[redacted] b(6)-4

DIAGNOSIS: Retinal bleed, Maxilla fx, Shrapnel (R) knee

DRG: _____ ADMISSION DATE: 15 Sep 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: b(6)-2

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (*Specify*): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: 0700 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☐ (L) pupil unreactive to light ⊘ round scleral of (R) + (L) eye red. Pt able to see light in eye	☐ (L) pupil remains dilated. Pt claims to see light's shadows, (L) eye has some redness & blood to lateral side of eye	☐ Eyes red (B). (L) eye dilated pupil responds minimally to light. Blurred vision and VVISION to eye
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☑
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☑	☑	☑
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ multiple wounds to face and (R) arm no s/s infection	☐ multiple wounds to (L) face. Most sutures removed covering & bandages continues. ⊘ s/s infection. Also IV.	☐ multiple shrapnel wounds to (L) face. Sutures removed, healing well
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☑	☑
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

	TIME: 0700 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
IV patency ✓ q ___ hr:		IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr:
IV site care provided:	flush assess	IV site care provided:	IV site care provided:
IV tubing changed:	(L) FA OK	IV tubing changed:	IV tubing changed:
	LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1:		IV Site #1: (L) FA / OK	IV Site #1: (L) FA / OK
IV Site #2:		IV Site #2:	IV Site #2:
Comments:	HL'd	Comments: HL (flushed)	Comments: HL, flushed

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:						
COLOR						
CAPILLARY REFILL						
TEMPERATURE						
EDEMA						
SENSATION						
MOTION						
PASSIVE FLEXION						
PERIPHERAL PULSE						

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	0700	1400	2230
ID band visible/legible	[redacted]		
Orient to environment prn	[redacted]		
Side rails (2/4) up		[redacted]	
Bed position low		[redacted]	
Call light within reach		[redacted]	

OTHER

Review & post lab results		[redacted]	
Notify MD abnormal labs			
Incontinent urine/stool			
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Reg	TYPE: Reg	TYPE: Regular
PERCENT CONSUMED:	PERCENT CONSUMED:	PERCENT CONSUMED: 75%
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED: OK
☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: 0700 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
CONTENT: - call for assist	CONTENT: - Staff orientation - Call for help - Pain management	CONTENT: Call for assistance Eye gels IV safety
☒ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
CIV [redacted] b(6)-2 b(6)-4	[redacted]	[redacted]	D
		[redacted]	14-22
		[redacted]	22-06

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE

SECTION IV - NOTES

26Sept03 0740 Pt amb w difficulty showered this am. yw c/o pain or discomfort. Will see Iraqi Dr. today. [redacted] SPC/91WM6

26Sep03 0830 - IV DC @ 0815. New IV started @ 0825 hrs. 20 GA to back of (R) hand. PRN in place and flushed w NS. PFC [redacted] 91W10

1400 → Assumed pt care. Pt seen by Iraqi retinal specialist. PAD [redacted] for surgery at Iraqi hospital for retinal surgery. [redacted]

26Sep03 2030 Pt sleeping easily arousable w verbal stimuli. Ø complaints @ this time. Will continue to monitor [redacted] U/RN

b(6)-2 All

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 27 Sep 03 | PATIENT ACUITY LEVEL: II | POST-OP DAY: 10 | HOSPITAL DAY: 13

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0400	1200	2000	0415												
BP ARTERIAL LINE		—	—	—												
BP CUFF	116/53	102/62	111/60	106/51												
TEMPERATURE	97.3	98.4	98.3	97.4												
PULSE	86	94	95	91												
RESPIRATORY RATE	16	18	16	16												
OXYGEN (L/%)	—	—	—	—												
PULSE OXIMETER	98	98%	99%	99												
O2 METHOD	RA	RA	RA	RA												

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	0640	1400	2000	2230				
PAIN INTENSITY (10 / 5 / 0)								
MED ADMINISTERED (Y/N)	N	N	N	N				
RELIEF ACCEPTABLE (Y/N)	N/A	Y	NA	NA				

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

SPECIAL NEEDS

	TIME:		
*Skin breakdown prevention			
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

Civ [redacted] b(6)-4

[redacted]

Kurdish soldier

DIAGNOSIS: retinal bleed, maxillary & frontal (E) (Case)

DRG: _____ ADMISSION DATE: 15 Sep 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: b(6)-2

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (*Specify*): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

b(6)-2

	TIME: 0640 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑ Language barrier (L) pupil unreactive to light & round. (R) eyes red. (R) pupil reactive & round	☑ Verify (L) pupil remains dilated unresponsive to light. States that he sees some small amounts of light. (R) pupil PERRLA.	☐ (L) pupil remains dilated & minimally responsive to light. Pt states he can see the light. (R) pupil normal
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☐ Congestion noted to RUL on exhale. No cough noted	☑	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☑
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ Full ROM to (R) shoulder ⊂. Sm amt of pain	☐ Complains to c/o small amounts of (R) shoulder pain. ROM limited by this pain	☑
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Facial wounds healing well (R) arm slings wounds healing OTA	☐ Facial lacerations healing well. Ø s/s infection. Ø sutures remaining	☐ Facial wounds healing well. (R) arm healing
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☑	☑
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 0640 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
IV patency ✓ q 5 hr:	IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr:
IV site care provided: Flush	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (R) FA / OK	IV Site #1: (R) hand / OK	IV Site #1: (R) hand / OK
IV Site #2:	IV Site #2:	IV Site #2:
Comments:	Comments: HL (Flushed).	Comments: HL

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:						
COLOR						
CAPILLARY REFILL						
TEMPERATURE						
EDEMA						
SENSATION						
MOTION						
PASSIVE FLEXION						
PERIPHERAL PULSE						

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	0640	1400	2230
ID band visible/legible	[redacted]		
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			

OTHER

Review & post lab results	[redacted]		
Notify MD abnormal labs			
Incontinent urine/stool			
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Reg	TYPE: Reg	TYPE: Regular
PERCENT CONSUMED:	PERCENT CONSUMED:	PERCENT CONSUMED: 75%
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED: OK
☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: 0640 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
CONTENT: · Call for assist · plan of care	CONTENT: - Staff orientation - Call for help - Pain management	CONTENT: - Staff orientation - Call for assistance - Pain management - Eye care
☒ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
C[redacted] b(6)-4	b(6)-2	[redacted] SR/9	D
		[redacted]	14-22
		[redacted]	22-06

MEDCOM FORM 689-R (TEST) (MCHO) MAR 99

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1800	(L) eye	pupil not round unreactive to light sclera red	Stts q 2°
	2230	(L) eye	Sclera red, pupil not responsive not round	gtts q 2°

SECTION IV - NOTES

27 Sept 03 0700 Pt seen by Iraqi doctor yesterday. arrangements are being made for pt to go to Mosul hospital for surgery. [redacted] SUMO

1400 → Assumed pt care. [redacted] SAV

27 Sep 03 2230 Pt sleeping, easily arousable to verbal stimuli. ∅ c/o pain at this time. Eye gtts continue q 2°. Will continue to monitor [redacted] T/N

b(6)-2 A11

MEDCOM FORM 689-R (TEST) (MCHO) MAR 99

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 28 Sep 03 | PATIENT ACUITY LEVEL: II | POST-OP DAY: N | HOSPITAL DAY: 14

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (Specify): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1200	2000	0400													
BP ARTERIAL LINE	/	/														
BP CUFF	124/70	132/75	130/70													
TEMPERATURE	99.6	98.9	98.4													
PULSE	90	99	96													
RESPIRATORY RATE	16	16	18													
OXYGEN (L/%)	/	/														
PULSE OXIMETER	97%	99	99%													
O2 METHOD	RA		RA													

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	0900	1400	2230	0400				
PAIN INTENSITY (10 / 5 / 0)								
MED ADMINISTERED (Y/N)	N	N	N					
RELIEF ACCEPTABLE (Y/N)		Y	NA					

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)	N/A							

SPECIAL NEEDS

TIME:	1400	2230	
*Skin breakdown prevention	NA	NA	
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: NA

TODAY'S WEIGHT:

WEIGHT CHANGE:

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

Civ [redacted] b(6)-4

[redacted]

Kurdish Soldier

DIAGNOSIS: retinal bleed, maxillofx, shrapnel (R) knee

DRG: _____ ADMISSION DATE: 15 Sep 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: b(6)-7

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (Specify): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: 0900 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑ talks a little English (L) pupil unresponsive (R) pupil responsive & red in outer corner	☐ (L) pupil dilated to 6mm, unresponsive (R) pupil PERRLA.	☐ (L) pupil dilated, unresponsive (R) pupil PERRLA, appropriately responsive
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑ b/(u)-2 All	☑	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☑
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☑	☑	☑
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Some small bruises & abrasions noted to arms & face	☐ Multiple abrasions to face. Band-aids applied	☐ Small triangular wounds to face healing well
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ 3/10 no pain meds given	☐ see pg 1	☑
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 0900 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
IV patency ✓ q ___ hr:	IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr:
IV site care provided:	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (R) wrist / OK	IV Site #1: (R) wrist / OK	IV Site #1: (R) wrist / OK
IV Site #2:	IV Site #2:	IV Site #2:
Comments: HL	Comments: HL (flushed)	Comments: HL
IV antibiotics		

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:						
COLOR						
CAPILLARY REFILL						
TEMPERATURE						
EDEMA						
SENSATION						
MOTION						
PASSIVE FLEXION						
PERIPHERAL PULSE						

N/A

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	0900	1400	2230
ID band visible/legible	[redacted]		
Orient to environment prn	[redacted]		
Side rails (2/4) up	[redacted]		NA
Bed position low	[redacted]		
Call light within reach	[redacted]		

OTHER

Review & post lab results	[redacted]		
Notify MD abnormal labs			
Incontinent urine/stool			
Linen change prn	[redacted]		
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Regular	TYPE: Regular	TYPE: Regular
PERCENT CONSUMED: 75%	PERCENT CONSUMED: 75%	PERCENT CONSUMED: 75%
HOW TOLERATED: well	HOW TOLERATED: ok	HOW TOLERATED: ok
☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: INITIALS:	TIME: 1400 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
CONTENT: - Pain control - Ambulation	CONTENT: - Staff orientation - Call for help - Pain management	CONTENT: Call for assistance Pain management Eye gtts
☐ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
Civ [redacted] b(6)-4 b(6)-2	[redacted]	[redacted] Det AN	D
		[redacted] LPN	14-22
		[redacted] NT/RN	22-06

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE

SECTION IV - NOTES

MOO → Assumed pt care [redacted] MOO

28 Sep03 2230 Pt awake and alert, ambulating in hallways I assistance. Ø complaints [redacted] O/M

b(6)-2 All

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 29Sep03 | PATIENT ACUITY LEVEL: II | POST-OP DAY: 12 | HOSPITAL DAY: 15

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (Specify): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0400	1200														
BP ARTERIAL LINE	—	—														
BP CUFF	130/70	114/60														
TEMPERATURE	98.6	95.2														
PULSE	96	69														
RESPIRATORY RATE	16	18														
OXYGEN (L/%)	—	—														
PULSE OXIMETER	99	100%														
O2 METHOD	RA	RA														

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	0030	1200	1450					
PAIN INTENSITY (10 / 5 / 0)								
MED ADMINISTERED (Y/N)	N	N	N					
RELIEF ACCEPTABLE (Y/N)	NA	NA	Y					

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

SPECIAL NEEDS

	TIME:		
*Skin breakdown prevention			
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

Civ [redacted] b(4)-4

[redacted]

Kurdish soldier

DIAGNOSIS: retinal blood, maxillofx, shrapnel @ knee

DRG: _____ ADMISSION DATE: 15 Sep 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: b(4)-7

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (Specify): [redacted]

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: 0830 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☐ - OS pupil nonreactive to light - OU sclera red - pt stated that he sees red when light shined into OS	☐ OS pupil remains non-reactive to light & dilated. Sclera of (R) eye reddened. States he can see some light.	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑ b (ce)-2 All	☑	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☑	☑	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ - Scars below OS & on (R) side of face - dime size open wound to upper (R) chest	☐ Multiple abrasions to (L) face. Bruising	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☑	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☐

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 0830 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: INITIALS:
IV patency ✓ q ___ hr:	IV patency ✓ q 8 hr:	IV patency ✓ q ___ hr:
IV site care provided:	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: NO IV	IV Site #1:	IV Site #1:
IV Site #2: access	IV Site #2: No	IV Site #2:
Comments:	Comments: IV Access	Comments:

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:						
COLOR						
CAPILLARY REFILL						
TEMPERATURE						
EDEMA						
SENSATION						
MOTION						
PASSIVE FLEXION						
PERIPHERAL PULSE						

N/A

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	0830	1400	
ID band visible/legible	[redacted]		
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			

OTHER

Review & post lab results	[redacted]		
Notify MD abnormal labs			
Incontinent urine/stool	[redacted]		
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Regular	TYPE: Regular	TYPE: Regular
PERCENT CONSUMED: 25%	PERCENT CONSUMED:	PERCENT CONSUMED: 75%
HOW TOLERATED: well	HOW TOLERATED:	HOW TOLERATED: OK
☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: 0830 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: - Call for assistance	CONTENT: - Staff orientation b(4)-2 - Call for help - Pain management	CONTENT:
☐ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
CIV [redacted] b(6)-4 [redacted]	b(4)-2	[redacted] DT/AN	06-14
		[redacted] LT/AN	14-22

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	0830	(R) upper chest	- red, moist c̄ sml amt. of serous drainage	- bacitracin & dry 2x2 placed over wound

SECTION IV - NOTES

1400 -> Assumed pt care. [redacted]

1615 -> Pt ambulatory upon DC (actually, transfer to Zmyi hospital). Eye meds provided. X(ray) sent c̄ pt. Pt transferred to Zmyi hospital via Zmyi ambulance. Transfer summary [redacted] provided.

b(4)-2

MEDICAL RECORD	PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT For use of this form, see AR 40-66; the proponent agency is The Office of the Surgeon General.
1. AGE: 22y/o HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): NKOA 3. PREVIOUS SURGERY [X] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE:

left eye exploration

5. ADDITIONAL INFORMATION: Last PO: This am Medical Hx: ∅ Implants: ∅ Medications: ∅
Jewelry removed: yes/no Family waiting: yes/no

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

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

#[redacted]

b(a) - 4

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; shock; previous surgery	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o ~~Place and take down legs from stirrups with slow bilateral motion~~ [redacted] o Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to sedation; pain; injury E.2. ✓ Potential discomfort due to injury; pain	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. ✓ Disminished visual perception due to being injury; sedation; F.2. ✓ Potential for decreased communictaion due to language barrier; sedation F.3. Potential injury due to dentures. none	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from _____ side. o Validate pt.'s understanding of verbal communications. o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS. Or continuation of above interventions.

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

[redacted] AJ AN 15 Sept 03 DATE

11. POSTOPERATIVE EVALUATION: b(4)-2

Bovie Site: N/A

Drsg: c/d/i

Breathing: ØSOB

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title) [redacted] MJ AN	13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title [redacted]
DATE: 15 Sept 03 TIME: 1600	DATE: 15 Sept 03 TIME:

REVERSE OF DA FORM 5179, JUN 91

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: Gurney BY LTC [redacted]

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

3. DATE: 17 Sep. 03 TIME PATIENT [redacted] IN SUITE: 0800

4. PATIENT IN ROOM TIME: 0800 NUMBER: 2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

b(6)-2

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc. [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	LTC [redacted]	RELIEF CIRCULATOR	b(6)-2 CPT [redacted] - 0950 - 1010 CPT [redacted] - 1100 - 1130

7. POSITION AND POSITIONAL AIDS (Specify) pillow under knees; arms tucked to sides c fingers free

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

COMMENTS: Body maintained in proper alignment

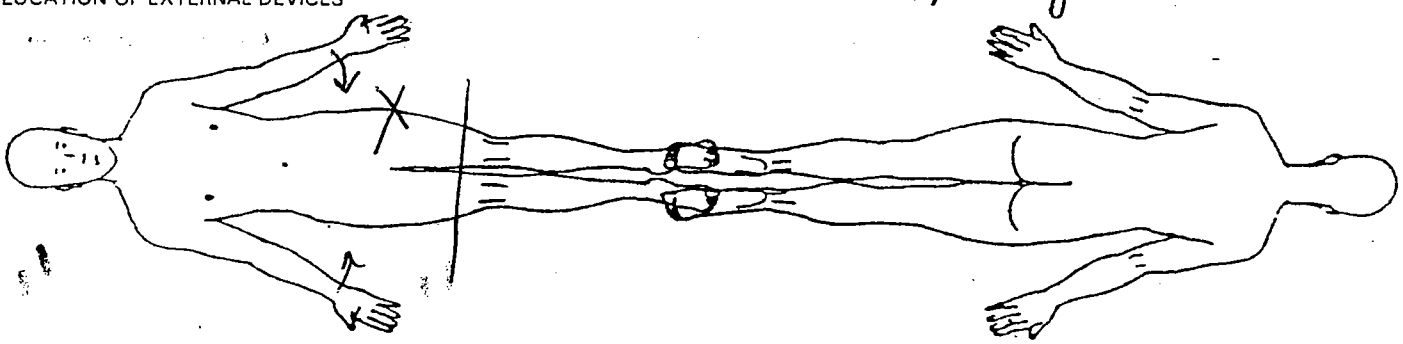
8. SKIN PREPARATION

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

COMMENTS:

PREP SOLUTION (Specify) Betadine scrub/paint
SITE: face/neck BY WHOM: LTC [redacted]
SITE: Lt ear BY WHOM:
COMMENTS: No pooling noted b(6)-2

9. LOCATION OF EXTERNAL DEVICES



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

b(6)-2

C = Correct I = Incorrect

10. COUNTS		Initial Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No	✓	C	C	Spc. [redacted]	LTC [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

cut: 35 coag: 35

☒ ESU NO: R8B10239S Valleylab Force 40
GROUND PAD: BRAND Polyhesive REM II
LOT NO: 68245

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

3. PROSTHESIS, IMPLANTS [X] YES [ ] IF YES NAME: ID NUMBER; MANUFACTURER KLS Martin Plating
.5 Curved 7 hole plate x1 2.0 7mm Screw x1 Modular Osteosynthesis Syst. Mod. 15 System
5 curved 7 hole plate x1 2.0(E) 7mm Screw x2 KLS Plating
& Six screws (See screws listed) 4-hole plate x1 1.5 5mm screws x14
~~curved 7 hole plate x~~ 2.0 5mm Screw x1

4. MEDICATIONS/ORDERS

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

MEDICATIONS, SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
% xylo. & 1:100,000 epi	~~40~~	intraop	local inj	[redacted]	Dr. [redacted]
Bacitracin oint	qs	post op	topical	[redacted]	" b(6)-2

WOUND IRRIGATION [X] YES [ ] NO, TYPE(S):
0.9% NaCl -

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN [redacted] b(6)-2

5. X-RAY [redacted] ROOM IF YES, SITE
YES [ ] NO [X]

6. 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	

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

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

18. DRESSING/IMMOBILIZATION (Specify)
kerlix fluffs roll } Rt. hand/arm
"
Bacitracin to face

19. ADDITIONAL INFORMATION
Surgeons: Drs. [redacted], & [redacted]
Anesth: LTC [redacted], CRNA b(6)-2
DA 5179 in chart
Teeth Brushed & Chlorhexidine Gluconate oral rinse preoperatively

20. OPERATION(S) PERFORMED
Repair (ORIF) of (Lt) 2 MC fx; wash out & change of dsg. Rt. hand/arm

21. PATIENT TRANSFERRED TO b(6)-2 PACU TIME 1250 METHOD via Gurney

22. REGISTERED [redacted] SIGNATURE LTC, AN / [redacted]

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 [redacted] MAJAN

3. DATE 15 Sept 03 TIME PATIENT ARRIVED IN SUITE 1600

4. PATIENT IN ROOM TIME 1600 b(4)-2 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] b(4)-2	RELIEF SCRUB	b(4)-2
ASSIGNED CIRCULATOR	Maj [redacted]	RELIEF CIRCULATOR	CPT [redacted] (810-~~EOC~~ 1840)

7. POSITION AND POSITIONAL AIDS (Specify)

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

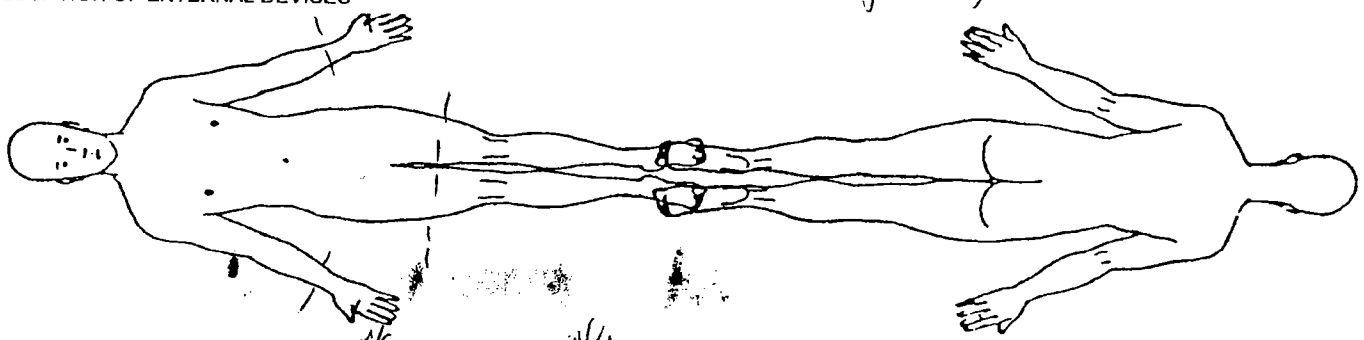
COMMENTS: proper body alignment maintained

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) betadine solution
SITE: (L) Eye BY WHOM: Maj [redacted] b(4)-2
SITE: BY WHOM:
COMMENTS: Ø packing

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect Initial: [redacted]

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

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

#[redacted] b(4)-4

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

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

MEDCOM - 19232

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
Miochol-E	QS	Intraop	gtts	[redacted]	D[redacted]

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

NS

OTHER ORDERS	TIME	CARRIED OUT BY
None		

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM IF YES, SITE

YES ☐ NO ☒

16. LABORATORY SPECIMENS

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

18. DRESSING/IMMOBILIZATION *(Specify)*

eye pad
face shield

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

19. ADDITIONAL INFORMATION

WC I

Surgeons: [redacted] Anesthesia: [redacted] Anesthesia Type: General

Bovie Pad site intact pre-op [redacted]; post-op_____ Bovie Settings: Coag/Cut D (cu) - 2 A11

Tourniquet Site intact pre-op [redacted] post-op_____

Tourniquet Time: Up [redacted] Down_____

20. OPERATION(S) PERFORMED

Left eye exploration, Repair of Ruptured Globe

21. PATIENT TRANSFERRED TO	TIME	METHOD
PACU	see DA7328	Litter

22. REGISTERED NURSE SIGNATURE

[redacted] MAJ AN [redacted] CPT AN

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY		1																					
POST- DAY		DOS																					
MONTH-YEAR	DAY	15		16		17			18	19		20		21		22							
19	HOUR		2	8	1	2	8			3	1				2		0.1	20					
PULSE (0)	TEMP. F (°)		0	4		0	4			0	2		0		0		0						TEMP. C
	105°		0	0		0	6			0	0		0		8		0						40.6°
180	104°			0		0	0																40.0°
170	103°																						39.4°
160	102°																						38.9°
150	101°																						38.3°
140	100°																						37.8°
130	99°																						37.2°
	98.6°																						37.0°
120	98°																						36.7°
110	97°																						36.1°
100	96°																						35.6°
90	95°																						35.0°
80																							
70																							
60																							
50																							
40																							

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICW2

C[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 Sep 19 05 | DAY | HOUR

23 24 25 26 27 28 29

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. ICW2

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

CIV [redacted] b(6)-4

1/72 99.1
88 14/00
69%
16

Ward/Section: | REQUESTING PHYSICIAN: | CHEMISTRY RESULT FORM (Subject to the Privacy Act [redacted])

LAST, FIRST, MI. [redacted] b(6)-4 | DATE 09/15/03 | TIME 1157 | SSN/PSEUDO [redacted]

(i-STAT)

TEST	RESULT	REF. RANGE
Na		
K		
Cl		
pH		
PCO2		
PO2		
TCO2		
HCO3		
sO2		
BEecf		
AnGap		
Ca		
BUN		
GLU		
Creat		
Hct		
Hgb		
TE		
Tropo		
Drug Abu		

======= PICCOLO =======
15/09/03 12:45
REFERENCE RANGE: MALE
PATIENT #: [redacted]
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(6) [redacted]
.....

ALB	3.5	3.3-5.5	G/DL
ALP	60	26-84	U/L
ALT	22	10-47	U/L
AMY	59	14-97	U/L
AST	37	11-38	U/L
TBIL	0.7	0.2-1.6	MG/DL
BUN	9	7-22	MG/DL
CA++	9.4	8.0-10.3	MG/DL
CHOL	137	100-200	MG/DL
CRE	0.9	0.6-1.2	MG/DL
GLU	104	73-118	MG/DL
TP	7.8	6.4-8.1	G/DL

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

(Piccolo) Chemistry 12

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

Piccolo) Metlyte 8

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

i-STAT EC8+

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

Glu_____95 mg/dL
BUN_____12 mg/dL
Na_____141 mmol/L
K_____4.3 mmol/L
Cl_____109 mmol/L
TCO2_____27 mmol/L
AnGap_____10 mmol/L
Hct_____35 %PCV
Hb*_____12 g/dL
*via Hct
PH_____7.345
PCO2_____47.7 mmHg
HCO3_____26 mmol/L
BEecf_____0 mmol/L

Sample Type_:

15SEP03 12:46

Oper: [redacted]

Physician:_____

Ser# [redacted]
Ver: [redacted]

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: EMTT	REQUESTING PHYSICIAN: [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI [redacted] b(6)-4	DATE 15SEP03 / TIME 1245	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WI	ID [redacted] WB	
RI		
HI		
HI		
M		
PI		
L		

WBC	11.3 H	x10^3/uL	
RBC	4.00 L	x10^6/uL	4
Hgb	11.9	g/dL	11
Hct	37.2	%	35
MCV	93.1	fL	8
MCH	29.8	pg	27
MCHC	32.0 L	g/dL	33
Plt	409.	x10^3/uL	1
LY%	13.7	%	7
LY#	1.5 *	x10^3/uL	

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

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Tobacco

NKDA

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)												
Midazolam	(mg)	2											
Fentanyl	(mcg)	50	50		50	50		50	50		50	50	
Lidocaine	(mg)		100										
Propofol	(mg)		150										
Sux	(mg)		80								20		
Rocuronium	(mg)	5		50		20		10	20		20		
VOLAT AGENT: ISO	% del		1.5	1.5	1.0	1.9	1.2	1.2	1.2	1.2	1.2 X	1.0	0.8
	% e.t.												
AIR	L/Min												
N2O	L/Min												
O2	L/Min	10	2	2	2	2	2	2	2	2	2	2	2

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

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

TOTALS	
2	TOTAL EBL min
400	
	TOTAL URINE
	Ø

FLUIDS – SUMMARY
CRYSTALLOID– 1600
COLLOID–
BLOOD– Ø

FLUIDS: LINE site 18 G (R) HO [ ] Warmed; 16 G (L) A [X] Warmed; [ ] Warmed; [ ] Warmed

NS #(400) LR #1 — 200 Anesthesia IVPs 400 — 400 — 800 #2

LOSSES: EST BLOOD LOSS Ø; URINE – Ø

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 76 (KG) LB

HEMATOCRIT: 37.2

INITIAL DATA: BP – 127/54; HR – 95

GRIP CHECK: OK? – (Y) N

PATIENT RECHECK: OK for PROCEDURE? JN; TIME – 1600

TIME → 1600 . 30 . 1700 . 30 . 1800 . 30 .

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

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

Breck & Bony CRNA

VITALS

VT – ml		740	740	740	810	760	750	780	770	750	180	470
f – breaths/min	–	10	7	7	7	8	8	8	8	8	10	11
Peak inf pres / PEEP	–	17	17	17	18	18	18	19	19	19	14	–
MODE– S(pon), A(ssist), C(on)	S	S	C	C	C	C	C	C	C	C	S	S
ET CO2 (torr)	–	46	35	32	34	33	33	33	33	33	48	45
FIO2 (Frac or %)	0.6	0.6	0.6	0.6	0.5	0.47	0.47	0.47	0.48	0.48	0.48	.47
SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100	100
ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
TEMP- site				98.3 oral								
N-M Block (T/4)	Ø/4			4/4	2/4	4/4	1/4	4/4	2/4	4/4	2 SUST	
Warming blkt	✓	x1 sheet										
Conv warmer												

Mark with letters & symbols, explain under REMARKS — EVENTS (1) (2) (3) (4)
Position → 0-1 turned 190°

REMARKS – Code drugs with numbers, events with letters

(1) Pre-op assessment & the interpreter questions answered NPO status verified
(2) Room, monitors, PIV x 2 attempts, Dr [redacted] induced, eyelids taped, soft lite block, no fasciculations observed
(3) Reglan 10 mg IV
(4) Neostigmine 3 mg & robinul 0.4 mg IV

RECOVERY AT 1915
PACU / ICU _____ (Specify)
OTHER T – 99.9 Ax
CONDITION: stable, responsive
RESP – 12 SpO2 – 98
BP – 119/51 HR – 64

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1530	1600	1920
	Ready	Begin	End
PROC	1620	1655	1910

PROCEDURES and CPT Codes: Orbital Exploration B; Repair ruptured Lt globe

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA; Modified RSI; Cricoid pressure

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: DL x1 MAC 4 Grade 1 view 8.0 stylette OETT 22cm @ 20 teeth + BBS dust ETCO2

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

SURGEON [redacted] b(4)-2

[redacted] CRNA/MAJ

PROCEDURE LOCATION: 1

DATE: 15 Sept 03

PAGE 1 OF 2

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 19238

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

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS

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

DRUG	(Units)
Fentanyl (100)	( )
	( )
	( )
	( )
	( )

VOLAT AGENT: ISO % del 0.8 1000; % e.t.

AIR L/Min; N2O L/Min; O2 L/Min 2.0

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

FLUIDS

LINE site 18G (R) HO ☒ Warmed CR #2

16G (L) A ☒ Warmed LR #1

☐ Warmed

☐ Warmed

LOSSES: EST BLOOD LOSS; URINE –

TOTALS: TOTAL FILL See; TOTAL URINE PG

FLUIDS – SUMMARY: CRYSTALLOID –; COLLOID – #1; BLOOD –

REMARKS – Code drugs with numbers, events with letters

(5) SO RR 8>4<30 BPM TV > 4mL/kg, responsive OP suctioned Extubated 5 Complications

(6) To Pitts & To PACU. Report to RN

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: See KG LB

HEMATOCRIT:

INITIAL DATA: BP – PG; HR – 1

TEMP CHECK: OK? – Y N

PATIENT CHECK: OK for PROCEDURE? TIME – ✓

TIME → 1400 . 30 . 2000

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

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

VT – ml	450
f – breaths/min	12
Peak inf pres / PEEP	–
MODE – S(pon), A(ssist), C(on)	C

MONITORING / ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	47
BP / oth	FIO2 (Frac or %)	.48
ART line	SpO2 (%)	100
Steth- PC/ES	ECG	SR
Gas analyzer	TEMP- site/qual	
	N-M Block (T/4)	
Warming blkt	x1 sheet →	
Conv warmer		

Mark with letters & symbols, explain under REMARKS — EVENTS (5) (6); Position →

RECOVERY AT: PACU ICU _____ (Specify); OTHER See; CONDITION: RESP – PG; SpO2 –; BP –; HR –

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	#1		
PROC	Ready	Begin	End

PROCEDURES and CPT Codes

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments — PG #1

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

CIV #[redacted] b(6)-4

SURGEONS: b(6)-2

[redacted] ETISTS [redacted] CRNA/MA

[redacted] MEDICAL RECORD – ANESTHESIA

PROCEDURE LOCATION 1

DATE 15 Sept 03

PAGE 2 OF 2

WAMC OP 376 REVISED Jan 99

MEDCOM - 19239

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

NKDA

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "1"=CONSTANT INFUSION	DRUG	(Mg/Ml)	
	Succ	(Mg)	
	Fentanyl	(Ug)	(10)
	MSO4	(Mg)	(10) 2 3 5
		( )	
	Propofol	(mg)	10/10/10
		( )	
	VOLAT AGENT	1.50 % del	1.5-1.5-1.5-1.2-1.2 X
		% e.t.	
	AIR	L/Min	
	N2O	L/Min	
	O2	L/Min	2-2-2-2-2-8

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

TOTALS	TOTAL FLUID
20	TOTAL URINE

FLUIDS – SUMMARY
CRYSTALLOID–
COLLOID–
BLOOD–

REMARKS–
Code drugs with numbers, events with letters

FLUIDS	LINE site	Warmed
	RJ LA	Warmed
		Warmed
		Warmed

LOSSES	
	EST BLOOD LOSS
	URINE –

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 75 KG LB

HEMATOCRIT:

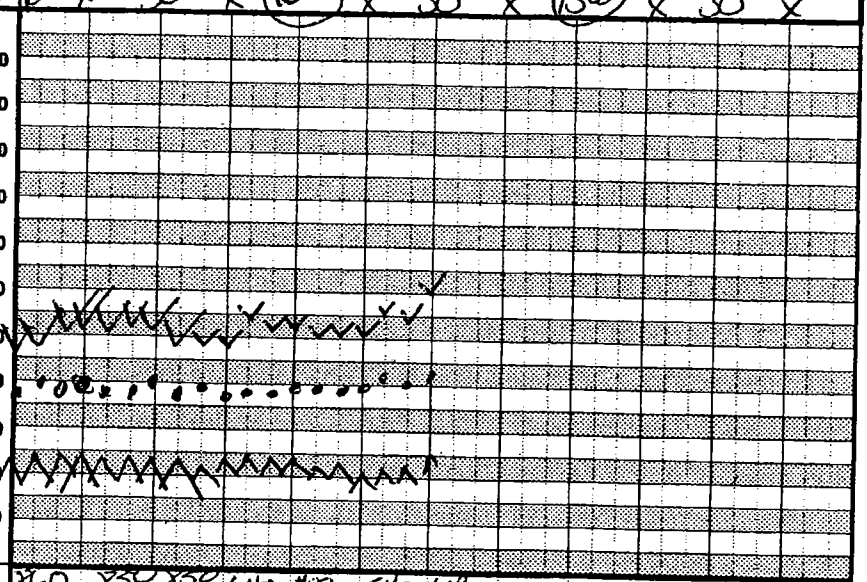
INITIAL DATA: BP – 108/39 HR – 69

BOHP CHECK: OK? – Y N

PATIENT RECHECK: OK for PROCEDURE? Y TIME – 0740

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

TIME → 10 X 30 X (12w) X 30 X (13w) X 30 X



MONITORS, EQUIPMENT, ETC								
	VT – ml	360	350	350	640	400	540	610
	f – breaths/min	8	8	8	5	8	11	7
	Peak inf pres / PEEP	20	20	20	18			
	MODE– S(pon), A(ssist), C(on)	CV	CV	CV	C	S	S	S
BP/Auto Cuff	ET CO2 (torr)	33	34	34	42	47	45	47
BP / oth	FIO2 (Frac or %)	.72	.72	.72	.73	.7	.7	.7
ART line	SpO2 (%)	100	100	100	100	100	100	100
Steth- PC/ES	ECG	NS	NS	NS	SR	SR	SR	
Gas analyzer	TEMP site AX	36.5	36.6	36.6	36.6	36.5	36.0	
	N-M Block (T/4)			4/4				
Warming blkt								
Conv warmer								

Mark with letters & symbols, explain under REMARKS

EVENTS: ad –
Position → Arms tucked padded

RECOVERY AT
PACU ICU_____ (Specify)
OTHER_____
CONDITION:
RESP– SpO2–
BP– HR–

ANESTHESIA PROVIDER TIME

	Start	Room	End
ANES			
PROC	Ready	Begin	End 1245

PROCEDURES and CPT Codes
ORIF (L) zygoma IX

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
See pg 1

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

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

SURGEONS: [redacted]
ANESTHETISTS: [redacted] b(4)-2

PROCEDURE LOCATION 2-2
DATE 17 Sept 03
PAGE 2 OF

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED Jan 99

MEDCOM - 19240

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

10.22