b.6-2 All

PROGRESS NOTES

DATE	
27 Jun 03	1100 - Foley catheter pulled. [redacted]
1700	Assumed care of Pt @ 1300, VSS, A+O x 3. Penrose Drain putting out Ø to scant drainage to ABD pad. Ø c/o pain. Ø s/s of infection. (C) and PIV patent. Ø Wounds WNL, Will Monitor [redacted]
27 Jun 03	Rec'd pt. @ 21:00. Awake + Alert in bed. Amb. to commodes difficulty
2017	Skin w/D. PERLLA(+) WNL. LCA(B). BS(+)x4. (+)PPP(B). Penrose patent scant amt. drainage blood tinged. ⊖ c/o pain @ this time. Will cont. to mon. [redacted] DLT/MN
28 Jun 03	General Surgery
0830	POD #3 Ex-laparotomy perforated ileum
	Doing well, tol. diet, ⊖ BM & flatus
	⊖ voiding problems, ambulating well
	AFB VSS
	Abd soft, NT ND
	perineum - no drainage from wound
	penrose ⊖ purulence
	Impr: Doing well
	- transfer to high hospital care
	flu capsules
	- if ⊖ motion occurs tomorrow left
	OR with Dr. Lewis & Dr. [illegible]
	[redacted]

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

B6-2 All (except last)

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28 Jun 03	Assumed care of pt @ 0500. Pt is awake and alert. VSS. Lungs CTA. Bowel sounds x 4 quads. Pt has transfer/d/c note. Pt will go to an Iraqi hospital. Transportation is being organized. Will continue to monitor [redacted] SGT, USA
28 Jun 03 1825	assumed care @ 1300 - VSS - pt. washed himself & dinner - IV patent - pt. is awaiting transport to Iraqi hospital no complaints - dsg on perineum [redacted] RN
28 Jun 03 22:06	Rec'd pt @ 21:00. Awake and Alert in bed. Skin PWD+L CAB PERRLAE WNL. BS x4 (+) PPP(B). PIV @ patent. D/C'd. Wound to perineum c̄ penrose intact. drainage noted. c/o little amt. of pain offered pain med. pt refused. will cont. to mon [redacted] PLT/AN

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

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

EPW # [redacted] B6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28 JUNE 03 0820	General Surgery - Transfer Summary DATE OF ADMISSION 25 JUNE 03 DATE OF TRANSFER 28 JUNE 03 DATE OF SURGERY 25 JUNE 03 HPI: Approx 30 yo Iraqi civilian reported to have fallen from height 5-6 feet - receiving penetrating injury to perineum. Pt presented to FST - taken to OR - RAM under anesthesia. Hemodynamically stable. Proctoscopy negative for rectal injury. Wound exploration w/ intraperitoneal injury. No bladder injury. Penrose drain placed in tract of wounds. Foley cath placed - clear urine. Tract approx 10 cm deep. Hospital course: Pt c̄ uncomplicated hospital stay. Tolerating regular diet. ⊕ blood in stool voiding spontaneously ⊃ Foley removal. Ambulating well. No significant pain from wounds. Minimal drainage. Plan: Remove - pack out - penrose drain pos 4/5. Able to d/c c̄ f/u. [redacted] B6-2 [redacted] as [redacted] the surgeon.

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

#[redacted]

B6-4

RECORDS MAINTAINED AT:

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 26 Jun | 26 Jun | 27 | 28 | 29 | 30 | 31

19 | HOUR

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

105° — 40.6°
104° — 40.0°
103° — 39.4°
102° — 38.9°
101° — 38.3°
100° — 37.8°
99° — 37.2°
98.6° — 37.0°
98° — 36.7°
97° — 36.1°
96° — 35.6°
95° — 35.0°

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

RESPIRATION RECORD

BLOOD PRESSURE

SpO2

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. LCW 2

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

#[redacted] B6-4

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM MN HOURS TO MN HOURS | TOTAL HOURS COVERED 24 | DATE 6-26-03

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0730	H_2O	240	240
1200	H_2O	120	360

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
MN	500	LR	250	09	475
		LR	225	05	700
05	500	LR	500		1200
10	50	cefotan	50		1250
1400	500	LR	500	2045	1750
2100	500	LR	250	MN	2000
2200	50	Cefotan	50	2230	2050

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

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
04	CYU	1600	1600
12	Cyu	1600	3200
08		500	3700
~~2045~~	700 C/U	1000	4700
2045	C/U	1200	5900

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

#[redacted] b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

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

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL

*U.S.GPO:1998-404-613/30343

TWENTY-FOUR HOUR PATIE... INTAKE A... OUTPUT WORKSHEET

FRO... H... TO 2359 HOURS | TOTAL HOURS COVERED 24 | DATE 28 JUN 03

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0700	Oatmeal	1/2	
0700	applesauce	1/2	
0700	water	120	120cc

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0800	Lt yellow urine	600cc	600 cc

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

[redacted] b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

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

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 7;

MEDCOM - 12046

*U.S.GPO:1996-404-613/30343

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM MN TO MN HOURS | TOTAL HOURS COVERED 24 | DATE 6-27-03

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
MN	250	LR	150	01	150
		Hep Lock			

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

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
04	CYU	550	550
1000	Cyu	475	1020
1600	CYU	700	1720
2100	Cyu.	625	2345

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

#[redacted] b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

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

DD FORM 1 JAN 74 792 — EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL

*U.S.GPO:1998-404-613/30343

TWENTY-FOUR HOUR PATIE... ...TAKE AND OUTPUT WORKSHEET	FRO ___ HOURS TO ___ HOURS	TOTAL HOURS COVERED	DATE

IN

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
2000	500	LR	500	2040	500
2200	50	Cefotetan	50	2230	550

Output

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
2040	CYU	750cc	750cc

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

#[redacted] b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

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

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3830(TEMP) 1 JUL 72 WHICH MAY BE USED.

*U.S.GPO:1998-404-613/3034

b(6)-4

Ward/Section: ICU 2	R[redacted]NG PHYSICIAN: [redacted] b(6)-2	[redacted]RATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST [redacted] b(6)-4	DATE 25 JUN	TIME 1940	SSN/PSEUDO SSN: [redacted]

b(6)-1

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	15.7	4.8-10.8 x 10^3
RBC	4.17	4.7-6.1 x 10^9
Hgb	12.9	14-18 g/dl (M) 12-16 g/dl (F)
Hct	40.5	42-52% (M) 37-47% (F)
MCV	97.0	80-94 fl (M) 81-99 fl (F)
Plt	315	130-500 x 10^3 verified
Lymph %	10.4	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

[redacted] Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS: [redacted]

REPORTED BY: [redacted] **DATE:** **LAB ID NO.:**

b(6)-2

ICW2 b(6)-2

Ward/Section:	PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST [redacted] b(6)-4	DATE 20Jun	TIME 1440	SSN/PSEUDO SSN: [redacted] b(6)-4

(I-STAT)

TEST	RESULT	REF. RANGE
Na	141	138-146 mmol/L
K	3.3	3.5-4.9 mmol/L
Cl	105	98-109 mmol/L
pH	7.374	7.31-7.45
PCO2	45.9	35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2	28	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	27	22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf	2	(-2) – (+3) mmol/L
AnGap	12	10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN	11	8-26 mg/dl
GLU	123	70-105 mg/dl
Crea		0.[illegible]-1.5 mg/dl
Hct	34	38-51% PCV
Hgb	12	12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY: [redacted]	DATE: 20 June 2003	LAB ID NO.:

ICW#2 CBC

BPW# [redacted] b(6)-4 | 6/26 | 0315

(Hematology) CBC		
TEST	RESULT	REF. RANGE
WBC	13.4	4.8-10.8 x 10^3
RBC	4.23	4.7-6.1 x 10^9
Hgb	13.6	14-18 g/dl (M) 12-16 g/dl (F)
Hct	40.9	42-52% (M) 37-47% (F)
MCV	96.6	80-94 fl (M) 81-99 fl (F)
Plt	319	130-500 x 10^3 verified
Lymph %	19.5	20.5-51.1%

(Hematology) Manual Differential			
Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

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

CSF		
Cell Count		
Directigen		Negative

Misc. Serology		
TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

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

Microscopic Urinalysis

Blood Bank	
MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED	
ABO/Rh	

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

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

REMARKS:

REPORTED BY: [redacted] **DATE:** **LAB ID NO.:**

b(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
# [redacted] b(6)-4			26 JUNE 03 1840 HOURS	
			(1) ADMIT TO ICW ✓	
			(2) GSW PENETRATING injury TO PERINEUM ✓	
			(3) STABLE	
			(4) STABLE	
NURSING UNIT	ROOM NO.	BED NO.	(5) NKDA ✓	
ICW 2		10	(6) OPIOIDS 5 q 4 o [illegible] ✓	

PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER	
# [redacted] b(6)-4			HOURS	
			(7) ACTIVITY: AMBULATE [illegible] ✓	
			(8) DIET: NPO ✓	
			(9) IVF: LR @ 125 cc/o ✓	
			(10) ABX: CEFOTEFAN 2gm IVq 12° ✓	
			MSO4 1-6mg IVq 10 PRN ✓	
NURSING UNIT	ROOM NO.	BED NO.		
ICW 2		10	(11) LABS: CBC in AM 26 JUNE 03 ✓	

PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER	
# [redacted] b(6)-4			HOURS	
			(12) NURSING: ABD PAD PERINEUM FOLEY PO DRAINAGE ✓	
			b(6)-2 [redacted]	
NURSING UNIT	ROOM NO.	BED NO.		
ICW 2		10	b(6)-2 [redacted] UTAN 6-28-03	

PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER	
EPW [redacted] b(6)-4			26 June 03 0800 HOURS	
			~~D/C to Iraqi Hospital.~~	
NURSING UNIT	ROOM NO.	BED NO.	CX [redacted] b(6)-2	
ICW2		3		

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

#[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW 2		10

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

6 26 03 2130 VO. Dr. Dixon / LTB Bunchard

(1) Cosing Tylenol PO x 1 now [redacted] LTB

[redacted] b(6)-2

PATIENT IDENTIFICATION

#[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW 2		10

DATE OF ORDER — TIME OF ORDER

26 JUNE 03 2100 HOURS

(1) Regular diet

(2) IV IV

(3) DC Ceftriaxone after last dose

[redacted] b(6)-2

PATIENT IDENTIFICATION

#[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW 2		10

[redacted] 10 [redacted] 27-03 0010.

DATE OF ORDER

27 June 03 0010 HOURS

(1) DC Foley

[redacted] b(6)-2

27 June 03 1000 [redacted] b(6)-2

[redacted]

PATIENT IDENTIFICATION

#[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW 2		10

DATE OF ORDER

28 June 03 0050 HOURS

(1) Transfer to ward [redacted]

[redacted] b(6)-2

b(6)-2 [redacted]

b(6)-2 [redacted]

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JU[redacted]

All b(6)-2 (except last)

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 25	26	27	28	29	30	31
25	[redacted]	VS q 4	4	/	[redacted]					
			8	/						
28	[redacted]	G&S	12	/						
			16	/						
			20							
			24							
25	[redacted]	I & O's	6	/	[redacted]					
			14	/						
			21							
25	[redacted]	Activity ambulate c assist	6	/	[redacted]					
			14	/						
			21							
25	[redacted]	Diet: NPO	6	/	[redacted]					
			12	/						
			17	/						
25	[redacted]	foley to gravity	6	/						
			14	/						
			21							
25	[redacted]	abd pad to perineum	6	/	[redacted]					
			14	/						
			21							
26	[redacted]	Reg Diet	7	X	X	X	[redacted]			
			11	X	X	X				
			17	X	X	X				

DC'd 28 Jan

D/C

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS: S/P penetrating injury to perineum

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

All b(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 6 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
25	[redacted]	admit ICW 2				[redacted]
25	[redacted]	Dx: S/P penetrating injury to perineum				[redacted]
25	[redacted]	condition: stable				[redacted]
25	[redacted]	CBC in AM	26	04	04	[redacted]
27	[redacted]	D/C Foley	27	- done -		[redacted]
28	[redacted]	Transfer to Iraqi hospital				
	-----	when mission becomes avail.				
	-----	- no meds needed				
	-----	- transfer summary written				

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

All b(6)-2 (except last)

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. 6 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	31
25	[redacted]	IV LR @ 125cc/hr	6	/	[redacted]					
			14	/	[redacted]					
			21	[redacted]						
25	[redacted]	cefotan-2gm IV	10	/						
		q 12°	22	[redacted]				D/cd 6-26-03 2230		
6-26	[redacted]	HL IV	5	X	X	[redacted]				
			13							
			21							

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: S/P penetrating injury to perineum

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

All b(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo.____ Yr. ____
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
6-26	[redacted]	650mg Tylenol PO x1 now	6-26	2130	2130	[redacted]
6-26	[redacted]	D/C cefotan @ next dose	6-26	2230	2230	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
25	40	MSO4 1-6mg IV	27 [illegible] 1100 4ms													
		q 1° PRN	[redacted]													

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.)
A L L D 1	I Z

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
[redacted]	b(6)-4 UWX EPW	EPW	M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
—	[redacted]	X	9	MUSLIM

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—	U	1930	— 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 [X] NO

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

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

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
—

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
26		0 3 0 6 2 8

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
		0 3 0 6 2 5

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: S/P penetrating wnd to perineum

b(6)-2 [redacted] Trauma

[redacted] 9

Dx: 8796
E8880
E9208

[redacted]

ADMITTING OFFICER (Sig

b(6)-2

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

DA FORM 2085

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

INPATIENT TREATMENT RECORD COVER SHI

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

b(6)-4

1. REGISTER NUMBER [redacted]	2. NAME (Last, First, MI) EPW [redacted] b(6)-4			3. GRADE N/A	ADMISSION REMARKS
4. SEX M	5. AGE 28y	6. RACE Z	7. RELIGION UNK	8. LENGTH OF SVC N/A	9. ETS N/A	10. PREVIOUS ADMISSION NO
11. FMP 99	12. SSN [redacted] b(6)-4		13. ORGANIZATION N/A			14. WARD 1 CW2
15. FLYING STATUS N/A	16. [redacted] OSG	17. DEPT BEN K79	18. BRANCH/CORPS N/A	19. UIC/ZIP		20. TYPE CASE BS1
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from ER				22. HOURS OF ADMISSION 0212	23. CLINIC SERVICE AEAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION 50		26. DATE OF DISPOSITION 30 Jun 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) —			27b. TELEPHONE NO. —		28. DATE OF THIS ADMISSION 27 Jun 03	ADMITTING OFFICER Dr. [redacted] b(6)-2
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b(2)-2					30. DATE OF INITIAL ADMISSION	32. UNITS [redacted] COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW Hip s/p I+D (L) thigh

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/CDOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	4	4

36. Total Days All Facilities

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/CDOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	4	4

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

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

DA [redacted] b(6)-2 EDITION OF 1 [redacted] b(6)-2

USAPPC V1.10

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

2 days Iraqi EPW

cc: (D) Thy GSW

shot @ MP's 3 hrs ago

(D) Pmc

Orients

MEDS

PHYSICAL EXAMINATION

[illegible] VS [illegible]

Min Head wound Scalp

(D) Thy 7-10 cm Long Deep wound

(B) Left Medial / Lat HP

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

A/ L Lat HP GSW Nar Bn

P/ I & D w/ shot (V) HP

b(6)-2

SIGNATURE OF PHYSI[redacted]	DATE	IDENTIFICATION NO.	ORGANIZATION

PATIENT'S IDENTIFICA[redacted] *ritten entries give Name last, first, date; hospital or medical facility)*	REGISTER NO.	WARD NO.

EPW [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

MEDICAL RECORD	PROGRESS NOTES
DATE	
28 JUN 03 1530	Assumed care of Pt @ 1300 upon transfer from ICW #3. VSS, A+O x3. Pain controlled c̄ PO percocet. (L) Bicep PIV flushes well, IV ABX. Dsg to head CDI. Dsg to (L) thigh/hip GSW intact. No new drainage, old dry bld drainage outlined. Wound elevated and iced. (+) sensation, palp. pulse, cap refill <3sec, mvt of toes (L) foot. (B) LS CTA, (+) BS x4 HR. b(6)-2 [redacted] O/W Assessment WNL. Will Monitor [redacted]
2230	Assumed Pt care @ 2100. VSS, a+ox3, 0 pain. Lung sounds CTA, pulses palpable x4, b(+) x4 quads. Dsg to head CDI, Dsg to (L) thigh CDI, no drainage noted. Pt c̄ (+) ROM and sensation. Pt NPO to OR in am. Will continue to monitor. [redacted] b(6)-2 9LW/MLP
0030 29 JUN 03 1000	IV infiltrated, restarted @ RFA. IV ABX running. [redacted] b(6)-2 9LW/MLP
	Pt. in bed asleep easily aroused by verbal stimuli. Dressing to (L) thigh saturated c̄ old blood. Pedal pulses in (L) LE (+), sensation (+), cap refill <3sec. Pt. c/o HA x1, Percocet given. Pt. c/o heartburn. Pt. is been NPO since MN, awaiting washout in OR this AM. Lung sounds clear bilat, bowel sounds (+) x4 quads. All other assessment findings WNL. Pt. ∅ other complaints @ this time. IV HL in (R) FA flused well c̄ 3cc NS ∅ s/s of infection or infiltration. Will continue to monitor. [redacted] b(6)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

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

CPW [redacted] b(6)-4

PROGRESS NOTES

DATE	
29 June 03 1330	Assumed pt care @ 1300 from previous shift. pt is NPO waiting to go to OR for washout. VSS. dressing to top of head Δd, 1" lac. c̄ 8 staples 5 s/s of infection noted, 4x4 gauze applied secured c̄ kerlix dressing. Sore to (R) side of nose healing. 3 diff. lung sounds CTA, abd soft BS(+). (L) hip dressing saturated c̄ old blood drainage, (+) new drainage noted pt able to wiggle toes. <3 sec cap refill, faint pulse noted. (R) ext c̄ full ROM(+) pulse. BUE c̄ full ROM(+) pulses. HL to RFA ø s/s of infection noted. pt complaining she wants to eat, (+) complaint of pain voiced @ this time. Will cont to monitor — [redacted] 9/WMC SGT b(6)-2
29 June 03 1500	pt taken to OR via litter in stable condition — b(6)-2 [redacted] 9/WMC SGT
29 June 03 1700	pt returned from OR via ICU 1 on litter in stable condition. VSS. dressing to head CDI. dressing to (L) hip CDI. will cont to monitor — b(6)-2 [redacted] 9/WMC SGT
29 June 03 1825	pt ate 100% dinner tray, tol po fluids well, IV fluid to be HL'd per orders. pt c/o pain given ii percocet per prn orders will cont to monitor — b(6)-2 [redacted] 9/WMC SGT
2245	Pt. care assumed @ VSS. HR Reg. lungs CTA, ABD soft c̄ BS(+) x4. Dsng to scalp CDI. Drsng to (L) thigh CDI. Pt. has pulse 2+ (L) ft c̄ brisk cap refill, (+) ROM, (+) sensation. will cont. to monitor. — [redacted] b(6)-2
30 Jun 03 0600	Pt. in bed awake & alert. Wound to head approx. 2 inches in length, well approximated, ∅ s/s of infection. HL in (L) FA flushes well c̄ 3 cc NS ∅ s/s of infection. Lung sounds clear bilat. VSS. Dressing on (L) leg CDI, weak pedal pulses, ROM(+), sensation(+). Pt. c/o reflux pain, possibly will have pt. eat breakfast & monitor for pain. All other assessment findings

STANDARD FORM 509 (REV. 7-93) BACK
USAPPC V1.00

MEDICAL RECORD | PROGRESS NOTES

DATE | NOTES

30Jun03 0600 1830 WNL. Pt. ∃ other complaints @ this time. Will continue to monitor. [redacted] b(6)-2
Assumed care of Pt @ 1300, VSS. A+O x 3. Pain controlled with percocet. (L) thigh elevated / iced. Dsg / Ace wrap CDI. Pt voiding <100cc Q hrs. Cathed pt c 16F Foley cath, drained 600cc, clamped for 30min, unclamped drained 600cc for total of 1200cc CYU, left foley cath in place. Stapled to top of head CDI. Pt c/o acid reflux, obtained order for Zantac. Ovr assessment WNL. Will cont to monitor [redacted] b(6)-2

2015: Pt. care assumed @ 2100, VSS. HR Reg, Lungs CTA, BS ⊕ X4. IV infusing to (R) UE ∃ difficulty. IV site ∃ s/s infection. Dsng to (L) thigh CDI. Pt has brisk cap refill to (L) ft c̄ pedal pulse at, ⊕ROM, ⊕ sensation. Will cont. to monitor. [redacted] b(6)-2 / CTI RN

1July03 0530 Assume pt care @ 0500. pt awake and alert. VSS. C/O pain to (L) thigh. (L) thigh dsg CDI. ⊕ sensation ⊕ movement below dsg. IV LR @ 100cc/hr to (R) FA no s/s redness/infiltration. Foley to gravity draining CYU output, approx 400cc @ this time. NPO for surgery. HR Reg. Lungs CTA Abd: soft BS x4 active. ⊕ percocet (cont)

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR'S ID NO (SSN or Other)

SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

EPW # [redacted] b(6)-4

PROGRESS NOTES
Medical Record
STANDARD FORM 509

FIRST NAME	MIDDLE INITIAL	ID NUMBER

NOTES

1July03 0530 c̄ sm sips of H_2O for pain. Will continue to monitor. b(6)-2 [redacted] SIWMP

1July03 1020 pt returned from recovery. VSS. Dsg to (L) thigh CDI. (L) LE elevated. No c/o pain. Will continue to monitor. b(6)-2 [redacted] SIWMP

1040 pt c/o pain to (L) thigh ⅔ percocet cdm [redacted] SIWMP

1245 1400cc CYU output this shift b(6)-2 [redacted] SIWMP

1July03 1430 assumed pt care @ 1300. pt sleeping easily aroused to verbal stimuli. VSS. Staples to top of head OTA. airway patent, lung sounds CTA, abd soft nontender BS(+)x4 quads. R ext c̄ full rom (+) pulse. (L) thigh drsing CDI, leg elevated (+) pulse. HL (R) FA c̄ UR infusing s̄ diff. (D) c/o pain voiced @ this time. Will cont to monitor b(6)-2 [redacted] SIWMP

Foley cath to gravity intact, draining s̄ diff - [redacted] SIWMP b(6)-2

1Jul03 2230 VSS. NAD. DSG to affected thigh DCI IVF as ordered, site s̄ redness or edema. Lungs CTA & = bilat. Pulses strong & =. BS(+)x4 resting quietly c̄ present s̄ c/o. b(6)-2 [redacted] b(6)-2 [redacted]

1Jul03 2307 UOP 800cc CYU b(6)-2 → [redacted] SIW b(6)-2

2Jul03 0310 UOP 700cc CYU → [redacted] SIW

2Jul03 0330 c/o pain in affected leg. Pt medicated as ordered c̄ Percocet ⅔ PO. [redacted] b(6)-2

2July03 0800 - Pt alert lying in bed. Voicing Ø complaints. VSS, lungs CTA, HR reg, BS(+). Dsg intact to (D) thigh. Pulse palpable. Pt able to wiggle toes. IV to (L) arm infusing LR. Will cont to monitor [redacted] 2Jul03 b(6)-2

AUTHORIZED FOR LOC

:DICAL RECORD

PROGRESS NOTES

DATE	NOTES
2 July 03	1230 - Dsg Δ done to (L) thigh. Old dsg ⊖ large amount of old drainage. Incision ⊖ sutures → intact ⊘ drainage noted. One small holes to (L) of incision. Some red draining from site. New Dsg CDI. Gave percocet for pain. [redacted] b(6)-2
1445	Assumed care of Pt @ 1300. VSS. 40x3. Resting comfortably pain controlled with PO percocet. Pt ambulated ⊖ assistance. Dsg (L) thigh/ace wrap CDI (+) sensation, cap refill <3sec, ROM, palp. pulse (L) FA PIV patent ⊖ LR @ 100 and IV ABX. Q4 assess. WNL. Will monitor &
	b(6)-2 [redacted]
02 JUL 03	Rec'd pt @ 21:00. Awake + alert in bed. Skin W/D. PERRLA.
21:31	LCA (B) BS (+) x4. (+) PPP (B) (L) leg ↑ thigh, Ace wrap drsg CDI. (L) foot (+) mobility, sensation, and <3 sec cap refill. (L) foot cooler to touch than (R) foot. 1+ faint pedal pulse (L) foot. C/O pain ↑ Percocet given. Will cont to mon [redacted] b(6)-2 DLT/AN
0000	Pt c/o pain Demerol and Phenergan given. Will mon [redacted] DLT/AN b(6)-2
03:12	Pt c/o pain ↑ Percocet given [redacted] DLT/AN
0330	Pt voided x2. 1st time in commode 100cc [redacted] DLT/AN

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

/SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

EPW [redacted]

b(6)-4

PROGRESS NOTES
Medical Record
STANDARD FORM 50

AUTHORIZED FOR LOCAL REPRODUC

:AL RECORD | PROGRESS NOTES

:E	NOTES
3 Jul 1015	Assumed care of pt @ 0500. Pt is awake. VSS Lungs CTA. Bowel sounds x4 quads. OOB to br. Pt did personal hygiene. Pt is awaiting for Marines to pick him up. Pt can only leave with Marines: [redacted] 2PN, SGT b(6)-2

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

RVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV 5/1
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
27JUN03	b(6)-4
0300	Received from OR, EPW [redacted], S/P I & D (L) thigh
VS: 118/75-	from GSW. Recovered fully @ 10 upon arrival.
104-21	Alert, able to verbalize needs. Foley draining clear
97-7	yellow urine, IVF LR @ 100 cc/hr set upon admission
	via dialflow. Pt able to understand some basic
	English. (L) thigh dressing c̄ bloody drainage noted.
	Orders noted on POC (plan of care). Monitor wound
	drainage + pain management. Pt denies pain @ this time
	Instructed to ask pain medicine as needed. Monitor
	pt closely. EPW protocol observed, MP @ bedside.
	b(6)-2 [redacted] Maj/AN
0430	Pt sound asleep @ this time. Vascular check normal
98.1-62-	cap refill <3 seconds, able to move toes, pedal pulses (+).
22-108/57	T98.7. NSR, 80s O2 sat 100% b(6)-2 [redacted] Maj/AN
0500	Pt medicated c̄ Demerol 50 mg + Phenergan 25 mg IVP for c/o wound
	pain left thigh b(6)-2 [redacted] Maj/AN
27Jun03 0530	Received pt who is sleeping quietly s̄ c/o complaints of pain.
	IVF infusing into (L) AC site as ordered. Dressing to (L) thigh
	intact w/ blood mark noted. V.S.S. Foley cath draining clear yellow
	urine. Will discuss w/ interpreter concerning expression of
	pain + nausea. RA w/ 100% sats. Cont. to monitor. b(6)-2 [redacted] TC/AN

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

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

EPW [redacted] b(6)-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
27 Jun 03 1000	Pt ate 3 slices of oranges & eggs. At this time, c/o ↑ pain in (L) thigh, describing area by knee to drsg. Sit as a burning sensation. HR ↑ 120's. Demerol 50mg IV w/ Phenergan 25mg given. BP ↓ to 86/60. IVF open infusion of LR. ↑ c/o pain. B/P repeated 101/55. Demerol 50mg given (total 100mg). B/P 103/51 Will cont. to monitor. b(6)-2 [redacted] LTC/AN. b(6)-2
27 Jun 03 1030	Pt resting quietly. No c/o pain, V.S.S. Cont. to monitor. [redacted] LTC/AN
b(6)-2 27 Jun 03 1305	Awake, comfortable, eating lunch & asking about another pt. Pt follows instruction to move leg out & in and extend/flex ankle. Drsg to head dry + intact. NV ✓ (+) w/ cap. refill < 3 sec. [redacted] b(6)-2
27 Jun 03 1600	Awaken & resting w/ eyes closed. No request for pain meds. Encouraged to move legs. Washed face + feet. Drsg. to (L) thigh noted w/ blood, small amt. oozing d.w. drsg. Drsg. enforced. b(6)-2 V.S.S. Cont. on RA & sats > 96%. Cont. to monitor. [redacted] TC/A
1800	Change of shift note: Pt awake, given dinner. Denies pain at this time, dressing D+I. NV ✓ WNL [redacted] Kaj/AN
2200	Pt had dinner, takes p.o. liquid. ∅ difficulty. IV replaced b(6)-2 after 2200 Ceref. Flush & maintain patency of Ceref administration. Medicated c̄ Percocet 1 p.o. c̄ relief. b(6)-2 [redacted] Via fn
0145	Medicated c̄ 1 Percocet p.o. for c/o pain (L) thigh. Urinated clear yellow urine 125 cc. Pt went back to sleep. b(6)-2 [redacted]
0400	Slept throughout the night ∅ any complaints. EPW protocol observed. Pt chained 2 points in bed. [redacted] /AN
0515	Given another Percocet 1 p.o. for c/o moderate pain. b(6)-2 Voided 215 cc clear yellow urine. (L) thigh dressing intact ∅ any additional drainage. b(6)-2 [redacted] /AN
0500	Received report from previous shift. Pt has 2 point restraints. (L) ½ HA pain @ this time. NV ✓ cont'd

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-600/50618

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28JUN03 0500	cont'd... completed. IV (L) AC S.L. and intact. Will cont. care. b(6)-2 [redacted]
0900	Pt c/o pain in head and leg. Gave percocet + tab. Will cont. to assess pain level. b(6)-2 [redacted]
1150	Pt c/o pain in (R) leg. Gave Demerol 50mg and phenergan 25mg. Will cont to assess pain level. b(6)-2 [redacted]
1250	Prepared pt for Transfer. Gave report to [redacted] b(6)-2

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

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

EPW [redacted] b(6)-4

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

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL DATE DAY	MONTH	YR.	TIME
26	JUN	03	2306

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify) medevac

CURRENT MEDS. (tetanus immunization and other data): Ø / Ø

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): GSW to (L) thigh.

SEX: M AGE: 28

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 2307

VITAL SIGNS

TIME	2306	0005	
BP	111/64	117/72	
PULSE	86	52	
RESP.	100% 18	16	
TEMP.	96.7	100% RA	
WT. (Child)	65 Kg		

CATEGORY (See reverse)

- ☐ EMERGENT
- ☒ URGENT
- ☐ NON-URGENT

ORDERS	INITS.	TIME
Tetanus IM 0.5ml	[redacted]	2311
Gram Ancef IV	[redacted]	2311
5mg MSO4 IV	[redacted]	2312
5mg MSO4 IV	[redacted]	2350

b6-2

ASSESSMENT/DIAGNOSIS: GSW (L) thigh; (R) scalp laceration, bleeding

DISPOSITION (Check all that apply)

- ☐ HOME ☐ FULL DUTY
- QUARTERS: ☐ 24 Hrs. ☐ 48 Hrs. ☐ 72 Hrs.
- MODIFIED DUTY UNTIL: DAY / MONTH / YEAR
- REFERRED TO (Indicate clinic)
- ☐ EMERGENCY ☐ TODAY
- ☐ 72 HOURS ☐ ROUTINE
- ADMIT. TO HOSP. UNIT/SERVICE: ☒ FCW #2

CONDITION UPON RELEASE

- ☒ IMPROVED ☐ UNCHANGED
- ☐ DETERIORATED

TIME OF RELEASE: 0010

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

Pt presents c̄ GSW c̄ (L) thigh. Also hit c̄ back of head. Pt smokes lite drug/EtOH

28yo ♂ EPW s/p opening fire on MP's, they fired BACK. ≈ 3hrs pt arrived here by the MP unit that's hit him.

6" wd, wd, mod. A.o.

Hi (R) scalp laceration ≈ 3/4 inch, actively from ≈ s/p GSW

No complaints

LICZA (R) parietal

Bleeding c̄ h/s

Fragments

(R) scalp stapled / Ancef / d7 / MSO4 given

IV - to OR. E[redacted]

b6-2

PMHx - Ø

PSH - Ø

(R) 70B

(L) Thigh - Ø shrapnel

Pelvis - WNL

CXR - WNL

Skull - Ø shrapnel

139	106	12	12
4.3	23	0.7	

P7 - 12

P77 - 21

CK - 388

(CONTINUE ON SF 507, IF NEEDED)

PATIENT'S IDENTIFICATION (Mechanical imprint)
FOR WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).

SIGNATURE OF PROVIDER AND ID STAMP: [redacted] 2267

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

b(6)-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:

HEIGHT:

WEIGHT:

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

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

4. PROPOSED SURGICAL PROCEDURE:

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition_____
Tobacco____ppd X___yrs. Body Piercing_____ Diabetes (Y) (N) ROM_____ ASA/Motrin w/72 hrs (Y) (N)
ETOH_____ Implants_____ Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures_____ Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

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	o Pt. verbalizes any specific anxiety. o Pt. Exhibits relaxed body posture. Emergency	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. Parents to stay with pt.
B. AERATION _____Potential for respiratory dysfunction due to: _____1) Positioning _____2) Effects of Anesthesia _____3) Medical/Smoking History	o Pt. will be able to breathe without difficulty during immediate intraoperative 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 integrity due to: _____1) Intraoperative Immobility _____2) ESU Pad Placement _____3) Positional Aids _____4) Prosthesis _____5) Pooling of Prep Solutions	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)

Epo H[redacted] b(6)-4

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

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION _____Potential for inadequate tissue perfusion due to: _____1) Intraoperative Mobility _____2) Positioning _____3) Existing Disease _____4) Safety Devices _____5) Hypothermia	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o Check that rings 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	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, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1._____Diminished visual perception due to being: _____1) Pre-Medicated _____2) W/O Glasses F.2._____Potential for decreased communication due to: _____1) Diminished Hearing _____2) Language Barrier F.3._____Potential injury due to dentures: _____1) Upper _____4) Caps _____2) Lower _____5) Crowns _____3) Bridges	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 communication. 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 COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTION S NOTED.

b(6)-2 [redacted] PT/AN 26 Jan 03 DATE

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

12. PREOPERAT[redacted]PARED BY (Signature and Titl[redacted] PT/AN

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title)

DATE: 26 Jan 03 TIME: b(6)-2 DATE: TIME:

REVERSE OF FORM 5179, JUN 91 USAPA V1.0

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: 28

HEIGHT:

WEIGHT: 65 kg

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

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

4. PROPOSED SURGICAL PROCEDURE:

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition_____
Tobacco ✓ ppd X___yrs. Body Piercing_____ Diabetes (Y) (N) ROM_____ ASA/Motrin w/72 hrs (Y) (N)
ETOH_____ Implants_____ Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures_____ Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

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	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. Parents to stay with pt.
B. AERATION _____Potential for respiratory dysfunction due to: _____1) Positioning _____2) Effects of Anesthesia _____3) Medical/Smoking History	o Pt. will be able to breathe without difficulty during immediate intraoperative 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 integrity due to: _____1) Intraoperative Immobility _____2) ESU Pad Placement _____3) Positional Aids _____4) Prosthesis _____5) Pooling of Prep Solutions	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)

EPW # [redacted] b(6)-4

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

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ___ 1) Intraoperative Mobility ✓ 2) Positioning ___ 3) Existing Disease ___ 4) Safety Devices ✓ 5) Hypothermia	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o. Check that rings 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	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, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated ___ 2) W/O Glasses F.2. ✓ Potential for decreased communication due to: ___ 1) Diminished Hearing ✓ 2) Language Barrier F.3. NA Potential injury due to dentures: ___ 1) Upper ___ 4) Caps ___ 2) Lower ___ 5) Crowns ___ 3) Bridges	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 communication. 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 COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTION S NOTED.

b(6)-2 [redacted] /MAJ AN 29 Jun 03 DATE

11. POSTOPERATIVE EVALUATION:
LEVEL OF CONSCIOUSNESS: [redacted]
LEVEL OF ACTIVITY: ☑ Moves All Extremities

SKIN INTEGRITY: Bovie Pad Site: ☑ Clean and Dry ☐ Red ☐ N/A
☑ Drowsy ☐ Sleepy ☐ Intubated
☐ Moves Upper Extremities
☐ Transferred to litter ~~with roller due to spinal~~ by OR staff

DRESSING DRY & INTACT: (Y) (N)
BREATHING EASY: (Y) (N)

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title)
b(6)-2 [redacted] MAJ AN
DATE: 29 Jun 03 TIME: 1450

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title)
[redacted] b(6)-2 MAJ AN
DATE: 29 Jun 03 TIME: 1601

REVERSE OF FORM 5179, JUN 91

USAPA V1.0

b(6)-2 All (except last)

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 1LT [redacted]

3. DATE: 1 Jul 03 TIME PATIENT ARRIVED IN SUITE: 0805

4. PATIENT IN ROOM TIME: 0805 NUMBER: 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NPO p MN, NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	1LT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) Pt. supine on padded OR table. BUE on padded armboards <90°. Safety strap across mid abdomen.

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

COMMENTS: Normal anatomic body alignment maintained.

8. SKIN PREPARATION

HAIR REMOVAL [ ] YES [X] NO

DONE BY: [ ] OR [ ] NURSING UNIT

METHOD: [ ] DEPILATORY [ ] RAZOR [ ] CLIP

COMMENTS: N/A

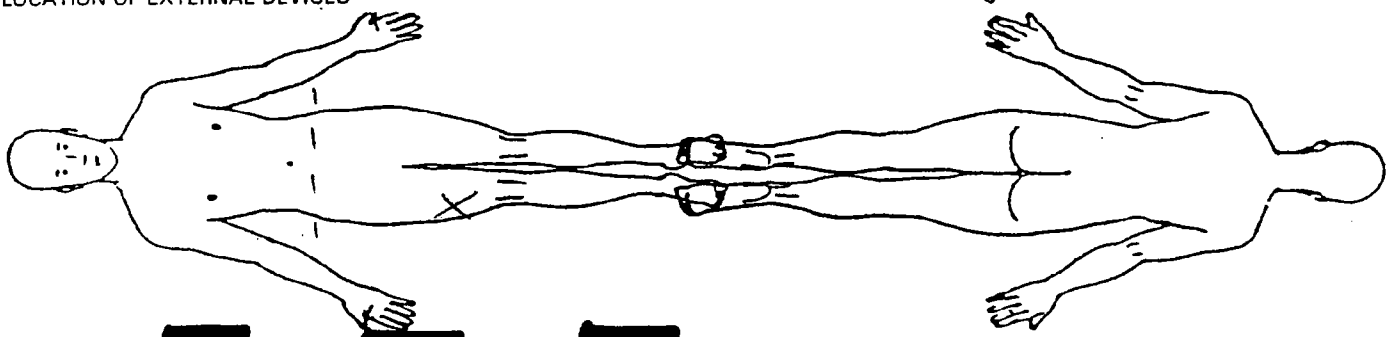
PREP SOLUTION (Specify) Betadine / Betadine

SITE: Left thigh BY WHOM:

SITE: BY WHOM: 1LT [redacted]

COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



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

Initial: SPC [redacted] 1LT

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	[X] Yes	[ ] No		C	C	SPC [redacted]	1LT [redacted]
Needle Sharp	[X] Yes	[ ] No					
Instrument	[ ] Yes	[X] No					
Other	[ ] Yes	[X] No					

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

[redacted] b(6)-4

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

[X] ESU NO: #1 cut 30 coag 30

GROUND PAD: BRAND VL Rem Polyhesive #

LOT NO: 662216 Exp 2004-11

[ ] ESU NO:

GROUND PAD: BRAND

LOT NO:

[ ] BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS. SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
0.9 % NaCl- Q.S

b(6)-2

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs, kerlix, ACE

19. ADDITIONAL INFORMATION
Surgeon: Dr [redacted] b(6)-2
Anesthesia: MA [redacted]
b(6)-2

Pt. arrived in OR c̄ patent Foley cath.

DA5179 in chart

20. OPERATION(S) PERFORMED
I&D [redacted] wound

21. PATIENT TRANSFERRED TO ICU b(6)-2 TIME 0854 METHOD LITTER c̄ O2

22. REGISTERED NURSE SIGNATURE [redacted] RN

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

b(6)-2 All (except last)

MEDICAL RECORD — INTRAOPE[illegible] DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY CPT [redacted] / MAJ [redacted]

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE [illegible]D BY MAJ [redacted]

3. DATE 29 Jun 03 TIME PATIENT ARRIVED IN SUITE 1500

4. PATIENT IN ROOM TIME 1500 NUMBER 1-2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies:

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

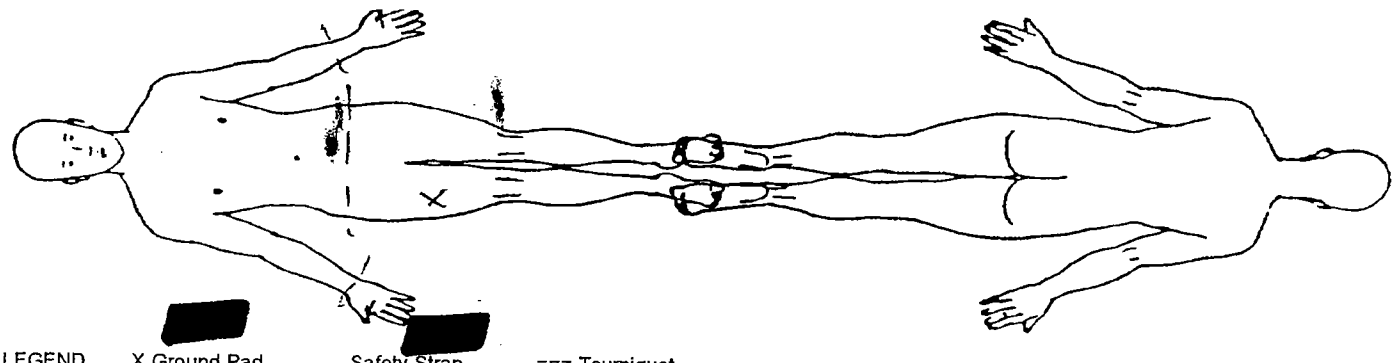
COMMENTS: 3L bag NS. under Lt hip, both arms on padded armboards at cuff.

8. SKIN PREPARATION < 90°

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		C	C	PFC [redacted]	MAJ [redacted]
Needle Sharp	☑ Yes ☐ No		C	C	PFC	MAJ
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;)*

EPW # [redacted]

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

☑ ESU NO: Valleylab #2
GROUND PAD: BRAND Valleylab
LOT NO: 65706 Exp 2004-11

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

13. PROSTHESIS, IMPLANTS ☐ YES ☑ NO IF YES NAME: ID NUMBER; M. JFACTURER

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): N.S. x 7L.

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE b(6)-2

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

16. ORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

TYPE/SIZE	1. 3/8" Penrose	2.	3.
SITE	1. Left thigh	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs
Kerlix Ace

19. ADDITIONAL INFORMATION

WC

Surgeons [redacted] b(6)-2

Anesthesia: CRT [redacted] b(6)-2 Anesthesia Type: GETA

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

20. OPERATION(S) PERFORMED

I&D Left upper thigh wound

21. PATIENT TRANSFERRED TO ICU TIME 1555 METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] b(6)-2 RN MN AN 29 Jun 03

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

b(6)-2 All (except last)

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: Anes. Staff

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

3. DATE: 26 Jun 03 TIME PATIENT ARRIVED IN SUITE: EMT → OR

4. PATIENT IN ROOM TIME: 0/05 NUMBER: 1-R

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC. [redacted] (91D)	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT. [redacted] (66E)	RELIEF CIRCULATOR	
	CPT. [redacted] (66E)		

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS: Bean Bag utilized for (L) side up. pillow under (R) leg & (L) arm.

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☑ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS: X

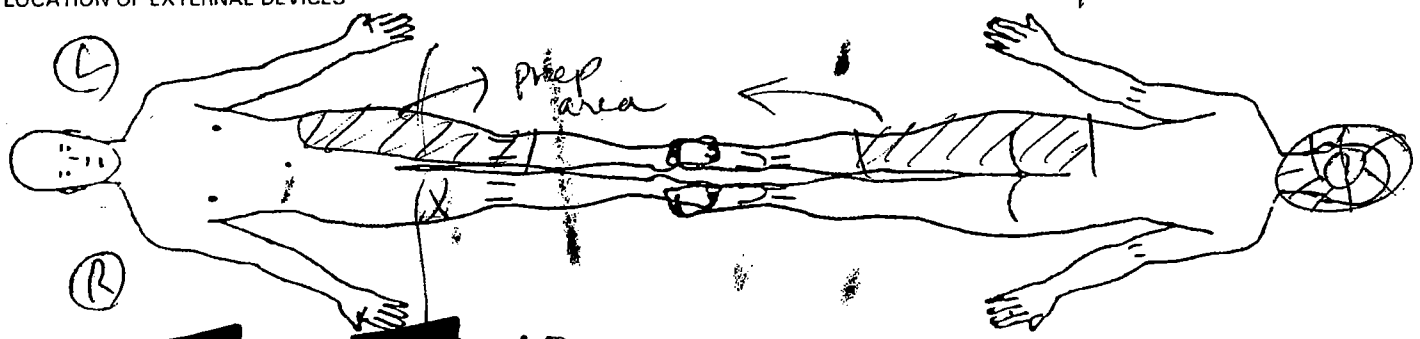
PREP SOLUTION (Specify) Betadine S/Sol

SITE: Lt. thigh & Hip BY WHOM: CPT. [redacted] AN

SITE: BY WHOM:

COMMENTS: X pooling of Sol.

9. LOCATION OF EXTERNAL DEVICES



LEGEND X [redacted] -- [redacted] = Tourniquet

C = [redacted] I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes ☐ No	/				
Needle Sharp	☑ Yes ☐ No		C	C	SPC [redacted]	CPT [redacted]
Instrument	☐ Yes ☑ No	/	/	/		
Other	☐ Yes ☑ No					

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

EPW # [redacted]

b(6)-4

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

☑ ESU NO: Valley Lab #2

GROUND PAD: BRAND: poly hesive

LOT NO: 69652

☐ ESU NO:

GROUND PAD: BRAND:

LOT NO:

☐ BIPOLAR NO:

Coag 230
40 230

THESIS, IMPLANTS ☐ YES ☑ NO IF YES NAME: ID NUMBER; ACTURER

MEDICATIONS/ORDERS

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

EDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):

or 9% Nacl

b(6)-2

OTHER ORDERS	TIME	CARRIED OUT BY
CBR Foley inserted in O.R	Intra-op	CPT [redacted]

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

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

16. LABORATORY SPECIMENS

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

18. DRESSING/IMMOBILIZATION *(Specify)*

4x8
fluffs
ABD's Tape

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

TYPE/SIZE	1. 3/8" Penrose	2. Drain	3. Gauze
SITE	1. Lt. Thigh	2.	3. Lt Thigh

19. ADDITIONAL INFORMATION

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

Anes: Maj [redacted] (CRNA)

b(6)-2

20. OPERATION(S) PERFORMED

Lt. Thigh, I & D c̄ Wash out.

21. PATIENT TRANSFERRED TO	TIME	METHOD
CCU	See Anes Record	Litter

22. RE[redacted] CPT/AN

b(6)-2

REVERSE OF DA FORM 5179-1, OCT 87 MEDCOM - 12080 USAPA V1.01

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR: June 2003

DAY: 28, 29, 30, 1, 2, 3, 4

HOUR

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

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

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

[redacted] b(6)-4

REGISTER NO.

WARD NO. ICW2

STANDARD FORM 511 (REV. 7–95) BACK

Ward/Section: EMT

LAST, FIRST, MI

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

CHEMISTRY RESULT FORM

(Subject to the Privacy Act of 1974)

DATE: 26Jan03

TIME: 2325

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

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	123	73-118 mg/dl
BUN	12	7-22 mg/dl
CRE	0.7	0.6-1.2 mg/dl
CK	388	39-380 u/l (M) 30-190 u/l (F)
NA^+	134	128-145 mmol/l
K^+	4.3	3.3-4.7 mmol/l
CL^-	106	98-108 mmol/l
tCO_2	23	18-33 mmol/l

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

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

DATE: 26Jan03

LAB ID NO.:

Ward/Section: EMT	REQ [redacted]	PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of [illegible])
LAST, FIRST, MI. b(6)-2	DATE 26 Jan 03	TIME 2325	SSN/PSEUDO SSN # [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	25.7	4.8-10.8 x 10^3
RBC	5.47	4.7-6.1 x 10^9
Hgb	14.8	14-18 g/dl (M) 12-16 g/dl (F)
Hct	47.3	42-52% (M) 37-47% (F)
MCV	86.5	80-94 fl (M) 81-99 fl (F)
Plt	180	130-500 x 10^3 verified
Lymph %	10.0	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

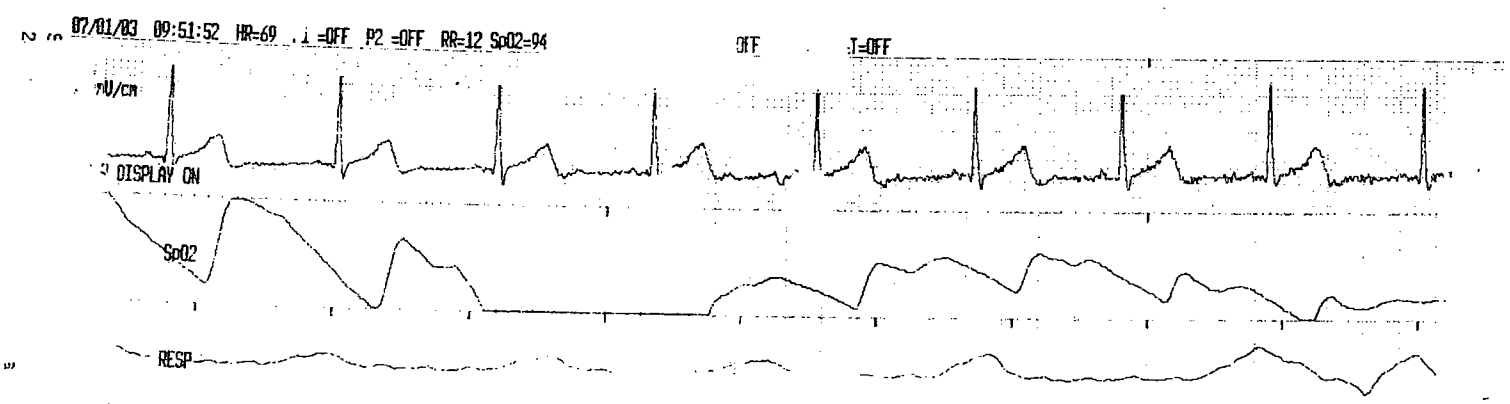
TEST	RESULT	REF. RANGE
PT	12.3	9.8-13.6 secs
APTT	21.2	21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] b(6)-2 | **DATE:** 26 Jan 03 | **LAB ID NO.:**


07/01/03 09:51:52 HR=69 I =OFF P2 =OFF RR=12 SpO2=94
OFF
T=OFF
mV/cm
DISPLAY ON
SpO2
RESP

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)	
versed	(mg)	2.5
MSO4	(mg)	2/2 2 2
propofol	(mg)	50
	( )	
	( )	
	( )	
VOLAT AGENT I-50	% del	1.5 1.5 0.6
	% e.t.	
AIR	L/Min	
N20	L/Min	
O2	L/Min	6 — 4 — 3 — 6

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

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS ▶ 1 2 3

FLUIDS		
LINE site 20g RAC	☐ Warmed	RL500↑ — /#2
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES	
EST BLOOD LOSS	
URINE –	

TOTALS	TOTAL EBL
2.5	min
4	
	TOTAL URINE
	NM

FLUIDS – SUMMARY

CRYSTALLOID – 500

COLLOID – Ø

BLOOD – Ø

REMARKS – Code drugs with numbers, events with letters

No Δ in pt status since last anesthetic. Plan general
1. To room, SOC monS, smooth IV ind
2. 2 ofran 4mg IV.
3. To recovery stable.

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 65 (KG) LB

HEMATOCRIT: 47

INITIAL DATA: BP – 97, 46 HR – 68

EQUIP CHECK: OK? – (Y) N

PATIENT RECHECK: OK for PROCEDURE – Y TIME – 0755

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

TIME → 00 → 30 → 07 → 30 → 10 → 30 → 11

220 200 180 160 140 120 100 80 60 40 20

VT – ml	350	300
f – breaths/min	11	14
Peak inf pres / PEEP	—	—
MODE – S(pon), A(ssist), C(on)	S	S
✓ BP/Auto Cuff / ✓ ET CO2 (torr)	45	44
BP / oth / ✓ FIO2 (Frac or %)	0.75	0.75
ART line / ✓ SpO2 (%)	100	100
Steth – PC/ES / ✓ ECG	SR	SR
Gas analyzer / TEMP – site	available	
N-M Block (T/4)		
Warming blkt		
Conv warmer		

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

RECOVERY AT: PACU (ICU) ____ (Specify) OTHER ____

CONDITION: RESP – 20 SpO2 – 100 BP – 104/55 HR – 62

ANESTHESIA / PROCEDURE TIMES	Start	Room	End
ANES	0755	0802	0900
PROC	Ready	Begin	End
	0807	0830	0845

PROCEDURES and CPT Codes: I&D Lt thigh

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GM

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Eyes taped, #9 OA placed, easy mask.

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

[redacted] b(6)-4 28yo

ICW 2 NKDA

SURGEONS: [redacted] b(6)-2

AN[redacted]MAJ, CRNA

[redacted]ECORD – ANESTHESIA

b(6)-2

PROCEDURE LOCATION: 1-1

DATE: 7/1/03

PAGE 1 OF 1

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 12085

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

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 28 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: I&D washout (L) leg
SURGICAL SERVICE: Ortho
NPO SINCE: 1300

ASA Physical State 1 (2) 3 4 5 (E)
WT: 45 KG/LB HT: ____ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: (+)
ETOH: denies
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) Ancef
( ) 5mg MSO4 2312
( ) 5mg MSO4 2350
( ) ____
( ) ____
( ) ____

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

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

25.7 / 14 / 47 < 180

139 | 106 | 12 < 123
4.3 | 23 | 0.7

PT-12
PTT-21

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	GSW (L) thigh
	N	Y	Lac back of head
Familial HX	N	Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Ø

PHYSICAL EXAMINATION
BP 117/72 HR 92 R 16 T 96.7
Pain Scale 0-10 ____
HEENT - Teeth Intact
TM 3FB Trachea midline
TMJ/Neck ____
Oropharnyx ____
Nares ____
CHEST: CTA
CARDIAC: RRR
EXTREMITIES: dressing
IV Access: 18ga (L) arm
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since 1300

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ (X) General: Mask Intubation
Plan aquestions thru interpreter

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

The patient [redacted] b(6)-2 understand and agrees. Questions answered.
Signed: [redacted] Date: 6/27/03 Time: 0100 Hrs

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

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

Patient Identification: (Ward) ____

EPW [redacted] b(6)-4

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

29 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

ASA Physical State 1 2 3 4 5 E
WT: 65 KG/LB HT: ____ IN.
ALLERGIES: NKDA

OSED PROCEDURE: (R) ~~ARM~~ I+D Thigh
ICAL SERVICE: ortho
INCE: p m

S:
ACCO: +
ETOH: ø
RUGS: ø

ENT MEDICATIONS:
dered as premed
Ancef 1 gm Q8°

EDICATIONS:
Yes (@ ____ Hrs) /CC
- ____ mg IV IM PO
- ____ mg IV IM PO
- ____ mg IV IM PO

RATORY STUDIES:
T: ____/____
R: ____

27 June 25.7 | 14 / 47 | 180
139 | 104 | 12
4.3 | 23 | 0.7 | 123
PT 12 | PTT 21

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:
- Acuta/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 NA

Other Significant Hx:
- N Y GSW (R) thigh
- N Y Scalp LAC (BACK OF head)

Familial HX N Y

ASSESSMENT

PAST SURGICAL/ANESTHETIC

I+D (R) thigh 5 comp

PHYSICAL EXAMINATION

BP 120/80 HR 74 R 16 T 98.8
Pain Scale 0-10 ____
HEENT - Teeth Intact
Trachea midline
TMJ/Neck WFB
Oropharnyx grade 2
Nares ____
CHEST: CTA
CARDIAC: S1 S2 5 (M)
EXTREMITIES:
IV Access: 18G (L) Arm
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since p MN

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

No interpreter present / chart reviewed

IMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of [redacted] been explained to a
sed with the patient/legal guardian.

[redacted] MA J, CRNA

tient/legal guardian seems to understand and agrees. Questions answered.
d: ____ Date: 29 June 03 Time: 1032 Hrs

b(6)-2

ANESTHESIA EVALUATION AND NOTE (NON ASU)
APPARENT ANESTHETIC COMPLICATIONS { } OTHER

d: ____ Date: ____ Time: ____ Hrs

t Identification: (Ward) ____

[redacted] (ICW2 - ICU2)

b(6)-4

SEDATION KEY:

1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is no necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may

Tobacco

NKDA

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)	
Midazolam	(mg)	2
Fentanyl	(mcg)	50 – 20
Propofol	(mg)	50 [redacted] b6-2
	( )	
	( )	
	( )	
VOLAT. AGENT: ISO	% del	2.0 2.0 2.0
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	2 2 2 10

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	TOTAL FLUID
2	30
70	
50	TOTAL URINE
	Ø

FLUIDS – SUMMARY
CRYSTALLOID– 300
COLLOID– Ø
BLOOD– Ø

FLUIDS: LINE site 18GR A ☒ Warmed ☐ Warmed ☐ Warmed ☐ Warmed — CP#1

LOSSES: EST BLOOD LOSS 20; URINE – Ø

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 65 (KG) LB

HEMATOCRIT: 47

INITIAL DATA: BP – 120/86; HR – 74

HOMP CHECK: OK? – (Y) N

PATIENT RECHECK: OK for PROCEDURE? JR; TIME – 1500

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

TIME → 1500 · 30 · 1600 · 30 · 1700

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

VT – ml	230 300 330 300	
f – breaths/min	10 14 7 11	
Peak inf pres / PEEP	— — —	
MODE– S(pon), A(ssist), C(on)	S S S S	
BP/Auto Cuff	ET CO2 (torr)	50 49 52 44
BP / oth	FIO2 (Frac or %)	0.88 0.88 0.88 0.90
ART line	SpO2 (%)	100 100 100 100
Steth- PC/ES	ECG	SR → SR
Gas analyzer	TEMP- site	Available
	N-M Block (T/4)	
Warming blkt	Room warmed →	
Conv warmer	x1 Blanket x1	

REMARKS – Code drugs with numbers, events with letters

(1) Pre-op Dx b(6)-2 MAT [redacted]
(2) Room monitor O2; mask induct
(3) 50 Tv > 5ml/kg RR > 8 & < 30 BPM Oral airway remove
(4) To litter to ICU 1 – Report to nurse

RECOVERY AT 1600
PACU (ICU) 1 (Specify)
OTHER T-97.1 Ax
CONDITION: Stable cardiac but hypoxemic SpO2-99
RESP – 20
BP – 98/52 HR – 62

ANESTHESIA PROVIDER TIMES

	Start	Room	End
ANES	1500	1505	1605
	Ready	Begin	End
PROC	1515	1525	1543

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

PROCEDURES and CPT Codes: I+D (L) thigh (SW)

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GMA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Oral airway 9mm; Clin support

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

EPW #[redacted] b(6)-4

b(6)-2 { SURG[redacted] AN[redacted] RNA/CPT [redacted] MEDICAL [redacted] – ANESTHESIA

PROCEDURE LOCATION 1
DATE 29 Jun 03
PAGE 1 OF 1

WHMC OP 376 REVISED 1 Jan 99

PATIENT RECORD

MEDCOM - 12088

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

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)	
Versed	(mg)	2.5
Fent	(µg)	150
Midazolam/propofol	(mg)	170
Succs	(mg)	80
Nimbex	(mg)	6
Phenylephrine	(µg)	100
VOLAT AGENT	% del	
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	8 7

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

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS → Robinul .2mg

FLUIDS		
LINE site NS	☐ Warmed	500
2R	☐ Warmed	900
	☐ Warmed	
	☐ Warmed	

LOSSES		
EST BLOOD LOSS		M
URINE –		700

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

BODY WEIGHT: 65 (KG) LB

HEMATOCRIT: 47

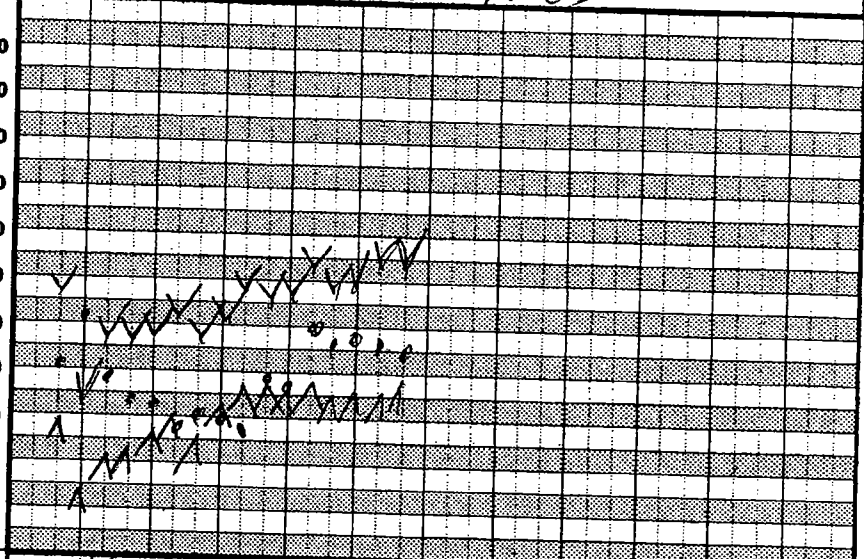
INITIAL DATA: BP – 117/72 HR – 92

EQUIP CHECK: OK? – (Y) N

PATIENT READY: OK for PROCEDURE? TIME – 0100

SYMBOLS: BP by cuff ∨ ∧; Heart rate ●; Resp rate ⊗; BP (transduced) ⊥ T; TOURNIQUET T – ⁄; ANES – X-X; PROC – ⊙ – Ø

TIME → 01 X 30 X 02 X 30 X 03



VT – ml		1050	710	620	570	SV
f – breaths/min		9	6	7	8	11
Peak inf pres / PEEP		18	22	20	16	
MODE – S(pon), A(ssist), C(on)		(S) CV	CV	CV	CV	SV
BP/Auto Cuff	ET CO2 (torr)	30	28	29	30	35 44
BP / oth	FIO2 (Frac or %)	.80	.80	.85	.85	.84 .84
ART line	SpO2 (%)	100	100	100	100	100 100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR SR
Gas analyzer	TEMP- site	Available				
	N-M Block (T/4)	(+) twitch –		4/4 single twitch		
Warming blkt						
Conv warmer						

Mark with letters & explain under REMARKS — EVENTS — Position → 6

TOTALS	
TOTAL BLD	Min
TOTAL URINE	700

FLUIDS – SUMMARY
CRYSTALLOID – 1300
COLLOID –
BLOOD –

REMARKS – Code drugs with numbers, events with letters

0105 PIED, NOB in pre-op status. mask applied
0110 I ⊕ Bilat BS –
0220 Spont Resp oral suction, purposful movement extubated – had two episodes of croupy like cough responded to pos pres assistvent, 3 puffs albut MOI improved croupy sounds. pt transferred toward PACU report 910PM

RECOVERY AT 0235
PACU ICU #3 (Specify)
OTHER
CONDITION: awake
RESP – 18 SpO2 – 99
BP – 178/63 HR – 138

ANESTHESIA / PROCEDURE TIMES	Start	Room	End
ANES	0030	0105	0300
PROC	Ready	Begin	End
	0115	0140	0215

PROCEDURES and CPT Codes: washout (6) thigh wound I&D

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: attempt c 3 MAC grade 2 view, secured at 23 cm teeth. 8.0 ETT placed one

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

EPW [redacted] ICU-3

SURGEONS: [redacted] b(6)-2

ANESTHETISTS: [redacted] b(6)-2

PROCEDURE LOCATION 28th PRESS

DATE 6/27/03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

PATIENT RECORD

MEDCOM - 12089

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

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

ERW

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 27 Jun 03 TIME OF ORDER: 0230 HOURS

LIST TIME ORDER NOTED AND SIGN

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

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

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

NURSING UNIT | ROOM NO. | BED NO.

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

b(6)-2

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

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 27 Jun 03 TIME OF ORDER: 1635 HOURS

V.O.

1. Demerol 50mg / Phenergan 25mg } IV q 3° prn

2. Δ' dressing to @ thigh prn.

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

[redacted] Maj/AW

[redacted]

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

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

EPW [redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 27 June 03 TIME OF ORDER: 2020 HOURS

LIST TIME ORDER NOTED AND SIGN

NO [redacted] for [redacted] b(6)-2

DC foley, notify MD if not urinate [redacted] b(6)-2

[redacted] Maj IAW

[redacted] b(6)-2

PATIENT IDENTIFICATION

EPW [redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 30 JUN 03 TIME OF ORDER: 1605 HOURS

1. I&O cath, 1st UOP <500 cc's, leave in to drain
2. NPO after midnight
3. IV - LR at 100 cc/hr
4. Zofran 1 mg IV [redacted] b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME [redacted] ORDER

HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

HOURS

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: EPW [redacted]

NURSING UNIT: ICW 2 | ROOM NO.: 24 Vs | BED NO.: 27 30

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

28 Jun 03 [redacted] b(6)-2

NPO p MN
for washout 29 JUN 03 b(6)-2 [redacted]

PATIENT IDENTIFICATION: EPW [redacted]

NURSING UNIT: ICW 2 | ROOM NO.: | BED NO.: 17

DATE OF ORDER / HOURS

29 June b(6)-2 1600
Transfer PACU → DCW2
SA Washout / DPC
Same
Continue Same Med / IV
Orders

PATIENT IDENTIFICATION: EPW [redacted]

NURSING UNIT: ICW 2 | ROOM NO.: | BED NO.: 17

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

Reinforce DSD PRN noted b(6)-2 [redacted]

b(6)-2 [redacted]

9 Wm6
29 June 03
1705

b(6)-2 [redacted]

24 Vs [redacted] 1 ICTAN 6-29-03 2245

PATIENT IDENTIFICATION: EPW [redacted]

NURSING UNIT: ICW 2 | ROOM NO.: | BED NO.: 17

DATE OF ORDER / TIME OF ORDER / HOURS

1 JULY 03 0830

Transfer PACU → DCW2
SA washout / DPC ✓
Same
Cont Med order ✓
DSD BID & PRN ✓
OK to DC to EPW Cont 2/3 [redacted]

noted b(6)-7 [redacted]
Shumb
1 July 03
1000

b(6)-2 [redacted]

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE

NOTES

29 Jun 03 Ortho DP Note
Prop Dx: (R) Thigh Gsw
Procedure: (L) Thigh Washout / Delayed primary closure
Surgeon: [redacted] b(6)-2
EBL: 2 min
IV: ¢
TO PACU Stable
Drain Penrose clamp to PRU @ 480
Keep Ace wrap on (R) thigh at times

[redacted] b(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
1 July 03	Ortho OP/EUAC NOTE
	28 yo EPW Iraqi Shot (R) leg
	Preop Dx (R) Quad TT GSW
	c Soft tissue Defect with
	Procedure washout/DPC
	Surgeon [redacted] b(6)-2
	EBL [redacted]
	TFL (R)
	Findings: Clean wound
	2L washout
	Closed primary
	Plan: Finish IV Abx tomorrow 2 Sep
	A to PO Abx and OK for DC
	No Need for further operative
	[redacted] b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted]

b(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	QMD ap Nizde
	Prep Rt Thigh GSW
	Pt to Dx i Sme c
	SPA Lac
	Surgeon [redacted] b(6)-2
	BBL 2 [redacted]
	TT 2 d
	To PAcu Stable
	Fdings SPA Actn y Thyech
	Tolerated
	wnl Dehm 3l wgh
	Pnrcse Dfan mtrSla

[redacted] b(6)-2

HOSPITAL OR MEDICAL FACILITY

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

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

[redacted] b(6)-4

REGISTER NO.	WARD NO.

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

All b(6)-2 (except last)

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 XX Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 27	28	29	30	1	2	3	4
27 June	[redacted]	Admit to ICU 3	05	[redacted]							
			17	done [redacted]							
			X								
27 June	[redacted]	Condition: stable	05	[redacted]							
			17								
			X								
27 June	[redacted]	VS: per routine	05	[redacted]							
			17								
			X								
27 Jun	[redacted]	Activity: bed lib	05	[redacted]							
			17								
			X								
27 Jun	[redacted]	Foley to gravity	05	[redacted]	D/C 27 JUN 03						
			17								
27 Jun	[redacted]	Vascular ✓ q 2 hours	05	[redacted]	D/C						
		x4	17								
27 Jun	[redacted]	Ice to left thigh:	05	[redacted]							
		c̄ elevation	17								
27 Jun	[redacted]	Adv. Reg. diet	05	[redacted]							
			17								
28	[redacted]	Foley to Gravity	5	/	/	/	/	[redacted]			DC'd
			13	/	/	/					
			21	/	/	/					
1	[redacted]	Dsg D QD c̄ ace	10	/	/	/	/	[redacted]			
		wrap									

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW Hip s/p I+D (L) thigh

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

EPW [redacted] b(6)-4

ACTION TIMES — USE PENCIL. CIRCLE ACTION TIMES

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

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

All b(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo June Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
	-----	~~Reinforce dressing~~ error				
27 June	[redacted]	DC foley, notify MD if not urinate in 8 hours	27 June	2020	done	[redacted]

28	[redacted]	TRANSFER TO ICW #2	28		1300	[redacted]
28	[redacted]	NPO p MN for washout 29 JUN 03	28	2355	done	
30	[redacted]	ITO CAMT, if UOP > 500cc, leave in	30	1600	1600	[redacted]
30	[redacted]	NPO p MN	30	2355	2400	[redacted]
1 July	[redacted]	transfer PACU → ICW2	1 July			
1	[redacted]	S/P washout (L) thigh	1 July		done	[redacted]
1	[redacted]	Continue med orders	1 July	~~0400~~		[redacted]
1	[redacted]	D/C to DC to EPW camp 2 or 3 July	2003			

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
27 June	[redacted]	Reinforce dressing	27 June 1600													
-----	-----	PRN	[redacted]	D/C 27 Jun 03												
27 Jun	[redacted]	Δ' dressing to (L)														
-----	-----	thigh prn.														
29 June	[redacted]	Reinforce dressing														
-----	-----	prn														
-----	-----															
-----	-----															
-----	-----															
-----	-----															

USAPA V1.00

All b(6)-2 (except last)

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 06 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 27	28	29	30	1	2	3	4	5
27 June 03	[redacted]	IVF: LR 100 cc hour	05	[redacted]								
		DC when tolerating PO	17	[redacted]			H.L					
		H.L. flush after each	X									
27 June 03	[redacted]	Ancef 1 gm IV	06	[redacted]								
		q8°	14	[redacted]								
			22	[redacted]								
			X									
27 June	[redacted]	Sleneral 50-100 mg ĉ	05	50/25	100/250	10						
		Phenergan 25 mg IV				on back (p.r.n.)						
		q3 hours.										
28	[redacted]	HL IV when tol PO	5	/	/	[redacted]						
			13	/	[redacted]				DID			
			21	/	[redacted]							
30	[redacted]	IVF: LR @ 100 cc/hr	5	/	/	/	/	[redacted]				
			13	/	/	/	[redacted]					
			21	/	/	/	[redacted]					
30	[redacted]	Zantac 150 mg PO BID	10	/	/	/	/	[redacted]				
			22	/	/	/	[redacted]					

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW Hip S/P I+D (L) Thigh

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

All b(6)-2

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
27 Jun	[redacted]	Percocet ii p.o.	28 Jun 0900	28 Jun 1500	28 June 0630	29 June 1215	29 June	30 June 0700	30 June 0730	30 June 1400	30 June 2030		1 July	1 July		
		q4° prn for pain	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	[redacted]		
27 Jun	[redacted]	Demerol 50mg / Phenergan 25mg } IV q3° p.r.n.	27 Jun 1330 50mg	28 Jun 1200	[redacted]	[redacted]										
27 Jun	[redacted]	Percocet ii PO	1 July 1010	1 July 1500	1 July 2124	2 July 0330	2 July 0900	2 Jul 1030	2 Jul 1900	3 Jul 0131	3 Jul 0831					
		q4° prn for pain	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]					

} Copies below

USAPA V1.00

MEDICAL RECORD-SUPPLEMENTAL MEDICAL

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

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

OTSG APPROVED (Date)

Date: 27 JUN 03
Time In: 0245
Allergies: NKDA
Pre-op V/S: 117/72
Procedures: I + D (L) thigh Wound

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

OR Intake: Crystalloid 1300 Colloid —
OR Output: UOP 700 EBL Minimal
Meds/Times: 200 mcg Fentanyl 2.5 mg Versed 3 puffs Albuterol

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds History

Time																
SaO2																
FiO2																
Methods																
240																
220																
200																
180																
160																
140																
120																
100																
80																
60																
40																
20																
RR																
T																

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
0245	LR	150	(D) KE		700

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	122/76	118/75	
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2	
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2	2	
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C,	10	10	

Codes

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

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

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

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

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

DEPARTMENT/SERVICE/CLINIC: ICU3

DATE: 27JUN03

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

EPW [redacted] b(6)-4

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

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

USAPPC V2.00

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: 6/29
Time In: 1100
Allergies: NKDA
Pre-op V/S: 120/56 HR74
Procedures: GSW Left Leg, Head Repair
Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 300 Colloid
OR Output: UOP 30 EBL
Meds/Times: Tomcyfent, Zyrtec

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

Pre Op Meds History

Time	1100	1200	1300	1315	1400	1500
SaO2	100	100	100	100	100	96
FiO2	100	6L	5	5	5	5
Methods	T/M	FM	FM	F	NRB	RA
240						
220						
200						
180						
160						
140						
120						
100						
80						
60						
40						
20						
RR	10	14	16	11	12	14
T	97.7	98	98	98	98	

Time				
Pain (0-10)	6	4	0	0
LOS	[redacted]			

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	2	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2	2	2
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C,	11	12	12

Codes

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

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

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

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

PREPA[redacted] b(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU I

DATE: 6/29/09

Name – last, first, middle; grade; date; hospital or medical facility)

EPW [redacted] b(6)-4

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

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

USAPPC V2.00

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

NURSING NOTES

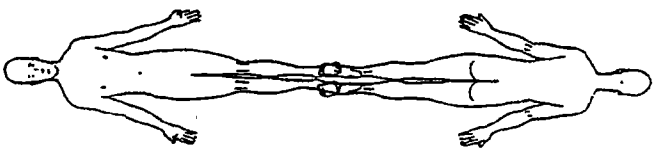
Pt left ICU via litter accompanied by RN. ax0x3. Pulse ox 96% RA denies any pain. T-max 97.8. Scalp and LE dry, NT

NEUROVASCULAR							
Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	LL	LL	+	+	+	W	NR
15'	+	+	+	+	+	W	NR
30'	+	+	+	+	+	W	NR
45'	+	+	+	+	+	W	NR
60'	+	+	+	+	+	W	NR
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) thigh	Bulky	Ø
30'	✓	✓	✓
60'	✓	✓	✓
D/C			



PACU OUTPUT			
Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?

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

WAMC OP 173-E

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: 01Jul03
Time In: 9:00
Allergies: NKDA
Pre-op V/S:
Procedures: Tibial Design

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid LR Colloid
OR Output: UOP NM EBL minimal
Meds/Times:

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds History

Time	9:00	9:05	9:10	9:15
SaO2	99%	98%		
FiO2				
Methods				
240				
220				
200				
180				
160				
140				
120				
100	✓		✓	✓
80		✓		
60	•	•	•	•
40	^	^	^	^
20				
RR	8	8	9	8
T	96.3			

Time	
Pain (0-10)	
LOS	

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2		2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2		2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2		2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1		2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2		2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	[redacted] 2		NA
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C,	[redacted] 9		10

Codes

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

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

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

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

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

DEPARTMENT/SERVICE/CLINIC

DATE 01JUL03

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

#[redacted] b(6)-4

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

All b(6)-2

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

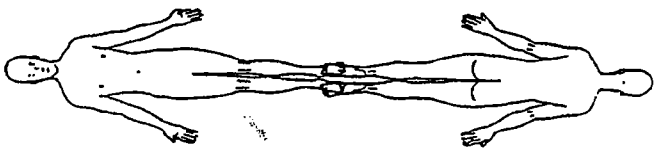
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L)UE	Fce Groundgauze	Ø
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
0944	Foley	Yellow	425

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0951	NSR		Yes

WAMC OP 173-E

NURSING NOTES

Pt. from O.R. to ICU 1 for recovery. Responds to verbal & painful stimuli. VSS. SpO2 100 RA. IV site (R) forearm infusing LR. Foley to gravity, yellow urine. I & D to (L) arm. Ace bandage around gauze. Ø obvious drainage @ this time. +2 radial and pedal pulses. [redacted] 9ICU

0955. VSS Ø distress noted. [redacted] 9ICU

Discharge Criteria:
Date: 01 Jul 03 **Time:** 9:51 **PARS:**
BP: 107/64 **T:** 96.8 **HR:** 63 **RR:** 9 **Sa02:** 98
Pain Level at D/C (0-10):
Intake: Ø **Output:** 425cc
Additional Data: None
Transferred To: ICU 1
Report Given To: Spc [redacted]
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: Spc [redacted]
Cleared IAW Recovery [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

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0600	INITIALS [redacted]	b(6)-2	INITIALS		INITIALS
	PUPILS	PERRLA				PERRLA, Alert	
	SENSORIUM	Pt responds to verbal & tactile stimuli				Verbalizes need	
	RESPIRATORY PATTERN	Even + unlabored				Unlabored, BBS	
	BREATH SOUNDS	Clear bilateral				CTA, on RA	
	SECRETIONS	Ø				SAO2 97%	
		Pt on RA w/ Sats @ 100%				No secretions	
	COLOR	Normal				Normal	
	INTEGRITY	GSW to (L) thigh. Drsg. intact w/ blood noted + marked				(L) thigh GSW S/P debridement, drsg	
	LOCATION	(L) AC				(L) UE, LR @ KVO	
	CONDITION	IVF LR @ 100cc infusing into (L) AC site. 5 S/S of infection.				converted to 100 cc/hr site intact	
	ABDOMEN	Soft, non tender				Soft Nontender	
	BOWEL SOUNDS	(+) B.S. x 4 quads but faint				Hypoactive BS	
	URINE: COLOR/CLARITY	Foley to gravity w/ > 50cc/hr. clear yellow drain drainage				Foley to gravity draining clear yellow urine	
	CARDIAC RHYTHM	S1 S2 and 3 L, Ø S3 S4 NSR, reg. 5 ectopy. HR 60-70's				NSR 5 ectopy rate 80's. Radial + pedal pulses strong palpable, NV ✓ as ordered cap refill < 3 sec	
		(+) pedal pulse w/ cap. refill < 3 sec. VSS					

LEGEND: Cr - Creatinine; F_IO_2 - Fraction of inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; S/A - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

b(6)-2 EPAR [redacted] Maj/AN

DEPARTMENT/SERVICE/CLINIC: ICU 2 west

DATE: 27JUN

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

EPW [redacted] b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

27JUN | DX GSW Hip | HOSPITAL DAY

TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20
Arterial Line																	
Cuff		109/56		107/59		84/40	Dopp 100/55	110/57		115/64	100/53		104/54				99/54
Temperature		98(A)		98.4(A)		99.4(A)		98.8(A)			99.1(A)		99(A)				99.5
Pulse		64		68		121		82		96	80		74				82
Respiratory Rate		20		16		25		18		20	16		14				26
Sats		99%		100%		96%		99%		99	97		100				100
RA																	RA
Vascular ✓s		+	+	+	+	+	+	+		+	+	+	+	+		+	
Cap. refill		<3sec	<3sec	<3sec	<3sec	<3sec	<3sec	<3sec		<3sec	<3sec	<3sec	<3sec			<3sec	
Intervention																	

TIME	05	06	07	08	09	10	11	12	8°T								
IVF	900	100	100	100	100	100	100	100	1500	100	100	100	100	100	100	100	100 (800)
Ancef		50									50						(100)
PO															240		240

TOTALS

URINE	HOUR / TOTAL	275 / 275	125 / 400		100 / 500		150 / 650	50 / 700			575 / 1275		150 / 1325				Foley out 285 / 285
	30 gr																+225
	S/A																510
NG	OUTPUT																
	pH																
	GUIAC																
EMESIS																	
STOOL																	

EPW [redacted] b(6)-4

1140
510
630

21	22	23	24	01	02	03	/
		114/				112/	
		83				63	
		69				67	
		17				21	
		98				97	
		RA				RA	
							8° T
IVF	200	0	0				
Aug	50						
/	/	/	/	/	/	225/ 225	225

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

		TIME							
MODE									
F_iO_2									
TV									
RATE									
PEEP									
A	pH								
	PCO_2								
	pO_2								
B	HCO_3								
	SAT								
G	BASE								

LABORATORY DATA

TIME								
GLUCOSE								
Na/K	/	/	/	/	/	/	/	/
Cl/CO_2	/	/	/	/	/	/	/	/
BUN/Cr	/	/	/	/	/	/	/	/
WBC/PLATELET	/	/	/	/	/	/	/	/
Hct/Hgb	/	/	/	/	/	/	/	/

ACTIVITIES OF DAILY LIVING

TIME	1600		
MOUTH CARE			
BATH			
SKIN CARE	KP		
FOLEY CARE			
TRACH CARE			
ROM EXERCISES	KP		

TURN — TIME

SUCTION

24° I&O TOTALS

wt Yesterday ______

wt Today 65 kg

INTAKE
IV 900
po 240
1140

OUTPUT
Urine: 510

balance: +630

NURSE'S SIGNATURE

b(6)-2

[redacted]

KP

b(6)-2

PAGE

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0515	INITIALS [redacted]	b(6)-2	INITIALS		INITIALS
NEURO	PUPILS	PERRLA					
	SENSORIUM	Alert, able to follow simple commands					
RESPIRATORY	RESPIRATORY PATTERN	RRR					
	BREATH SOUNDS	Clear throughout					
	SECRETIONS	Ø secretions noted @ this time					
SKIN	COLOR	WNL for race					
	INTEGRITY	GSW (L) thigh, drsg D+I; Drsg to head D+I					
IV SITE	LOCATION	(L) AC S.L. Ø s/s of infection					
	CONDITION						
GASTRO	ABDOMEN	soft and nondistended					
	BOWEL SOUNDS	BS(+) throughout					
GU	URINE: COLOR/CLARITY	uses urinal					
CARDIOVASCULAR	CARDIAC RHYTHM	SR c̄ Ø s/s of ectopy; pulses palpable throughout; all ext. Cap. refill 2-3 sec					

LEGEND

Cr - Creatinine
F_IO_2 - Fraction of inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU 3 east

DATE: 28 June 03

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

EPW [redacted] b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specif

☐ DIAGNOSTIC STUDIES

PAG

	DX													HOSPITAL DAY			
TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20
Arterial Line																	
Cuff		97/62				104/58		103/58									
mperature		99.4				98.5		99.0									
lse		70				67		93									
spiratory Rate		19				10		12									
NV ✓		+		+		+		+									
cap refil		<3sec		<3sec		<3sec		<3sec									
pedal pulse		+		+		+		+									
O2 sats		98%						96%									
TIME	05	06	07	08	09	10	11	12	8°T	13	14						
Ancef		50															
TALS																	
HOUR / TOTAL		140/140		175/315					275/590	590							
INE sp gr																	
S/A																	
OUTPUT																	
IG pH																	
GUIAC																	
ESIS																	
IOL																	

EPW CO [redacted] b(6)-4

	21	22	23	24	01	02	03	~~04~~
BP								
T								
P								
R								
NVV								
cap refill								
pedal pulse								
								8° T

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

		TIME								
		MODE								
		F_iO_2								
		TV								
		RATE								
		PEEP								
A		pH								
		PCO_2								
		pO_2								
B		HCO_3								
		SAT								
G		BASE								

LABORATORY DATA

TIME								
GLUCOSE								
Na/K								
Cl/CO_2								
BUN/Cr								
WBC/PLATELET								
Hct/Hgb								

ACTIVITIES OF DAILY LIVING

TIME			
MOUTH CARE			
BATH			
SKIN CARE			
FOLEY CARE			
TRACH CARE			
ROM EXERCISES			

	TIME			
TURN				
SUCTION				

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE OUTPUT

IV ______ Urine: ______

PO

NURSE'S SIGNATURE

[redacted] ~~[illegible]~~ AUR

b(6)-2

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

TIME		INITIALS		INITIALS		INITIALS
PUPILS						
SENSORIUM						
RESPIRATORY PATTERN						
BREATH SOUNDS						
SECRETIONS						
COLOR						
INTEGRITY						
LOCATION						
CONDITION						
ABDOMEN						
BOWEL SOUNDS						
URINE:						
COLOR/CLARITY						
CARDIAC RHYTHM						

LEGEND
Cr - Creatinine
F_IO_2 - Fraction of inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SA$\bar{1}$ - Saturation
TRACH - Tracheostomy

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC: ICU 2 unit

DATE: 6/28/03

(If typed or written entries give: Name—last, first, rank; grade; date; hospital or medical facility)

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

EPW # [redacted] b(6)-4

	DX													HOSPITAL DAY			
TIME																	
Arterial Line																	
Cuff																	
emperature																	
ulse																	
espiratory Rate																	
Vascular ✓s																	
TIME									8° T								
LR																	
OTALS																	
	HOUR / TOTAL																
JRINE	sp gr																
	S/A																
	OUTPUT																
NG	pH																
	GUIAC																
MESIS																	
TOOL																	

ACUITY LEVEL CLASSIFICATION

8° T

RESPIRATORY DATA										
		TIME								
		MODE								
		F_IO_2								
		TV								
		RATE								
		PEEP								
	A	pH								
		PCO_2								
		pO_2								
	B	HCO_3								
		SAT								
	G	BASE								

LABORATORY DATA									
	TIME								
	GLUCOSE								
	Na/K								
	Cl/CO_2								
	BUN/Cr								
	WBC/PLATELET								
	Hct/Hgb								

ACTIVITIES OF DAILY LIVING									
	TIME				TURN	TIME			
	MOUTH CARE								
	BATH								
	SKIN CARE								
	FOLEY CARE				SUCTION				
	TRACH CARE								
	ROM EXERCISES								

24 HR I&O TOTALS

NURSE'S SIGNATURE

wt Yesterday _____ wt Today _____

[redacted] KPO

b(6)-2

INTAKE

IV _____

po

OUTPUT

Urine: _____

MEDCOM - 12114

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF						2. LOCATION		
1	2	3	4	5	6	7	8	(State or Country Code.)
A	1	1	D	1		I	Z	

3. REGISTER NUMBER							NAME (Last, First, Middle Initial)	4. PAY GRADE		5. SEX
9	10	11	12	13	14	15	EPW [redacted] b(6)-4	16	17	18
[redacted] b(6)-4										M

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

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
N/A	46: U	0212	N/A

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: Ø	1CW2	—
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
[redacted] b(2)-2		—
		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
		—

21. TYPE OF DISPOSITION		22. MTF TRANSFERRED TO						23. DATE OF DISPOSITION (YYMMDD)					
73	74	75	76	77	78	79	80	81	82	83	84	85	86
5	Ø							Ø	3	Ø	6	3	Ø

24. CLINIC SVC - ADMITTING				25. MTF TRANSFERRED FROM						26. DATE THIS ADMISSION (YYMMDD)					
87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102
A	E	A	A							Ø	3	Ø	6	2	7

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

FOR LOCAL USE

Dx: GSW Hip S/P I+D (L) thigh

Dx: 8900 Pr: 8628
9041 3888
E9912 8659 (2)
Inj Trauma
450 1

Dx: 8901
E9912

Pr: 8659 (x2)

1 450

ADMITTING OFFICER (Si[redacted]s required)	SIGNATURE OF ADMITTING CLERK
[redacted]	[redacted] PFC, 91G10

DA FOR[redacted]

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

MEDCOM 12114

INPATIENT TREATMENT RECORD COVE.

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

1. REGISTER NUMBER: 0013649	2. NAME (Last, First, MI): UNK EPW					3. GRADE: EPW	ADMISSION REMARKS
4. SEX: M	5. AGE: 45	6. RACE: X	7. RELIGION: MUSLIM	8. LENGTH OF SVC: —	9. ETS: —	10. PREVIOUS ADMISSION: NO	
11. FMP: 99	12. SSN: [redacted]		13. ORGANIZATION: b(6)-4			14. WARD: ICU3	
15. FLYING STATUS: —	16. OSG: —	17. BEN: K78	18. BRANCH/CORPS: —	19. UIC/ZIP: —		20. TYPE CASE: WIA	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: DIRECT FROM ER				22. HOURS OF ADMISSION: 0045	23. CLINIC SERVICE: AAAA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: —				25. TYPE DISPOSITION: D/C TO EPW CAMP	26. DATE OF DISPOSITION: 28 JUN 03		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): —				27b. TELEPHONE NO.: —	28. DATE OF THIS ADMISSION: 27 JUN 03		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted]					30. DATE OF INITIAL ADMISSION		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. [redacted]

b(2)-2

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

Pt. Shot by — US SOLDIERS.

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW (R) THIGH

E910.0
E991.2

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	1	1

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER: [redacted]

DR [redacted]

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

DA FORM [redacted]

USAPPC V1.10

All b(6)-2 (except last)

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
27 JUN 0100	Patient received from EMT. Patient moved from stretcher to bed unassisted. LR@75cc/h via 18g (L) AC. N Patient A&O×3 Follows commands, speaks English. PERRLA. R Lungs clear c̄ bilat equal rise & fall of chest. RA c̄ SaO_2 97%. Ø secretions. CV SR, S1/S2. Ø edema noted. Pulses +2 x 4. Cap Refill < 3sec x4. GI Patient states Ø pain c̄ voiding. GU Abd flat, soft and nontender c̄ BS(+) x 4 quad. Skin Color normal for race. GSW to (R) thigh c̄ drsg CDI. Line 18g (L) AC, Ø s/s of infection noted, drsg CDI. VSS. Will monitor vital q4h. Patient states he is not currently in pain. Patient positions self for comfort. [redacted] T/AN
27JUN 0500	Patient slept throughout night s̄ incidence. VSS@0500. Report given to dayshift; briefed on orders. [redacted] T/
27JUNE 0531	Recieved report from Lt. [redacted] Pt. resting in bed c̄ eyes closed Ø distress Noted. IV site intact s̄ reddness/swelling noted to site (LtAC) Bandage intact to (RtA) leg. Will ~~be~~ continue to monitor for s/s of distress. — Sgt. [redacted]
0600	Drsg Δ done this AM. Ø edema noted to GSW site. Ø c/o pain voiced @ present time, Will continue to monitor. — Sg [redacted]

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

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

EPW [redacted] b(6)-4

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

A11 b(6)-2

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
0832	Resting in bed c̄ eyes opened. Denies Any pain. Ø distress Noted. Will continue to monitor. — Sgt [redacted]
1011	Resting in bed s̄ distress. Ø complaints, Will cont. to monitor. — Sgt [redacted]
1209	Resting in bed, Ø distress noted. Will continue to monitor. — Sgt [redacted]
1356	Resting c̄ eyes closed. Ø distress noted. Will continue to monitor. — Sgt [redacted]
1534	Sitting-up in bed s̄ distress. Ø complaints voiced at this time. Will continue to monitor. — Sgt [redacted]
1800	Pt awake, given self bed bath, changed clothes. No complaints of pain @ this time. Dinner served. Interactive c̄ staff, speak and understand English. VSS [redacted]
28JUN03 0500	Received report from night shift. Pt resting in bed quietly c̄ eyes closed. Ø % of pain @ this time. Gave keflex per D/C order. 2 point restraints in place (R) wrist, (L) ankle. Will ✓ pulses Q1°. Ø needs expressed @ this time. SL (L) HC. Will continue [redacted]
0700	Pt resting quietly c̄ eyes closed. Ø % of pain. Will continue care. — [redacted]
late entry 0600	Gave pt keflex 1 tablet 250mg OP med. [redacted]
1200	Gave pt keflex 250mg 1 tab per Outpatient med written. — [redacted]
1240	Prepare pt for transfer to ICW2 via stretcher. Gave report to 1Lt [redacted] — [redacted]
1245	Received pt. from ICU3. VSS. —

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-600/50618

All b(6)-2 (except last)

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

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28 JUN 03 1530	Pt ~~admitted~~ transferred to ICW#2 ~~via stretcher~~ ambulatory [redacted] s/p GSW @ thigh. VSS. A+O x3. Dsg applied to wound. Ø s/sx of infection, 4x4 & Kerlex wrap applied CDI. ⊕ sensation, palpable pulse, cap refill <3 sec. Amb. w/ assistance. D/C meds @ bedside. Patient demonstrates knowledge of prescribed orders. Guard escort to EPW camp. Will monitor — [redacted]
2217	Pt care assumed @ 2100. VSS, alert and awake Ø% pain. Lung sounds CTA, pulses palpable x4, BS⊕ x4 quads. Abrasions c̄ Kerlix dsg on RLE CDI, ⊕ sensation and ROM, Ø swelling. Pt d/c to EPW camp in AM, will continue to monitor. — [redacted] 91WM6
29 Jun 03 0830	Pt. awake & alert in bed. Wounds on (R) leg are healing c̄ scabs s̄ s/s of infection. Dressing CDI. IV in (L) AC removed per MD order. Pt. without complaints @ this time. All other assessment findings WNL. Pt. awaiting evac to EPW camp. Will continue to monitor. — [redacted] DLY/AN
29 June 03 1310	assumed pt care @ 1300. pt AAO x3. VSS. lung sounds CTA, abd soft BS⊕ x4. BLE c̄ full rom ⊕ pulses. (R) leg c̄ 2 wound sites, both sites healing s̄ s/sx of infection draing A/d ⊖ drainage noted. applied 4x4 gauze to each site secured c̄ tape. pt denies pain @ this time. pt has d/c orders. will cont to monitor — [redacted] 91WM6 SGT

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

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

EPW [redacted]

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

558-1,03 (See Instructions on Back of this Sheet. NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY [redacted] b(2)-2

LOG NUMBER

ARRIVAL DATE			TIME
DAY	MONTH	YR.	
27	JUN	03	0005

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify) AIR

CURRENT MEDS. (Tetanus immunization and other data): Ø

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code):

HOME TELE. NO. (Inc. area code):

CHIEF COMPLAINT(S) (Include symptom(s), duration): GSW — Ethyl - Tob - Ø

SEX: M AGE: 45

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 0010

VITAL SIGNS			
TIME	0005		
BP	136/95		
PULSE	105		
RESP.	15		
TEMP.	98.0		
WT. (Child)	75		

CATEGORY (See reverse)
- EMERGENT
- URGENT
- ✕ NON-URGENT

ORDERS	INITS.	TIME
CBC, Mo18, UA		
(R) Femur X-Ray	[redacted]	0000
0.5 tetnus 7m		0000
1 gm Ancef IV		0010

ASSESSMENT/DIAGNOSIS: GSW (R) thigh

DISPOSITION (Check all that apply)
- HOME ☐ FULL DUTY
- QUARTERS: ☐ 24 Hrs. ☐ 48 Hrs. ☐ 72 Hrs.
- MODIFIED DUTY UNTIL: DAY / MONTH / YEAR
- REFERRED TO (Indicate clinic)
- ☐ EMERGENCY ☐ TODAY
- ☐ 72 HOURS ☐ ROUTINE
- ADMIT. TO HOSP. UNIT/SERVICE: FCU #3

CONDITION UPON RELEASE
- ✕ IMPROVED ☐ UNCHANGED
- DETERIORATED

TIME OF RELEASE: 0035

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

(S) A 45 yo ♂ c̄ GSW to (R) thigh. Lastmal 2 hrs ago. Ethyl Ø tobacco Ø. Patient states "shot @ pistol." wound is through and through. He was medicating a Fight and shots started and he was hit with a Bullett.

(O) VSS

b(6)-2 G: WD WF, NAD, AAOX3

H: NCAT, PERRLA, EOMI, c/p, TM ⊖

N: ⊖ negativis

L: CTA (B) ⊖ r/r/rhs

B: RRR ⊖ M/r/g

Ext: NVI, FA Rom All Joints (B) Hips/knees/Ankles + Toes

Pt c̄ Bruise + Exit wound @ Post thigh

6.0 / 13.6 / 252 / 43.9

(R) Femur - ⊖ Shaft ⊖ frx

2 Jun 03 0930 Addendum: Pt

(A/P) Ambulatory / NT / TF / Dressed & cleaned will be D/C'd tomorrow c̄ Keflex / rest and Percocet.

(CONTINUE ON SF 507, IF NEEDED)

PATIENT'S IDENTIFICATION (Mechanical imprint)
FOR WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD)

[redacted] b(6)-4

14 Mar 1950

[redacted] b(6)-4

SIGNATURE OF PROVIDER AND ID STAMP: [redacted] 2265 [redacted]

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

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

EMERGENCY CARE AND TREATMENT

Copy

STANDARD FORM 558 (Rev. 6-82) Prescribed by GSA and ICMR FIRMR (41 CFR) 201-45.505

MEDCOM - 12119

:DICAL RECORD

AUTHORIZED FOR LOCAL RE

PROGRESS NOTES

DATE	NOTES
27 June 0800	Discharge Summary 45 yo male c̄ GSW to (R) thigh otherwise no other issues. Given 1 dose of Ancef, afebile, wound dressing changed @ 0600, VSS. Pt being ~~the~~ discha c̄ percocet, motrin & Keflex and crutches to EPW comp, VSS throughout hospital stay. Pt N/V intact throughout course. Tol pos well. ~~this~~ flu c̄ comp medics. [redacted] b(6)-2

:NSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID N: (SSN or Other)
	LAST	FIRST	MI	

/SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

EPW #[redacted] b(6)-4

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (F

27JUN PTS NAME

	0100	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	
	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP	130/80	16			108/87	104/80			107/69		111/65			104/68						106/79				
TEMP	98				98	96.8			97.9		98.5			97.1						98				
HR	87	71			71	70			90		85			85						84				
RR	18				18	20			18		20			20						20				
SA02	97	98			98	97			97		97			98						98				
O2 Source	RA				RA	RA			RA		RA			RA						RA				
INPUT																								
PO																								
IV	75	75	75	75	75	75																		
NGT																								
IVPB						50																		
TOTAL	75	75	75	75	75	125																		
	75	150	225	300	375	500																		
OUTPUT																								
URINE										500						525						425		
NGT																								
STOOL																								
TOTAL																								
BALANCE																								

EPW [redacted] b(6)-4

MEDCOM - 12121

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY	1	2
POST- DAY		
MONTH-YEAR / DAY	June 2003 / 28th	29
HOUR	2	8

PULSE (0) — TEMP. F (°) — TEMP. C

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

(Centigrade Equivalents, for Reference only)

PULSE (0): 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40

RESPIRATION RECORD: R 4b 24

BLOOD PRESSURE: 118/68 110/92 118/72

HEIGHT: WEIGHT → 90 98% 98% 99%

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**

EPW [redacted] b(6)-4

Ward/Section: EM-1

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

LA[illegible]ATORY RESULT FORM
(Subject to the Privacy Act [illegible])

LAST, FIR[redacted] b(6)-4

DATE 27 JUN 03 | TIME 0057 | SSN [redacted] b(6)-4

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

TEST	RESULT	REF. RANGE
Color	yellow	N/A
App	clr	N/A
Glu	n	Negative
Bili	n	Negative
Ket	n	Negative
SG	1.030	N/A
Bld	lrg	Negative
pH	6.0	N/A
Prot	n	Negative
Urob	n	0.2-1.0
Nit	n	Negative
Leuk	n	Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

25-50 RBC mucous light
1-5 WBC light bacteria
~~amorphus sed~~

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: [redacted] b(6)-2

REPORTED BY: [redacted] **DATE:** **LAB ID NO.:**

b(6)-2

Ward/Section: EMT	REQU May [redacted]	LA ATORY RESULT FORM (Subject to the Privacy Act of ...)
LAST, FIRST, MI.	DATE 27JUN	TIME 0015	SSN/PSEUDO SSN [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	6.0	4.8-10.8 x 10^3
RBC	5.05	4.7-6.1 x 10^9
Hgb	13.6	14-18 g/dl (M) 12-16 g/dl (F)
Hct	43.9	42-52% (M) 37-47% (F)
MCV	86.9	80-94 fl (M) 81-99 fl (F)
Plt	252	130-500 x 10^3 verified
Lymph %	32.3	20.5-51.1%

(Hematology) Manual Differential

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS: b(6)-2

REPORTED BY: [redacted] **DATE:** 6/26 **LAB ID NO.:**

[redacted]

b(6)-4

b(6)-2

Ward/Section: CMT

LAST, FIRST, MI: MAJ [redacted]

CHEMISTRY RESULT FORM

(Subject to the Privacy Act of 1974)

DATE: 27JUN

TIME: 0005

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

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	95	73-118 mg/dl
BUN	9	7-22 mg/dl
CRE	1.1	0.6-1.2 mg/dl
CK	109	39-380 u/l (M) 30-190 u/l (F)
NA^+	139	128-145 mmol/l
K^+	4.6	3.3-4.7 mmol/l
CL^-	106	98-108 mmol/l
tCO_2	25	18-33 mmol/l

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:

DATE:

LAB ID NO.:

[redacted] b(6)-4

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.
ICU3		9

DATE OF ORDER: 27 June 03 — TIME OF ORDER: 0050 HOURS — LIST TIME ORDER NOTED AND SIGN

- Admit to ICU #3
- Dx: GSW (R) thigh
- Condition: stable
- Vitals: per Routine
- AU: NaDA — IVF: 75 cc/hr NS
- meds: Ign Ancef IV @ 0600 27 Jun 03; 5 mg MSO4 IV Q 4° PRN PAIN

PATIENT IDENTIFICATION

Noted 28 Jun 03 2200 [illegible]

[redacted] b(6)-2

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER — TIME OF ORDER — HOURS

- 12.5 mg phenergan IV Q 4° with MSO4
- Diet: Regular
- Acting on tentol
- Nurse, change Percocet in A.M.
- (2) Fill prescription for Keflex / Percocet / motrin
- (3) D/C IV @ 0630
- (4) Return to EPW camp. — Discharge @0800
- (5) crutches to go with patient

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER — TIME OF ORDER — HOURS

IVF

[redacted] 2200

b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.
	24°/s	2200

DATE OF ORDER: 28 Jun — TIME OF ORDER: 1900 HOURS

D/C to EPW Campus
Have been Ambulating
Mode

b(6)-2

28 Jun 03 [redacted] [redacted] b(6)-2

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

All b(6)-2 (except last)

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. JUN Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED				
				~~26~~	~~26~~	~~27~~	28	29
27 JUN	[redacted]	Condition Stable	05	/	[redacted]			
			17	[redacted]				
27 JUN	[redacted]	Vitals per Routine	05	/	[redacted]			
			17	[redacted]				
27 JUN	[redacted]	Diet Regular	05	/	[redacted]			
			17	[redacted]				
27 JUN		Activity as tolerated	05	/	[redacted]			
			17	[redacted]				

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
GSW (R) Thigh

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

All b(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo JUN Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
27JUN	[redacted]	Admit to ICU3	27JUN	0100	0100	[redacted]
27JUN	[redacted]	Nursing to change dressing in AM	27JUN	0600	0600	[redacted]
27JUN	[redacted]	Fill prescriptions for Keflex, Percocet, Motrin	27JUN	0600	0600	[redacted]
27JUN	[redacted]	Return to EPW camp D/C @ 0800	27JUN	0800		
27JUN	[redacted]	Crutches to go w patient	27JUN	0800		
28	[redacted]	Transfer ICW #2	28		1300	[redacted]
28	[redacted]	D/C to EPW camp when arrangements made				

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

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 26 27 28
27JUN	[redacted]	IVF 75cc/h NS	05	[redacted] D/C @ 0630 27 JUN
		D/C IV @ 0630 27JUN	17	[redacted]
b(6)-2				
27JUN	[redacted]	b(6)-2		

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: GSW (R) Thigh

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

EPW [redacted] b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

All b(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				Mo. JUN Yr. 03
Order Date	**Clerk/ Nurse**	**SINGLE ORDER, PRE-OPERATIVES**	**Date to be Given**	**Time to be Given**	**Time Given**	**Initials**
27JUN-	[redacted]	Ancef 1gm IV	0600	27JUN	27JUNE 0600	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED													
27MAY-	[redacted]	MSO4 5mg IV Q4°														
-----	-----	PRN PAIN give c phenergan														
27MAY-	[redacted]	Phenergan 12.5mg														
-----	-----	IV Q4° c MSO4														
-----	-----															
-----	-----															
-----	-----															
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USAPA V1.00

PAGE

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0515	INITIALS [redacted]	b(6)-2	INITIALS		INITIALS
NEURO	PUPILS	PERRLA					
	SENSORIUM	Alert, able to follow commands					
RESPIRATORY	RESPIRATORY PATTERN	RRR					
	BREATH SOUNDS	Clear throughout					
	SECRETIONS	Ø secretions @ this time					
SKIN	COLOR	WNL in face					
	INTEGRITY	GSW (R) thigh, ~~dress to head Dt [redacted] dsg Dt~~		b(4)-2			
IV SITE	LOCATION	(L) AC Ø S/S of infection					
	CONDITION	S.L.					
GASTRO	ABDOMEN	soft, nondistended					
	BOWEL SOUNDS	(+) throughout					
URINE	URINE:	uses urinal					
	COLOR/CLARITY						
CARDIAC RHYTHM	CARDIAC RHYTHM	SR ~ Ø S/S ectopy					
		pulse palpable +2 in all ext.					

LEGEND

Cr - Creatinine
F_IO_2 - Fraction of inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SA$\bar{1}$ - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU 2 unit

DATE: 28JUN83

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

EPW [redacted] b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

	DX													HOSPITAL DAY			
TIME	Ø5	Ø6	Ø7	Ø8	Ø9	1Ø	11	12		13	14	15	16	17	18	19	2Ø
Arterial Line																	
Cuff	1	104/69				105/68		98/73									
mperature		98⁶				96⁷		96⁴									
lse		83				81		83									
spiratory Rate		2Ø				18		18									
[illegible]																	
[illegible]																	
TIME									8° T								
TALS																	
RINE HOUR / TOTAL	[illegible]		375 / 375														
RINE sp gr																	
RINE S/A																	
IG OUTPUT																	
IG pH																	
IG GUIAC																	
ESIS																	
OL																	

ACUITY LEVEL CLASSIFICATION

8° T

RESPIRATORY DATA	TIME								
	MODE								
	F_IO_2								
	TV								
	RATE								
	PEEP								
	A	pH							
		PCO_2							
		pO_2							
	B	HCO_3							
		SAT							
	G	BASE							

LABORATORY DATA	TIME								
	GLUCOSE								
	Na/K								
	Cl/CO_2								
	BUN/Cr								
	WBC/PLATELET								
	Hct/Hgb								

ACTIVITIES OF DAILY LIVING	TIME				TURN	TIME			
	MOUTH CARE								
	BATH								
	SKIN CARE								
	FOLEY CARE				SUCTION				
	TRACH CARE								
	ROM EXERCISES								

24° I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE

IV _____

PO

OUTPUT

Urine: _____

NURSE'S SIGNATURE

[redacted]

b(6)-2

ADMISSION AND CODING INFORMATION

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

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

b(6)-4

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
—	45Y	X	9	MUSLIM

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—	U	0045	— b(6)-4

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0 b(2)-2	ICU3	—

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
[redacted] b2-2	—

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
—

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
05		030628

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
AAAA		030627

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

FOR LOCAL USE

DX: GSW (R) thigh

DX - 8900
E9912
T-1
I-450

ADMITTING OFFICER (Signature, as required) b(6)-2 [redacted] MD

DR [redacted] b(6)-2

SIGNATURE [redacted] b(6)-2

b(6)-4

INPATIENT TREATMENT RECORD COVER SHE

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

1. REGISTER NUMBER [redacted]	2. NAME (Last, First, MI [redacted] EPW b(6)-4			3. GRADE N/A	ADMISSION REMARKS
M / 30y / Z	7. RELIGION unk	SVC N/A	9. ETS N/A	10. PREVIOUS ADMISSION No	
11. FMP 99	12. SSN [redacted]	13. ORGANIZATION N/A		14. WARD ICU1	
15. FLYING STATUS N/A	16. OSG b(6)-4	BEN K79	18. BRANCH/CORPS N/A	19. UIC/ZIP	20. TYPE CASE N/A
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from ER			22. HOURS OF ADMISSION 1371	23. CLINIC SERVICE AEAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION 50	26. DATE OF DISPOSITION 15 July 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)			27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION 27 Jun 03	ADMITTING OFFICER b(6)-2 Dr [redacted]
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted]				30. DATE OF INTIAL ADMISSION	32. UNIT COMPONENT TRANSFUSED

31. [redacted]

b(2)-2

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

S/p (D) leg fasciotomy

823.20
958.8
910.0
911.0
E819.7

79.66
86.59
93.54
93.59

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	19	19

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
Ø	Ø	Ø	Ø	19	19

SIGNATURE OF ATTENDING M [redacted] Dr [redacted] SIGNATURE OF PAD OR MEDICAL RECORDS [redacted] For [redacted]

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

DA FORM 2 EDITION OF 1 AUG 78 IS OBSOL USAPPC V1.10

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

30 [illegible] EPW
Car Bomb Ped Ast
[illegible] Foot wb tone Bp
sent for Resch
No Dyspnea

PHYSICAL EXAMINATION

[illegible]
[illegible]
[illegible]
[illegible]
[illegible]

(D) LE 2+ pitting edema
Mult (T)
(T) [illegible]
T-Case Compression
(D) Midpht Tender

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

Dx (P) LE Comp Sm dm c tibia R
Dx Fractures / Spine plus Plate tibia

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

PATIENT'S IDENT[redacted] *typed or written entries give Name last, first, [redacted]dle; grade; date; hospital or medical facility)*

REGISTER NO.	WARD NO.

b(6)-2

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
	95% RA
	31 male - hit by car:
1300/64	fusi / Ext Fx
94	- 100 mg Fentanyl
fluids:	1L LR
CBL:	mma
UO:	550

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

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE

NOTES

Ortho op Note

prep Dos Clean Throughout Medial thigh for
Fe (D) & Comp Synthes

procedure Fasciotomy

Surgeon: [redacted] b(6)-2
EBL: min
TT: 0
Fxn: Comp Synthes
unstable to
medial Fascia
AO Splint
Muscle Approximable

plan Plate this was not
done

[redacted] b(6)-2

b(6)-4

[redacted] b(6)-4

b(6)-4 [redacted]

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD

PROGRESS NOTES

DATE	NOTES
27 JUN03	30 y/o m c/o pain & tenderness @ (L) leg. Crepitous noted
1105	@ tib/fib. Pt also c/o pain/tenderness @ (R) shoulder.
BP: 138/92	Pedal pulse present both legs.
P: 116	— Pt also c/o pain tenderness @ back. No stepoff
R:	found. Pt says he was in a car
T: 98.8	accident 26 JUN 2100.
Ox-t: 96%	PA Note
	Pt s/p MVA last night MOI - struck by auto
	c/o immediate inability to bear wt, pain + swelling.
	Exam Pt carried in by MPs
	(L) LE ecchymotic, swollen and extremely TTP
	(+) crepitus
	A/P (1) S/P MVA
	(1) MAY Tib/Fib
	(2) Ortho consult A/ FX
	(3) Pain control MSO4, Motrin
	(4) IVF
	[redacted] CPT, SP b(6)-2

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

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

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1)
USAPA V1.0

[redacted] b(6)-4

All b(6)-2

PROGRESS NOTES

DATE	
28 June 03	0845 (cont) Dry & intact, drainage marked; date and time. ⊕ sensation @ movement to toes. pt tolerated reg diet well, IV deplocked. to (L) FA. No meds given for pain @ this time. Will continue to monitor. [redacted] SWMC
28 June 03	1215 ½ percocet adm for pain in RLE and LLE. Will continue to monitor [redacted]
28 June 03 1500	assumed pt care @ 1300. VSS. abrasions [redacted] forehead & back area. lung sounds CTA, abd soft nontender BS⊕x4 quads. foley cath to gravity intact. RLE full rom ⊕ pulse. LLE c̄ splint & ace wrap, old drainage noted, ⊖ new drainage noted to dressing. <3 secs cap refill. ↑ ext c̄ full rom ⊕ pulses, IV site (L) FA HL'd ⊖ redness or edema noted. ⊖ c/o pain voiced @ this time. Will cont to monitor [redacted] 91WMC SGT
2330	Pt care assumed @ 2100 VSS. IV flushed ∑ difficulty. Dsg to (L) LE c̄ old marked damage. ⊕ sensation, ⊕ rom, brisk cap refill (L) LE. Foley to gravity draining clear yellow urine, HR reg, lungs CTA. Will cont to monitor. [redacted]
29 Jun 03	0640 - Pt alert sitting in bed c̄ (L) leg elevated. VSS. lungs CTA, HR reg, BS⊕. Dsg to (L) leg c̄ old drainage marked. No new drainage noted. Able to wiggle toes, ⊕ sensation, cap refill <3 sec. Voiding ⊖ complaints. O/C to BR [redacted]

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

All b(6)-2 (except last)

MEDICAL RECORD	PROGRESS NOTES
DATE	
27 June 03 1745	Rec'd pt from ICU 2 via litter, VS BP 142/84, P 78 temp 98.9, O2 sats RA 98%, R 16. airway patent, lung sounds CTA, abd soft nontender nondistended BS⊖ Foley cath to gravity intact, draining cl yellow urine ∑ diff. RLE c̄ full rom ⊕ pulse. LLE c̄ splint et ace wrap from knee to toes, unable to palpate pulse <3 secs cap refill. BUE ext c̄ full ROM ⊕ pulses. LOV ⊕ FA c̄ LR @ 100cc/hr infusing ∑ diff. LLE elevated on blanket c̄ bag of ice applied. pt resting quietly @ this time. Will cont to monitor — [redacted] 91WMC
	abrasions noted to forehead — [redacted] 91WMC
2026	bloody drainage noted to drain area sm amount. site marked et timed. — [redacted] 91WMC SGT —
0030	Pt care assumed @2100. VSS, pt resting awake to verbal
28 Jun 03	stimuli, c/o slight pain in LLE. Lungs CTA, pulses palpable in UE and RLE, bs⊖x4 quads. Dsg on LLE c̄ small amount of drainage on anterior. Pt has ⊕ sensation and cap refill in LLE. IV @ LFA @ 100cc/hr, pt on IVABX. Will continue to monitor. [redacted] 91WMC
28 Jun 03	Pt c/o pain, ∞ Percocet given PO. [redacted] 91WMC
28 June 03	0840 Assume pt care @ 0500. pt asleep, easy to awake. VSS. HR reg. Lungs CTA, Abd soft BS x 4 active. c/o pain to RUE @ shoulder. Abrasions located c̄ bruising on back, also to forehead. Dsg to LLE — (cont) [redacted]

(Continue on reverse side)

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

REGISTER NO.

WARD NO. ICW2

PROGRESS NOTES
Medical Record

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

EPW #[redacted] b(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

25 Nov 03
1000

Author Op Note:

Pre-Op Dx: Fracture (L) leg
(L) closed (L) tibia fracture

Post Op Dx: Same

Procedure: I+D (L) leg with IMN of medial fracture

Surgeon: [redacted] b(6)-2

ASA: IV

Findings: Wounds clean, able to close medial wound. Did 80% closure of lateral wound with vessel loops. Sterile bag splint applied

Plan: Repeat I+D 1 Dec 03

[redacted] b(6)-7

SURGN

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)

SSN [redacted] b(6)-4

REGISTER NO.

WARD NO. ICW 2

PROGRESS NOTES
Medical Record

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

All b(6)-2 (except first)

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

DATE	NOTES
29 Jun 03 1100	Pt received from ICU II via litter. VSS, lungs CTA. Soft cast to (L) entire leg. Able to wiggle toes, (+) sensation. LR @ 100%. Foley patent → will be removed. Voiding ∅ complaints. Will cont. to monitor- [redacted]
29 Jun 03 1430	assumed care @ 1300 - VSS - IV patent, 20g HL in (D) FA - abx continue as scheduled - Splint cast CDI on (L) LE, pt. can wiggle toes, [redacted] <3 sec cap refill in (L) toes, no c/o pain @ this time - pt. voided 250 cc spontaneously - (+) BS - [redacted] A ✓
29 Jun 03 2000	Rec'd Pt @ 21:00. Awake and Alert. VS WNL according to flow sheet. Skin WID. PERRLA (+). LS exp. wheeze in mid lobes to (R) and (L) lungs. BS (+) x4. (+) PPP (B). PIV to (L) FA patent (+) PPP (B) ACE wrap + cast to (L) ↓ ext. intact. Pt able to move and feel toes. will cont. to mon [redacted] 4/AD
Addendum	c/o pain @ 4 hrs time [redacted] 4/AD
30 June 03	0745 Assume pt care @ 0500. Pt awake and alert. Abrasions to forehead and back. Sm amt of pain to (R) shoulder. HR reg - Lungs CTA. Abd soft
0635 T 97.0	BS x4 active. LLE Splint and ace wrap. (+) movement
P 68	(+) sensation to toes. HL IV to (D) FA no s/s redness/infiltration
R 16	a flush. plan to go to OR 1 July for I+D. Will
BP 124/76	Continue to monitor. [redacted]
99%	0755 ii percocet for pain and discomfort - [redacted]

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

All b(6)-2 (except last)

AUTHORIZED FOR LOCAL R

EDICAL RECORD	PROGRESS NOTES
DATE	NOTES

30Jun03 1450 assumed care @ 1300 - VSS - 20% pain @ this time - pt. can wiggle (D) toes, CZ sec cap. refill in same toes - (D) FA IV site leaking and painful, 18g SL started in (D) FA, flushes well - splint cast on (D) leg CDT & elevated [redacted] AN

0045 31 July03 Pt care assumed @ 2100. VSS, alert and awake, 2/11 percocet given for pain. Lung sounds CTA, ~~pulses palp~~ bs(+) x4. IV @ RFA infiltrated, restarted. DSG on LLE CDI, pt able to wiggle toes. No complaints at this time, will continue to monitor. [redacted] 4

1 JUL 03 (0030) Pt resting quietly @ present. VSS. x4 ↑. Lungs CTA a = bilat. Pulse strong =. DSG D & I. S.L. intact & flushes easily, site ∃ redness or edema. BS(+) x4. [redacted] HOS/RN

00 98.1
13
20
128/72
99%

NSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID N (SSN or Other)
	LAST	FIRST	MI	
SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

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

PROGRESS NOTES
Medical Record
STANDARD FORM 509

[redacted] b(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

[redacted] b(6)-2

Ortho Op Note ~~and Transfer Note~~

Pre-Op Dx - (1) Closed (L) tibia fracture
(2) Compartment Syndrome (L) leg
Post-Op Dx - same
Procedure - DPC of fasciotomy incision.
Surgeon [redacted] b(6)-2
Findings - Able to close lateral wound with 0 prolene and 3-0 nylon. Both fasciotomies now closed.

Plan: ~~Evac to civilian hospital~~, splint long leg splint. Recommend dressing change in 48-72 hours. Treatment options for tibia fracture include casting, or plating after wounds have healed. This fracture is minimally displaced and would be ideal for a tibial nail.

[redacted] b(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER
	LAST	FIRST	MI	(SSN or Other)
		[redacted]		EDL na

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] b(6)-4

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

All b(6)-2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
1 JUL 03 1230	Received from ICU via litter. VSS. Pt awake &
104/70	alert. BBS CTA & C. BS (+) 4. Pulses strong & C. DSG
T	D+I. IVF as ordered, site ō redness or edema.
HR 100	Resting quietly @ present ō distress. Tolerated reg.
RR 16	diet well. [redacted]
O2 sat 98%	
1 Jul 03	assumed care @ 1300 - VSS - splint cast
1910	intact on (L) LE, <2 sec cap. refill in (L) toes,
	pt. can wiggle toes - no c/o pain @ this
	time - IV patent - scabs on fore head and
	back appear to be healing slowly - [redacted]
9 JUL 03	Rec'd pt @ 21:00 sleeping in bed easily awakened. Skin
2200	w/p. PERRLA (+) WNL. LCTA (B) (+) BS x 4. Bifurcated cast to (L) leg
	C/D/I. Able to move and feel toes. New PIV initiated
	(R) FA patent. Ø c/o pain @ this time will cont to mon [redacted]
2 July 03	0620 Assume pt care. Pt awake and alert. No
	c/o pain @ this time. Splint cast c̄ ace wrap
	CDI. (+) movement (+) sensation to toes cap refill <3 sec
	VSS. HR reg Lungs CTA Abd soft BS x 4 active.
	HL to (R) FA no s/s redness/infiltration c̄ flush.
	Will continue to monitor [redacted]
	1200 pt denies pain but moves c̄ discomfort
	and grimacing. ½ percocet given PO [redacted]
2 July 03	assumed pt care @ 1300. VSS. pt awake & alert.
1330	assessment findings WNL, (L) leg c̄ Splint cast c̄ ace
	wrap, drising CDI, pt able to move toes. (+) sensation
	→ cont'd

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

All b(6)-2 (except last)

AUTHORIZED FOR LOCA

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
cont'd 2 July 1330	(R) Lext c̄ full ROM (+) pulse. BUE c̄ full ROM (+) pulse HL (R) IV flushes s̄ diff ∅ S/Sx of infection. ∅ c/o pain voiced @ this time. Will cont to monitor — [redacted] 91WM6
03 July 03	Assumed pt nursing care bed. Alert. LSC [redacted], HAR IV patent + intact, flushes easily. Dry c/d/i Amb w/ crutches x1. Will cont to monitor.
	[redacted]
3 July 03	(0530) Pt awake + alert. VSS. NAD. cast D+I to affected extremity. Lungs CTA + = bilat, Pulses strong + =. BS (+) x4. SL intact, flushes easily,
0500 98.6	site s̄ redness or edema. Resting @ present c̄
72	affected leg ↑. — [redacted]
16	(0800) Saline Lock difficult to flush, s̄ cid c̄ cath.
120/66	intact. Saline lock started in (L) hand c̄ 18G+.
98%	cath., flushes easily, site s̄ redness or edema.
	[redacted]
3 July 03 1415	assumed pt care @ 1300. pt awake & alert, VSS. lungs CTA, abd soft BS(+)x4 quads (L) leg c̄ splint wrapped c̄ ACE wrap, drains CDI. (R) leg c̄ full ROM (+) pulse. BUE c̄ full ROM (+) pulses. HL (L) hand flushes s̄ diff, ∅ redness/swelling. ∅ c/o pain voiced. Will cont to monitor — [redacted] 91WM6 SG

SPONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S (SSN or Other
	LAST	FIRST	MI	
/SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

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. LCWR

EPW

#[redacted] b(6)-4

PROGRESS NOTES
Medical Record
STANDARD FORM 50

AUTHORIZED FOR LOCA

:DICAL RECORD

PROGRESS NOTES

DATE	NOTES
3JUL03 20:19	Rec'd pt @ 21:00. VS WNL per flowsheet. Restraints x1 to (D) wrist. C/o pain, H/A x1. 2 Tylenol given. Skin W/D. PERRLA (+). LCA WNL (B). BS (+) x4. (+) PPP (B). (D) ↓ ext cast in place. Able to move and feel toes. (+) <3 sec cap refill. toes warm to touch & edema. Will cont. to mon. [redacted] PT (AN) b(6)-2
4 July 03 0500 97.9 67 24 124/72 98%	(0600) VSS. 0 c/o. A&D. Lungs CTA q=. Pulses strong q=. BS (+) x4. SL intact, site ↓ redness or edema, flushes easily. Cast to leg D & I. Resting quietly c present & c/o. [redacted] b(6)-2
4JUL03 1440	assumed care @ 1300 - VSS - no c/o pain @ this time - pt. ambulated to BRC crutches and had a BM - SL patent - (D) leg split cast and ace wraps CDI, (D) toes <2 sec cap. refill, pt. can wiggle (D) toes - scabs on forehead continue to heal [redacted] AT b(6)-2

NSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S (SSN or Other)
	LAST	FIRST	MI	
SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

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

REGISTER NO

WARD NO ICW2

EPW # [redacted] b(6)-4

PROGRESS NOTES
Medical Record
STANDARD FORM 50

All b(6)-2 except last

EDICAL RECORD | PROGRESS NOTES | AUTHORIZED FOR LOCAL RE

DATE | NOTES

4 July @ 2200 Pt A/O X3, VSS, PERRLA, LCTA (B), (+) BS x4 qds abd: soft, ND, (-) TTP. can wiggle & feel toes. (-) edema noted. good cap refill. HL to (L) hand flushing easily s/s of infection/infiltration. Split cast & ace wrap to (L) leg CDI. (-) c/o pain @ this time. Will cont to monitor — [redacted] IWMC SPC —

5 July 03 @ 0230 Pt sleeping with (-) distress noted [redacted] IWMC S

5 JUL 03 0500 VSS. A&D. Pt awake and alert. Cast to (L) leg D&I. Lungs CTA+=. Pulses strong +=. BS (+) x4. — S.L. intact, flushes easily. Resting quietly & present [redacted] IWMC

5 July 03 1300 Assumed pt care @ 1300. pt resting quietly. VSS lungs CTA, abd soft nontender BS (+) x4 quads. (R) ↓ Ext c̄ splint & ace wrap, drsing CDI, (+) movement of toes good cap refill. (R) leg c̄ full ROM (+) pulse. HL (R) hand flushes s̄ diff, (-) redness/swelling noted. (-) complaints voiced @ this time. Will cont to monitor [redacted] IWMC

5 July @ 2344 Received pt resting in bed. VSS, Alert. LSCTAB, HRR, BS (+) x4, Abd SNT. IV (L) fa patent & intact. Toes on (R) LE warm, cap refill brisk. Amb to commode w/ assistance, dsg c/d/i [redacted]

NSHIP TO SPONSOR | SPONSOR'S NAME | LAST | FIRST | [redacted] | MI | SSN or Other

SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

EPW [redacted] b(6)-4

PROGRESS NOTES
Medical Record
STANDARD FORM 509

All b(6)-2

FIRST NAME	MIDDLE INITIAL	ID NUMBER

NOTES

5 July 03 0711 - Pt alert lying in bed c HOB elevated. Voicing no complaints. VSS, lungs CTA, HR reg, BS ⊕. Split cast to ⊖ leg. Able to wiggle toes, ⊕ sensation, warm to touch. HL to ⊖ hand infusing antibiotics. Will cont to monitor - [redacted]
0739 - New HL placed in ⊕ forearm - [redacted] 20 cm

July 03 1330 Assumed pt care @ 1300. pt sleeping arouses to painful stimuli. VSS. lungs CTA, abd soft BS⊕x4. ⊖LE c̄ splint et ace wrap, drsing CDI. ⊕ movement good cap refill. ⊕ leg c̄ full ROM ⊕ pulse. BLE c̄ full ROM ⊕ pulses HL to ⊕ FA ⊖ redness / swelling noted. ⊖ c/o pain voiced. Will cont to monitor - [redacted] 91WM6 SGT -

7 July 03 0324 Received pt resting in bed. Alert, VSS, LS CTABS, HRR, BS⊕x4, SNTABD, IV patent ⊕ fa. Amb to commode w/ crutches. SVQS. Medicated x1 for pain. Pt c/o to use for a cigarette. Sleeping intermittently. ~~Rt~~ no BLE dsg c/d/i. toes warm to touch, cap refill good [redacted]

7 July 03 0800 - [redacted] alert. VSS. NAD. S.L. intact, flushes easily, sites c̄ redness or edema. Cast to ⊖ leg D&I. BBSCTA=. Pulses strong=, strong [redacted] BS⊕x4.
0500 97.2 69 18 Ambulation c/T BR. Resting quietly c̄ present.
108/64 98%
[redacted]

1500 Assumed care of Pt @ 1300. VSS. A+Ox3. ⊕ unst PIV. HL ✗ IVABV patent. ⊕ LE cast/ace wrap CDI. ⊕ sensation, mvt toes, cap refill <3sec ⊖ foot. ⊖ c/o pain. O/W assessment unc. Will monitor [redacted]

AUTHORIZED FOR LOCAL REPRO

DICAL RECORD | PROGRESS NOTES

DATE	NOTES
7 July 2003	Received pt resting in bed. Alert, VSS see SF511 for details. LSCTAB, HRR, BS+X4, ABD SNT, SWG. IV in ⓡ fa patent & intact, flushes easily. LE dsg c/d/i, amb w/ no wt bearing on crutches b commode. Toes warm, cap refill good, able to wiggle toes. [redacted] b(6)-2
8 July 03	Assumed care of pt @ 0500. Pt is awake. VSS. Lungs CTA. Bowel sounds x4 quads. Abd. soft. HL in ⓡ arm - patent. Cast c̄ bandage to ⓡ LE.
0530 97.5 68 30 19/62 98%	Cap refill less than 3 sec. Pt can wiggle toes. Pt ambulates to BR c̄ crutches. ∅ c/o pain/ discomfort @ this time. b(6)-2 [redacted] LPN, SGT
8 July 03 1300	Assumed pt care @ 1300. pt resting quietly, easily aroused to verbal stimuli. Lung sounds CTA, abd soft nontender BS(+). HL to RFA flushes well. ⓘ S/S of infection. LE c̄ splint cast wrapped c̄ ace wrap. Pt able to wiggle toes. <3 sec cap refill. RLE c̄ full ROM ⓟ pulse. ⓘ complaints voiced @ this time. Will cont to monitor b(6)-2 [redacted] Allwine SGT
8 July 03 2300	Rec'd c/o pt. @ 21:00. Pt amb to BR c̄ crutches s̄ difficulty. Awake and alert. VS WNL. Per flow

IONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID N (SSN or Other)
	LAST	FIRST	MI	

T./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

T'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.

EPW [redacted] b(6)-4

PROGRESS NOTES
Medical Record
STANDARD FORM 509
Prescribed by GSA/ICMR FPMR (41CFR) 101-

All b(6)-2

.TE	NOTES
	sheet. Skin WD. PERRLA (+). LCA (B). BS (+) x4. (+) PPP (B). HL to (R) FA patent. (L) footcast CDI. Pt toes warm <3sec cap refill. Able to move + feel toes. Ø c/o pain @ this time. Will cont. to mon [redacted] RT/AW
9 July 03	Pt alert OOB bed X1 this AM. VSS, lungs CTA, HR reg, BS (+). Pulses (+). HL to (R) hand, patent. Cast to (L) ↓ extremity, intact. Able to wiggle toes, (+) sensation, warm to touch. Voi[redacted] Ø complaints. Will cont to monitor — [redacted] RT/AW
0600 98.5 14 22 110/66 98%	1425 - Assumed care of Pt @ 1300. VSS A+O x3. Ø c/o pain (L) LE cast CDI. (+) mvt, sensation, cap refill <3sec (L) foot. TOL RLA DIET. Ambulate to BSC ō assistance. O/W Assessment WNL. Will mon. for — [redacted]
9 JUL 03 2300	Pt. awake and alert in bed. VS WNL per flowsheet. PERRLA (+) LCA (B). BS (+) x4. (+) PPP (B). (L) leg c splint intact. able to move and feel ~~fingers~~ toes ~~fingers~~ toes warm to touch. <3sec cap refill. Ø c/o pain @ this time will cont to mon [redacted] RT/AW
10 July 03 0600	Pt. awake & alert in bed. VSS. HL in (R) FA ō s/s of infection. Pt. (L) LE ↑ at ~~[illegible]~~ 30°. Splint applied to (L) LE, full ROM in digits, (+) sensation, cap refill < 3sec. Pt. been NPO since MN, on call to surgery
0500 98.3 81 16 122/74 98%	this am. HR Reg. Lung sounds clear bilat, bowel sounds (+) x 4 quads. Pt. with white splotches on neck region, possibly fungus. All other assessment findings WNL. Pt. ō complaints @ this time. Will continue to monitor. — [redacted] RT/AW
0830	New IV placed in (R) FA — CT

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
10 July 03	ORTHO OP LEGAC NOTE 30 yo Iraqi O → EPW 3P peel Auto Injury PreOP Dx: (D) Midshaft Tibia FX c Butterfly Fragm 3P Fasciotomy Closure Procedure: Subcutaneous Plating Tibia Surgeon: [redacted] b(6)-2 EBL: min TT: 41 m TO PACU Stable Findings: Healed fasciotomy wounds Sub Q Plate Applied Good Reduction Strike Bone Plan: SR 5 Days SLC D/C to EPW Camp [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	RECORD MAINTAINED AT		

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

REGISTER NO. | WARD NO.

EPW [redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

All b(6)-2

TE	NOTES
11 Jul 03 1330	assumed pt care @ 1300. pt resting, easily aroused to verbal stimuli. VSS. assessment findings WNL (L) leg c̄ splint et ace wrap, dressing CDI. (+) sensation (+) movement <3 sec cap refill. (-) c/o pain. Will cont to monitor [redacted] 9/WM4
11 Jul 03 20:00	Rec'd c/o pt @ 21:00. Awake and alert in bed. VS WNL per flowsheet. Restraints x 2 (L) wrist + ankle. PERRLA (+) WR ICA (B). BS (+) x4. (+) PPP (B). HL (R) FA patent. (L) leg c̄ ace wrap soft splint C/D/I. Pt able to move and feel toes toes warm to touch and <3 sec cap refill. (-) c/o pain @ this time. Will cont. to mon. [redacted] 8ZT
12 July 03	0530 Assume pt care @ 0500. pt awake, moving around. HL to (R) FA no s/s redness / infiltration c̄ flush. VSS. no c/o pain. Fungus noted to neck and back. HR reg. Lungs CTA. Abd soft non tender non distended. BS x 4. LLE splint c̄ ace wrap CD+I (+) movement (+) sensation to toes. Voiding clear yellow urine. Amb c̄ crutches. Will continue to monitor. [redacted]
12 Jul 03 1325	assumed pt care @ 1300. pt sleeping, easily aroused to verbal stimuli. VSS. lungs CTA, abd soft nontender BS (+) x 4 (L) lower ext c̄ splint et ace wrap, dressing CDI. (+) movement (+) sensation. (R) ↓ ext c̄ full ROM (+) pulse. ↑ ext c̄ full ROM (+) pulses. HL to (R) FA (-) s/sx of infection noted. (-) c/o pain voiced @ this time. Clotrimazole cream et crutches @ bs. Will cont to monitor [redacted] 9/WM6

All b(6)-2 except last

AUTHORIZED FOR LOCAL REPRO

CAL RECORD | PROGRESS NOTES

TE	NOTES
10 July 03 1330	Assumed pt care @ 1300. pt sleeping, arouses to verbal stimuli. VSS. lungs CTA, abd soft BS(+) x4 quads. (R) leg c̄ splint & ace wrap - drsng CDI. Good cap refill. (R) Left c̄ full ROM (+) pulse. BUE c̄ full ROM (+) pulses. HL to (R) FA (-) redness/swelling noted. (-) complaints voiced @ this time. Will cont to monitor — [redacted] 9 Wm
10 Jul 03 22:40	Rec'd c/o pt @ 21:00. Sleeping in bed easily awakened. Restraints x1 to (R) wrist. Skin W/D. PERRLA (+) WNL LCA (-). BS (+) x4. PIV (R) FA patent. Soft splint to (R) leg C/D/I. Able to move and feel toes. toes warm to touch c̄ <3sec cap refill. (-) c/o pain @ this time will cont. to mon [redacted] /AW
0835	c/o pain ⅡⅡ Percocet given for pain (R) leg. will mon [redacted]
0856	ⅡⅡ Percocet ineffective for pain management 5mg MSO4 given will cont. to mon [redacted] /AW
11 Jul 03 0520	Assumed pt. care @ 0500. Pt. awake, A to x3. lungs CTA. (+) pulses x4. (+) BS x4. drsng c̄ ace wrap on (R) leg CDI, (+) sensation + movement in (R) toes. HL in (R) FA. Denies any discomfort @ this time. Will continue to monitor — [redacted] 9 Wm

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

SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

EPW: [redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

All b(6)-2

AUTHORIZED FOR LOCAL REPRO

CAL RECORD | PROGRESS NOTES

DATE	NOTES
12 Jul 03 2300	Pt awake and alert in bed. Restraints x 2 (R) wrist (L) foot. New IV initiated to (L) FA. (R) PIV DC'd & patent. VS WNL per flowsheet. PERRLA (+). LCA (B). BS (+) x 4. (+) BP (B). Soft splint to (L) ext C/D/I. Able to move and feel toes (+) warm to touch (+) < 3 sec cap refill. (-) c/o pain or itching @ this time. Will cont. to mon [redacted]
13 July 03 0715	Assume pt care @ 0500. Pt awake and alert. HL to (L) wrist no s/s redness/infiltration c̄ flush. VSS, HR reg Lungs CTA Abd soft
0550 96.5 84 16 116/79 98%	BS x 4 BM this am. Amb c̄ crutches. LLE splint and ace wrap CDI (+) movement (+) sensation to toes. Will cont. to monitor — [redacted] RNMS
13 July 03 1426	Assumed pt care @ 1300. pt sleeping arouses to verbal stimuli. VSS. assessment findings WNL. LLE c̄ splint & ace wrap draining CDI. (+) movement (+) sensation. HL to (L) wrist (-) redness/swelling noted. (-) c/o pain voiced. Will cont to monitor — [redacted] RNWMC
13 July 03 1830	Orders to remove splint & cast, rec'd. sutures removed c̄ diff & steri strips applied. Awaiting ortho to cast. (-) c/o pain voiced. Will cont to monitor — [redacted] RNWMC

SHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID (SSN or Other)
	LAST	FIRST	MI	
SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

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
Prescribed by GSA/ICMR FPMR (41 CFR) 101

All b(6)-2

TE	NOTES
7-13-03 2240	Pt. care assumed @ 2100. VSS. Pt. c/o ⊖ pain @ this time. Clotrimazole applied to back and neck as per order. Pt. denies itching to skin areas. HR Reg, lungs CTA, BS ⊕ x4. Cast to (L) LE CDI c̄ ⊕ sensation, ⊕ ROM toes, brisk cap refill. HL to (L) AC intact flushes easily. Will cont. to monitor. — [redacted] RTAN
14 July 03	Assumed care of pt @ 0000. VSS. Pt asleep. Lungs CTA. Bowel sounds x4 quads. HL to (L) arm patent. Pt has cast to (L) LE c̄ ⊕ sensation. ⊖ c/o pain/discomfort. Will continue to monitor.
0540 97.5 63 20 122/74 98%	[redacted] LPN, SGT
1350	Assumed care of pt @ 1300. VSS. A&Ox3. ⊖ c/o pain. (L) LE cast CDI, ⊕ sensation, cap refill <3 sec, mvt of (L) toes. Able to amb s̄ assistance. PIV (L) FA patent c̄ IV ABX. O/W assessment WNL. Will Monitor [redacted]
14 July 03 2240	Assume pt care @ 2100. Pt awake and alert. No c/o pain. VSS. HR reg. Lungs CTA. Abd soft BS x4. HL to (L) FA no s/s redness/infiltration c̄ flush. LLE cast intact, ⊕ movement ⊕ sensation to toes. Pt has DC orders and summary needs prescription for Keflex. Amb s̄ crutches. Will continue to monitor [redacted] RN/MS
15 July	1200 - Pt alert lying in bed. VSS, lungs CTA, BS ⊕. Cast to left leg intact. Will cont to monitor [redacted] RN

AUTHORIZED FOR LOCAL REPR(

DICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
15July03 R100	Assumed pt care@1300. pt resting quietly, arouses to verbal stimuli. VSS. Assessment findings WNL X ⓓ leg ⓓ LE c̄ SLWC ⊕ sensation ⊕ movement to toes <3 sec cap refill. ⓓ complaints voiced@ this time. ⓓ IV access noted. Will cont to monitor. — b(6)-2 [redacted] 91WM6
1530	pt discharged in stable condition, pt escorted off ward by MP's, medication taken c̄ pt. — [redacted] 91WM6 b(6)-2

ONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUM (SSN or Other)
	LAST	FIRST	MI	

T./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

'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 (RE
Prescribed by GSA/ICMR FPMR (41CFR) 101-11

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

b(6)-2

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT [redacted] b(2)-2

LOG NUMBER

ARRIVAL DATE DAY	MONTH	YR.	TIME
29	JUN	03	1320

TRANSPORTATION TO [redacted] (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify) Bird

CURRENT MEDS. (tetanus immunization and other data): ?

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: ? ?

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): N.V.A

SEX: M AGE: ?

POSSIBLE THIRD PARTY PAYER? ☒ YES ☐ NO

VITAL SIGNS			
TIME	1325		
BP	112/62		
PULSE	105		
RESP.	18		
TEMP.			
WT. (Child)			

CATEGORY (See reverse)
- ☐ EMERGENT
- ☒ URGENT
- ☐ NON-URGENT

ORDERS	INITS.	TIME
Morphine 5 Phenergan	[redacted]	1326
1 gm Ancef	[redacted]	1430
Tetanus IM	[redacted]	1420
Foley Cath.		
	bbd	

ASSESSMENT/DIAGNOSIS: Tibial Fx

DISPOSITION (Check all that apply)
- HOME ☐ FULL DUTY
- QUARTERS: 24 Hrs. ☐ 48 Hrs. ☐ 72 Hrs.
- MODIFIED DUTY UNTIL: DAY ___ MONTH ___ YEAR ___
- REFERRED TO (Indicate clinic)
- EMERGENCY ☐ TODAY
- 72 HOURS ☐ ROUTINE
- ADMIT. TO HOSP. UNIT/SERVICE: Ortho

CONDITION UPON RELEASE
- ☒ IMPROVED ☐ UNCHANGED
- ☐ DETERIORATED

TIME OF RELEASE:

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

TIME SEEN BY PROVIDER: 1900

30 y.o. Dragi male brought by Air evac s/p MVA last pm. Pt was struck by car → by report from BAS. Further history unobtainable from pt 2° language barrier.

O: ⊕ 105 pulse

HEENT: ⊕ multiple abrasions – forehead & battle's sign
Dentition – poor dentition

c-spine: ↓ TTP ↓ deformity ↓ step-off

X-ray: ⊕ ⊕ tibial fx

Chest: i) CTA ⊕
ii) RRR

Abd: soft, NT, NP, ⊕ marks

Ext: ⊕ edema, ecchymosis; ⊕ crepitus ⊕ open exc ⊕ abrasions, ⊕ TTP, 2⊕ D/P pulse, ⊕ ap-c pos mid-tibia

Back: ⊕ multiple superficial abrasions
↓ Deformity ↓ step-off ↓ TTP

Gen: no acute

P: i) 1 Gm Ancef now ii) Admit to ortho for fuller management.
ii) Foley
iii) ST tetanus

(CONTINUE ON SF 507, IF NEEDED)

PATIENT'S IDENTIFICATION (Mechanical imprint) FOR WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).

[redacted] b(6)-4

SIGNATU[redacted]ND ID STAMP [redacted] WO

INSTRUCT[redacted] (Include m[redacted]ations ordered, any limitations and follow-up plans)

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

EMERGENCY CARE AND TREATMENT

MEDCOM - 12159 Copy

STANDARD FORM 558 (Rev. 6-82) Prescribed by GSA and ICMR FIRMR (41 CFR) 201-45.505

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: } unknown
WEIGHT:

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

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

4. PROPOSED SURGICAL PROCEDURE: S/P MVA
Fasciotomy LLE

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition WNL X LLE
Tobacco 1 ppd X ___ yrs. Body Piercing Ø Diabetes (Y) (N) ROM WNL X LLE ASA/Motrin w/72 hrs (Y) (N)
ETOH ___ Implants Ø Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures Ø Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

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

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

[redacted]

[redacted] b(6)-4

VERIFICATIONS AT HOLDING AREA:
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO ~~Since~~ X 2 days ! Jewelry Removed
! UHCG/LMP ! Body Pierce Removed
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) (X)
! Family/Friend: Ø

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility ✓ 2) Positioning ✓ 3) Existing Disease ✓ 4) Safety Devices ✓ 5) Hypothermia	✓ Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	✓ Check for support stockings or ace wraps. If none, check with doctors. ✓ Check that safety straps are correctly applied. ✓ Offer pillow for under knees. ✓ Place and take down legs from stirrups with slow bilateral motion. ✓ Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to: ✓ 1) Pain ✓ 2) Intraoperative Hazards 3) Prosthesis ✓ 4) Positioning ✓ 5) Transfer pt. to/from OR table E.2. ✓ Potential discomfort due to: ✓ 1) Length of Surgery ✓ 2) Positioning 3) Arthritis	✓ Pt. will be transferred to OR table without difficulty. ✓ Pt. will not experience unnecessary physical discomfort.	✓ Have sufficient people available for transfer. ✓ Insure proper body alignment. ✓ Allow patient to lie in position of comfort while waiting for surgery. ✓ Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated 2) W/O Glasses F.2. ✓ Potential for decreased communication due to: 1) Diminished Hearing ✓ 2) Language Barrier F.3. Potential injury due to dentures: 1) Upper 4) Caps 2) Lower 5) Crowns 3) Bridges	✓ Pt. will be made aware of surroundings prior to anesthesia induction. ✓ Pt. will be transferred safely to OR table. ✓ Pt. will be able to understand instructions. ✓ Minimize danger of injury during intraop period.	✓ Introduce self. Keep pt. informed as to where he/she is and what is happening. ✓ Inform pt. in which direction to move and assist if necessary. ✓ Speak clearly and slowly. ✓ Address pt. from either side. ✓ Validate pt.'s understanding of verbal communication. ✓ Verify removal of dentures.
G OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

10. OR NURSING [redacted]NS COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTION S NOTED.

b(6)-2 [redacted] LT/RN 27 Jun 03 DATE

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

LEVEL OF CONSCIOUSNESS: ☐ A&O ☒ Drowsy ☐ Sleepy ☐ Intubated BREATHING EASY: (Y) (N)

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

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

DATE: 27 Jun 03 TIME: 1450

13. POSTOPERAT[redacted] PREPARED BY (Signature and Titl[redacted] b(6)-2

DATE: 27 Jun 03 TIME: 1614

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:

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

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

4. PROPOSED SURGICAL PROCEDURE:
washout / DPC LLE fasciotomy

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition WNL X LLE
Tobacco 1 ppd X ___ yrs. Body Piercing 0 Diabetes (Y) (N) ROM WNL X LLE X ASA/Motrin w/72 hrs (Y) (N)
ETOH ___ Implants 0 Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures 0 Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

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	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. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: ✓ 1) Positioning ✓ 2) Effects of Anesthesia ✓ 3) Medical/Smoking History	o Pt. will be able to breathe without difficulty during immediate intraoperative 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 integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement ✓ 3) Positional Aids ___ 4) Prosthesis ✓ 5) Pooling of Prep Solutions	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)

GPW # [redacted] b(6)-4

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

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility ✓ 2) Positioning ✓ 3) Existing Disease ✓ 4) Safety Devices ✓ 5) Hypothermia	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for/under knees. o Place and take down legs from stirrups with slow bilateral motion. o. Check that rings 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	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, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. Diminished visual perception due to being: 1) Pre-Medicated 2) W/O Glasses F.2. Potential for decreased communication due to: 1) Diminished Hearing 2) Language Barrier F.3. Potential injury due to dentures: 1) Upper 4) Caps 2) Lower 5) Crowns 3) Bridges	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 communication. 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 COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTION S NOTED.

b(6)-2 [redacted] PT/N 29 June 03 DATE

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

LEVEL OF CONSCIOUSNESS: ☐ A&O ☐ Drowsy ☒ Sleepy ☐ Intubated BREATHING EASY: (Y) (N)

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

Sleepy - Deep Extubation

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

DATE: 29 June 03 TIME: 0737

13. POSTOPERATIVE [redacted]ON PREPARED BY (Signature and Title) [redacted] b(6)-2

DATE 29 June 03 TIME: 0550

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 27 Jun 03 TIME PATIENT ARRIVED IN SUITE 1505

4. PATIENT IN ROOM TIME 1505 NUMBER R-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: S/P MVA
NPO x 2 days. NKDA

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Normal anatomic body alignment maintained.

8. SKIN PREPARATION

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

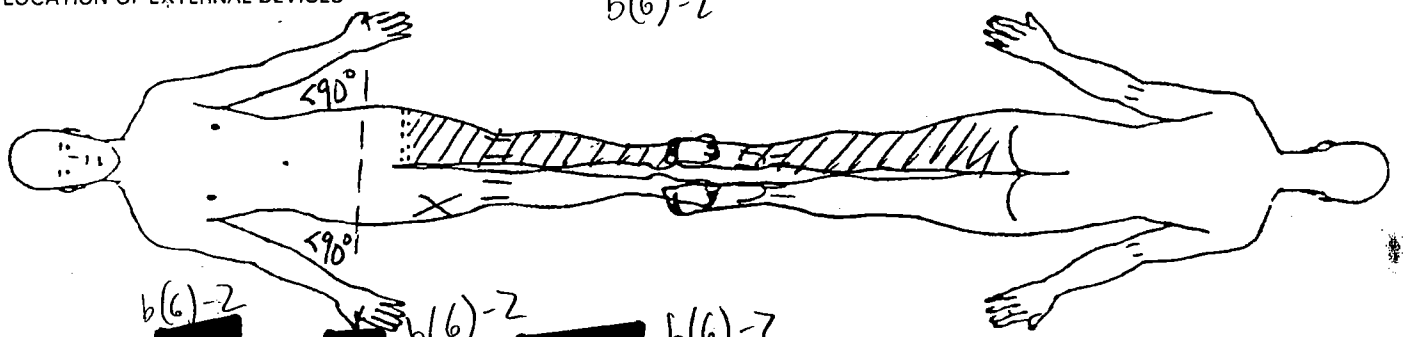
COMMENTS: No nicks or cuts noted

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

COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES

b(6)-2



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

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

Initial: SPC [redacted] MAJ

C = Correct I = Incorrect

10. COUNTS

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

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

[redacted] b(6)-4

[redacted] b(6)-4

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

[X] ESU NO: # 3 cut 30 coag 30
GROUND PAD: BRAND VL Pen PolyHesive II
LOT NO: 69652 Exp 2005-04

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

[ ] BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
N					
A					

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
0.9% NaCl - Q.S

OTHER ORDERS	TIME	CARRIED OUT BY
N		
A		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☐

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

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

19. ADDITIONAL INFORMATION
Surgeon: Dr. [redacted] b(6)-2
Anesthesia: MAJ [redacted] b(6)-2

DA 5179 Initiated

20. OPERATION(S) PERFORMED
Fasciotomy of LLE

21. PATIENT TRANSFERRED TO ICU 1 TIME 1612 METHOD LITTER & O2

22. REGISTERED NURSE SIGNATURE [redacted] LTC N [redacted]

MEDICAL RECORD — **INTRAOPER[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 Litt- b(6)-2 BY [redacted] / D[redacted]

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

3. DATE 29 Jun 03 TIME PATIENT ARRIVE[redacted] 0816 b(6)-2

4. PATIENT IN ROOM TIME 0816 b(6)-2 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: ~~Allergies:~~

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)* Arm proper body alignment, armboards < 90°, web at between tourniquet & skin, Tourniquet isolated

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

COMMENTS: From prep c lois u-drape.

8. SKIN PREPARATION

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

COMMENTS:

PREP SOLUTION *(Specify)* Betadine scrub/paint
SITE: left leg BY WHOM: CPT [redacted]
SITE: BY WHOM:

COMMENTS: No problem noted

9. LOCATION OF EXTERNAL DEVICES

Tourniquet not used

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

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

10. COUNTS — C = Correct I = Incorrect

Initial Counts SPC [redacted] / [redacted]

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

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

GPW# [redacted] b(6)-2

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

b(6)-2

☒ ESU NO: 1
GROUND PAD: BRAND valleylab
LOT NO: 65706

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S): 0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*

Kerlix, Stuffs, Ace, velcro, splint velcro, Ace

19. ADDITIONAL INFORMATION

WC

Surgeons: Dr [redacted] b(6)-2 Anesthesia: Dr [redacted] b(6)-2 Anesthesia Type: General

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

20. OPERATION(S) PERFORMED

Washout LLE Fasciotomies

21. PATIENT TRANSFERRED TO SCU #2 TIME 0943 METHOD Gurney

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

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

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

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

3. DATE 1 Jul 03 TIME PATIENT ARRIVED IN SUITE 0923

4. PATIENT IN ROOM TIME 0923 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NPO p MN, NKDA

6. NURSING PERSONNEL

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

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

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

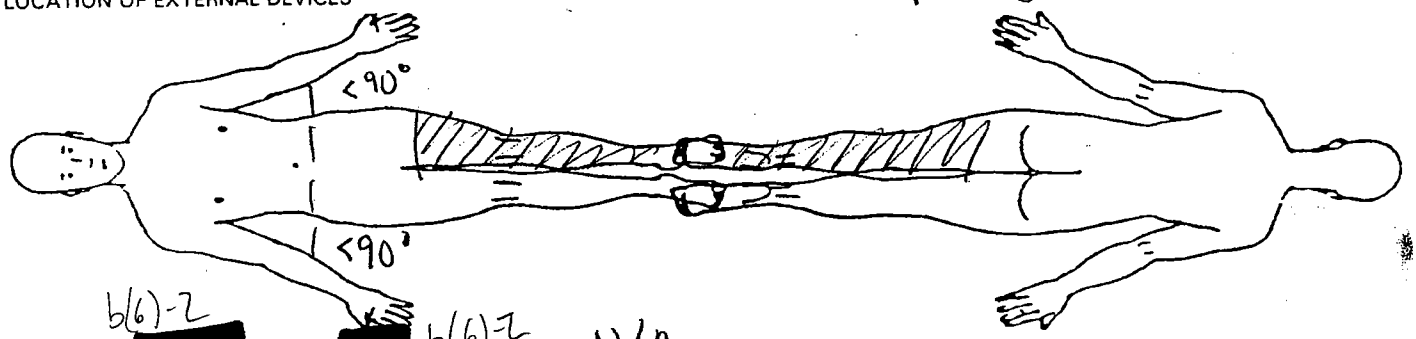
COMMENTS: Normal anatomic body alignment maintained

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine/Betadine
SITE: Left leg BY WHOM: ILT [redacted]
SITE: BY WHOM:
COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



b(6)-2 [redacted] [redacted] b(6)-2 N/A

LEGEND X Ground Pad Safety Strap = = = Tourniquet

Initial: SPC ILT [redacted] b(6)-2

C = Correct I = Incorrect

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

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

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

[redacted] b(6)-2

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

☒ ESU NO: # 1 cut 30 coag 30
GROUND PAD: BRAND VL REM Polyhesive II
LOT NO: 657060 Exp 2004-11

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
0.9% Na Cl - Q.S

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE [redacted]

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☐

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

18. DRESSING/IMMOBILIZATION *(Specify)*
fluffs, kerlix, webril
splint, ACE

19. ADDITIONAL INFORMATION
Surgeon: Dr. [redacted] b(6)-2
Anesthesia: MAJ [redacted]

DA 5179 in chart

20. OPERATION(S) PERFORMED
I&D of wound (L) ~~thigh~~ leg [redacted] b(6)-2 DPC

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU 2	1048	LITTER EO2

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

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 1LT [redacted] b(6)-2

3. DATE 10 Jul 03 TIME PATIENT ARRIVED IN SUITE 0903

4. PATIENT IN ROOM TIME NUMBER 2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NPO p̄ MN, NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	1LT [redacted] / LTC [redacted]	RELIEF CIRCULATOR	

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

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

COMMENTS: Normal anatomic body alignment maintained.

8. SKIN PREPARATION

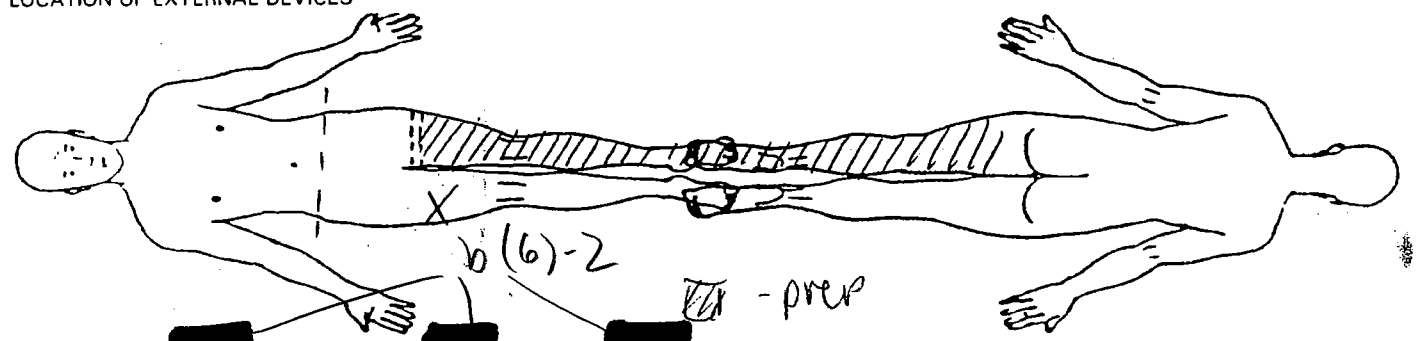
HAIR REMOVAL [ ] YES [X] NO
DONE BY: [ ] OR [ ] NURSING UNIT
METHOD: [ ] DEPILATORY [ ] RAZOR [ ] CLIP

COMMENTS: N/A

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

COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



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

Tourniquet @ 250 mmHg x 43 min

Initial: SPC [redacted] 1LT

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	[X] Yes [ ] No		C	C	SPC [redacted]	1LT [redacted]
Needle Sharp	[X] Yes [ ] No					
Instrument	[ ] Yes [X] No					
Other	[ ] Yes [X] No					

b(6)-2

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

[redacted] b(6)-4

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

[X] ESU NO: # 000450 cut 30 coag 30
GROUND PAD: BRAND VL REM Polyhesive II
LOT NO: 65706 Exp 2004-11

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

[ ] BIPOLAR NO:

13. PROSTHESIS, IMPLANTS ☒ YES ☐ NO IF YES NAME: ID NUMBER; MANUFACTURER 06187-01

9 Hole plate
34 Screw - cortex

ASIF Bozd # 06187-01

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
0.9% NaCl - Q.S

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE [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 ☒

	1.	2.	3.
TYPE/SIZE			
SITE			

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

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

DA 5179 In Chart

20. OPERATION(S) PERFORMED
Sub-Q. plate Left Tibia

21. PATIENT TRANSFERRED TO ICU, b(6)-2 TIME 1050 METHOD LITTER c O2

22. REGISTERED NURSE SIGNATURE [redacted]

REVERSE OF DA FORM 5179-1, OCT [redacted] USAPA V1.01

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY

19 | HOUR

PULSE (O) | TEMP. F (•)

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

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

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

EPW [redacted] b(6)-4

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY												
POST-	DAY											
MONTH-YEAR	DAY	11		12		13		14		15	16	17
19	HOUR	6	12	2 PM	6	12	6	12	6	12		
PULSE (0)	TEMP. F (•)	98.6	98.6		98.6	98.6	98.6	98.6	98.6	98.6		
	105°											
180	104°											
170	103°											
160	102°											
150	101°											
140	100°											
130	99°											
	98.6°											
120	98°											
110	97°											
100	96°											
90	95°											
80												
70												
60												
50												
40												
RESPIRATION RECORD		18	18	18	16	16	16	18		18		
BLOOD PRESSURE		120/64		108/80	124/80	116/70		122/74		124/68		
		116/78		108/78		112/76		120/78		112/70		
HEIGHT:	WEIGHT →	98%			97%	98%		98%		98%		
				98%				98%				

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)

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR June 2003 — DAY: 27, 28, 29, 30, 1, 2, 3

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

142/84 | 110/70 | 116/70 | 116/80 | 124/76 | 134/70 | 128/72 | 104/70 | 130/60 | 120/66 | 118/58

HEIGHT: | WEIGHT →

100% | 99% | 96% | 99% | 99% | 98% | 98% | 98%

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

EPW # [redacted] b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

Ward Section: ICW2	REQUESTING PHYSICIAN: [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI: Cpl [redacted] b(6)-4	DATE: 28 Jan	TIME: 0400	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	10.7	4.8-10.8 x 10³
RBC	4.00	4.2-6.1 x 10⁶
Hgb	11.9	14-18 g/dl (M) 12-16 g/dl (F)
Hct	37.6	42-52% (M) 37-47% (F)
MCV	94.0	80-94 fl (M) 81-99 fl (F)
Plt	256.	140-500 x 10³ verified
Lymph %	16.7	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

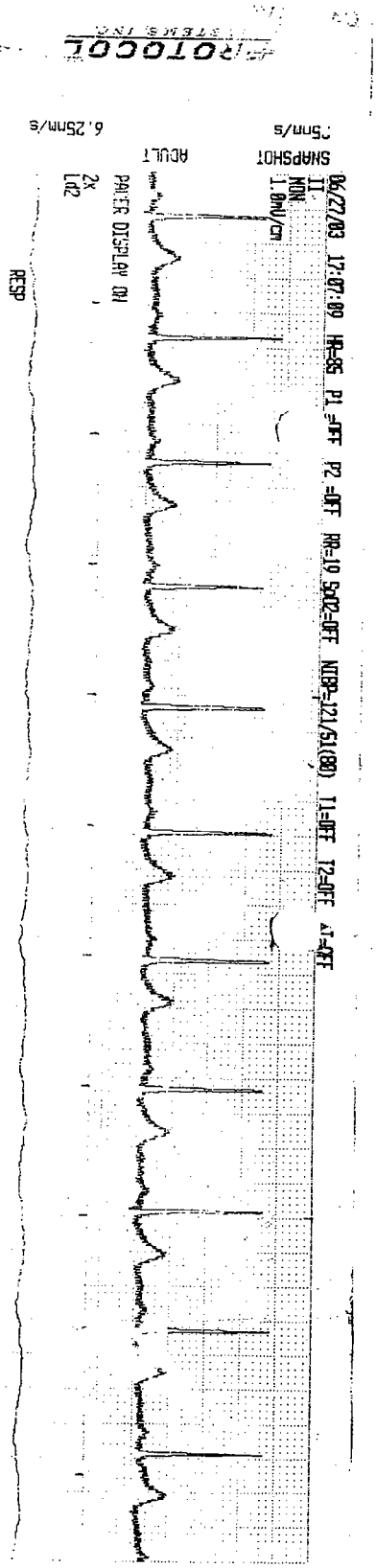
TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

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

UNIT	TYPE	CROSSMATCH

REMARKS: Misc. NCT (repeated elevation)

REPORTED BY:	DATE:	LAB ID NO.:


PROTOCOL SYSTEMS, INC.
06/27/03 17:07:09 HR=86 P1=OFF P2=OFF RR=19 SpO2=OFF NIBP=121/51(80) T1=OFF T2=OFF ΔT=OFF
II
MON
1.0mV/cm
SNAPSHOT
75mm/s
ACULT
PAPER DISPLAY ON
2x
Ld2
6.25mm/s
RESP

MEDICAL RECORD — ANESTHESIA

DRUG	Dose	1	2	3	4	5
Versed	(mg)	2				
Fent	(mcg)	100				
Lido	(mg)	50				
Propofol	(mg)	110				
Succs	(mg)	80				
Vec	( )	3				
VOLAT AGENT: Sevo	% del	.8	1.5			
	% e.t.					
AIR	L/Min					
N2O	L/Min					
O2	L/Min	8	2	2	2	8

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

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

FLUIDS			
LINE site LR	☐ Warmed	500	
AJS	☐ Warmed	500	
	☐ Warmed		
	☐ Warmed		

LOSSES	
EST BLOOD LOSS	
URINE –	550

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

BODY WEIGHT: 65 (KG) LB

HEMATOCRIT:

INITIAL DATA: BP – / HR–

EQUIP CHECK: OK? – (Y) N

PATIENT RECHECK: OK for PROCEDURE? TIME – 1445

TIME → 15 X 30 X 16

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	HF	650	CMV	500	CV
f – breaths/min	16	10	10	8	12
Peak inf pres / PEEP		25	26	22	
MODE – S(pon), A(ssist), C(on)	S2	CV	CV	CV	
BP/Auto Cuff / ET CO2 (torr)	38	34	31	36	48
BP / oth / FIO2 (Frac or %)		.68	.86	.86	
ART line / SpO2 (%)		99	99	99	
Steth- PC/ES / ECG		SR	SR	SR	
Gas analyzer / TEMP- site	Available				
N-M Block (T/4)		0/4			
Warming blkt					
Conv warmer					

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

TOTALS	
+	

TOTAL EBL: min

TOTAL URINE: 550

FLUIDS – SUMMARY: CRYSTALLOID – 1000; COLLOID –; BLOOD –

REMARKS – Code drugs with numbers, events with letters

1505 in OR. Pt I-D&I. transfer to bed monitors applied
1510 – I & I (+) Bilat BS's difficulty.
1549 Reversal 3mg Neostigmine 1.4mg Robinul
1600 spont Resp (+) swallow extubated
~~1610 Pt spont Resp to ICU c Facemask~~ [redacted]
~~O2 Spont Resp~~
ICU 1 Spont Resp arousable. Report Given b(6)-2

RECOVERY AT 1615

PACU ICU / (Specify)

OTHER

CONDITION:

RESP – 18 SpO2 – 95

BP – 101/49 HR – 85

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1445	1505	1620
	Ready	Begin	End
PROC	1515	1523	1554

PROCEDURES and CPT Codes (L) TIBIA Fx Post Compartment Fasciotomy

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

EPW# [redacted] b(6)-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: 8.0 ETT placed one attempt Grade 2 view, 3 MAC blade DL. Secured 23cm teeth (+) Bilat BS

SURGEONS: [redacted] b(6)-2

ANESTHETIST: [redacted] CRNA

PROCEDURE LOCATION [redacted]

DATE 6/27/03 b(2)-2

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

b(6)-2 WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 12177

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

ESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

31 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

ASA Physical State 1 (2) 3 4 5 (E)
WT: 75 KG/LB HT: ____ IN.
ALLERGIES: NKDA

POSED PROCEDURE: Fasiotomy
GICAL SERVICE: ____
SINCE: ____

ITS:
BACCO: Smoker
ETOH: ____
DRUGS: ____

RENT MEDICATIONS:
ordered as premed

MEDICATIONS:
e Yes (@ ____ Hrs) /CC
__ . ____ mg IV IM PO
__ . ____ mg IV IM PO
__ . ____ mg IV IM PO

ORATORY STUDIES:

ICT: ____/____

IER: ____

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT

PAST SURGICAL/ANESTHETIC

PHYSICAL EXAMINATION

BP ___ HR ___ R ___ T ___
Pain Scale 0-10 ____
HEENT - Teeth ____
Trachea ____
TMJ/Neck ____
Oropharnyx ____
Nares ____
CHEST: CTA
CARDIAC: $S_1 S_2$
EXTREMITIES:
IV Access: 18G (L) FA
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since X2 DAYS

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

ORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to ussed with the patient/l[redacted]dian. b(6)-2

patient/legal g[redacted]and and agrees. Questions answered.
ned: [redacted] CRNA Date: 27 JUN 03 Time: 1450 Hrs

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

ned: ____ Date: ____ Time: ____ Hrs

ent Identification: (Ward) ____

EPW # [redacted] b(6)-4

SEDATION KEY:

1. **MINIMAL** (Anxiolysis) Patient responds normally to verbal commands
2. **MODERATE** (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is n necessary.
3. **DEEP SEDATION/ANALGESIA.** Patient responds purposefully following repeated or painful stimulation. Airway assistance may be necessary.

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)	
fentanyl	(mcg)	50 50 50 25 25 50
propofol	(mg)	130 30
SCH	( )	100
	( )	
	( )	
	( )	
VOLAT AGENT ISO	% del / % e.t.	2.0-2.5-2.0-1.5-1.5-1.5-1.5-1.0
AIR	L/Min	
N2O	L/Min	
O2	L/Min	6-2-2-2-2-2-2-2-4

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

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

TOTALS	
fentanyl 250mcg	TOTAL BLD: Minimal
	TOTAL URINE: 400ml

FLUIDS – SUMMARY
CRYSTALLOID – 400 ml
COLLOID – Ø
BLOOD – Ø

FLUIDS

LINE site		
LTC	☐ Warmed	250 — 350 — 400
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES

EST BLOOD LOSS	Minimal
URINE –	200 — 400

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 70 (KG) LB

HEMATOCRIT: >30

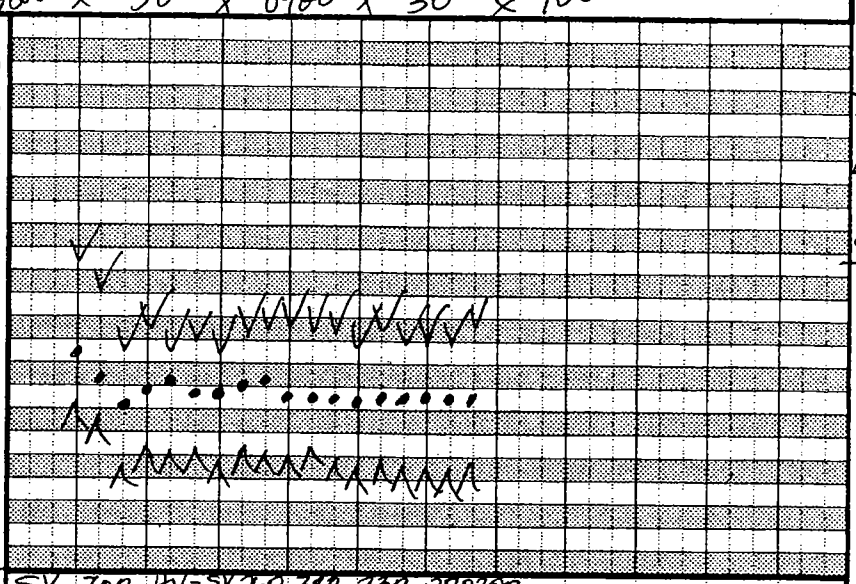
INITIAL DATA: BP – 133, 71 HR – 94

EQUIP CHECK: OK? – (Y) N

PATIENT RECHECK: OK for PROCEDURE? Y TIME – 0810

TIME → 0800 X 30 X 0900 X 30 X 1000

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



VENTIL								
VT – ml	SV 700	HV-SV 260	380	330	270	280		
f – breaths/min	10	8	16	10	9	10	14	14
Peak inf pres / PEEP	26							
MODE – S(pon), A(ssist), C(on)	S	C	C	S	S	S	S	S	S

MONITORING / ACCESSORIES									
X BP/Auto Cuff	X ET CO2 (torr)	+	34	46	51	56	50	51	50
BP / oth	X FIO2 (Frac or %)	.7	.7	.7	.7	.7	.7	.7	.7	.7
ART line	X SpO2 (%)	100	100	100	100	100	100	100	100	100
Steth- PC/ES	X ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	X TEMP- site	Available							
	N-M Block (T/4)								
Warming blkt									
Conv warmer									

Mark with letters & symbols, explain under REMARKS

EVENTS — Position → SUPINE →

REMARKS – Code drugs with numbers, events with letters

Pt ID'd – chart reviewed. No change since initial pre-anesthetic assess on 6/27/03.

To OR – monitors placed. Smooth induction and intubation s complication.

End of case – pt c̄ regular spont. vent. – TV 380ml RR 14 SpO2 100%. extubated deep

RECOVERY AT: PACU (ICU) #2 (Specify)
OTHER: BP stable
CONDITION: Stable
RESP – 18 SpO2 – 95% on RA
BP – Monitor HR – 120

ANESTHESIA & PROCEDURE TIMES

	Start	Room	End
ANES	0805	0816	0954
PROC	Ready 0821	Begin 0848	End 0944

PROCEDURES and CPT Codes: I&D Left Leg

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA – Eyes Taped – Arms padded & secured
ETT c̄ 22 cuff lips

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
Pre-O2: AT DL x1 c̄ Miller 2 – Gr I view – 8.0 ETT in – (+) ETCO2: equal breath sounds

PATIENT IDENTIFICATION – Typed or written entries: Name, Grade/Rate, Medical facility
EPW # [redacted] ICW 2
b(6)-4

SURGEONS: [redacted]
ANEST [redacted] M.D.
b(6)-2

PROCEDURE LOCATION: /
DATE: 29 JUN 03
PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA
WAMC OP 376 REVISED 1 Jan 99

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

MEDICAL RECORD — ANESTHESIA

DRUG	(Dose)	
MSO4	(mg)	5 10 4 2 2 2
Versed	(mg)	2.5
	( )	
	( )	
	( )	
	( )	
VOLAT AGENT: I-50	% del	1.5 1.5 2.0 1.2 1.2 1.5
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	6 — 3 — 3 — 3 — 3 — 3 — 6

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

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS ▶ (1) (2) (3) (4)

TOTALS	
20	
2.5	
1	

TOTAL SIM: min

TOTAL URINE: NM

FLUIDS – SUMMARY

CRYSTALLOID– 500

COLLOID– Ø

BLOOD– Ø

FLUIDS		
LINE site 18g RW	☐ Warmed	Infiltrated/DCd
new 18g LW	☐ Warmed	RL 500↑
	☐ Warmed	
	☐ Warmed	

LOSSES: EST BLOOD LOSS / URINE –

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 65 (KG) LB

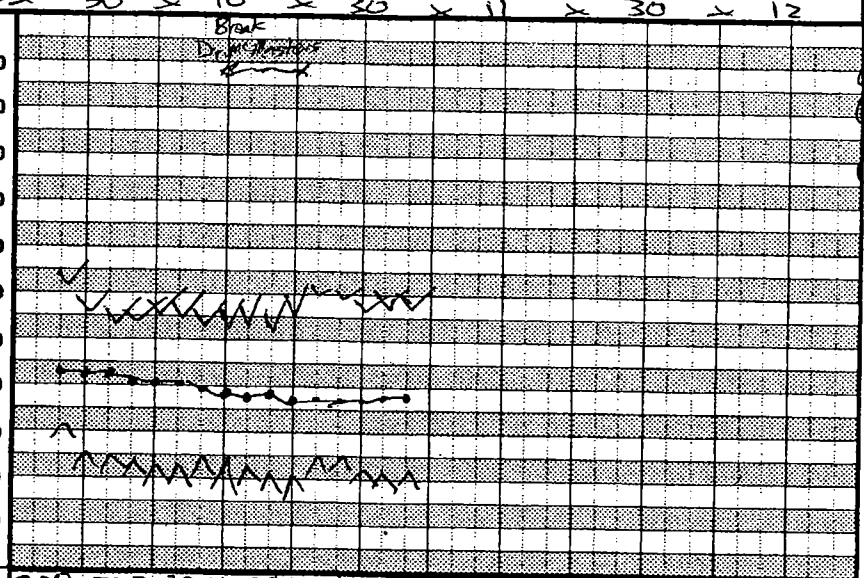
HEMATOCRIT: 37.6

INITIAL DATA: BP – 126/65 HR– 83

COMP CHECK: OK? – (Y) N

PATIENT RECHECK: OK for PROCEDURE ✓ TIME– 0915

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



VT – ml	300	300	300	330	450	380
f – breaths/min	28	26	20	16	14	14
Peak inf pres / PEEP	—	—	—	—	—	—
MODE– S(pon), A(ssist), C(on)	S	S	S	S	S	S
✓ BP/Auto Cuff / ✓ ET-CO2 (torr)	33	40	36	40	41	40
BP / oth / FIO2 (Frac or %)	0.8	0.8	0.8	0.8	0.8	0.8
ART line / SpO2 (%)	100	100	100	100	100	100
Steth- PC/ES / ECG	SR	SR	SR	SR	SR	SR
Gas analyzer / TEMP- site AV 91						
N-M Block (T/4)						
Warming blkt						
Conv warmer						

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

REMARKS– Code drugs with numbers, events with letters

Pt ⊼ ⊼ ØΔ since last anesthetic. Plan general.
(1) To room, 50cm applied, preO2.
(2) Smooth IV indx
(3) Promethazine 12.5mg IV.
(4) To recovery stable.

RECOVERY AT: PACU (ICU) (Specify) OTHER 968

CONDITION: RESP– 18 SpO2– 98 BP– 143/72 HR– 102

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0915	0923	1100
	Ready	Begin	End
PROC	0930	0942	1045

PROCEDURES and CPT Codes
(1) I-BD/DPC Lx lateral calf
(2) DPC same

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GM

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
Eyes taped, #9 OA, easy mask. b(6)-2

PATIENT IDENTIFICATION– Typed or written entries: Name, Grade/Rate, Medical facility
EPW # [redacted] b(6)-4
NKDA ICW2
35 yo ♂

SURGEONS [redacted] MAS, CRNA
b(6)-2 [redacted]

PROCEDURE LOCATION 1-1
DATE 7/1/03
PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA
376 REVISED
1 Jan 99

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

ICW2 → ICW2

Drawer Case

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)	
Insulin	(mg)	<10> <10> 2 2 1 <5>
Versed	( )	2
Propofol	( )	50 50
Lidocaine	(mg)	50
	( )	
20 Fentanyl	(mg)	4
VOLAT. AGENT: Halothane	cc	1.1-0.8-0.7-0.8-1.3-1.1-0.X
	% c.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	8-2-2-2-2-2-10

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

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

LINE site: 18g (R) Arm — Warmed / Warmed / Warmed / Warmed — LR —— (40c) —— 500

EST BLOOD LOSS: Not Measured

URINE –

TIME: 900 15 30 45 1000 15 30 45 1100 15 30 45 1200

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

TOT 250 mg/hr

TOT 43 mg

	900	15	30	45	1000	15	30	45	1100	15	30	45	1200
VT – ml	21	19	18	15	21	16	14	16					
f – breaths/min													
Peak inf pres / PEEP													
MODE– S(pon), A(ssist), C(on)	S	S	S	S	S	S	S	S					
ET CO2 (torr)	35	40	43	44	40	45	50	40					
FIO2 (Frac or %)	>.21	>.21	>.21	>.21	>.21	>.21	>.21	>.21					
SpO2 (%)	100	100	100	100	100	100	100	100					
ECG	SR	SR	SR	SR	SR	SR	SR	SR					
TEMP- site			97	97	97	97	97	97					
N-M Block (T/4)													

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

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

TOTALS: 30 / 2 / 100 / 50

TOTAL EBL: Min

TOTAL URINE: N/A

FLUIDS – SUMMARY: CRYSTALLOID– 500 cc; COLLOID– Ø; BLOOD– Ø

REMARKS – Code drugs with numbers, event with letters

0850 Pt. in ICW2. To OR via litter.
0900 In room. ⊕ monitors ⊕ O2. Smooth IV/intubat induction. Pt padded. Hyp <90.
0915 Pt on low litotomy – Pos by surgeon. Pt padded.
0957 Incision.
1045 Procedure complete. Oral Airway out → To ICW2 awake c ⊕ O2. Report to RN

PATIENT CHECK: for PROCEDURE Okay; TIME– 0900

PATIENT STATUS: 1 2 3 4 5 E

BODY WEIGHT: 75 KG LB

HEMATOCRIT: 37.6

INITIAL DATA: 110, 60; R– 88

EQUIP CHECK: K?– ✓ N

RECOVERY AT 1055; PACU CU2 (Specify); OTHER; CONDITION: Stable, awake; RESP– 20; SpO2– 100%; BP– 140/70; HR– 105

TIME	THEATER	PROCEDURE TIME	
ANES	Start 0850	Room 0900	End 1100
PROC	Ready 0908	Begin 0957	End 1048

PROCEDURES and CPT Codes: (L) Tibial Plating

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GA

AIRWAY MANAGEMENT: Intubation route, blade, technique, complications: Eyes taped, Ears, nose free pressure. Anesthesia mask,

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

SURGEONS: [redacted] b(6)-2

ANESTHETIST: [redacted] CRNA CRT

PROCEDURE LOCATION: [redacted] b(2)-2

DATE: 10 Jul 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

U.S. GPO: 1999 – 528-336/10

PATIENT RECORD

[redacted] b(6)-4

b(6)-2 [redacted]

[redacted] b(6)-4

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 31 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: (L) tibia SQ plating
SURGICAL SERVICE: Ortho
NPO SINCE: 5 MN

ASA Physical State 1 (2) 3 4 5 E
WT: 75 KG/LB HT: ____ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: +
ETOH: ____
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Ancef 1 gm
( ) ____
( ) ____
( ) ____
( ) ____
( ) ____

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

LABORATORY STUDIES:
HB/HCT: ____ / 37.6
U/A: ____
OTHER: ____
1 gm

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 NA

Other Significant Hx:
- N Y ____
- N Y ____

Familial HX N Y ____

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Sp (L) leg fasciotomy
I & D (L) Leg

PHYSICAL EXAMINATION
BP 110/66 HR 88 R 16 T 98 Subj 98% R
Pain Scale 0-10 ____
HEENT - Teeth poor dentition
Trachea midline
TMJ/Neck 3FB
Oropharnyx grade 2
Nares
CHEST: slight Rhonchi bilat
CARDIAC: S1 S2 S (a)
EXTREMITIES:
IV Access: 18G @ Arm
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since 5 MN

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): [redacted] b(6)-2 { } General: Mask Intubation
Via Intubation [redacted] MAC CRNA

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

The patient/legal guardian seems to understand and agrees. Questions answered.
Signed: ____ Date: 10 Jul 03 Time: 0135 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____
[redacted] ICW2 b(6)-4
[redacted]

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

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				27 June	1600 HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
ICW 2		3				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
ICW 2		5				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
ICW 2	24Vs	0130	28	Jun 03 [redacted] b(6)-2		[redacted] b(6)-2 noted 27 June 03 1815
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
				28 June	1900 HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
ICW 2		5	[redacted]			[redacted] b(6)-2 noted 28 June 2049

DA FORM 1 APR 79 4256 REPLAC [redacted]

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

GPW [redacted] b(6)-4

NURSING UNIT: ICW2 | ROOM NO.: 24 Vdne | BED NO.: [redacted] b(6)-2

DATE OF ORDER: 29 JUN 03 | TIME OF ORDER: 0945 HOURS | LIST TIME ORDER NOTED AND SIGN

(1) RESUME PHARMACY ORDERS
(2) D/C FOLEY ON WARD
(3) REGULAR DIET
(4) IV - LR AT 100 cc/hr. HEP LOCK WHEN TOLERATING P.O. WATER
(5) [redacted] b(6)-2

PATIENT IDENTIFICATION

EPW [redacted] b(6)-4

NURSING UNIT: ICW2 | ROOM NO.: 24 Vs | BED NO.: 3

DATE OF ORDER: 30 JUN 03 | TIME OF ORDER: [redacted] b(6)-2 | LIST TIME ORDER NOTED AND SIGN

(1) NPO after midnight
(2) For OR tomorrow
[redacted] b(6)-2

1 JUL 03 [redacted] b(6)-2

PATIENT IDENTIFICATION

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

DATE OF ORDER: 1 JUL 03 | TIME OF ORDER: 0850 HOURS | LIST TIME ORDER NOTED AND SIGN

(1) RESUME PHARMACY ORDERS
(2) REGULAR DIET
(3) IV - LR AT 100 cc/hr, HEP LOCK WHEN TAKING P.O. WATER.
(4) GVBL TO CRUTCHES AFTER [redacted] TOMORROW

Noted 1 JUL 03 1215 [redacted]

PATIENT IDENTIFICATION

EPW [redacted] b(6)-4

DATE OF ORDER: [redacted] b(6)-2 | TIME OF ORDER: [redacted] b(6)-2

NURSING UNIT: ICW 2 | ROOM NO.: | BED NO.: 5

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	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
EPW #[redacted] b(6)-4	FCW 2			[illegible]	[illegible] HOURS	
				NPO to MW for CAT SP 10 days		noted 2200 9 Jul 03 [redacted] b(6)-2
				b(6)-2		
				24° / one [redacted]		
PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	
[redacted] b(6)-4				[redacted]	HOURS	
PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	
EPW #[redacted] b(6)-4	FCW 2				HOURS	
PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	
EPW #[redacted] b(6)-4	FCW 2				HOURS	

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT: ICW 2 | ROOM NO. | BED NO. 5

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

10 JUL 03 1100

Transfer PACU → ICW 2

Cap (P) Tylenol plus

Enoxa

Vicoprofen

Vital Asa Ad lib WRAP

Resp Dept

NS 2 REDOO c h

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT: ICW 2 | ROOM NO. | BED NO. 3

DATE OF ORDER | TIME OF ORDER | HOURS

FLL IV when NPO

median Arect Tmin 100 gtt

Thin Kflex 250 (250) x 20 h

MSO 2-10 mg IVPO 2 h

Procet II PO Q4 h

Phenergan 25 mg IV-PO Q4 h

Place NG PO BID

Tylenol 650 PO Q4 h

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT: ICW 2 | ROOM NO. | BED NO. 24 ✓done

DATE OF ORDER | TIME OF ORDER | HOURS

Plan C ART @ 5 Dmso

✓ Sf the Dr to

EPW Camp

10 July 03 1240 [redacted] b(6)-2

[redacted] b(6)-2

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT: ICW 2 | ROOM NO. | BED NO. 3 24 ✓done

DATE OF ORDER | TIME OF ORDER | HOURS

17 JUL b(6)-2 0217

50 mg Benadryl IV TID prn pruritis

b(6)-2

[redacted]

Note 0217 17 JUL

[redacted]

[redacted]

DA FORM 1 APR 79 4256 REPLACES EDITION OF

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

NURSING UNIT	ROOM NO.	BED NO.
ICW2	24	5

DATE OF ORDER: 12 Jul 03 TIME OF ORDER: 0750 HOURS

Clotrimazole cream apply to affected area TID b(6)-2 [redacted] noted [redacted] 9 Jul 03 0800

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

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

NURSING UNIT	ROOM NO.	BED NO.
ICW2	24	5

DATE OF ORDER: 13 Jul 03 TIME OF ORDER: 2345 HOURS

SR / SLWC tody b(6)-2 noted [redacted] 9 Jul 03 1818

b(6)-2 [redacted]

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

NURSING UNIT	ROOM NO.	BED NO.
ICW2	24	5

b(6)-2 [redacted] DATE OF ORDER: 14 Jul 03 TIME OF ORDER: 2315 HOURS

TO DERM b(6)-2 [redacted]

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

NURSING UNIT	ROOM NO.	BED NO.
ICW2	24	5

b(6)-2 [redacted] DATE OF ORDER: 15 Jul 03 TIME OF ORDER: 0 HOURS

NURSING UNIT	ROOM NO.	BED NO.
ICW2		5

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

All b(6)-2 except last

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. 6 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	27	28	29	30	1	2	3	4	5	6	7	8	9	10
27	[redacted]	VS q Shift	6	/	[redacted]												
			14	/													
			21	[redacted]													
27	[redacted]	Bedrest	6	/													
			14	/													
			21	~~SS~~													
27	[redacted]	Regular Diet	6	/													
			12	/													
			17	/													
27	[redacted]	Elevate, Ice to Leg	6	/													
			14	/				/	D/C 29 Jun								
			21	[redacted]													
27	[redacted]	foley to gravity	6	/													
			14	/				/	D/C 29 Jun								
			21	[redacted]													
29 Jun	[redacted]	Elevate ⊖ leg	06	/	/	/	[redacted]										
			14	/	/												
			21	/	/												

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P (L) leg fasciotomy

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

EPW # [redacted]

b(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

All b(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 6 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
27	[redacted]	transfer to ICW 2	—	—	—	[redacted]
27	[redacted]	S/P (L) leg fasciotomy				
27	[redacted]	condition stable	—			[redacted]
27	[redacted]	CBC in AM	28 June	0400	0400	[redacted]
28	[redacted]	NPO p MN for OR in AM	29	2400	2100	[redacted]
29	[redacted]	D/C Foley	29	— done —		[redacted]
30	[redacted]	NPO p MN for OR in AM	1	0001		[redacted]
1 Jul 03	[redacted]	~~EVAC. TO CIVILIAN AOSR TOMORROW~~	~~2 Jul 03~~	~~ASAP~~		
0900 8 Jul	[redacted]	NPO p MN for OR in AM 10 Jul	10 Jul	[redacted]	Done	[redacted]
10 Jul	[redacted]	PLAN: CAST IN 5 DAYS OR SO,				
	-----	Then D/C to EPW Camp				
13 Jul	[redacted]	SR / SLLC	13 Jul	today	1900	[redacted]
H	[redacted]	TO DRI	15			

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

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(All b(6)-2 except last

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. 07 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
10JUL	[redacted]	VS Q shift	06	[redacted]													
			14														
			22														
10JUL	[redacted]	~~Bedrest~~ Ad Lib	06														
			14														
			22														
10JUL	[redacted]	Regular Diet	06														
			14														
		17	22														
10JUL	[redacted]	Elevate (L) leg	06														
			14														
			22														

DCD

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
S/P (L) leg fasciotomy

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

All b(6)-2 except last

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 11	12	13	14	15	16	17	18						
10Jul	[redacted]	HL IV when tol po,	5	[redacted]													
		LR @ 100cc/hr	13														
			21														
10Jul	[redacted]	Ancef 1 gm IV q 8°	6														
			14														
			22														
10Jul	[redacted]	Colace 100 po BID	10														
			22														
10 Jul	[redacted]	Keflex 250mg q 6	6														
		x 10 days	12														
			18														
			24														
12Jul-4	[redacted]	Clotrimazole cream	8	[redacted]													
		applied to affected area TID	16														
			24														

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: S/P (L) leg fasciotomy

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ___

PATIENT IDENTIFICATION:

EPW # [redacted] b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

All b(6)-2 except last

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. 6 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 27	28	29	30	1	2	3	4	5	6	7	8	9	10
27	[redacted]	LR @ 100cc/hr (HL)	6	/	[redacted]												
		when taking PO	14	/													
			21	[redacted]													
27	[redacted]	Ancef 1gm IV q8°	6	/	[redacted]												
			14	/													
			22	[redacted]													
27	[redacted]	Gentamycin 500mg IVX1 now	19	WD 3	DC'd												

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P (L) leg fasciotomy

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

EPW # [redacted] b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

All b(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)					Mo. 06 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials	
	- - - - -						
	- - - - -						
	- - - - -						
	- - - - -						
	- - - - -						
	- - - - -						
	- - - - -						
	- - - - -						
	- - - - -						
	- - - - -						
	- - - - -						
	- - - - -						
	- - - - -						

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
27	[redacted]	MSO4 2-10mg IVP	11 Jul 5mg IVP @0355	11 Jul 5mg IVP 1030												
- - - -	- - - - -	q 2° prn pain	[redacted]	[redacted]												
27	[redacted]	percocet i-ii po q	11 0430	1215	1810	25	11 PO	11 PO	11 PO	1200	11/3	2009	11 0945	July		
- - - -	- - - - -	4hrs	0810	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	1845		
27	[redacted]	Tylenol 650mg	0800	3 Jul 0819												
- - - -	- - - - -	po q 4 prn	0850	[redacted]												
27	[redacted]	MOM prn														
10	[redacted]	Phenergan 25mg														
- - - -	- - - - -	IVP q 4° PRN														
11 Jul	[redacted]	Benadry 50mg IV	11 Jul 0817													
- - - -	- - - - -	TID PRN pruritis	50mg IVP [redacted]													
- - - -	- - - - -															
- - - -	- - - - -															

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MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 27 JUN 03
Time In: 1625
Allergies: ?
Pre-op V/S: 120/64
Procedures: fasciotomy LLE

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid _____ Colloid 1L
OR Output: UOP 650cc EBL minimal
Meds/Times: _____

Drains		Airway
Hemovac	1	Nasal
NG		Oral
JP		ETT
T-tube		Trach
Foley		Other
TLS		

Pre Op Meds History

Time	1610	1615	1620
SaO2	94		
FiO2			
Methods			
240			
220			
200			
180			
160			
140			
120			
100			
80			
60			
40			
20			
RR	20	20	20
T	98.2	98.2	98.1

Time	1610	1615	1620
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
Fusile (L)		Presence of infiltration	CDL		Signs

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced, (0) Cyanotic	2	2	
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2	2	
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	11	11	

Codes

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

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

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

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

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: PCU #1

DATE: 27 Jun 03

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

#[redacted] b(6)-4

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

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		+	+	P	B	W	Pk
15'		+	+	P	B	W	Pk
30'		+	+	P	B	W	Pk
45'							
60'							
90'							
D/C							

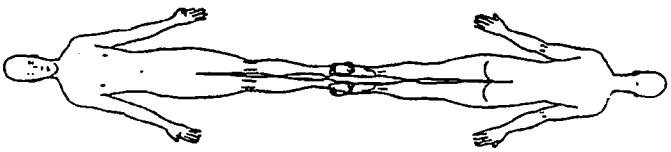
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) LE	Bandage around cast	Ø
30'			Ø
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1720	~~S.S.~~ SR	NO	Yes

WAMC OP 173-E

NURSING NOTES

Pt. from OR. to ICU 1, recovery Fasciotomy (L) LE. VSS SpO2 96% RA IV site in (L) FA infusing LR, Foley to gravity, intact. Dressing & cast wrap (L) LE, Ø obvious drainage, CDI Stable post op Recovery Transport to ICU [redacted] b(6)-2

Discharge Criteria:
Date: 25 Jun 08 **Time:** 1720 **PARS:**
BP: 121/51 **T:** **HR:** 80 **RR:** 19 **Sa02:** 95
Pain Level at D/C (0-10):
Intake: _____ **Output:** _____
Additional Data: _____
Transferred To: ICU 2
Report Given To: Lt [redacted] b(6)-2
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: _____
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: _____

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 29 JUN 03
Time In: 0945
Allergies: NKA
Pre-op V/S: 133/71 94
Procedures: I+D (R) Thigh

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 400 Colloid
OR Output: UOP 400 EBL Minimal
Meds/Times: —

250 mcg Fent

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds

History

Time	0900	1005	1010	1015	1020	1025	1030	1035	1040	1045	1050
SaO2	98	100	100	100	100	100	100	100	100	100	100
FiO2	10L	10L	10	8	8	6	6	5	2	2	1
Methods	NRB	NRB	NRB	NRB	NRB	NRB	NRB	NC	NC	NC	FM
240											
220											
200											
180											
160											
140											
120											
100											
80											
60											
40											
20											
RR	12	12	13	14	14	17	17	12	16	20	18
T	97										

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1050	LR	100cc	L FA	IV	100cc

X-rays:

Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	1	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2	2	2
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	9	11	12

Codes

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

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

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

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

Time	0950	1040
Pain (0-10)	0	0
LOS	X	X

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

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC: TCU 2

DATE: 29 JUN 03

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

EPW # [redacted] b(6)-4

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

All b(6)-2

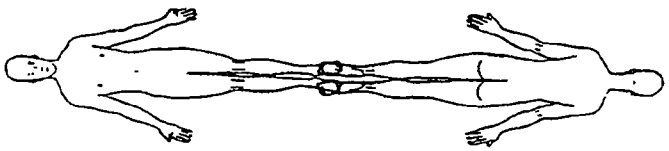
MEDICATIONS						
Allergies:						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR							
Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(L) LE	+	+	P	S	C	PK
15'	(L) LE	+	+	P	B	C	PK
30'	(L) LE	+	+	P	B	C	PK
45'	(L) LE	+	+	P	B	C	PK
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			X				
Lochia			X				
Peripad#			X				
Fund. Cond.			X				

DRESSINGS			
Time	Location	Type	Drainage
Adm	(L) LE	Soft Cast & Ace Wrap	Ø
30'			
60'			
D/C			



PACU OUTPUT			
Time	Source	Color/Appearance	Amount
1050	Foley	Yellow/Clear	100

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

0950 Recieved Asleep but arousable. oral airway (J) in. O_2 SAT @ 89% Placed on 10L NRB. IV to (L) Arm patent/flushed. Foley to Gravity. I & D of (L) LE DRSG Intact, Clean/DRY. Palpable femoral (L) LE. All other Pulses good. Will Continue to monitor. — [redacted] 91WM SGT

0953 SP/t out J tube, coughing up thick yellow secretion ↓ NRB to 8L lungs clear (CTA) bilaterally (-) BS x 4 quads. Will Continue to monitor Ø c/o Pain — [redacted] SGT 91WM

1035 Placed on 5L NC SAT 100% Asleep but arousable. — [redacted] 91WM SGT

1045 Sitting up awake. Ø Complaints of Pain able to Cough & Deep breathe. O_2 @ 2L via NC. — [redacted]

1050 Awake & stable for transport to ICW. Report Given to Charge Nurse ICW 2 — [redacted] SGT 91WM

Discharge Criteria:
Date: 29Jun03 Time: 1100 PARS: 12
BP: 121/73 T: 97.9 HR: 87 RR: 18 Sa02: 100%
Pain Level at D/C (0-10): 0
Intake: 100 Output: 100
Additional Data: (L) LE DRSG, CDI
Transferred To: ICW 2
Report Given To: LT [redacted]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: SGT [redacted]
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature [redacted]

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED *(Date)*

Date: 1 JUL 03
Time In: 1053
Allergies: [illegible]
Pre-op V/S: [illegible]
Procedures: 100 DPM(R) [illegible]

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 500 Colloid
OR Output: UOP EBL
Meds/Times: [illegible]

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds History

Time	1045	1100	1115	1130	1200	1230
SaO2	95	95	97	97	97	96
FiO2	RA	RA	RA	RA	RA	RA
Methods						
240						
220						
200						
180						
160						
140						
120						
100						
80						
60						
40						
20						
RR	26	25	12	14	23	24
T	98	98	98	98	98	98
Time	1100	1130	1200			
Pain (0-10)	2/10	2/10	0/10			
LOS						

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	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	2	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	—	—	—
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	9	10	10

Codes

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

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

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

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

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

(Continue on reverse)

PREPARED BY (S[redacted] b(6)-2 [redacted] 99 [illegible]

DEPARTMENT/SERVICE/CLINIC: [illegible]

DATE: [illegible]

PATIENT'S IDEN[redacted] *yped or written entries give: first, middle; grade: [redacted] or medical facility)* *Name – last,*

EPW [redacted] b(6)-4

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

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 10 July 03
Time In: 1055
Allergies: NKA
Pre-op V/S: 110/60 98
Procedures: ORIF Plating

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 500 Colloid 0
OR Output: UOP 0 EBL Min
Meds/Times: 30mg of 2 versed

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

Airway: ~~Nasal~~ Oral ETT Trach Other

Pre Op Meds / History

Time	1100	1105	1110	1115	1120	1125	1130
SaO2	99	97	99	99	96	96	97
FiO2	60	RA	RA	RA	RA	RA	RA
Methods							
240							
220							
200							
180							
160							
140	✓	✓	✓	✓			
120					✓	✓	✓
100							
80							
60							
40							
20							
RR	22	22	22	19	18	20	18
T	97						98
Time							
Pain (0-10)	0					0	
LOS							

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	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	1	1
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] LPN

b(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU #2

DATE: 10 July 03

(Typed or printed entries give: Name – last, first, middle; grade, [redacted] hospital or medical facility)

#[redacted] b(6)-4

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

All b(6)-2

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

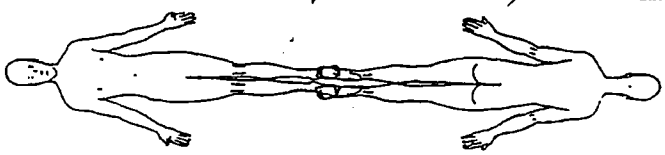
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	LLE	Splint & Ace	Ø
30'	LLE	Splint & Ace	Ø
60'	LLE	Splint & Ace	Ø
D/C	LLE	Splint & Ace	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

10 July 03 - Nursing - Pt admitted for Recovery. VSS. Pt easily arousable. Pt placed on 2L simple mask sats 99-100%. Drsg - splint & Ace wrap clean, dry, intact. Neurochecks to LLE, WNL. [redacted] LPN
1:30 - Pt off O2 sats 95-98 b/a VSS. Drsg C/D/I. Pt awake. Able to move all extremities. [redacted] RN
2:05 - Pt VSS. Alert. Able to move all extremities. DRSG to LLE C/D/I. Neuro checks WNL.
[redacted] LPN

Discharge Criteria:
Date: 10 July 03 **Time:** 12:10 **PARS:** 9
BP: 135/65 **T:** 98 **HR:** 82 **RR:** 18 **Sa02:** 97
Pain Level at D/C (0-10): Ø
Intake: Ø **Output:** Ø
Additional Data: Ø
Transferred To: ICW #2
Report Given To: LL [redacted]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Recovery [redacted]
Charge Nurse Signature [redacted]

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF						2. MTF LOCATION		(State or Country Code.)
1	2	3	4	5	6	7	8	
A	1	1	D	1		I	Z	

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
9 10 11 12 13 14 15 [redacted]	b(6)-4 EPW [redacted] b(6)-4	16 17 1	18 M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19 20 21 22 23 24 25 26	27 28 29: 3 0 y	30: Z	31: 9	Wpk

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
N/A	46: U	1317	N/A b(6)-4

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52: K 7 9	53 54 55 56 57 58 59 60 61

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
62 63	64 65 66 67 68 69 70	71	YEAR; [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: 0 b(2)-2	ICU1	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted]		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

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

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
87 88 89 90: A E A A	91 92 93 94 95 96	97 98 99 100 101 102: 0 3 0 6 2 7

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

FOR LOCAL USE

Dx: S/P (2) leg fasciotomy

T: 9
Inj: 104

Dx: 82320
9588
E8147

PR: 7817
8314
8659
9359
7906

ADMITTING OFFICE	SIGNATURE OF ADMITTING CLERK
[redacted] b(6)-2 b(6)-2 Dr [redacted]	[redacted] b(6)-2 PFC, 91610

DA FORM 3081, MAY

b(6)-4

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER [redacted]	2. NAME (Last, First, MI) EPW# [redacted] b(6)-4			3. GRADE EPW	ADMISSION REMARKS
4. SEX M	5. AGE 35y	6. RACE —	7. RELIGION —	LENGTH OF SVC —	9. ETS —	10. PREVIOUS ADMISSION NO
11. FMP 99	12. SSN [redacted]	13. ORGANIZATION b(6)-4				14. WARD ICW#2
15. FLYING STATUS —	16. DSG —	BEN K78	18. BRANCH/CORPS —	19. UIC/ZIP —		20. TYPE CASE WIA
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from ER			22. HOURS OF ADMISSION 1710	23. CLINIC SERVICE AEAA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: UNK			25. TYPE DISPOSITION 21	26. DATE OF DISPOSITION 1 Jul 03		b(6)-2
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK			27b. TELEPHONE NO. —	28. DATE OF THIS ADMISSION 27 June 03		ADMITTING OFFICER Dr. [redacted]
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b(2)-2				30. DATE OF INTIAL ADMISSION		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW and Thighs to buttocks

956.0 — 27 Jun 03
890.1 — 86.28
877.1 — 29 Jun 03
86.28
86.59

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	3	3

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFF[redacted] RECORDS OFFICER

Dr [redacted]

DA FORM 3647, MAY [redacted] IS OBSOLETE

b(6)-2 MEDCOM - 12202 b(6)-2

USAPPC V1.10

INPATIENT TREATMENT RECORD COVER SHEET

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

b(6)-4

1. REGISTER NUMBER [redacted]	2. NAME (Last, First, MI) EPW# [redacted]			3. GRADE	ADMISSION REMARKS
4. SEX M	5. RACE 374	7. RELIGION —	8. DATE OF SVC b(6)-4	9. ETS b(6)-4	10. PREVIOUS ADMISSION NO
11. EMP 99	12. SSN b(6)-4 [redacted]		13. ORGANIZATION —		14. WARD ICW#2
15. FLYING STATUS —	16. RATING/DSG —	17. DEPT/BEN K78	18. BRANCH/CORPS —	19. UIC/ZIP —	20. TYPE CASE WIA
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from ER			22. HOURS OF ADMISSION 1575	23. CLINIC SERVICE AEAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK		25. TYPE DISPOSITION 50		26. DATE OF DISPOSITION 27 June 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK		27b. TELEPHONE NO. —		28. DATE OF THIS ADMISSION 27 June 03	ADMITTING OFFICER DR.
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b(2)-2				30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: GSW bilateral thighs & Buttocks

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	1	1

36. Total Days All Facilities

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

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

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

35 yo male c GSW to b/l LE & buttocks
underwent washout & exploration by PST. Now, pt
doing well. Pain controlled.

PMH: PSH: Meds: Allr:

PHYSICAL EXAMINATION

Gen: NAD, NAD
Mouth: WNL
Lungs: CTA
Card: RRR s/p
Abd: soft, nt, nd BBS
Rectal: bypass or
Pelvis: stable

Vasc:

9.6 12/246 39.7

Neur: pt unable to sensation right leg. Also unable to move toes & sensation on right

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

Prog: GSW to b/l LE & buttocks
Plan: to OR for exam & washout
& exam under anesthesia

[redacted] b(6)-2

SIG[redacted]N	DATE 27 Jun 03	IDENTIFICATION NO.	ORGANIZATION
[redacted]FICATION	*(For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)*	REGISTER NO.	WARD NO. ICW2

EPW

[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

MEDICAL RECORD	PROGRESS NOTES

DATE
27 JUN 03
10 00 (4)

OPERATIVE NOTE

DIAGNOSIS: s/p GSW (B) Thighs / (R) buttock (Ø fxs)

PROCEDURE: 1) Proctoscopy
2) I+D (R) Buttock, FB Removal
3) I+D (R) thigh, FB Removal, wound expl, tagged injured sciatic
4) I+D (L) thigh

SURGEON: [redacted]

FINDINGS [redacted] b(2)-6 A11

Anesth: GOTA

Findings: Ø rectal injury. High division of sciatic nerve c̄ disruption of lat trunk. Tagged.

FLUIDS: EBL: 100 cc

Comps: Ø

Plans: Remove along tract of (R) thigh through + through GSW.

Disp: To ICU/Recovery stable, extubated.

b(2)-6

[redacted]

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

b(2)-4

[redacted]

33 yo JM

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

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
7JUN03	SURGERY PRE-OP DX: GSW TO RIGHT THIGH & BUTTOCKS c NEUROLOGICAL DEFICIT 2° TO SCIATIC NERVE INJURY & GSW TO LEFT THIGH PROC: WASHOUT OF WOUND - SCIATIC NERVE TAGGED SURG: [redacted] / [redacted] ANES: MAC FLUIDS: 1200 LR UO: 1400cc COMPLICATIONS: NONE NEUROSURG EVAL IN OR RECOMMEND WAITING 3 WKS TO REPAIR NERVE PATIENT STABLE TO PACU [redacted] b(6)-2
8JUN03	SURG: PROGRESS NOTE POD#2 PT STABLE APFEB VSS LUNGS: CTA CVS: RRR WOUNDS: EUA TODAY & POSSIBLE DISCHARGE IMP: STABLE PLAN: TO OR TODAY [redacted]

MEDICAL RECORD	PROGRESS NOTES
DATE	
27 June 03 2000	Rec'd pt from ICU 2 via litter, dx: GSW buttocks & thighs, condition stable. VS BP 142/76, P 84 temp 101.1 O2 sats 96% on RA. lung sounds CTA, abd soft round nontender. BS(+). ↓ext c̄ drains to ↑ thighs bilat (R) side c̄ mod amount of bloody drainage noted (+) pulses bilat, (L) side CDI. pt unable to move or wiggle toes on (R) side. ↑ ext c̄ full ROM (+) pulses. IV (L) FA c̄ LR @ 100cc/hr, (-) redness or edema. pt is NPO for poss. surgery in AM. Drains to buttocks CDI. MD aware of pts temp. (-) med ordered. (-) c/o pain @ [redacted] voided @ this time — [redacted] 91WME
	-foley cath to gravity intact draining cl yellow urine 3 diff. will cont to monitor — [redacted] 91WME b(6)-2
28 Jun 03 0300	Pt care assumed @ 2100. BP @ 178/86 @ 2100, pt c/o pain, 2mg MSO4 given for relief. At 0100 pt c̄ no pain, BP 120/84. Lung sounds CTA, pulses palpable x4, BS(+). Dsg on (L) Buttock CDI, (R) side heavily saturated. Dsg reinforced @ 0200. Pt c̄ (+) pulse, sensation and capillary refill in lower extremeties. IV @ LFA [redacted] running LR @ 100 cc/hr. Pt to OR in AM, NPO right now. Will continue to monitor. b(6)-2 [redacted] 91WME
28 Jun 03	0625 - Pt alert, VSS, lungs CTA, HR reg, BS(+). Dsg to (R) buttocks c̄ moderate drainage. Pulses (+) & strong bilat to ↑ & ↓ extremities. IV to (L) forearm infusing LR @ 100 cc/hr.

(continue on reverse side)

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

REGISTER NO.

WARD NO. ICW 2nd floor

EPW # [redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

All b(6)-2

PROGRESS NOTES

DATE	
	Gave MSO4 for pain. Pt sleeping comfortably. O/C to OR this Am — [redacted] 2/rtn
28 June 03 1515	assumed pt care @ 1300. ipt sleeping, arouses to painful stimuli. VSS. lung sounds CTA, abd soft nontender nondistented BS(+). drains to (R) upper thigh c̄ heavily saturated drainage, re-enforced. (L) upper thigh drains CDI, drains to buttock area c̄ mod amt of drainage. (+) pulses to ↓ ext. ipt given 4mg MSO4 @ 1315 by Maj [redacted] for pain. HL to CTA (-) s/sx of infection. BUE c̄ full ROM (+) pulses. Will cont to monitor — [redacted] 91WMC SGT
28 June 03 1913	ipt states "no feeling in (R) foot" pt stuck c̄ a pin (D) feeling on bottom, side of toes, started feeling around heel area. drains Ad to buttocks & thighs, wound site to (R) buttock 3" long approx 4" deep, wound packed c̄ wet to dry Kerlix covered by gauze, 1/2" wound to LR Buttock packed c̄ wet to dry Kerlix covered by gauze. (R) thigh c̄ 1" wound packed c̄ wet to dry Kerlix, (L) thigh 1" wound packed covered c̄ gauze. (-) signs of infection all sites c̄ sm amt of bleeding. ipt premedicated c̄ 4mg MSO4 ipt tol drains Δ well. Will cont to monitor — [redacted] 91WMC SGT
	- New IV started (R) hand c̄ 18g x 1 stick, HL (L) CTA dc'd intact ∃ diff — [redacted] 91 WMC SGT

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

All b(6)-2 except last

AUTHORIZED FOR LOCAL R

:DICAL RECORD

PROGRESS NOTES

DATE	NOTES
29June03	0640 Assume pt care @ 0500. pt awake and alert. VSS, temp 99.1. pt NPO for surgery today. Dsg Δ's done to ® thigh and buttock. Old dsg saturated c̄ yellow drainage. Dsg Δ to ® inner thigh. New dsgs CD&I. HR reg. Lungs CTA BS x 4 active. pt has no c/o pain @ this time. Will continue to monitor — [redacted]
29June03	HL to ® hand flushes well — [redacted] SWM6
1000	Pt is unable to wiggle toes on ® foot, ⊖ sensation ⊖ babinski reflex. pt c/o pain "10" percocet c̄ sip of H_2O odn — [redacted] SWM6
29JUN03	OP NOTE PROC DX: b/l THIGH WOUNDS & BUTTOCK WOUNDS c̄ KNOWN SUPATIC NERVE injury PROC: WASH-OUT & closure of POSTOPER WOUNDS SURG: [redacted] / [redacted] FLUIDS: 600 cc LR UO: NA STABLE TO RR BBL: min ∅ complication [redacted] JP DRAIN placed

INSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID N (SSN or Other)
	LAST	FIRST	[redacted]	

/SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO.

EPW # [redacted] b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (F
Prescribed by GSA/ICMP FPMR (41CFR) 101-1

All b(6)-2 except first

EPW0[redacted] b(6)-4 | MIDDLE INITIAL | ID NUMBER

NOTES

29Jun03 returned from OR via litter in stable
2000 condition - DTV @ 2400 - LR @ 100cc/hr
infusing into (R) FA IV - dsg's x4 CDI, 3
on (R) thigh/buttock, 1 on inner aspect of (L) thigh -
JP x1 from (R) buttock dsg c̄ 20cc bloody
drainage - tolerated water & an orange, given
1 Percocet PO and 2mg MSO4 IVP for pain @
1930 - (+) BS, lungs CTA (B), (+) 2 pedal pulses
(B), sensory deficit remains in (R) foot. MP
awake - pt. awake and oriented [redacted] AL
30Jun03 Rec'd pt @ 21:00 29Jun03. Pt. sleeping, easily awakened.
0259 Alert, Skin W/D. VS WNL according to flowsheet. PERRLA (+)
LCA (B). BS (+) x4, (+) PPP (B). Dsg to ↑ (R) thigh C/D/I. JP drain intact
~~o c/o~~ [redacted]. Attempted to get pt. out of bed. Pt. refused and said
tomorrow he'll try. c/o pain x1 1/2 Percocet given. Will
cont to mon [redacted] SGT/AN
Addendum Pt. voided 300cc clear yellow urine c̄ strong odor [redacted] AN
30Jun Assumed care of pt @ 0500. Pt is awake and
alert. HL in (R) arm, patent and flushed. Pt received
percocet 1/2 tabs @ 0500 for pain. Lung sounds CTA.
Bowel sounds x 4 quads. Will continue to monitor.
[redacted] SGT Quimb
30Jun Dsg d'd @ 1000 hrs. ∅ drainage. ∅ s/s of infection.
[redacted] Quimb, SGT

PREVIOUS EDITION IS USABLE

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
27 June 03	(3) Dyo. of sustained mult. GSW's VS. Frag. wnds to both lower Ext. + Buttocks. Pt A+O x3, c/o pain in (R) leg.
B/p: 136/68	
P: 93	O: HEENT: WNL
R: 18	Chest: Sym mm. Resp. Eff.
	Lungs: equal BS (B)
PMHx: ?	Heart: RRR
	Abd: Soft & tender, ↑ trauma
PSHx: ?	Genit: WNL
	Rectal: NST, ↑ gross Blood
allergies: ?	Pelvis: stable.
	Buttocks: wnds x2 in (R) Buttock lateral to anal verge.
	Ext: upper Ext: WNL
	(R) leg: Entrance wnd medial post thigh, Exit wnd lat thigh. Distally vasc. intact. ? decreased sensation distally. Pt unwilling to fully straighten hip joint. (over)

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.

Iraqi Male

[redacted] b(6)-4

33 yo JM

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)
	(2) thigh; single wnd lat. thigh No exit seen. Distally N/V intact c/ full ROM.
	xRays; Retained frags in Buttocks + both thighs. No fx's seen.
	Imp: Multi. fragwnds left.
	Plan: (1) to OR for rigid proctos + washout/ debridement.
	[redacted]

STANDARD FORM 600 (REV. 6-97) BACK

All b(6)-2 except last.

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
30JunO3 1400	assumed care @ 1300 - VSS - medicated for pain in buttocks - 18g SL placed in (R) AC, old site in (R) FA tender to touch & S/S infection - dsg intact on (L) thigh & (R) buttock/thigh x3. JP draining small amount — [redacted]
30JunO3 2130	Pt care assumed @2100. VSS, a&ox3, @pain. HL @ RAC patent, IV ABX. Lung sounds CTA, pulses palpable x4, bs(+)x4 quads. Dsg on (R) thigh CDI, (R) buttock CDI. All dsg's on (R) thigh CDI, JP site intact. Pt with (+) ROM, sensation and capillary refill in both lower extremeties. No complaints, will continue to monitor. [redacted] 9LWM6
0400 1 July	25cc drained from JP tube [redacted] 9LWM6
1 July03 0500 98.8 80 16 110/80 97%	0700 - Pt alert lying in bed. Dsg to wounds intact. Will Δ later this shift. VSS, lungs CTA, HR reg, BS(+). Pulses strong + equal bilat to ↑ & ↓ extremities. HL to (R) forearm infusing antibiotics. Voicing ∅ complaints at this time. Will cont to monitor. [redacted] 2LTAK

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. TWR

EPW [redacted] b(6)-4

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
1 Jul 03 1610	assumed care @ 1300 - VSS - no % pain @ this time - pt. reported through interpreter that he was not eating because he does not want to have a BM due to the pain it may cause, through interpreter he stated understanding that he must eat to promote wound healing - (R) buttock and thigh wound undressed by MD and left open to air, JP drain in place in (R) buttock wound - pt. has dc orders for Iraqi hospital when transport [redacted] available - IV patent, abx continue [redacted] BAN

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

Ortho EMAC Note

[illegible] 3520 Iraqi ↑ GSW (P) post thy & Buttocks

prop Dx: (D) Thy GSW

Post op Dx: same ± (e) Sciatic N. Inj

procedures: I&D, wound irrigation

Delayed 1° closure

tagged Sciatic N. & drained for later Rep

Surgeons: [redacted] b(6)-2

Hosp Course: [redacted]

Plan) Cont abx warm

DSG Δ BID DSD

WBD if needed

Neurosurg eval 6 weeks for

Cable Graft repair Sciatic N.

Pain mgmt [illegible]

b(6)-2 [redacted]

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

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

[redacted] b(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
1 JUL 03	TRANSFER NOTE PT IS MULTIPLE FRAGMENT & GSW TO POSTERIOR THIGH & BUTTOCK S/P WASHOUT & DEBRIDEMENT ON 2 OCCASIONS & NOW IS LARGE POSTERIOR WOUNDS CLOSED. PT DOING WELL c/o FOOT NUMBNESS & DROP c/w SCIATIC injury MONITORED WITH SURGERY o/w IS COMPLIANT DIAGNOSIS: MULTIPLE WOUNDS RIGHT PARTIAL SCIATIC NERVE INJURY IS NEUROLOGICAL SEQUELA PLAN: May TRANSFER TO CIVILIAN HOSPITAL DC DRAIN WHEN DRAINAGE LESS THAN 30cc/day REMOVE SUTURES IN 7-10 DAYS CONT bid WET TO DRY DRESSING AS UNTIL ANTERIOR WOUNDS HEALED CONTINUE Tz 1-2 PO q4° FOR PAIN. b(6)-2 [redacted]

AUTHORIZED FOR LOC/

:DICAL RECORD

PROGRESS NOTES

DATE	NOTES
1July03 @2345	Pt. sleeping, easily aroused. VSS. LCTA (B), (+) BS all quads, good peripheral pulses. HL to (R) FA infusing abx ∃ complications. Drsgs intact on (R) thigh & buttocks. (+) sensation & good cap refill in all extremities. Given II Percocet for pain. Will con't to monitor — b(6)-2 [redacted] (PN SR
2July03 @0400	JP drained 7cc watery/bloody fluid c̄ small 4mm size clot noted. — [redacted] 91WM6 b(6)-2

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

/SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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 50

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TRE[redacted] b(2)-2

LOG NUMBER

ARRIVAL			
DATE			TIME
DAY	MONTH	YR.	
27	JUN	03	1515

TRANSPORTATION TO H[redacted]DS. (tetanus immunization and other data)
(Attach care enroute sheet)
☐ PRIVATE VEHICLE ☐ AMBULANCE
☐ OTHER (Specify) Medevac Ø

HISTORY OBTAINED FROM
☑ PATIENT ☐ OTHER (Specify) Via interpreter

ALLERGIES PCN

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration) Pt's GSW → S/P Bilateral Thighs & Buttocks

SEX M AGE 35

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

VITAL SIGNS			
TIME	1515	1630	
BP	141/72	134/70	
PULSE	97	90	
RESP.	20	18	
TEMP.	100.1		
WT. (Child)	100 kg	95%	

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

35yo Iraqi ♂ S/P GSW's to thighs & buttocks.
POC: ICU for recovery

TIME SEEN BY PROVIDER

CATEGORY (See reverse)
- EMERGENT
- URGENT
- ✓ NON-URGENT

ORDERS	INITS.	TIME
IVF's	[redacted]	1515
CBC, Chem12, Lytes	[redacted]	1530
CXR	[redacted]	1600

b6-2

ASSESSMENT/DIAGNOSIS
S/P GSW's to buttocks + thighs

DISPOSITION (Check all that apply)
- HOME
- FULL DUTY
- QUARTERS: 24 Hrs. / 48 Hrs. / 72 Hrs.
- MODIFIED DUTY UNTIL: DAY / MONTH / YEAR
- REFERRED TO (Indicate clinic)
- EMERGENCY / TODAY
- 72 HOURS / ROUTINE
- ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
- IMPROVED
- UNCHANGED
- DETERIORATED

TIME OF RELEASE:

(CONTINUE ON SF 507, IF NEEDED)

PATIENT'S IDENTIFICATION (Mechanical imprint)
FOR WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: [redacted] FACILITY HOLDING TREATMENT RECORD [redacted]

b(6)-4

SIGNATURE OF PROVIDER AND ID STAMP

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

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: 33

HEIGHT:

WEIGHT: 100 kg

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

3. PREVIOUS SURGERY [ ] NO [ ] YES (type): b(6)-2

4. PROPOSED SURGICAL PROCEDURE: [redacted] s/p GSW ~~Proctoscope~~ I&D of wounds

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition Multiple bruises & cuts
Tobacco Ø ppd X___yrs. Body Piercing Ø Diabetes (Y) (N) ROM ↓ ASA/Motrin w/72 hrs (Y) (N)
ETOH Ø Implants Ø Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures Ø Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

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

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

[redacted] b(6)-4

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

All b(6)-2

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOME	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility ✓ 2) Positioning ✓ 3) Existing Disease ✓ 4) Safety Devices ✓ 5) Hypothermia	✓ Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	✓ Check for support stockings or ace wraps. If none, check with doctors. ✓ Check that safety straps are correctly applied. ✓ Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. ✓ Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to: ✓ 1) Pain ✓ 2) Intraoperative Hazards 3) Prosthesis ✓ 4) Positioning ✓ 5) Transfer pt. to/from OR table E.2. ✓ Potential discomfort due to: ✓ 1) Length of Surgery ✓ 2) Positioning 3) Arthritis	✓ Pt. will be transferred to OR table without difficulty. ✓ Pt. will not experience unnecessary physical discomfort.	✓ Have sufficient people available for transfer. ✓ Insure proper body alignment. ✓ Allow patient to lie in position of comfort while waiting for surgery. ✓ Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated 2) W/O Glasses F.2. ✓ Potential for decreased communication due to: 1) Diminished Hearing ✓ 2) Language Barrier F.3. Potential injury due to dentures: 1) Upper 4) Caps 2) Lower 5) Crowns 3) Bridges	✓ Pt. will be made aware of surroundings prior to anesthesia induction. ✓ Pt. will be transferred safely to OR table. ✓ Pt. will be able to understand instructions. ✓ Minimize danger of injury during intraop period.	✓ Introduce self. Keep pt. informed as to where he/she is and what is happening. ✓ Inform pt. in which direction to move and assist if necessary. ✓ Speak clearly and slowly. ✓ Address pt. from either side. ✓ Validate pt.'s understanding of verbal communication. ✓ Verify removal of dentures.
G OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

10. O[redacted] COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTION S NOTED.

[redacted] 7ND 27JUN03 DATE

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

LEVEL OF CONSCIOUSNESS: ☐ A&O ☒ Drowsy ☐ Sleepy ☐ Intubated BREATHING EASY: (Y) (N)

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

12. PREOPERATI[redacted] EVALUATION PREPARED BY (Signature and Title) [redacted] 7D

DATE: 27JUN03 TIME: 1700

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

DATE: 27JUN03 TIME: 1815

REVERSE OF FORM 5179, JUN 91 MEDCOM - 12220 USAPA V1.0

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: 33 yrs.

HEIGHT:

WEIGHT:

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

3. PREVIOUS SURGERY [ ] NO [✓] YES (type):
IDD Rt Buttock & thigh

4. PROPOSED SURGICAL PROCEDURE:
Washout IDPC Thigh (R)

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition_____
Tobacco____ppd X___yrs. Body Piercing_____ Diabetes (Y) (N) ROM_____ ASA/Motrin w/72 hrs (Y) (N)
ETOH_____ Implants_____ Respiratory Disease (Asthma/COPD) (Y) (N) /Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures_____ Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

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	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. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: ___ 1) Positioning ✓ 2) Effects of Anesthesia ___ 3) Medical/Smoking History	o Pt. will be able to breathe without difficulty during immediate intraoperative 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 integrity due to: ___ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement ___ 3) Positional Aids ___ 4) Prosthesis ✓ 5) Pooling of Prep Solutions	o Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	o Utilize pressure preventing devices on OR table and accessories. o Check for proper positioning and support to maintain good body alignment. o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling.

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

#[redacted] b(6)-4

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

A11 b(6)-2

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility 2) Positioning 3) Existing Disease ✓ 4) Safety Devices ✓ 5) Hypothermia	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o Check that rings 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	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, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated 2) W/O Glasses F.2. ✓ Potential for decreased communication due to: 1) Diminished Hearing ✓ 2) Language Barrier F.3. NA Potential injury due to dentures: 1) Upper 4) Caps 2) Lower 5) Crowns 3) Bridges	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 communication. 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 COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTION S NOTED.

[redacted] 29 Jun 03 DATE

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

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

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

BREATHING EASY: (Y) (N)

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title)

[redacted] MAJ AN

DATE: 29 Jun 03 TIME: 1225

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

DATE: 29 Jun 03 TIME: 1700

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

For use of this form, see AR 40-407, the proponent [illegible]cy is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA BY

2. PATIENT IDENTIFIED [redacted] OCEDURE
VERIFIED BY

3. DATE 27 June 03 TIME PATIENT ARRIVED IN SUITE 0730

4. PATIENT IN ROOM [redacted]
TIME 0745 NUMBER 60 b(6)-2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Interpreter Present, All to PCN - Itching

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Ax roll, Blankets padded

8. SKIN PREPARATION

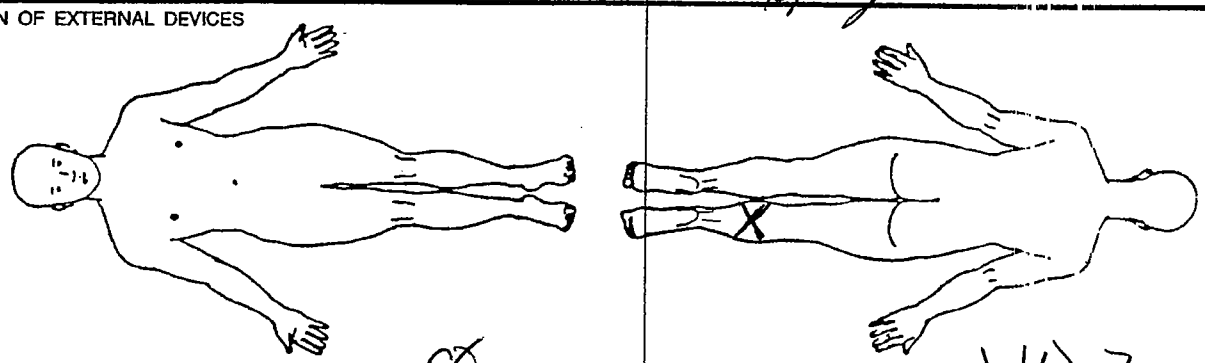
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine
SITE: Buttocks Blat BY WHOM: Cpt [redacted]
SITE: BY WHOM:

COMMENTS: Opaqueing b(6)-2

9. LOCATION OF EXTERNAL DEVICES



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

b(6)-2

C = Correct I = Incorrect

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

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

[redacted] b(6)-4

33 yo ZM

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

10/10

☐ ESU NO: F1043
GROUND PAD: BRAND Valley Lab
LOT NO: 64289

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

13. PROSTHESIS, IMPLANTS ☐ YE NO IF YES NAME: ID NU MANUFACTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

NSS - Pulse lavage - 8L

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 5/4" Penrose	2. 1/4" Net Gauze	3. 5/8" Penrose
SITE	1. (R) thigh	2. Buttock	3. (L) thigh

18. DRESSING/IMMOBILIZATION (Specify)

Fluffs
Kerlix
Medical Tape

19. ADDITIVE INFORMATION

DR. [redacted] LTC
DR. [redacted] LTC
DR [redacted] Col
Anes - LTC - Gen
[redacted]

b(6)-2

Bullet removed, Penrose placed
Blot P lavage of 8 L.

20. OPERATION(S) PERFORMED

I & D Right lateral thigh & buttock

21. PATIENT TRANSFERRED TO Jan TIME 1015 METHOD Litter

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

VERSE OF DA FORM 5179-1, OCT 87

*U.S. Government Printing Office: 1995 — 386-733/23952

MEDICAL RECORD

INTRAOPERAT[illegible] DOCUMENT

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

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

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

3. DATE 27 Jun 03 TIME PATIENT ARRIVED IN SUITE 1704

4. PATIENT IN ROOM TIME 1705 NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS: Normal anatomic body alignment maintained

8. SKIN PREPARATION

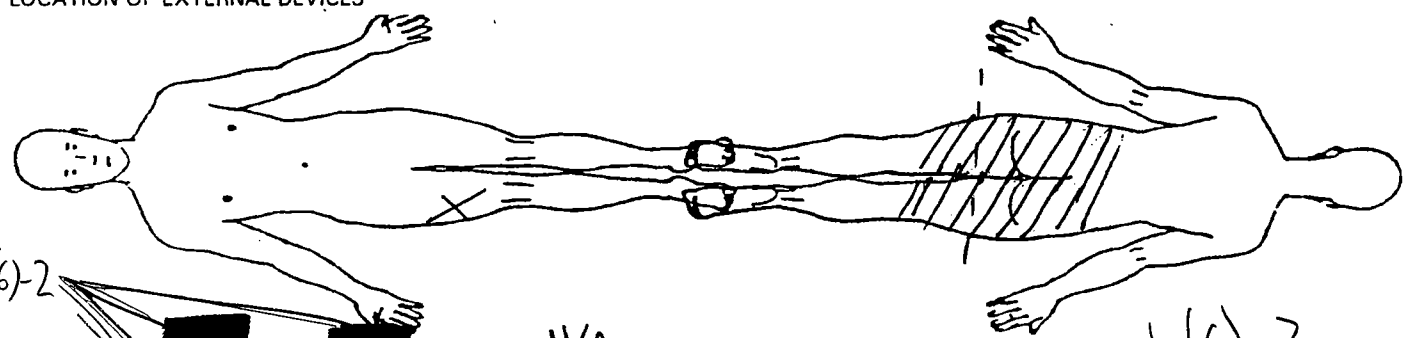
HAIR REMOVAL [X] YES [ ] NO
DONE BY: [X] OR [ ] NURSING UNIT
METHOD: [ ] DEPILATORY [X] RAZOR [ ] CLIP

COMMENTS: No nicks or cuts

PREP SOLUTION (Specify) Betadine/Betadine
SITE: lower back to knees BY WHOM: ILT [redacted]
SITE: BY WHOM:
b(6)-2

COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



b(6)-2 [redacted] [redacted] N/A

LEGEND X Ground Pad [redacted] Safety Strap = = = Tourniquet ☒ - prep b(6)-2

Initial: PFC [redacted] ILT

C = Correct I = Incorrect

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

[redacted] b(6)-4

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

[X] ESU NO: #3 Cut 30 Coag 30
GROUND PAD: BRAND VL REM Polyhesive
LOT NO: 69652 Exp 2005-03

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

[ ] BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
0.9% NaCl - Q.S.

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. ~~Right thigh~~ kerlix	2.	3.
SITE	1. Right thigh	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
fluffs, kerlix, ABD

19. ADDITIONAL INFORMATION
Surgeon: Dr. [redacted]
Anesthesia: MAJ [redacted] } b(6)-2

b(6)-2 DA 5179 initiated

20. OPERATION(S) PERFORMED [redacted]
~~Proctoscope~~
I x D of wounds

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU	1815	LITTER + O2

22. REGISTERED NURSE SIGNATURE [redacted] 117 N

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

b(6)-2 MEDCOM - 12226

b(6)-2

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Litter BY CPT [redacted] MAJ [redacted]

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY MAJ [redacted]

3. DATE: 29 Jun 03 TIME PATIENT ARRIVED IN SUITE: 1745

4. PATIENT IN ROOM TIME: 1745 NUMBER: 1-2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Pillows under chest, pelvis, lower legs, head on foam donut

8. SKIN PREPARATION

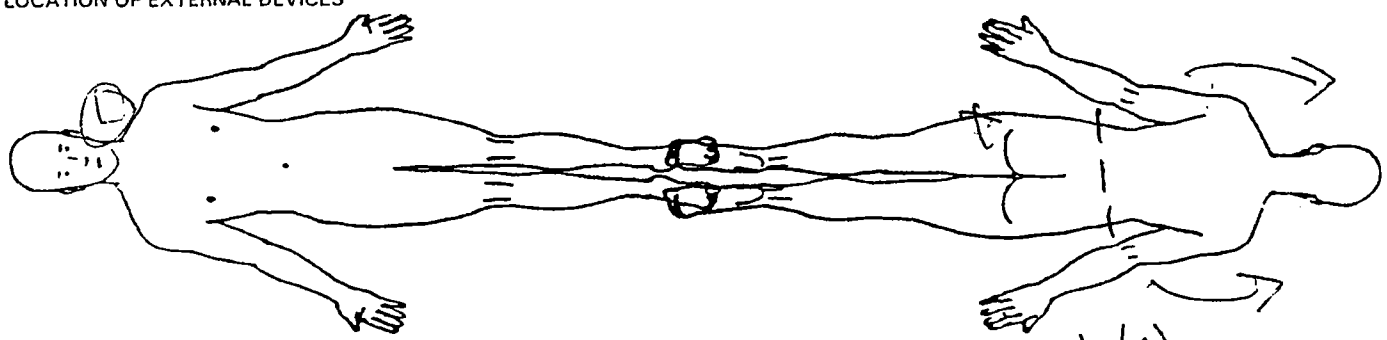
HAIR REMOVAL ☐ YES ☑ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Povidone scrub & solution
SITE: Rt buttock & thigh BY WHOM: CPT [redacted]
SITE: BY WHOM:
b(6)-2

COMMENTS: No pooling of solution

9. LOCATION OF EXTERNAL DEVICES



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

b(6)-2

10. COUNTS

C = Correct I = Incorrect

		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No		C	C	[redacted]	[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

[redacted]

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

☒ ESU NO: Valleylab #2
GROUND PAD: BRAND Valleylab
LOT NO: 68936 Exp 2005-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES D... ...ICH IS OBSOLETE. USAPA V1.01

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):
Nacl

OTHER ORDERS	TIME	CARRIED OUT BY
none		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. JP Drain	2.	3.
SITE	1. (R) thigh	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs
X-ray

19. ADDITIONAL INFORMATION

Surgeon: [redacted] [redacted]
anes: CPT [redacted]
Bovie plate site

b(6)-2

20. OPERATION(S) PERFORMED
Washout I DPC (R) thigh

b(6)-2

21. PATIENT TRANSFERRED TO ICU 1 TIME see DA 7389 METHOD Litter

22. [redacted] CPT IAN [redacted]

REVERSE OF DA [redacted] 7 USAPA V1.01

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR June 2003 | DAY: 27, 28, 29, 30, 2, 3, 4 | HOUR

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

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

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

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICW2

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

CIV [redacted] b(6)-2

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET	FROM 0[illegible] HOURS TO 0500 HOURS	TOTAL HOURS COVERED 24	DATE 29 June

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
	NPO		

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL

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

TIME	~~TYPE~~ OUTPUT	AMOUNT	ACCUMULATIVE TOTAL
1220	Dark Tea Colored Urine	475	

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

[redacted] b(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3830(TEMP) 1 JUL 72

*U.S.GPO:1998-404-613/30343

TWENTY-FOUR HOUR PATIENT . AKE AND OUTPUT WORKSHEET	FROI HOURS TO HOURS	TOTAL HOURS COVERED	DATE

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
12	H2O	100	
18	Milk	240	340

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
2100	C/U	700	700
0900	Cyu	1000	1700
0930	Foley pulled		
1400	Cyu	700	2400
1335	Cyu	750	3150
1700	Cyu	400	7550

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

EPW [redacted] b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

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

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JU

*U.S.GPO:1998-404-613/30343

TWENTY-FOUR HOUR PATIENT IN...E AND OUTPUT WORKSHEET	FROM 2 HOURS TO 0000 HOURS	TOTAL HOURS COVERED 24	DATE 30 Jun

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0830	H_2O	200	200
0630	H_2O	200	400
1200	H_2O	120	520

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
06	50	ancef	50		50
14	50	ancef	50		100

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0300	dk yellow strong odor	300	300
0700	dk yellow	280	580
0850	lt. yellow urine	600	1180
1355	lt. yellow urine	425	1605
1700	" "	400	2005
2214		400	2405

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE JP Drain

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0420	sanguinous	25	25
0904	bloody drainage	10	35
1925	bloody drainage	15cc	50cc

GRAND TOTAL INTAKE

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

EPW [redacted] b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

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

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 7... WHICH MAY BE USED

*U.S.GPO:1996-404-613/30343

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET	FROM ___ HOURS TO 2359 HOURS	TOTAL HOURS COVERED 24	DATE 30 Jun 03

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0200	Ado	200cc	200cc
0630	H_2O	200	500

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL

DPL only

Urine ~~IRRIGATIONS (N/G, Bladder, etc.)~~

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0320	dk yellow c strong odor	300cc	300cc
0700	dk yellow	280cc	580cc
0950	lt yellow urine	600cc	1180 cc
1355	" "	425cc	1700 cc

See Dylan Doc

BLOOD/BLOOD DERIVATIVES

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

JP Drain ~~OTHER INTAKE~~

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0620	serosanguinous	25cc	25cc
0904	bloody drainage	10 cc	35 cc

GRAND TOTAL INTAKE

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

EPW # [redacted] b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

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

DD FORM 1 JAN 74 792 — EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL

*U.S.GPO:1998-404-613/30343

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM _____ HOURS
TO _____ HOURS

TOTAL HOURS COVERED

DATE 1 July 05

INT

JP Correct

TIME	TYPE	AMOUNT	ACCUM TOTAL
0400	Bloody fluid IJ	25cc	25
1000	Bloody fluid	15	40
1200	Bloody fluid	25cc	75

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL

Urine

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
1250	Yellow urine	300cc	

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

CPL [redacted] b(6)-4
C LV

INTAKE EQUIVALENTS (Serving levels cc)

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

DD FORM 1 JAN 74 792

ION OF 1 SEP 54 IS OBSOLETE. REPLACES ORM 3630(TEMP)
L 72 WHICH MAY BE USED.

*U.S.GPO:1998-404-613/30343

TWENTY-FOUR HOUR PATIENT INT... AND OUTPUT WORKSHEET

FROM 0 HOURS TO _____ HOURS | TOTAL HOURS COVERED | DATE 2July03

INT

JP OUTPUT

TIME	TYPE	AMOUNT	ACCUM TOTAL
0400	bloody fluid.	7cc	7cc

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

INTAKE EQUIVALENTS (Serving levels cc)

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

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 72

*U.S.GPO:1996-404-613/30343

EMT

[redacted]

b(6)-2
21 jun 03 1580

[redacted] b(6)-4

(i-STAT)

TEST	RESULT	REF RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BExcf		(-2)-(+3) mmol/L
AnGap		10-20 mmol/L
iCa		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		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB	3.0	3.5-5.5 g/dl
ALP	60	26-84 u/l
ALT	31	10-47 u/l
AMY	31	14-97 u/l
AST	55	11-38 u/l
TBIL	0.8	0.2-1.6 mg/dl
BUN	8	7-22 mg/dl
CA	8.1	8.0-10.3mg/dl
CHOL	112	100-200 mg/dl
CRE	0.9	0.6-1.2 mg/dl
GLU	107	73-118 mg/dl
TP	5.9	6.4-8.1 g/dl

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		8-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA	~~140~~ 140	128-145 mmol/l
K	3.8	3.3-4.7 mmol/l
CL	105	98-108 mmol/l
tCO_2	28	18-33 mmol/l

REMARKS:

REPORTED BY: [redacted]

DATE: 27 Jun 03

LAB ID NO.:

b(6)-2

CBC

b(6)-2

Ward/Section: EMT | REQUES: [redacted] | **LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: #[redacted] b(6)-4 | TIME: 1530 | SSN/PSEUDO SSN

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	9.6	4.8-10.8 x 10^3
RBC	4.56	4.7-6.1 x 10^9
Hgb	12.2	14-18 g/dl (M) 12-16 g/dl (F)
Hct	39.7	42-52% (M) 37-47% (F)
MCV	87.0	80-94 fl (M) 81-99 fl (F)
Plt	246	130-500 x 10^3 verified
Lymph %	26.2	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] b(6)-2 | DATE: 27 JAN 05 | LAB ID NO:

0730 cefotetan 2 gm IV

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)										
Fent	(cc)	2	1	2							
Ephed	(mg)	200									
Sux	(mg)	100									
Insc4	(mg)					2	2	2	2	2	
	( )										
	( )										
VOLAT AGENT	% del	1.5	1.5	2	2	2	2	2	1.5	X	
	% e.t.										
AIR	L/Min										
N2O	L/Min										
O2	L/Min	5	5	4.5	5	5	5	5	5	5	

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

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

FLUIDS

LINE site										
(L) ☐ Warmed	1000	1200	1500	2000	2200	2300				
(R) ☐ Warmed	1000	1100	1400							
☐ Warmed										
☐ Warmed										

LOSSES — EST BLOOD LOSS; URINE – 200, 900

TIME	0745	0800	0815	30	30	0900	30	30	1000	30	x	1020

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 100 KG LB

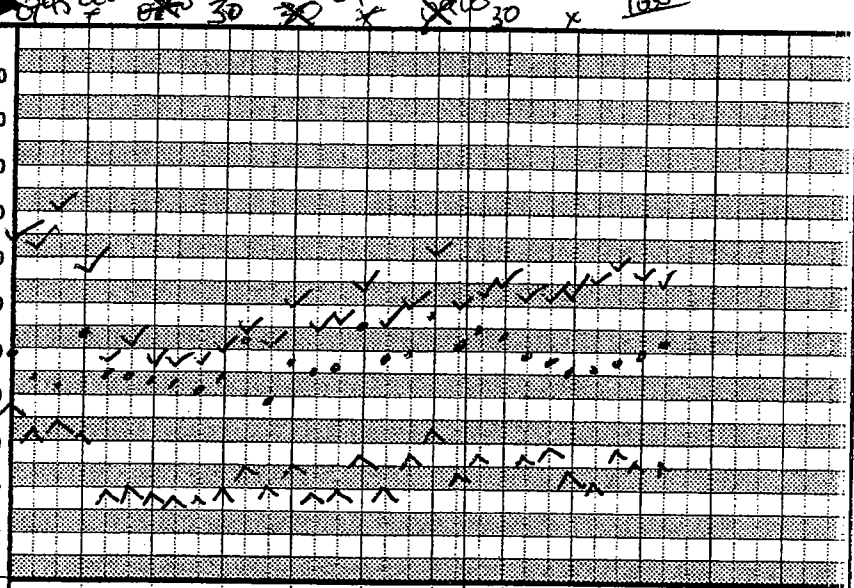
HEMATOCRIT:

INITIAL DATA: BP – 147, 71; HR – 99

EQUIP CHECK: OK? – Y N

PATIENT RECHECK: OK for PROCEDURE – Y; TIME – 0738

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



VENTIL

VT – ml										
f – breaths/min		23	25	35	25	30	32	24	24	24
Peak inf pres / PEEP										
MODE – S(pon), A(ssist), C(on)		S	S	S	S	S	S	S	S	S

MONITORS / ACCESSORIES

X BP/Auto Cuff	X ET CO2 (torr)	48	50	44	54	53	51	52	48	45
BP / oth	X FIO2 (Frac or %)	.7	.7	.7	.7	.7	.7	.7	.7	.7
ART line	X SpO2 (%)	100	98	98	97	99	100	100	100	100
X Steth- PC/ES	X ECG	SR	SR	SR	ST	ST	SR	ST	SR	SR
Gas analyzer	TEMP- site									
	N-M Block (T/4)			4/4						
Warming blkt										
Conv warmer										

Mark with letters & symbols, explain under REMARKS — EVENTS: on (R) off; Position: on

TOTALS — TOTAL EBL: 100; TOTAL URINE: 900

FLUIDS – SUMMARY: CRYSTALLOID – 3700; COLLOID –; BLOOD –

REMARKS – Code drugs with numbers, events with letters

0730 - pt interviewed thru intubation
0745 in OR
0800 - turned (L) lat. Ar roll in place; eqpt exam checked BS - BL.
0815 - turned supine
1010 - extubated

RECOVERY AT 1015; PACU: ICU (Specify); OTHER; CONDITION: stable SV; RESP – 21; SpO2 – 100; BP –; HR – 97

TIMES

	Start	Room	End
ANES	0730	0745	1020
PROC	Ready	Begin	End
	0800	0815	1010

PROCEDURES and CPT Codes: EUA/proctoscopy, drg. of (R) thigh + (R) buttock wounds; (L) thigh

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Pre OP PLT 1, chews 2 jaw, intubated 2 ETT, BS = BL & 2 cm, extubated BS = BL & TOL WX 1

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

SURGEONS: [redacted]

ANESTHETIST: [redacted] b(6)-2

PROCEDURE LOCATION: OR

DATE: 27 JUN 03

PAGE 1 OF

b(6)-4

b(6)-2

ESTHESIA PLAN OF CARE PRE...OCEDURAL ASSESSMENT (Sedation/Anesthesia)

35 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

ASA Physical State 1 (2) 3 4 5 (E)
WT: 100 (KG)/LB HT: ____ IN.
ALLERGIES: PCN

POSED PROCEDURE: I&D Leg Wounds
GICAL SERVICE: Gen Surg
SINCE: 12hr

ITS:
BACCO: Ø
ETOH: ____
DRUGS: ____

RENT MEDICATIONS:
ordered as premed

Zofran Zantac
Cefotan 2gms 0730
MSO4

MEDICATIONS:
e Yes (@ ____ Hrs) /CC
__. ____ mg IV IM PO
__. ____ mg IV IM PO
__. ____ mg IV IM PO

ORATORY STUDIES:

HCT: ____/____
IER: ____

9.6 / 12.3 / 39.7 / 246

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	GSW to thigh & buttocks
	N	Y	
Familial HX	N	Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Wound exploration at FST
Hodge f

PHYSICAL EXAMINATION
BP 134/70 HR 90 R 18 T 100.1
Pain Scale 0-10 ____
HEENT - Teeth ____
Trachea ____
TMJ/Neck ____
Oropharnyx ____
Nares ____
CHEST: ____
CARDIAC: ____
EXTREMITIES: ____
IV Access: ____
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since ____

ESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ (X) General: Mask Intubation
Information from previous FST pre-op

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

patient/[redacted]rdian seems to understand and agrees. Questions answered.
ned: [redacted] Date: 27 Jun 03 Time: 1640 Hrs

b(6)-2

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

ned: ____ Date: ____ Time: ____ Hrs

ent Identification: (Ward) ____

EPW [redacted] b(6)-4

SEDATION KEY:

1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is n necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may be necessary.

NKDA

MEDICAL RECORD — ANESTHESIA

DRUG	(Route)	
Midazolam	(IV)	2
Glycopyrrolate	(IV)	0.2 / MSO4 3-4
Fentanyl	(IV)	50-<200
Lidocaine	(IV)	100
Propofol	(IV)	150
Sux	(IV)	100
VOLAT AGENT: ISO	% (in)	1.5 1.5 1.0 1.5
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	10 2 2 2 2 6

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

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

TOTALS	
2	
17	
250	

TOTAL URINE: Ø

FLUIDS – SUMMARY
CRYSTALLOID– 600
COLLOID– Ø
BLOOD– Ø

FLUIDS — LINE site 18G (R) A ☒ Warmed: LR #1 (500) — 500
☐ Warmed
☐ Warmed
☐ Warmed

LOSSES — EST BLOOD LOSS: MIN
URINE – Ø

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 100 (KG) LB

HEMATOCRIT: 39.7

INITIAL DATA: BP – 120, 80 HR– 88

EQUIP CHECK: OK?– (Y) N

PATIENT RECORD: OK for PROCEDURE? JM TIME– 1740

TIME → 1745 1800 30 1900 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	900	830	850	820	740
f – breaths/min	10	8	8	8	8
Peak inf pres / PEEP	27	28	27	27	27
MODE– S(pon), A(ssist), C(on)	S/C	C	C	C	C
ET CO2 (torr)	35	34	33	34	33
FIO2 (Frac or %)	0.89	0.89	0.89	0.89	0.89
SpO2 (%)	99	99	99	100	100
ECG	ST	ST	ST	ST	ST
TEMP- site AU					
N-M Block (T/4) BS	+	+			
x1 Blanket	→	→	→	→	

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

Mark with letters & symbols, explain under REMARKS — EVENTS (1) (2) (3) (4)
Position → supine / supine prone

REMARKS– Code drugs with numbers, events with letters

(1) Pre-op assessment NPO, PIV, meds pre-medicated Placed Glycopyrrolate
(2) Reviewed airway Rocuronium Induced O2 via bite block see airway management
(3) Turned prone eyes, nose, genitalia legs + arms flexed neck aligned + stable
(4) Turned supine Orotracheal bite. RR 78 + < 30 BPM; T 37.4 Responsive. OP suctioned. Extubated. Oropharynx suctioned. No problems

RECOVERY AT 1855
PACU ICU (Specify)
OTHER T-100.5
CONDITION: Stable awake
RESP– 12 SpO2– 100
BP– 143/73 HR– 110

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	1730	1740	1910
	Ready	Begin	End
PROC	1750	1806	1850

PROCEDURES and CPT Codes: I+D (R) thigh + (R) posterior

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA b(6)-2 Placed Ob + soft Bite Block

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: OLx1 MAC 4 Grade 1 view: 7.0 stylet OETT, 24cm Patent: 7.0 cuff: +BBS + Sust ETCO2

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

FPW # [redacted] b(6)-4

SURGEON [redacted]

AN[redacted] CRNA

[redacted] – ANESTHESIA

[redacted] b(6)-2

PROCEDURE LOCATION 1

DATE 29 Jan 03

PAGE 1 OF 1

OP 376 REVISED 1 Jan 99

MEDCOM - 12240

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