(b)(6)-2 all

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
0705		Demerol 25mg	IVP			[redacted]
0745		MSO4 1/2	IVP			[redacted]

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
0705	LE						
Adm	Below	Limited	+	P	B	W	WNL
15'	Below	Limited	+	P	B	W	WNL
30'	Below	Limited	+	P	B	W	Pk
45'							
60'							
90'							
D/C							

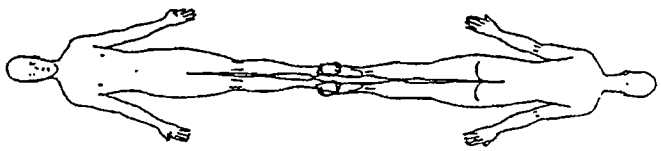
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 0705	(L) Arm	Kerlix	
30'	(R) Foot	ace	
60'	(R) Arm	Kerlix	
D/C	(R) Foot	ace	



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0705	S, SZ NSR		

WAMC OP 173-E

NURSING NOTES

Received Pt on OR via stretcher USS follows verbal commands Resp lg em. Spo2 98-99 2L O2 via NC. HR-S.S. NSR BS (+) x4 quads Peripheral pulses +3 (R) Radial +2. cap refill > 3 sec color WNL. [redacted]

0800. Pt alert and responsive to verbal and physical stimuli. Pt has Kerlix dressing (R) arm and ace bandage (L) foot. Pt resting on (R) side. Pt left Rectal edematous +1. dressing intact from above (L) elbow to wrist. (R) foot dressing intact from above toes to above ankle, no drainage [redacted]

0805. Pt DC to TCU. Pt alert and oriented x3. Pt in no distress. able to sleep quietly, awakens to deep breathe Q 5 mins - [redacted] Maintaining sat of 95 [redacted]

Discharge Criteria:
Date: 11/13/03 **Time:** 0805 **PARS:** 10
BP: 145/87 **T:** 99.0 **HR:** 135 **RR:** 20 **Sa02:** 95%
Pain Level at D/C (0-10):
Intake: 250cc RL **Output:**
Additional Data:
Transferred To: TCU
Report Given To: SPC [redacted]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature [redacted]

(b)(2)-2

Admission and Coding Information

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

1. Reporting MTF	2. MTF Location			
[redacted]	IZ			
3. Register Number	Name (Last, First, MI)		4. Pay Grade	5. Sex
0015255	[redacted] (b)(6)-4		FGN	M
6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
		X	9	
10. Length of Service	ETS	11. FMP	12. Social Security Number	
		99	[redacted] (b)(6)-4	
Organization (Active Duty Only)		13. Marital Status	Hour of Admission	Branch / Corps:
			22:00	
14. Flying Status	15. Beneficiary Category		16. Zip Code of Residence:	
	K78-PRISONER OF WAR/INTERNEES			
17. Unit Location	18. MOS	19. Trauma	Prev. Admission	
		DIS	NO	
20. Source of Admission	Ward:	Name / Relationship of Emergency Addressee		
Direct from ER	ICW2	Address of Emergency Addressee		
Name and Location of Medical Treatment Facility: [redacted] No Install Provided (b)(2)-2		Telephone Number of Emergency Addressee		
21. Type of Disposition	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD)		
TRF-OTH		2003-11-18		
24. Clinic Svc - Admitting	25. MTF Transferred From	26. Date this Admission (YYYYMMDD)		
ABA - GENERAL SURGERY		2003-11-12		
27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission		
		2003-11-12		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: S/P DEBRIM L ARM (MULT (PENETRATING WNDS)

Procedure Narrative(s):

Cause of Injury Narrative:

880.03
955.2
892.0
875.0
890.0
E991.9
86.28

Admitting Officer (Signature, as [redacted] (b)(6)-2

Signature of Admitting Clerk [redacted] (b)(6)-2

Automated Facsimile - DA FORM 2985, MAR 2000

ADMISSION AND CODING INFORMATION

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

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

3. REGISTER NUMBER							NAME (Last, First, Middle Initial)	4. PAY GRADE		5. SEX
9	10	11	12	13	14	15		16	17	18

6. DATE OF BIRTH (YYYYMMDD)								7. AGE AT ADMISSION			8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19	20	21	22	23	24	25	26	27	28	29	30	31	

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

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

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
		NAME AND LOCATION OF MEDICAL TREATMENT FACILITY / 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

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

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 8840 8910 9552 E9912

Pr 8628

Inj Trauma 450

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK

DA FORM 2985, MAR 89 EDITION OF MAY 79 IS OBSOLETE USAPPC V1.00

1. Register Nbr 0015286 | 2. Name [redacted] (b)(6)-4 | 3. Grade FGN | Admission Remarks

4. Sex M | 5. Age 50Y | 6. Race X | 7. Religion | 8. LnthOfSvc | 9. ETS | 10. PrevAdm NO

11. FMP 99 | 12. SSN [redacted] (b)(6)-4 | 13. Organization | 14. Ward ICU2

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

21. Source of Admission Direct from ER | 22. Hour Of Adm: 18:20 | 23. Clinic Service ABA - GENERAL SURGERY

24. Name/Relation of Emergency Addressee | 25. Type Disp HOME | 26. Date of Disp 2003-11-21

27a. Address of Emergency Addressee | 27b. Telephone No | 28. Date This Adm: 2003-11-19 | AdmittingOfficer: [redacted] (b)(6)-2

29. ReportingMTF [redacted] (b)(2)-2 | 30. Date Init Adm 2003-11-19 | 32. Units Blood Components

31. Selected Administrative Data

Marital Status: | DoB: 1953-01-01

In/Out Patient: Inpatient | MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

FACAIL BURNS,MULT CORNEAL PERF OD

871.6
871.0
941.30
945.10
944.17
948.00
366.20
371.20
372.89
364.70
E993
PR 86.28
11.59
11.1

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	3	3

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	3	3

[redacted] (b)(6)-2 Signature of PAD [redacted] (b)(6)-2

Automated Facsimile - DA FORM 3947, May 79

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

2 days' wait by explosion 2d ago. Burn to face, superficial burns to chest. Seen at Barana, MLE to US CSH 2d later.
No pu. Can't see clearly.

. PMH & ϕ

PHYSICAL EXAMINATION

100/60
NAD
Neck & clear. Eyes closed; exudate yellow. Vision [illegible]
fingers only
Neck → ϕ lesions
chest, CVA
Abd, superficial wounds
GU ϕ, (10) post thumb flex 2cm.

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

A/ 2day old Burn, shrapnel wd

P/ Admit
Clean off wounds & burn.

SIGNATURE	DATE	IDENTIFICATION NO	ORGANIZATION
[redacted]	11/13		

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

REGISTER NO

WARD NO

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRST ISSUE OF SF 539
OCTOBER 1975
GSAFPO 74-60

1357

21 Nov
DC HOME

ST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
5NOV03 1900)	VSS. Alert & Oriented (L) FA Saline lock patent/intact. OOB → BR. Voiding clear yellow urine. Consumed 50% of regular diet for dinner. Burns to face & arms cleaned & steriles NS Bacitracin oint applied & drying. OU sclera pink in color. Multi eye gtts instilled as ordered. 2 point restraints in place without compromising circulation or skin integrity. Will continue plan of care. [redacted]
26NOV03	(1325) Assumed care @ 0000. Pt alert, speaking Arabic. VSS. 0 c/o pain. Pt amb to BR for ⊘ shower ⊼ diff. SL in ⊙ ac flushes well ⊼ s/sx infection/infiltration. cont. OU gtts as ordered. Sclera cont to be pink. Pt applying Bacitracin to burns. Pt to go for eval @ Iraqi hospital on Saturday d/t holiday. 2-point restraints in place ⊼ s/sx complications. Will continue to monitor. [redacted]
26NOV03 (1900)	VSS. A&O. (L) FA Saline lock patent & intact. OOB → BR. Consumed 50% of regular diet for dinner. Burns to face & arms clean with sterile NS Bacitracin oint applied. OU clear pink Multi eye gtts instilled as ordered. Consumed 50% of diet for dinner. 2 point restraints intact

STANDARD FORM 509 (REV. 5/1999) BA[redacted]

(b)(6)-2 all

1307

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
13 NOV 03 (1200)	Pt awake, speaking arabic, VSS, ø complaints @ this time. HRRR, LCTAB, (+) BS x4. Back from OR. S/P. burn debridement to face & arm. Four small shrapnel wounds to forehead (packed c̄ iodoform). O2 sats @ 96-97% RA, resp. even & unlabored. Tol. fluids well. Bacitracin to face. Will notify eye clinic about pt. 2 pt restraints on ē any compromise to skin or circulation. Con't to monitor [redacted] Shrapnel wounds to (B) UE covered c̄ 2x2's, min bloody drainage noted [redacted]
13 NOV 03 2000	VSS Clear & Oriented. Refused dinner upon staff attempt to assist c̄ feeding. Consumed liquid from (L) FA heplock patent & intact. Four shrapnel wounds c̄ packing intact. areas < 1cm in ea. Shrapnel wounds to (B) UE ē dry & intact 2x2 cover. Bacitracin oint applied to facial burns. Pt Event unlabored, lungs CTAB. O2 SAT 95-97% ra (ø) c/o pain/discomfort @ this time. 2+ restraints applied without any discomfort or injury to s or restriction on circulation. I'll check restraints frequently. Will continue c̄ uncomfortable [redacted]

(b)(6)-2 all

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
13NOV.03 Ø100	Pt admitted to ICW #1, VSS, LS CTA(B) BS hypoactive x4, breathing ~~5~~ difficulties Ø%-99%, unlabored breathing, able to breath through nose, burns to face, arms and throughout upper body, shrapnel wounds throughout entire body, face appears puffy, eyelids puffy, unable to open eyes. IV (L) FA intact infusing LR @ 125cc/h. Ø c/o pain @ this time, NPO to OR in AM, peripheral pulses +2, equal (B), cap ref < 3 sec, 2 point restraint, Ø complications, pt understands some english, speaking arabic. [redacted]
Ø110	Will continue to assess [redacted] ing. [redacted]
13 NOV 0730	Pt awake, speaking arabic, VSS, LCTAB, resp even & unlabored, O2 sat @ 98% RA. Pt has facial burns, eyelids swollen shut, shrapnel wounds to UE. IV to (R) AC infusing LR @ 125cc/h NPO awaiting OR. Will monitor [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO.

1307

PROGRESS NOTES
Medical Record

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

(b)(6)-2 all

DICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11/13	Op Note
	PROCEDURE: wound debridement
	shrapnel removal
	eye exam under anesthesia.
	Surgeon Matutt
	Tolmar
	Pt tolerated well
	Body: numerous frags in face, arm.
	Lid closed w/ debridement
	corneal abrasions
	[redacted]
11/14/03	Ophth Note
	Eval by @ SLE: Hundreds of cornea foreign bodies OU
	multiple self sealed full thickness corneal wounds
	corneas not stable OU will need to stabilize cornea
	wounds to explore in order to better clean corneas to
	conj. [redacted]
	Plan Back to OR to remove f.b.

PITAL OR MEDICAL FACILITY	STATUS	DEPART./SE[redacted]
NSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR

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

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

[redacted] b6-4

(b)(6)-2 all

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
11/14/03 0900	Pt a/o, VSS, ∅ complaints verbalized, LCTAB, resp even & unlabored, eyelids swollen & shut. cornea red OU. Bacitracin applied to face. 2x2's to (B)UE CDT covering shrapnel wounds. Ancef IV given per orders. IV to (L)FA HL'd, flushing easily. 2pt restraints on while in bed ō compromise to skin or circulation. Will monitor — [redacted]
14NOV03 @2300	assumed care of pt @ 1930. Pt arrived post-op from recovery, via gurney, placed in bed ī 2pt restraints in place. alert, no c/o of pain/discomfort. (BIL) eyepads in place, CDI. (L)FA IV ī LR@TKO, IVABX. Foley to gravity ī clear/yellow urine. Facial burns healing, bacitracin applied. Multiple shrapnel spray to arms, chest, legs, ∅ drainage noted. Tol small amt of dinner & juice ī assistance. Plan: monitor disgs, ABX & solumedrol as ordered. Will monitor. — [redacted]
15 NOV 03 0800	- Assumed care of pt sleep yet easily arousable x4 ∅ VSS. Denies pain lungs CTA productive cough HCKR active BS Foley to gravity clear yellow urine ∅S PIV (L)Ac Hep locked tolerating PO well, Multiple burn sites and shrapnel wounds. Burns to face and bilat arms. bacitracin ointment applied. Bilateral Eyes post op foreign body removal. blood shot red closed shut photosensitive Eye drops tx cont. IV ABX TX pt afebrile Will cont to monitor — [redacted]

STANDARD FORM 600 (REV. 6-87) BA

(b)(6)-2 all

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
15 NOV 03 @2245	assumed care of pt @1800. VSS. alert, speaking arabic. no c/o pain. Eyes swollen, corneas red ou. Difficult to open lids for drops DIT edema, qHS cont. @2° as ordered. Bacitracin to face. (L) IV flushes well. IV Abx & IV solumedrol cont. (+) void post-foley D/C, approx. 450cc. Tol. liq diet, approx 50% of dinner. Enc po intake. 2pt restraints on S/S of skin/circulation compromise. Plan: Cont IV abx, eye gtts, enc po intake. Will monitor. [redacted]
16 NOV 03 0800	- Assumed care of pt. AEOx3. VSS Denies pain or discomfort @ this time Lungs clear HRRR Active BS Tolerating PO well. IV ABX Treatment Urinating spontaneously & difficulty. Eye drop therapy to cont. ISC @ bs. Wounds: multiple bruise sites face and (R) arm and anterior trunk. Bacitracin ointment applied to face and arm. Remaining affected wound to (R) buttock healing. Will cont to monitor [redacted]
1000	Upon further assessment & shower noticed wound to (R) buttock hip region appears to be a wound from the blast injury Encourage pt to [redacted] rotate while in bed to prevent breakdown

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

[redacted] b6-4

PROGRESS NOTES
Medical Record

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

USAPA V1.00

(b)(6) - 2 all

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
1000 Cont	Will cont to monitor [redacted]
1000	Informed MT [redacted] wound care nurse of pt's wound to (R) buttocks instructions given was to wash wound and dress c̄ duoderm leave for seven days then reassess - actions taken. Breakdown stage II circular superficial approx 3cm x 3cm pink vascular minor eschar removed small amts of bleeding upon washing duoderm intact Will cont to monitor [redacted]
16 Nov 08	2100 - assumed care of pt. @ 1800. VSS - A+O LS CTA (B), Resp. even unlabored, BS x4, abd. soft. non-tender. Pt. ambulated to shower c̄ assistance. (+) BM x1. Pt. showered + washed burns. Bactracin applied to burns. Voiding per urinal. Drops applied to (O) OU as ordered per MD orders. Duoderm applied to (L) Buttock, CDI. encouraging pt. to roll / change positions QC. IV (R) (2) FA. CDI (-) s/s/inf. will cont. to monitor pt. [redacted] Ice cin with alone [redacted]

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

(b)(6)-2 all

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
17 NOV 1400	Pt A&O, VSS, premedicated c̄ percocet ~~it~~ ~~RP~~ earlier today per MD. eye gtts con't, IV meds con't, bacitracin applied to face. ambulating c̄ assistance, voiding mod. yellow urine via urinal. Recub. to (R) butt c̄ comfoll drsg on. See wound & skin assessment sheet for further info. Encouraged to reposition often. IV HL'd (L) FA, ⊖ redness & edema @ site. 2 pt restraints on 5 compromise to skin or circulation. Will monitor [redacted]
2010 -	VSS, A+O Pt washed ~~fce~~ face + applied bacitracin to burns on face/(R) Arm. Tolerated well. Eye gtts cont. to OU. IV HL (L) FA c̄ ⊖ s/s/x inf, flushes well. Pt. voiding amber urine via urine encouraging pt PO. skin breakdown to (R) Buttock c̄ duoderm in place. Instructed pt. to roll often. Two pt restraints in place c̄ ⊖ skin breakdown (+) Circulation, will monitor pt [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME		
	LAST	FIRST	[redacted]

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/199
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1
USAPA V1.(

[redacted] 66-4

(b)(6)-2 of 11

4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
18 Nov 03 0545	Running late on IV meds missed 2400 Solu-Medrol 0600 administered [redacted]
11/18/03	S/p repair of ruptured globe OS S/p removal of multiple f-b's epithelium is healing OS. Plan: CPM add Erythromycin ung qid OS [redacted]
18 NOV 03 1000	Pt alo, VSS, premedicated c̄ ii̇ Percocet PO before going to eye clinic @ 0900. after visit: pt now opens OU. Eyes ~~hazy~~ cloudy c̄ redness decreased. Erythromycin opth. ointment applied to OU. Pt stated that he could see the trash can but it was blurred. Ø clo photosensitivity. Pred. acetate gtt cont Q2°, ocuflux gtts QID. cont. Pt clo not being able to sleep @ night. [redacted] ordered Ambien @ HS. PRN. IV meds cont. 2 pt restraints on while in bed ∃ compromise to skin/circulation. Will monitor [redacted] LPN
1255	Pt clo headache often (temporal). Tylenol 325mg ii̇ PO given [redacted]

(b)(6)-2 all

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
19NOV03@ 0200	assumed care of pt @1800. VSS, no c/o pain. alert, speaking Arabic; LS CTA; (+)BS, tol reg diet well; void per urinal QS. BIL eyes / corneas red; eye gtts given per schedule. (D)FA flushes well, ∅ S/Sx infection. Bactracin applied to face & (R)FA burns. 2pt restraints on S/Sx skin/circ compromise. Plan: cont IV meds & gtts per schedule, monitor pain control. [redacted]
19NOV'03	assumed care at 0615 pt Awake + oriented x 3, VSS IV left antecubital patent and intact. Voiding dark yellow urine via urinal. Pt receiving eye drops as scheduled and monitor. Dsg Δd on (L) buttock, a little drainage, cleaned and dressed with duoderm. Pt ambulate independently and care with minimal assistance. restraints x2 in place, (+) circulation [redacted] (1650) I concur c̄ above. [redacted]
20NOV03 @0200	Assumed care of pt @1800. VSS, c/o h/a & tinnitis, MD aware. Alert, Speaking some English; LS CTA; (+)BS, tol reg diet well, void per urinal/toilet QS. ↓ edema to BIL eyes, pt able to open eyes c̄ difficulty, corneas red, eye gtts cont'd. Bactracin to RUE & face applied, burns healing well. Pt amb c̄ assist to BR. 2pt restraints on S/Sx skin/circulation compromise. (cont)

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

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

REGISTER NO.	WARD NO.

[redacted] 66-4

PROGRESS NOTES
Medical Record

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

(b)(6)-2 all

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
20 NOV 03 @0200	(CONT) Plan: cont eyegtts, monitor pain control, encourage intake, cont bacitracin to wounds. Will monitor. [redacted]
20 NOV 03	(1422) NSG - VSS. Pt c/o pain. Med c̄ ⅓ perc. pt appears comfortable at this time. Applied Bacitran to wounds. Pt did own AM care + applied Bacitran to face. Infusing IV ABX + Solumedrol to (R) FA. Continuing eye gtts. Pt amb c̄ assistance 2° pt ~~unable to~~ ↓ vision. Pt tol po well. Will continue to monitor pt's pain. [redacted]
11/20/03	Ophth svc
	S: See's shadows
	O: Epi healed
	Cornea c̄ multiple deep f-bs
	A/C c̄ 1+ cell OU
	Ins (+) Post synechiae present
	A: Will need PKP OU. / triple OD
	P: Await status Δ & consider evac for PK
	[redacted]
	1/6: (R) F.B's OU s̄ sig vitr [redacted]
	add Atropine trd OU.
	CPM.
21 NOV 03 @0415	Assumed care @ 1800; VSS, pt A&O speaking arabic; Ø c/o pain or discomfort @ this time; pt amb to opthalm clinic for appt c̄ [redacted] c̄ assistance.

STANDARD FORM 509 (REV. 5/1999) BAC

USAPA V1.0

(b)(6)-2 all

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
	(cont) pt applied Bacitracin to face & RUE; cont c̄ eye gtts; S/L in (R) AC patent, easily flushes ō s/sx infection/infiltration; cont c̄ IV alex; Restraint in place, (+) circ, ⊖ skin breakdown, cont to monitor [redacted]
21NOV03	(1800) NSG - VSS. ⊖ c/o pain. Bacitran applied to face + (R) arm. Pt urinating in urinal ō difficulty. Pt Amb to BR c̄ assist 2° ↓ vision to B/L eyes. Tol Reg diet. B/L eyes redness in sclera. Pt opens eyes c̄ manual assist. IV to (R) AC. ⊖ s of infection. Will continue to monitor. [redacted]
22NOV03 @0430	assumed care of pt @ 1800. VSS. no c/o pain. LSCTA, (+) BS, tol Rg diet, void per urinal ⊖ S. Bacitracin applied to face & RUE, both wounds healing well. (B/L) eyes c̄ red sclera & cloudy iris. 2 pt restraints ō s/sx of skin/circulation compromise. Plan: enc po, monitor burns, cont IV meds, pain control prn. [redacted]
22Nov03	Assumed care @ 0600 pt sleeping peacefully. 0601 pt awake + oriented with ⊖ c/o pain. Pt ambulated with guidance to perform AM care. Given drops as scheduled. IV (infiltrated) d/c'd right arm, initiated left wrist although running slowly. Bacitracin applied to right arm and pt self-applied to face. Initiated second IV in right AFOG but infiltrated. Restraints x2 in place (+) circulation ⊖ skin breakdown. [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

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PROGRESS NOTES
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
22NOV03	(1655) I concur c̄ assessment this shift, by SPC [redacted] Tylor. [redacted]
23NOV03 0300	assumed care of pt @1800. VSS, no c/o. cont eye gtts OU. B/L eyes c̄ reddened sclera. Pt states vision is improving. Bacitracin applied to RUE burns & facial burns. (R) FA IV flushes well, IVAbx cont. ~~P~~ 2pt restraints on c̄ s/sx of skin/circulation compromise. Plan: cont eye gtts, IVAbx, encpo, pain control. [redacted]
23NOV 03 0600	pt Awake + oriented x3, Vital signs stable, pt c/o of pain from ear + throat area, probably from irritation from the drops. Pt ambulated with ease and shown pt vision in left eye is returning. IV flushes well. Pt self applies bacitracin to face and (R) arm. Restraints x2 in place, (+) circulation. [redacted]
23Nov03 ~~230~~ 2130	(1910) I concur c̄ above assessment. [redacted] Pt A&O VSS. Denies Pain @ this time. cont OU gtts [redacted] ~~Eyes~~ Sclera ~~are~~ are red (B). Bacitracin applied to face and (R) Arm IV Abx infused via 20G IV cath in (R) FA. Will cont to monitor. [redacted] Opnth svc
24NOV03	O: Cornea/Vc cleaning OS - 20/200 view of retina 2° to cornea flo retina as flat. (+) Heme settled in inferior retina OS. OD/ traumatic cataract, more floes in cornea. Plan → eval d-thaytham if they are unable to fix him will write letter to Ministry to get surgery outside of country. Requires PKP OU; triple [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
24 NOV 03 0830	- Assumed care of pt. VSS Ø c/o pain or discomfort Lungs clear HRRR Active BS x4 quads. Tolerating PO well. Burn wounds to (R) arm and face healing bacitracin cream applied. Both eye starting to regain vision both open eye drops cont- IV Abx IV cont. Will monitor [redacted]
24 NOV 03 2330	Assumed care of Pt @ 1800 hours. [redacted] LS CTA (B). HRRR. (+) BS x4 quads. Tol PO Well. (R) Arm & facial Burns healing well. Bacitracin applied to R Arm & Face. OD gtts cont. IV Abx cont via [redacted] 18Gr IV cath R FA. Will cont to monitor. [redacted]
25 NOV 03 (1720)	Assumed care of Ø600. Pt alert, speaking Arabic. VSS. Ø c/o pain. Pt OOB - amb to BR S diff. Cont. OU gtts as ordered. 20Ø g IV started in (L) ac, flushes well S S/Sx infiltration IV in (R) forearm dlcd d/t infiltration. - cathete intact. Bacitracin applied to burns on face and arms by pt. 2 point restraints in place S S/Sx complications. Will cont. to monitor [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/199
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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
27NOV03 1624	Assume care of PT @ 0600. A+O, VSS Ø c/o pain today. Ambulate c̄ assistance. Exercise consists of ambulating in hallway [redacted] D/c'ed Anect and decreased PRED to 30mg. Eyes are getting better as well as facial burns. In apt restraints s̄ any skin irritation. Will continue to monitor. 91W SPC Wesley
27 Nov 03	1700 I concur c̄ above assessment [redacted]
27 NOV (1900)	VSS Alert & oriented. OOB → BR without assist just supervision. Ø c/o pain. Eye gtts instilled as ordered. IV D/C this AM. Cipro IV not given. ~~with order~~ [redacted] Bacitracin applied to Burn on face & U/E p̄ cleaning c̄ sterile saline. Will continue plan of care. [redacted]
28NOV03	(0930) NSG. VSS. Ø c/o pain. [redacted] D/C'ed IV Cipro. Orders noted. Continue Eyegtts to ~~B~~ OU. Pt amb to BR c̄ assistance 2° ↓ vision. Pt able to open eyes. BOU appear red c̄ semi-opaque film. Will monitor. [redacted]

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

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

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PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999
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USAPA V1.0(

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(b)(6)-2 all

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
28NOV03 JHS	assumed care of pt @ 1800. VSS. no c/o pain. Pt alert, speaks some English. States can see from (L) eye, vision in (R) eye. cont'd eye gtts as ordered. Pt OOB AMB c̄ min assistance. Tol reg diet, 100% of dinner. Void per urinal QS. 2pt restraints on c̄ S/Sx of skin/circulation compromise. Plan: cont eye gtts, monitor pain control, bacitracin to burns. [redacted]
29NOV0320915 (ERROR)	Assumed care of pt @ 0800. VSS. A&O. Ø c/o pain. ~~Pt. D/C to comp @ 0920.~~ (ERROR) [redacted] JAV
29NOV0320920	Pt. going to Iraqi Hospital for eye exam/eval. @0920. [redacted] JAV
29NOV0321230	Pt. received from Iraqi Hospital @ 1200. Bacitracin oint. applied to affected burned areas. Pt. ambulates well to BR, (+) BM. Pt. in 2-point restraints, Ø signs of skin breakdown. All other assessments WNL. [redacted] RCG
30NOV03 @ 0045	assumed care of pt @ 1800. VSS, no c/o pain. Ø Δ in vision status, cont eye gtts as ordered. Pt applied bacitracin to face/FA. ↑ AMB c̄ min assistance. Tol reg diet well, voiding QS. 2pt restraints on c̄ S/Sx of skin/circulation compromise. Plan: cont eye gtts, monitor pain. [redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
30 NOV03 @ 1700	Assumed care of pt. @ 0600. VSS, Ø c/o pain, Ø IV access. Pt. receives all PO & opthalmic meds & bacitracin oint to facial burns. Pt. has vision deficits, more so to OD. Pt. able to ambulate s assistance to BR & perform AM care. Pt. eating majority of meals, >75%. Pt. in 2-point restraints in bed, Ø signs of skin breakdown. All other assessments WNL. Will cont. to monitor [redacted]
01 DEC03 @ 0115	assumed care of pt @ 1800. VSS. No c/o pain. Eye gtts cont to BIL eyes. Ø Δ in vision status. Tol PO well, voids to BR s difficulty. Pt ↑ AMB to BR c minimal assist. 2pt restraints cns S/Sx of skin/circulation breakdown. Plan: cont eye gtts, enc PO intake, cont bacitracin to wound. Will monitor. [redacted]
1 Dec03 @ 0840	Pt resting comfortable in bed @ present time. Pt has facial, trunk and extremity burns [redacted]. Ø S/S of resp distress, pain or discomfort @ present time. Resp CTA. BS(+). Ø skin breakdown under restraints. Pt able to see out of OD more than OS. Will continue to monitor and assist as necessary. [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.
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PROGRESS NOTES
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(b)(6)-2all

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
1Dec03 1615	Pt ↑ to BR. Pt encourage to ambulate in hallways. Pt ambulate for 20 minutes and returned to bed. ⊖ c/o pain or discomfort during ambulance — [redacted] —
2DEC03 0015	assumed care of pt @1800. VS. no c/o pain. Cont eye gtts as ordered. ⊘ Δ in vision status. Eyes (BIL) cont to bered (sclera). Pt tol regdiet, 100% of dinner, voiding ⊼ difficulty, ↑ AMB ⊼ min assist. Currently sleeping ⊼ c/o. 2pt restraint on ⊼ ⊘ skin/circulation compromise. Plan: cont eye gtts, encOOB. Will monitor. — [redacted]
2Dec03 1612	Assume care of PT @ 0600. A to, VSS ⊘ c/o pain. Ambulate ⊼ minimal assistance due to vision. Vision gets better by the day. Maintaining regular diet. Voiding clear urine. In 2pt restraint ⊼ skin breakdown. Will cont. to monitor. — 9W SPC [redacted]
2Dec03 1700	I concur ⊼ above assessment. Pt continues on hourly OU gtts. — [redacted]
2Dec.03 2000	Pt A+Ox3, VSS, LS CTA(B), ⊕ BSX4, vision improving @ a day by day basis, tol reg diet well, voiding CVU ⊼ difficulties per urinal, eye drops tx cont, ⊘ c/o pain. [redacted]
	I concur ⊼ above assessment [redacted]
3 Dec 03 0900	Assumed care of pt. A+Ox3. Sleep yet arousable. Lungs clear SAT 100% RA. HRRR. Active BS X4 quad s urinates spontaneously ⊼ difficulty per urinal. Activ ad lib walk fine. Burn wounds to face and bilat upper

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
3 Dec 03 cont.	extremities healing Q Day shower and bacitracin ointment applied. Bilateral eyes injuries eye drop treatment cont Vision returning Will cont to monitor [redacted]
3 Dec 03 1715	- Pt resting in bed @ this time Ø c/o pain or discomfort. Will cont to monitor [redacted]
3 DEC 03 @ 2330	assumed care of pt @ 1800. VSS. no c/o pain. Alert, speaks arabic, some English. BIL sclera red, eye gtts cont as ordered. vision improving per pt (c interpreter) to BIL eyes. Pt tol 100% of dinner meal, ↑ AMB Ø min assist. Applied bactracin to face & (R) FA burns, both healing well. 2pt restraints ons S/SX of skin or circulation compromise. Plan: cont eye gtts as ordered, monitor vision status. [redacted]
4 Dec 03	- Assumed care of pt. Ato x3. VSS Ø c/o pain or discomfort. Lungs clear HRRR Active BS x4 quads Urinating spontaneously & difficulty AM shower care performed by pt. Burn wounds to face and bilat upper extremities healing bacitracin ointment applied. Bilat eye drop tx cont Pt ate well & Ø s/s of infection Will cont to monitor [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
4Dec.03 1930	Pt A+OX3, eye drops tx cont, (R) eye appears cloudy, Ø c/o pain, voiding CYU per urinal, applied bacitricin to face + arms, Ø s/sx of infex, LS CTA (B), (+) BS x4. — [redacted] I concur with above assessm[redacted]
5Dec.03 1432	Assume care of PT @ 0600. VSS, A+Ox3 Ambulate ō assistance. Eye drops q2. Ø c/o pain. Voiding c/y urine. Bacitracin applied to face and arms. No new major changes. On 2pt restraint ō skin breakdown. Will cont. to monitor. — [redacted] (1601) I concur ō above assessment. — [redacted]
5Dec.03 1845	Pt A+OX3, VSS, LS CTA (B), (+) BS x4, voiding CYU per urinal, Pred Acetate q 2°, Ø c/o pain, applied bacitricin to [redacted] face + arms (R) eye appears cloudy. — [redacted]
6Dec03 1326	Assume care of PT @ 0600. A+O, VSS. Ø c/o pain. Ambulate 2pt restraints ō skin breakdown. (R) [redacted] skin [redacted], A+ed, dry drsg. No longer [redacted] present. Voiding c/y urine. Administers bacitracin to face and arms on his own. Will cont. to monitor. — [redacted]
6Dec03@1800	I agree ō previous assessment. — [redacted] 2LT AN
6Dec.03 2100	Pt A+OX3, VSS, OOB → BR to wash face, applie bacitricin to face + arms, eye drops cont, (R) eye cloudy, CYU per urinal, Ø c/o pain, LS CTA (B), (+) BS x4, Ø s/sx of skin break[redacted] STAND[redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
7 Dec 03 0730	- Assumed care of pt sleep yet easily aroused A+O c VSS Ø c/o pain or dis comfort. Burn wounds to face and bilateral upper extremities healing bacitracin ointment applied BID. Both eyes redness vision returning eye drops tx cont. Lungs clear HRRR Active SS x 4 tolerates PO well. Urinates spontaneously & difficulty Ambulate good. Will cont to monitor [redacted]
2000 -	Assumed care of pt @ 1800 VSS A+O Ø c/o pain or discomfort @ this time. Bactroan ointment applied to Burn wounds. Eye gtts cont. (+) redness to (B) eyes. tol. PO well. voiding c/o via urinal. Pt. in two point restraints. (-) skin breakdown (+) circulation. will cont. to monitor pt. [redacted]
8 Dec. 03 0630	Assumed care of pt. A+O x3, VSS, ate 90% of diet; Ø c/o pain, cont eye drops tx, bacitricin ointment applied to burns [redacted] wounds on face + arms

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
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DEPARTMENT/SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
Cont.	voiding cyu per urinal amount sufficient, ø s/sx of skin breakdown. [redacted]
19DEC03	(0015) Assumed care @ 1800. Pt der[redacted]ic. VSS. ø c/o pain. Pt OOB to amb in hallway ⅀ diff. Cont ou gts as ordered. Bacitracin applied to burns by pt. WTD dsg placed on ® thigh wound ⅀ s/sx infection, pink and moist. Tol. reg diet well. Voiding ⅀ difficulty. 2 point restraints in place, ⅀ s/sx complications. Will cont. to monitor. [redacted]
9Dec03 0700	Assumed care of pt., A+O x3, VSS, ø c/o pain, cont on eye drops tx, ® eye has cloudy appearance + ø vision, able to see from ⓛ eye, bacitricin cream applied to burn sites on face + arms, ate 90% of diet, ® thigh wound has pink appearance, ø s/sx of infex, voiding CVU per urinal ⅀ [redacted] complications.
09DEC03	(2215) Assumed care @ ~~0000~~ 1800. Pt alert, sp[redacted] VSS. ø c/o pain. cont. ou gts as ordered. OD cloudiness noted. Pt amb in hallway ⅀ difficulty Bacitracin applied to burns by pt. Tol. reg diet well. voiding ⅀ difficulty. WTD dsg on ® thigh wound Δd. wound moist and red ⅀ s/sx infection. 2 point restraints in place ⅀ s/sx complications. Will cont. to monitor. [redacted]

(b)(6)-2 all

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
10 Dec 03 0900	VSS. Alert & oriented. Consumed 30% of breakfast. Face cleaned c soap & water during am care. Bacitracin applied to facial lesions. Multiple eye gtts instilled OU as ordered. Denies pain or discomfort @ this time. Voiding clear amber urine without difficulty. Referral summary on chart for visit to al-Hayatham for follow-up eval. Will continue plan of care [redacted] LTA. 2 point restraints in place without compromising circulation or skin integrity [redacted] LTA
11 Dec 03	(0400) VSS. Ø c/o pain. Pt amb to BR c̄ steady gait. Ø assistance required. Cont. eye gtts. Voids clear, yellow c̄ difficulty. Pt applied own Bacitran to face. * Pt did own PM care. ~~Pt asleep at this~~ Lung ~~sun~~ sounds CTA, (+) Bowel sounds. Will ~~cont~~ continue to monitor. [redacted]
11 Dec Ø3 1ØØØ	pt. taken to opthalmology clinic [redacted]
11 Dec Ø3 1245	pt. return from opthalmology clinic [redacted]
11 Dec Ø3 @ 16ØØ	Assumed care @ Ø6ØØ. VSS. A&O. Θ c/o pn. OOB to hallway

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

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

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

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PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV.
Prescribed by, OSD/DMS Ltr 10 (MOTR) 101-11.20

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NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
11 DEC 03 cont			

DATE	NOTES
1600	toilet ⅀ assistance. Voiding ⅀ difficulty. HRPR. LSCTA, consumed about 25% of regular diet. Apply bacitracin to self. Will continue to monitor — [redacted]
11 Dec 03 1610	I concur c̄ b̄ ft̄ assessment. 2 pt. restraint. Ø compromise to skin/circulation — [redacted]
11 Dec 03	(2150) VSS. Ø c/o pain. Pt applies own Bacitracin to face. Amb c̄ steady gait to BR ⅀ assist. BS CTA, ~~BS~~ BS ⊕ x 4 quads. Voids clear, yellow in urinal ⅀ difficulty. Tol PO well. Consumed 50% meal. 2pt restraints. Ø signs of skin compromise. [redacted]
12 Dec 03 1540	Assumed care @ Ø600. VSS. A & O, speaking arabic. ⊖ c/o pain. OOB → hallway, shower. Apply eye drops c̄ pt. opening own OD. 1st stage decub noticed on ® butt. Moderate sero-sang drainage on old drsg. Dry drsg applied. Apply bacitracin to self. tol. well PO req. diet. Voiding ⅀ difficulty. ⊖ s/sx of skin compromise on restraints. [redacted]
12 Dec 03	1600 I concur c̄ above note. ® buttock c̄ wet to dry drsg to stage II pressure ulcer. Appears as skin abrasion. Ø drainage. Follow up c̄ Wound care nurse — [redacted]
12 DEC 03 @ 1700	Dry drsg on ® butt decub changed to WD drsg [redacted]
13 Dec 03 @0100	assumed care of pt @1800. VSS. no c/o pain. Eye gets crit. ® eye cont. to look cloudy. LSCTA, tol po well, voids ⅀ difficulty. Amb c̄ minimal assistance. Applies bacitracin to face/® arm for self. 2pt restraints on ⅀ S/SX of skin/circulation compromise. ® buttocks drsg CDI, ~~no~~ drainage noted. (CONT [redacted]

(b)(6)-2 all

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
13DEC03 @0100	(CONT) Will ensure Woundcare nurse consult submitted. Plan: cont eye gtts, encOOB, enc turn side-to-side, enc independence, monitor drsg. — [redacted]
13DEC03 @ 1600	Assumed care of pt. @ 0600. VSS, A&O, Ø c/o pain. Pt. resting quietly in bed on (L) side. Cont. GTTS & oint to OU. WTD DSG Δ to (R) buttock wound, yellow exudate to old DSG, 4cm in diameter. Pt. OOB to BR & ambulated in hallway s̄ assist., steady gait. Pt. voids ī difficulty CYU. Pt. in 2-point restraints, Ø S/Sx of skin breakdown. Bacitracin oint to face, pt. applies to self. All other assessments WNL. Will cont. to monitor. [redacted]
14DEC03 @ 0030	assumed care of pt @ 1800. VSS. no c/o pain. Ø Δ in vision. pt ↑ AMB s̄ assistance, performs ADLs s̄ assistance. BS OTA, Ø BS, voids s̄ difficulty. Good appetite noted. Self applies bacitracin to face & arm. (R) buttocks wound drsg CDI. Eye gtts cont. 2 pt restraints on s̄ s/Sx skin or circulation compromise. Plan: cont eye gtts, enc OOB, enc PO intake. — [redacted]
14DEC03 @ 1530	Assumed pt. care @ 0600. VSS, A&O, speaking arabic. Ø c/o pn. OOB → hallway, shower, shaved off his beard. Req. diet tol well. WTD drsg Δ'd on (R) butt decub. Sero-sang

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
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DEPARTMENT/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 51
Prescribed by SGA/DCNR (FMC 140-8)

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(b)(6)-2 all

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
14DEC CONT 1530	drain on old dressg. Wound healing well. Eye drops, ointment continued per order. Voiding CYU ⅋ difficulty. ⊖ signs of skin compromise on restraints. Will continue to monitor. — [redacted]
14 Dec 03 ~~PM~~	Assume care of Pt @ 1800. A&O [redacted]
2300	HRRR, ⊕ BS x 4 quads. Voids [redacted] CYU qs ⅋ difficulty. Bacitracin oint. Applied to face. Burn marks to face fading. OU gtts cont. Pt taught and demonstrated proper application of eye gtts. ⊖ s/sx of skin integrity. ~~Pt~~ Will cont to monitor. — [redacted]
15 Dec 03	Opnon Note
	Requested info from OOC regarding level of care pt to receive as Walter Reed cannot do surgery. 4 COA given, & pt to receive observation per GTF7
	Plan decrease oral steroids continue topicals on slow taper add aqueous suppressants [redacted]
15 DEC 03 @ 1700	Assumed care of pt. @ 0600. VSS, A&O. Ø c/o pain. OOB to BR this AM, voiding CYU ⅋ difficulty. Pt. able to administer GTTS to eyes. Pt. applied bacitracin to face. Pt. in 2-point restraints, Ø S/Sx of skin breakdown. DSG to Entrust CDI. All other assessments WNL, — [redacted]

(6)(6)-2 all

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
16DEC03	(0015) Assumed care @ 1900. Pt alert, speaking Arabic. VSS. Ø c/o pain. OOB to amb in hallway s̄ difficulty. Cont. eye gtts as ordered. Pt applies Bacitracin to burns. OD cont. to be cloudy. Tol. reg diet well. Voiding s̄ difficulty. 2-point restraints in place s̄ s/sx complications. Will cont. to monitor. [redacted]
16 DEC 03 @ 1530	Assumed care of pt. @ 0600, VSS. A+O, Ø c/o pain. Pt. OOB to BR for AM care, voids s̄ difficulty, c/o. Pt. applied bacitracin to face. Cont. GTTS to OU. DSG to bilateral CDI. Pt. ambulated in hallway 10 minutes, ambulates well, steady gait. Pt in 2-point restraints, Ø s/sx of skin breakdown. Will cont. to monitor. [redacted] 2CT, AN
17DEC03	(0015) Assumed care of pt @ [redacted] 0000. Pt alert, speaking Arabic. VSS. Ø c/o pain. Cont eye gtts as ordered. OOB to amb s̄ difficulty. Dsg to @ thigh CDI. Tol. reg diet well. Voiding s̄ difficulty. 2-point restraints in place s̄ s/sx complications. Will cont. to monitor. [redacted]

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

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

PATIENT'S IDENTIFICATION: (For typed or written entries, print: Name - last, first, middle; ID No or SSN; Date of Birth; Rank/Grade) | REGISTER NO. | WARD NO. KW1

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PROGRESS NOTES
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STANDARD FORM 51
Prescribed by SECRETARY OF DEFENSE

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NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17 Dec 03 1000	VSS A&O OOB → BR to shower. Pt applied bacitracin oint to face. Pt escorted to eye clinic per Dr [redacted] request. Ambulate ≈ steady gait. ØHD pain noted in mirror. Mult eye gtts installed as ordered. Will continue plan of care. 2 pair restraints in place without compromising circulation or skin integrity. [redacted]
17 DEC 03	Assumed care at 1815 pt awake-oriented x 3 VSS pt hav Ø c/o pain at this time, pt receiving eye drops as per schedule and self applies bacitracin, pt OOB to shower and ambulate, pt performs task without difficulty, restraints x2 in place, Ø skin breakdown will monitor. [redacted]
18	(0245) I concur c above assessment. [redacted]

STANDARD FORM 509 REV 9/1999 BF

USAPA

(b)(6)-2-11

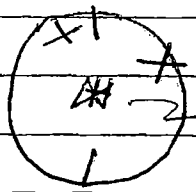
AUTHORIZED FOR LOCAL REPRODUCTION

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

11/14/03 Ophth Progress / OR Note

attempted I.B removal @ SLE - unable 2° to pt discomfort

Pre-op dx: multiple cornea f-b OU (ant seg)
perforating cornea injury OD ; traumatic cataract
Postop dx SAA + IOFB OD
Findings: multiple cornea perf OD
multiple f-b ant seg OU
PMI



round hole

repair corneal perf, multiple partial thickness lacs OD
removal of f-b OU

Consent ✓
EBL min
GETA
✓path

[redacted]

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

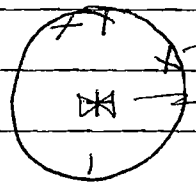
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*	REGISTER NO.	WARD NO.

#[redacted] 66-4

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

(b)(6)-2 all

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	el-Haytham referral note NOTES
11/25/03	Patient is an Iraqi soldier who walked out of police station and into an explosion. Sustained bilateral perforation injuries with hundreds of corneal foreign bodies each eye
	Exam: Ultrasound - bilateral intraocular foreign bodies -probably glass
	OD  limbal perf wound central perf. wound multiple partial thickness wounds
	Patient referred for evaluation of traumatic cataract of right eye.
	Left eye - vision continues to improve but corneal foreign bodies limit vision -
	[redacted]

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

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

#[redacted] b6-4

PROGRESS NOTES
Medical Record

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

(b)(6)-2all

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
10 Dec 03	24y/o Iraqi victim of car bomb c̄ IOFB OU
	traumatic cataract OD c̄ multiple corneal
	foreign bodies OU.
	Previous eval by yoc.
	Developing corneal edema
	V_d LP 20/50 T_a 22
	SLE YL tarso
	conj tarsoling
	K multiple cornea foreign bodies – (+) corneal edema
	A/C lens material OD
	Iris ~~[illegible]~~ dilated OD, + synechiae to lens OS
	Meds: Prednisone 40mg po qD
	Pred Acetate 1 gtts OD q2°
	Hom-Atropine 1 gtts OD bid
	Zantac 150mg po bid
	Referral to al-Haytham for follow-up eval lensectomy/
	vitrectomy c̄ IOFB removal [redacted]

ATIONSHIP TO SPONSOR | SPONSOR'S NAME [redacted] ER

LAST | FIRST

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

NT'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] b6-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. [illegible])

→ (b)(6)-2 all

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
10 Dec 03	24 y/o Iraqi victim of car bomb c̄ IOFB OU
	traumatic cataract OD c̄ multiple corneal
	foreign bodies OU.
	Previous eval by you.
	Developing corneal edema
	Va LP 20/50 Tac 22
	SLE: ½ tattoo
	conj tattooing
	K multiple cornea foreign bodies – ⊕ corneal edema
	A/c lens material OD
	Ins ~~[illegible]~~ dilated OD, + synechiae to lens OS
	Meds: Prednisone 40mg po qD
	Pred Acetate 1 gtts OD q2°
	HomAtropine 1 gtts OD bid
	Zantac 150mg po bid.
	Referral to al-Haytham for follow-up eval lensectomy/
	vitrectomy c̄ IOFB removal [redacted]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST

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

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

REGISTER NO. | WARD NO.

[redacted] b6-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1998)

(b)(6) - 2 of 11

THORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	TRANSFER SUMMARY
17DEC03	PT C̄ CORNEAL DECOMPENSATION, TRAUMATIC
	CATARACT & INTRAOCULAR FOREIGN BODY OD
	INTRAOCULAR FOREIGN BODY IS WITH NO INFLAMMATORY
	REACTION.
	SURGERY EXCEEDS IRARI CAPABILITY - NO CORNEAS AVAILABLE FOR TRANSPLANT
	SC / 20/LP — PT BEING RETURNED TO CAMP & D/C UNTIL
	d/A / 40 — CAPABILITY IS DEVELOPED
	CORNEA 100'S OF FOREIGN BODIES OU.
	A/C OPEN CAPSULE / LENS C̄ LENS MATL IN A/C
	INTRAVITREAL FOREIGN BODY
	MEDS: STEROID TAPER PRED 20 MG PO QD X 1WK
	15 MG PO QD X 1WK
	10 MG PO QD X 1WK
	5 MG PO QD X 1WK THEN D/C
	PRED ACETATE 1 GTTS OD Q3°
	TIMOPTIC 1 GTTS OD BID
	CILOXIN 1 GTTS OD QID.

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART[redacted]
SPONSOR'S NAME	SSN/ID NO.	RELATION[redacted]

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

[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

USAPA V2.00

MEDICAL RECORD	**PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT** For use of this form, see AR 40-66; the proponent agency is The Office of the Surgeon General.
1. AGE: 29 HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): not English NKA 3. PREVIOUS SURGERY: [ ] NO [ ] YES (type): unk pt speaking + no translator available

4. PROPOSED SURGICAL PROCEDURE:
Burn Debridement to Face

5. ADDITIONAL INFORMATION:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to surgery, OR environment	✓ ~~Pt.~~ verbalizes any specific anxiety. ✓ Pt. exhibits relaxed body posture.	✓ Allow pt. to verbalize freely. as possible ✓ Explain OR environment and answer questions regarding surgery. as pos ✓ Offer comfort measures, (e.g., warm blanket, touch) ✓ Explain all nursing procedures before they are done. ✓ Remain with pt. whenever possible. o Maintain family interface.
B. AERATION ✓ Potential for respiratory dysfunction due to Burn injury, facial involvement, intubation	✓ PT. will be able to breathe without difficulty during immediate intra-operative phase.	✓ Offer to elevate head of litter or offer pillow. ✓ Observe pt. while awaiting surgery for signs of distress ✓ Assist anesthesia during intubation and extubation
C. INTEGUMENT ✓ Potential impairment of skin integuity due to injury surgery OR environment equipment	✓ PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	✓ Utilize pressure preventing devices on OR table and accessories. ✓ Check for proper positioning and support to maintain good body alignment. ✓ Pad pressure points. ✓ Place ESU ground pad on non compromised skin surface area. ✓ Keep prep fluids from pooling.

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

[redacted] (b)(6)-4

(b)(6) - 2 all

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to operative equipment, positioning, injury	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to injury sedation. E.2. ✓ Potential discomfort due to injury, operative eq	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. ✓ Disminished visual perception due to ~~being~~ injury eyes swollen shut F.2. ✓ Potential for decreased communictaion due to lang. barrier F.3. Potential injury due to dentures.	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. as possible o Speak clearly and slowly. o Address pt. from either side. o Validate pt.'s understanding of verbal communications. o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS. Or continuation of above interventions.

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

[redacted] 13NOV03 DATE

11. POSTOPERATIVE EVALUATION:
Breathing: Reg, Nonlabored
Bovie pad site CDI

12. PREOPERTIVE EVALUATION PREPARED BY	13. POSTOPERTIVE EVALUATION PREPARED
[redacted] language barrier DATE: TIME:	[redacted] 13NOV03 TIME: 1040

REVERSE OF DA FORM 5179, JUN 91 USAPA V1.01

(b)(6) - 2 except for very bottom

MEDICAL RECORD	INTRAOPERATIVE DOCUMENT For use of this form, see AR 40-407, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA gurney BY Anesthesia	2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted]
3. DATE 13NOV03 TIME PATIENT ARRIVED IN SUITE 0850	4. PATIENT IN ROOM TIME 0850 NUMBER 2-3

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKA

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] 91D	RELIEF SCRUB	[redacted]
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	[redacted]

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt on padded OR Bed head on foam doughnut. Arms extended out to sides (90°) CAP secured to padded armboards. c safety straps. Folded towels under heels.

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

COMMENTS: Correct Body Position Maintained.

8. SKIN PREPARATION

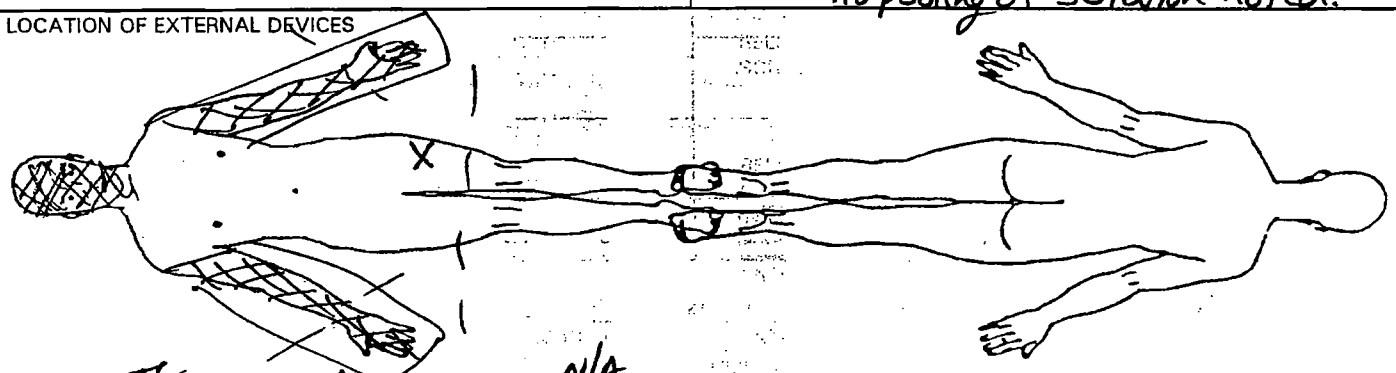
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Exidine Scrub Brush
SITE: Face, LUE, RUE BY WHOM: Dr [redacted]
SITE: BY WHOM:

COMMENTS: no pooling of solution noted.

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad TG Safety Strap N/A = = = Tourniquet

10. COUNTS C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes	☒ No					
Needle Sharp	☒ Yes	☐ No	C		C	PFC [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;)*

[redacted] (b)(6)-4

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

☒ ESU NO: R8B 102395 30/30 Blend I Fulg
GROUND PAD: BRAND Valleylab Polyhesive II REM
LOT NO: 70337/2005-05

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

(b)(6)-2 all

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Bacitracin Ointment	QS	post op	topical	[redacted]	Dr [redacted]

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

OTHER ORDERS	TIME	CARRIED OUT BY
[redacted]		

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. 16F Foley	2. 1/4" iodaform gauze	3.
SITE	1. urinary Bladder	2. multiple facial wounds	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
[redacted]

19. ADDITIONAL INFORMATION
WC-IV
Surgeon: Dr [redacted]
Anesthesia: Gen/Endo-CPT [redacted] CRNA

DA 5187 - initiated

20. OPERATION(S) PERFORMED
Burn + Fragment Debridement of Face, LUE, + RUE

21. PATIENT TRANSFERRED TO	TIME	METHOD
PACU	1035	gurney

22. REGISTERED NURSE SIGNATURE
[redacted] CPT/AN

USAPA V1.00

MEDCOM - 24482

(b)(6)-2 except very bottom

MEDICAL RECORD	INTRAOPERATIVE DOCUMENT or use of this form, see AR 40-407, the pr agen the office of The Surgeon General.
1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY Anesthesia	2. PATIENT IDENTITY, RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted]
3. DATE 14 Nov 03 TIME PATIENT ARRIVED IN SUITE /	4. PATIENT IN ROOM TIME 1458 NUMBER 5

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted]	RELIEF SCRUB	SPC [redacted] (1745-EOC)
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	CPT [redacted] (1815-EOC)

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Proper body alignment maintained. Rt. arm tucked at side.

8. SKIN PREPARATION

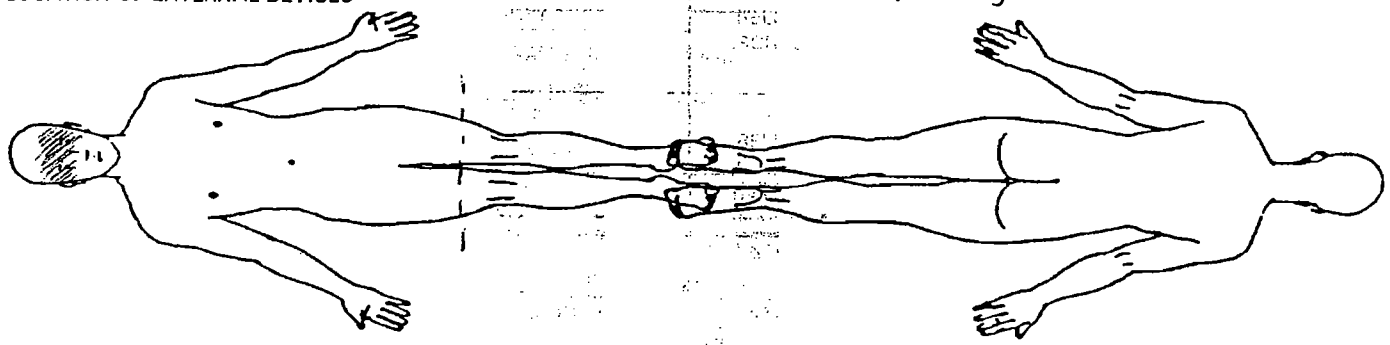
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine sol'n / NS
SITE: Bilat. eyes BY WHOM: [redacted]
SITE: BY WHOM:

COMMENTS: No pooling of fluids

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C = Correct I = Incorrect Initial C [redacted]

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

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

[redacted] (b)(6)-4

14 Nov 03

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

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

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

☐ BIPOLAR NO: _____

(b)(6)-2 all

13. PROSTHESIS, IMPLANTS ☐ ES NO IF YES NAME: ID NUMBER; M URER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Bacitracin Ophthalmic Oint.	QS	I 10	Topical	[redacted]	[redacted]
Tetracaine Ophthalmic Sol.	QS	I 10	Topical gtts		

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

BSS

OTHER ORDERS	TIME	CARRIED OUT BY
none		

PHYSICIAN [redacted]

15. X-RA [redacted] IF YES, SITE
YES ☐ NO ☒

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*

Eyepads
Tape

19. ADDITIONAL INFORMATION

Surg: [redacted] Anesth: [redacted] CRNA Anesth Type: General

-DA5179 on chart, ∅ 4's noted

20. OPERATION(S) PERFORMED

1. Repair multiple cornea perforation (R) + Removal multiple corneal foreign body's
2. Removal multiple anterior segment foreign body's (L)

21. PATIENT TRANSFERRED TO	TIME	METHOD
(ICW1) PACU	DA7389	PACU bed

22. REGISTERED NURSE SIGNATURE
[redacted] CPT/AN | [redacted] CPT/AN

6A

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY												
POST- DAY												
MONTH-YEAR DEC	DAY	3 Dec	4 Dec	5		6		7		08	09	
2003	HOUR	0700	0800	2100	0800		0800	2100	0800		0900	

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

RESPIRATION RECORD

BLOOD PRESSURE	109/71	112/70	109/70	106/64	115/68	121/80	102/71	111/68	115/68	107/72	140/88	107/64
	174		173	72	97	115	77	105		111		
	97.5		97.1	97.4	91	98.3	96.9	98.2		98.6		
HEIGHT: WEIGHT →	100%	99%	99%	99%								
	RA	RA	RA		99%	99%	99%	99%	99%	98%		
									RA	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.

(b)(6)-4

[redacted]

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR Nov 19 — DAY: 26, 26, 27, 28, 29, 30, 1, 2

HOUR: 0 2 8 2 0 2 8 2 0 2 8 2 0 2 8 2 0 2 8 2 0 2 8 2

PULSE (0) / TEMP. F (°): 105°, 104°, 103°, 102°, 101°, 100°, 99°, 98.6°, 98°, 97°, 96°, 95°

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

(Centigrade Equivalents, for Reference only)

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

RESPIRATION RECORD: 18 20 18 20 18 18 18 20 18 18 18 18 18 18

BLOOD PRESSURE: 113/64 116/64 115/72 117/69 114/69 116/60 108/64 111/66 107/70 112/75 116/72

98.2 97.3 82 98.5 97.3 112/68 97.2 97.1

59 97.7 82 98.3 114 71 76 83

HEIGHT: WEIGHT →

99% 99% 100% 98% 99% 99% 98% 98% 99% 99% 100% 98%

RA RA RA RA RA

115/64 98% RA

110/62 98% RA

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

VITAL SIGNS RECORDS
Medical Record

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

MEDICAL RECORD		VITAL SIGNS RECORD
HOSPITAL DAY		
POST-	DAY	
MONTH-YEAR NOV	DAY	NOV 20 · 21 · 21 · 22 · 23 · 23 · 24 · 25
19	HOUR	

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD: 24 · 20 · 18 · 18 · 107/67 · 20 · 16 · 18 · 18

Record special data only when so ordered													
BLOOD PRESSURE	118/81	124/76	113/	115/69	114/68	127/74		P 70	BP①	111/68	114/63	113/68	
	T 96.7			97.5	97.9			T 97.2	BP②			97.6	120/77
	P-69		P 89	89	60	96.8		SpO2 99	TEMP	98.6	98.7	64	
HEIGHT: / WEIGHT →	99%	99%	99%	99%					TEMP				
					99%	98%			O2Sat	98%	99%	98%	98
						[redacted]			SOURCE	[redacted]			
						(b)(6)-2			O2Sat			(b)(6)-2	
									SOURCE				

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

REGISTER NO.

WARD NO.

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

[redacted] (b)(6)-4

NSN 7540-00-634-4124

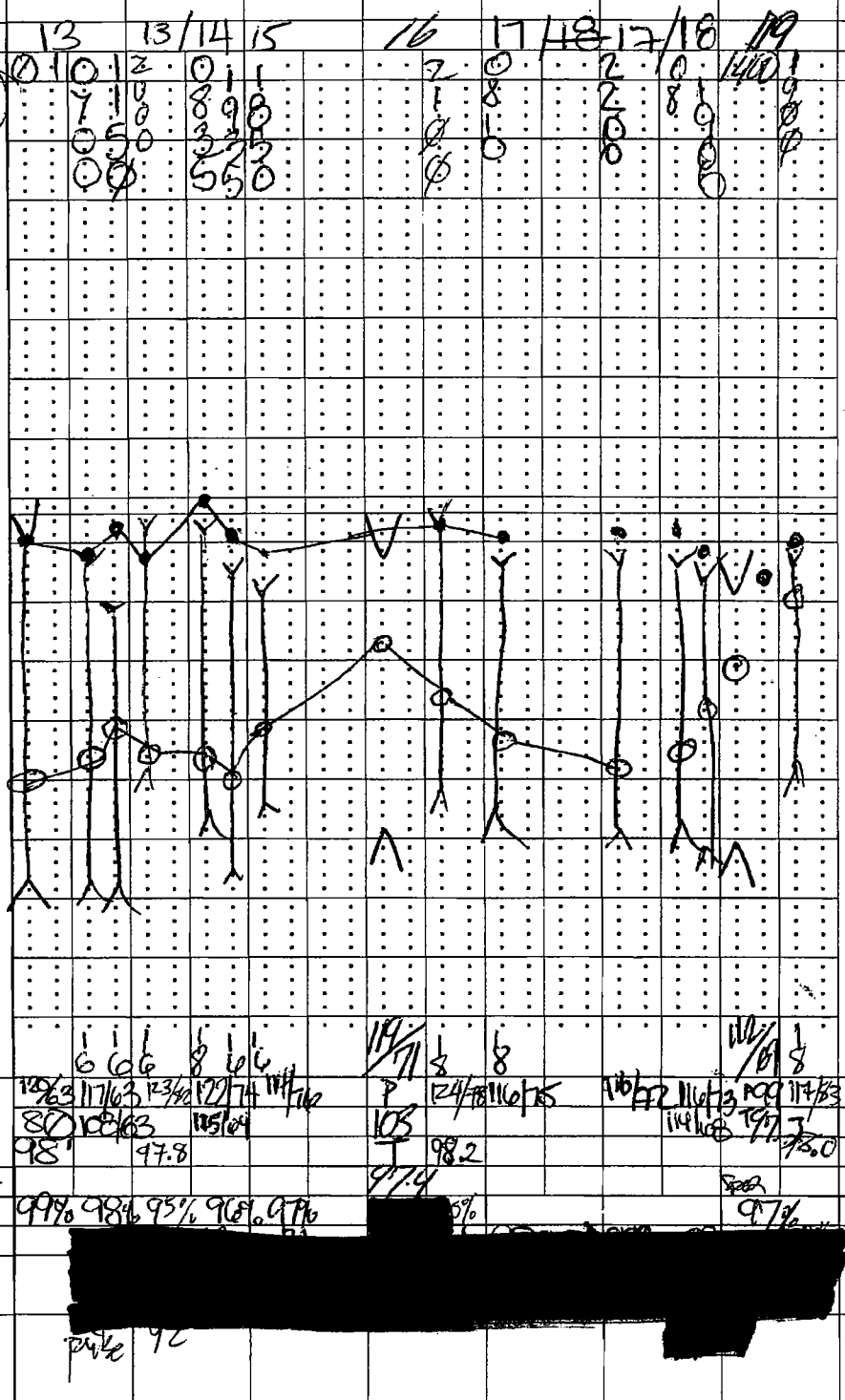
MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST-OP DAY

MONTH-YEAR | DAY | HOUR

PULSE (O) | TEMP. F (•)



RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

[redacted]

(b)(6)-2

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DEC 2003 | DAY 18 | HOUR

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

RESPIRATION RECORD: 18

BLOOD PRESSURE: 95/60

HEIGHT: | WEIGHT → 97.2

99%

[redacted] (b)(6)-2

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)*

(b)(6)-4

[redacted]

REGISTER NO.

WARD NO. ICU1

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																			
POST-	DAY																		
MONTH-YEAR	DAY	10 DEC		11	11	11	12	13	14		15	16		17					
19	HOUR	0		0	8	0	0	0	0		0	0	0	0					
PULSE (O)	TEMP. F (°)																		TEMP. C
	105°																		40.6°
180	104°																		40.0°
170	103°																		39.4°
160	102°																		38.9°
150	101°																		38.3°
140	100°																		37.8°
130	99°																		37.2°
	98.6°																		37.0°
120	98°																		36.7°
110	97°																		36.1°
100	96°																		35.6°
90	95°																		35.0°
80																			
70																			
60																			
50																			
40																			
RESPIRATION RECORD																			
BLOOD PRESSURE																			
HEIGHT:	WEIGHT →																		

(Centigrade Equivalents, for Reference only)

Record special data only when so ordered

[redacted]

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.

(b)(6)-4

[redacted]

VITAL SIGNS RECORDS

Medical Record

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

(b)(6)-2

Ward/Section: EMT	REQUEST NO: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: # [redacted] (b)(6)-4	DATE: 13 Nov	TIME: 0005	SSN/PSEUDO: # [redacted] (b)(6)-4

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10³	Color		N/A	RPR		Negative
RBC		4.7-6.1 x 10⁶	App		N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	Microbiology		
Hct		42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt		130-500 x 10³ verified	SG		N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	Microscopic Urinalysis		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	CSF			Blood Bank		
Sed Rate			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED		
Other			Directigen		Negative	ABO/Rh		

Coagulation Studies			Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)		
TEST	RESULT	REF. RANGE	UNIT	TYPE	CROSSMATCH
PT		9.8-13.6 secs			
APTT		21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

(b)(6)-4 except very top

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: # [redacted]	DATE: 13 Nov / TIME: 0005	SSN/PSEUDO SSN: #

i-STAT

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol
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. RANG
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE

======= PICCOLO =======
13/11/03 00:22
REFERENCE RANGE: MALE
PATIENT #: [redacted]
BASIC METABOLIC
DISC LOT #: 3325AA4
OPER #: 013 DR #: 000
SERIAL #: 0000100494

GLU	86	73-118	MG/DL
BUN	4*	7-22	MG/DL
CA++	9.0	8.0-10.3	MG/DL
CRE	0.7	0.6-1.2	MG/DL
NA+	138	128-145	MMOL
K+	4.6	3.3-4.7	MMOL
CL-	104	98-108	MMOL
tCO2	23	18-33	MMOL

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA		8.0-10.3 mg/dl
CRE		

======= PICCOLO =======
13/11/03 00:29 AM
REFERENCE RANGE: MALE
PATIENT #: [redacted]
LIVER PANEL PLUS
DISC LOT #: 3154AA7
OPER #: 013 DR #: 000
SERIAL #: 0000100684

ALB	3.0*	3.3-5.5	G/DL
ALP	45	26-84	U/L
ALT	12	10-47	U/L
AMY	45	14-97	U/L
AST	30	11-38	U/L
TBIL	0.8	0.2-1.6	MG/DL
GGT	7	5-65	U/L
TP	5.1*	6.4-8.1	G/DL

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

NA		
K		
CL		
tCO2		

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/13/03 00:34

Patient ID: [redacted] (b)(6)-4
Test Name :PT
Test Result:= 15.1 sec.
Ratio = 1.2
Calculated INR = 1.41
Sample Type:citrated wh. blood
Test Date :11/13/03
Test Time :00:32
Card Lot :080201
Operator : [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/13/03 00:36

Patient ID: [redacted] (b)(6)-4
Test Name :APTT
Test Result:= 38.5 sec.
Sample Type:citrated wh. blood
Test Date :11/13/03
Test Time :00:34
Card Lot :100212
Operator : [redacted] (b)(6)-2

(b)(6)-4

ID [redacted] 13-07-03
WB 01:55

			Patient Limits	
WBC	17.4 H	x10^3/uL	4.5	10.5
RBC	4.88	x10^6/uL	4.00	6.00
Hgb	13.9	g/dL	11.0	18.0
Hct	44.0	%	35.0	60.0
MCV	90.2	fL	80.0	99.9
MCH	28.4	pg	27.0	31.0
MCHC	31.5 L	g/dL	33.0	37.0
Plt	249.	x10^3/uL	150.	450.
LY%	22.5 *	%	20.5	51.1
LY#	3.9 *	x10^3/uL	1.2	3.4

(b)(6)-2 unless otherwise indicated. - [illegible]

29 YR IRAQI ♂ NKDA
ASA II BURNS x 48 hrs 2° Blast injury
NPO since 0800 0 PMH
R&H = Facial Burns Resident

MEDICAL RECORD - ANESTHESIA

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

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

DRUG (Units)	15	30	45	1600	x	30	x	1700	x	30	x	1800	TOTALS
Versed mg	11 11												5mg
HCL/Morphine mg	100/150												Minimal
~~Propofol mg~~													
Succinylcholine (MG)	100/					6		4					
Fentanyl (MCG)	150			100									500mg
VOLAT AGENT Sevo % del			1.0	1.2	1.2	1.2	1.2	1.2	1.2	1.5	1.5	1.5	
% e.t.													
AIR L/Min	0												
N2O L/Min	0					0							
O2 L/Min	6	6	2	2	2	2	2	2	2	2	2	2	

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS → 1 125mg Sauimerol

FLUIDS

LINE site		15	30	45	1600	x	30	x	1700	x	30	x	1800
☐ Warmed													
? gauge (L) UPE ☐ Warmed			500			800				1000			
☐ Warmed													
☐ Warmed													

LOSSES

EST BLOOD LOSS	minimal												
URINE - Foley			200							300			

PHYS STATUS 1 (2) 3 4 5 E

BODY WEIGHT: ≈65 (KG) LB

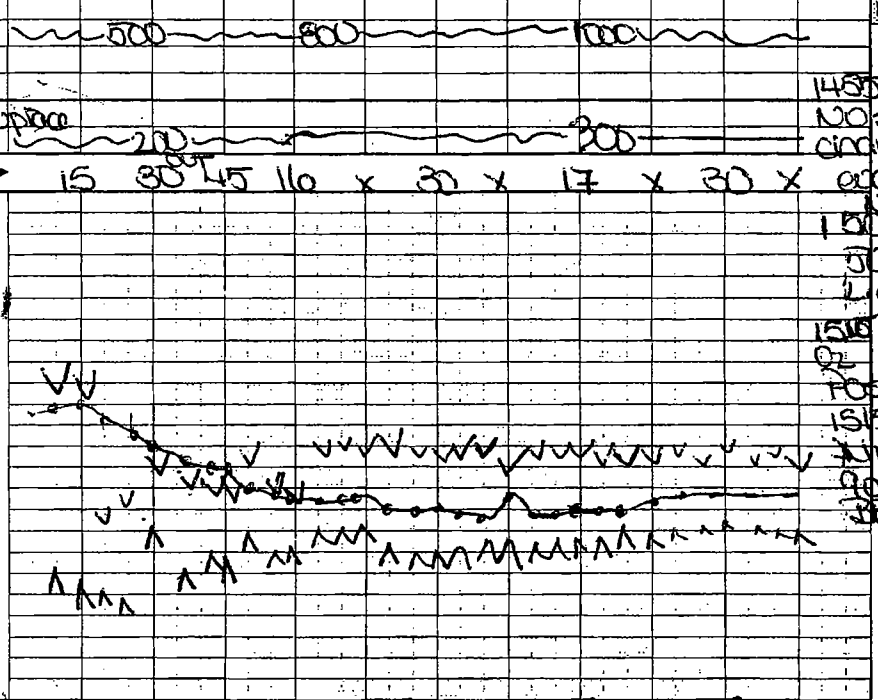
HEMATOCRIT:

INITIAL DATA: BP- 150/100 HR- 134

EQUIP CHECK OK? - (Y) N

PATIENT RECHECK OK for PROCEDURE (Y) TIME- 1510

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



VENTIL

	15	30	45	1600	x	30	x	1700	x	30	x	1800
VT - ml		600	700	600	600	600	600	600	600	600	600	600
f - breaths/min	16	12	9	9	9	8	8	8	8	8	8	8
Peak Inf pres / PEEP		17	17	16	16	17	17	17	17	17	16	16
MODE - S(pon), A(ssist), C(on)	SV	CV	CV	CV	CV	CV	CV	CV	CV	CV	CV	CV

MONITORS/ACCESSORIES

		15	30	45	1600	x	30	x	1700	x	30	x	1800
X BP/Auto Cuff	X ET CO2 (torr)	30	25	26	26	27	29	29	30	29	29	30	30
BP/oth	X FIO2 (Frac or %)	.39	.45	.46	.44	.44	.44	.40	.45	.45	.46	.46	.46
ART line	X SpO2 (%)	98	99	99	100	100	100	100	100	100	99	99	99
Steth- PC/ES	X ECG II	ST	ST	ST	ST	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site Skin		36°	36°	36°	36°	36°	36°	36°	36°	36°	36°	36°
	N-M Block (T/4)	4/4	0/4	0/4	0/4	1/4	3/4	0/4	0/4	0/4	0/4	0/4	0/4
Warming blkt	Room warmed												
Conv warmer													

Mark with letters & symbols, explain under REMARKS — EVENTS Position → Supine. (R) arm tucked (L) arm 90° abducted.

FLUIDS - SUMMARY
CRYSTALLOID- 1500 ml
COLLOID- 0
BLOOD- 0

TOTAL EBL Minimal

TOTAL URINE 350 ml

REMARKS — Code drugs with numbers, events with letters

1455 Chart review
No significant changes in prep
accumulation
NPO x 6 hrs
1500 10mg Reglan
50mg Zantac
2.0mg Versed
1510 Prep & Induction
O2 Monitors
Pitsthonine
1515 Induction
Intubation & incision
90° Bed turn
BBS = CTA
1745 to PACU

Report to SGT [redacted] LPN

RECOVERY AT 1840
PACU ICU ____ (Specify)
OTHER ____
CONDITION: PER 96 ST
RESP. 26 SpO2 97%
BP 139/78 HR 112

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1455	1505	1845
	Ready	Begin	End
PROC	1515	1540	1730

PROCEDURES and CPT Codes: Repair penetrating cranial injury + FB of hand Bilateral 64A [redacted]

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

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

[redacted] (b)(6)-4

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments DL x 1 Miller 2.0 Grade 1 view 2 ICHUMS ETT 6.0 Tube secure 3 BBS = CTA 90mm OPA

SURGEONS: [redacted]

ANESTHESIOLOGISTS: [redacted] MAX/CRNA/MSN

PROCEDURE LOCATION: OR 2-1

DATE: 14 Nov 03

PAGE 1 OF 1

(b)(6)-2 unless otherwise indicated

Page 2 of 2

MEDICAL RECORD - ANESTHESIA

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

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

DRUG (Units)	1800	30	1900	30								
Fentanyl (25mg)	150	100									500mg	
Vecuronium (mg)	5											
Propofol (mg)		0.625										
( )												
( )												
VOLAT AGENT Sevoflurane % del	~2			1200 hrs	1830							
% e.t.												
AIR L/Min												
N2O L/Min												
O2 L/Min	2	2	2	2	2~6							

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

FLUIDS

LINE site												
☐ Warmed												
IR (1300 hrs) ☐ Warmed												
☐ Warmed												
☐ Warmed												

LOSSES

EST BLOOD LOSS	400											
URINE - (300)					350							1875

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: ≈ 65 KG LB

HEMATOCRIT:

INITIAL DATA: BP- / HR-

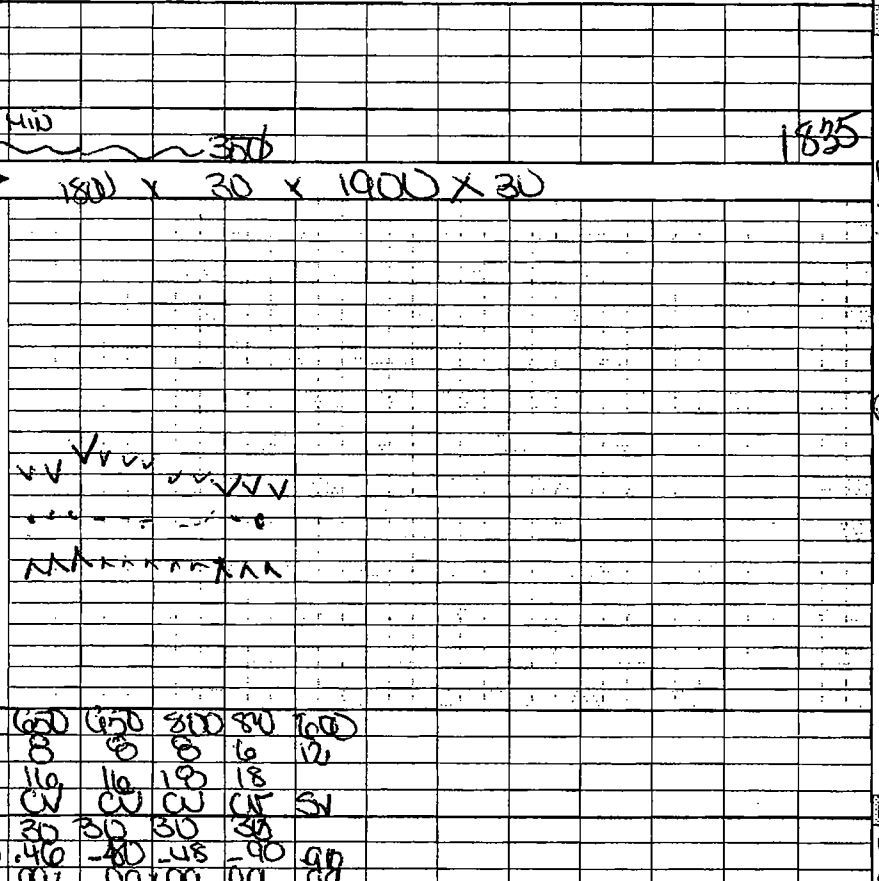
EQUIP CHECK OK? Y N

PATIENT RECHECK OK for PROCEDURE? TIME-

See page 1

TIME → 1800 x 30 x 1900 x 30

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



VENTIL

VT - ml	650	650	800	800	700
f - breaths/min	8	8	8	6	12
Peak inf pres / PEEP	16	16	18	18	
MODE - S(pon), A(ssist), C(on)	CV	CV	CV	CV	SV

MONITORS/ACCESSORIES

BP/Auto Cuff / ET CO2 (torr)	30	30	30	30	
BP/oth / FIO2 (Frac or %)	.46	.40	.48	.90	.90
ART line / SpO2 (%)	99	99	99	99	99
Steth- PC/ES / ECG II	SR	SR	SR	SR	SR
Gas analyzer / TEMP-site	36°	36°	36°	36	
N-M Block (T/4)	0/4	0/4	0/4	4/4 4/4 with sustained tetany x15 seconds	
Warming blkt	Warmed Bed				
Conv warmer				9/4 TO PACU HOB 45°	

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

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

FLUIDS - SUMMARY

CRYSTALLOID-

COLLOID-

BLOOD- See Page 1

REMARKS *Code drugs with numbers, events with letters*

Neuromuscular Reversal. Neostigmine 5.0 mg 0.3 mg Orad Extubated 5x3 FIO2 1.0 Trained 4/4 sustained tetany x5 seconds Head lift x6 sec

RECOVERY AT

PACU ICU _____ (Specify)

OTHER

CONDITION:

RESP- SpO2-

BP- HR-

ANESTHESIA PROCEDURE TIMES

	Start	Room	End
ANES			
PROC	Begin		End

See Page 1

PROCEDURES and CPT Codes:

Bilateral Repair corneal injury + FB Removal

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

[redacted] (b)(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

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

See Page 1

SURGEONS: [redacted]

ANESTHESIOLOGIST: [redacted] Major/CRNA

PROCEDURE LOCATION: OR 2-1

DATE: 14 Nov 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 — MEDCOM - 24495 — COPY 1 - PATIENT'S MEDICAL RECORD — USAPA V1.00

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)	
Fentanyl	(µg)	150/100 100 50
Propofol	(mg)	40/150
Zemuron	(mg)	30
	( )	
	( )	
	( )	

VOLAT AGENT		
Sevo	% del	1 → 1.5 → → → X
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	10 → 2 → → → → → → 10 →

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

FLUIDS

LINE site		
L wrist	☐ Warmed	1 → → → → → 2 → → →
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES: EST BLOOD LOSS; URINE -

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 70 KG LB

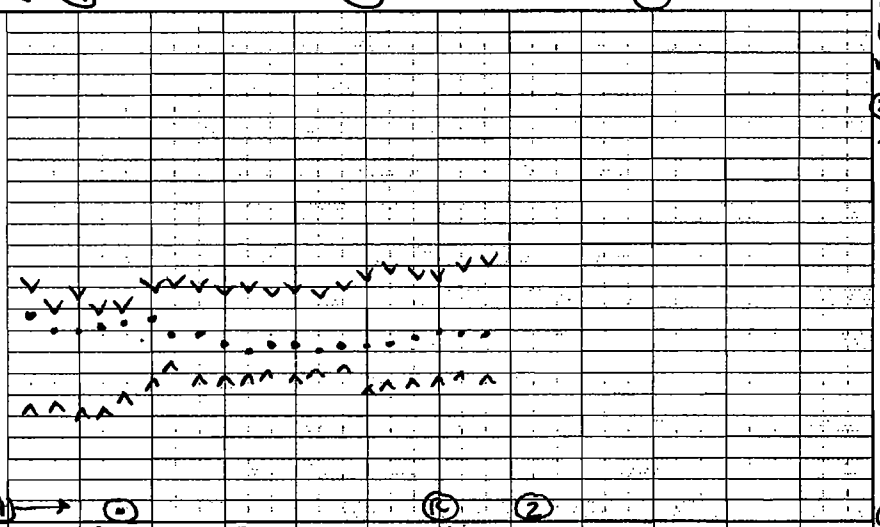
HEMATOCRIT:

INITIAL DATA: BP- 110 / 58; HR- 100

EQUIP CHECK: OK? - (Y) N

PATIENT RECHECK: OK for PROCEDURE? Y; TIME- 0850

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



VENTIL								
VT - ml	–	800	750	770	760	700	2500	
f - breaths/min	–	8	8	8	8	8	28	
Peak inf pres / PEEP	–	18	19	18	19	20	–	
MODE - S(pon), A(ssist), C(on)	SV	C	C	C	C	C	S/A	

MONITORS/ACCESSORIES								
BP/Auto Cuff	ET CO2 (torr)	–	30	30	31	30	37	36
BP/oth	FIO2 (Frac or %)	51	50	51	47	45	44	45
ART line	SpO2 (%)	100	100	100	100	100	100	100
Steth- PC/ES	ECG	ST	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site	–	95	95	95	95	95	
	N-M Block (T/4)							
Warming blkt								
Conv warmer								

Mark with letters & symbols, explain under REMARKS — EVENTS *Position* → (S), BUE on board, < 90° @ shoulders, pulses ↑

TOTALS	TOTAL EBL
	<10
	TOTAL URINE
	450

FLUIDS - SUMMARY: CRYSTALLOID- 1500; COLLOID- Ø; BLOOD- Ø

REMARKS — *Code drugs with numbers, events with letters*

(1) room/O2/monitors SIVI, easy mask ventilation c o/A. DVL x1 → OGTT Ant → (+) LTCL x1↑, BSBS, Ø A/W edema noted, grade I visible

(2) pt stable, extubated to PACU, report

(B) morphine • 2g > IV robinul 0.2g

RECOVERY AT: 1035

(PACU) ICU _____ (Specify)

OTHER _____

CONDITION: stable

RESP- 14 SpO2- 96%

BP- 124/68 HR- 107

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0840	0850	1040
	Ready	Begin	End
PROC	0900	0910	1025

PROCEDURES and CPT Codes: wcsh/debrid facial burns, BUE, LLE

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

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

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*: #8.0, Mac 3, 2 stylet, Ant, see (1)

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

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

PROCEDURE LOCATION: 2

DATE: 13 Nov 03

PAGE 1 OF 1

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 30 DAYS MOS YRS Sex (✓) MALE ( ) FEMALE

Physical State 1 2 3 4 5 E

WT: 65 KG/LB HT: ____ IN.

ALLERGIES: NKDA

PROPOSED PROCEDURE: ____

SURGICAL SERVICE: ____

NPO SINCE: ____

HABITS:

TOBACCO: yes

ETOH: ____

DRUGS: ____

CURRENT MEDICATIONS:

()= ordered as premed

() ____

() ____

() ____

() ____

() ____

() ____

PREMEDICATIONS:

None Yes (@ ____ Hrs) /CC

____. ____ mg IV IM PO

____. ____ mg IV IM PO

____. ____ mg IV IM PO

LABORATORY STUDIES:

HB/HCT: ____/____

U/A: ____

OTHER: ____

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT

PAST SURGICAL/ANESTHETIC

?

PHYSICAL EXAMINATION

BP ____ HR ____ R ____ T ____

Pain Scale 0-10 ____

HEENT - Teeth intact

Trachea midline

TMJ/Neck FROM

Oropharnyx 2nd + 3rd

Nares degree burn

CHEST: BS CTA to face

CARDIAC: RRR - ND

EXTREMITIES:

IV Access: PIV

Ulnar Filling: ____

BACK: ____

OTHER: ____

NPO Since Lunch 11-12-03

12Nov03 - Involved in car burning incident 11-11-03 22:35

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

With Interpreter present counseled for AFOI + P.O. intubation

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

(b)(6)-2

The patie[redacted] agrees. Questions answered.

Signed: [redacted] RSA/MAT Date: 13 Nov03 Time: 0800 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)

{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

SEDATION KEY:

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

(b)(6)-2 unless otherwise indicated

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 noted [redacted] 1530			① D/c foley ② Percocet 1-TT po q 4-6° pm pain ③ Pt can shower [redacted] 6014 LTC	HOURS	
NURSING UNIT	ROOM NO.	BED NO.			
24°/030 16NOV03 [redacted]					

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
24° ✓ 17 NOV 03 [redacted] (b)(6)-4 noted			0200 [redacted]	HOURS	
			✓ ① Erythromycin ophth oint gtd OU [redacted] 6014 LTC		
NURSING UNIT	ROOM NO.	BED NO.			

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
[redacted] (b)(6)-4 noted 0910			11/~~18~~17/03	0905 HOURS	
			✓ ① Ambien 10mg po qhs pm ✓ ② Tylenol 325 II po q 4-6° pm [redacted]		
NURSING UNIT	ROOM NO.	BED NO.	24°/ 19NOV03 [redacted] 0330		

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
[redacted] (b)(6)-4 noted [redacted] 1930			11/20/03	HOURS	
			Atropine 1% T gtts OU tid Fred 40mg po q D D/c Sdvma [redacted] 6014		
NURSING UNIT	ROOM NO.	BED NO.			
24° ✓ 21 NOV 03 0420 [redacted]					

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

(b)(6)-2 unless otherwise indicated

CLINICAL RECORD - DOCTOR'S ORDERS

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

PATIENT IDENTIFICATION

(b)(6)-4

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

[redacted]

DATE OF ORDER: 11/25/03 TIME OF ORDER: 0717 HOURS

LIST TIME ORDER NOTED AND SIGN

To el Haytham for eval [redacted]

Noted [redacted]

24° 2100 28 NOV 03 [illegible]

PATIENT IDENTIFICATION

(b)(6)-4

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

24° ✓ 03 DEC 0200

DATE OF ORDER: TIME OF ORDER: HOURS

Decrease Prednisone to 20mg po qD [redacted]

[redacted] 03 DEC 03 1140

[illegible] 2L7 [illegible]

PATIENT IDENTIFICATION

(b)(6)-4

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

[redacted] 09 DEC 03 1945

DATE OF ORDER: 9 DEC 03 TIME OF ORDER: 0822 HOURS

~~D/C~~ No drops 2400-0600 [redacted]

Noted [redacted]

PATI[redacted] 09DEC03 0005

24° ✓ NO [redacted] 09DEC03 2225

DATE OF ORDER: 09DEC03 TIME OF ORDER: 2245 HOURS

↑ Prednisone to 40mg po QD

V.O. [redacted]

(b)(6)-4

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

24° ✓ [redacted] 09DEC03 2250

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

(b)(6)-2 unless otherwise indicated

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

#[redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 11/27/03 TIME OF ORDER 0805 HOURS

LIST TIME ORDER NOTED AND SIGN [redacted]

1. D/C ANCEF
2. D/C IV
3. DECREASE PRED TO 30 MG QD [redacted]

D/C CIPRO [redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.
[redacted]		

DATE OF ORDER 11/28/03 TIME OF ORDER 0810 HOURS

D/C [redacted]

noted 28NOV03 0915

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER _____ HOURS

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER _____ HOURS

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

(b)(6)-2, unless otherwise indicated

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

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

Decrease Prednisone 20mg po qD x 4 days then 15mg po qd x 4 days then 10mg po qd

[redacted]

PATIENT IDENTIFICATION

NOTED 15 DEC @ [redacted] 2ST, MN

[redacted]

(b)(6)-4

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

Timoptic gtts OD bid (1.5%)

[redacted]

24 [redacted] 18DEC03 0005

PATIENT IDENTIFICATION

No new orders [redacted] 17DEC03 0005

No new orders [redacted] 19DEC03 0240

[redacted]

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 18DEC03 | TIME OF ORDER 1030 _____ HOURS

D/C TO CAMP

[redacted]

PATIENT IDENTIFICATION

(b)(6)-4

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

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

(b)(6)-2 unless otherwise indicated

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4 [redacted]

NOTED [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 11/13 | TIME OF ORDER: _____ HOURS | LIST TIME ORDER NOTED AND SIGN

1. Admit ICW
2. Burn Face
3. Stable
4. NPO
5. IV NS @ 125 ml/hr
6. VS routine
7. To OR 11/13 [redacted]

PATIENT IDENTIFICATION

(b)(6)-4 [redacted]

NOTED [redacted]

NURSING UNIT | ROOM NO. | BED NO. 1SIV04

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

1. Reg diet
2. Hepatologist
3. Send pt to optho clinic - coordinate time with Dr [redacted]
4. Ancef Fg inj q8 x 3 doses
5. Bacitracin to face [redacted]

PATIENT IDENTIFICATION

(b)(6)-4 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 11/14/03 | TIME OF ORDER: 1100 HOURS

Atropine tgtts OU tid
Ocuflox tgtts OU qid
NPO [redacted]

PATIENT IDENTIFICATION

(b)(6)-4 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

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

(b)(6)-4 unless otherwise indicated

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

#[redacted]

NURSING [redacted] | ROOM NO. | BED NO. [redacted]

~~ICW #1~~

DATE OF ORDER 11/14/03 TIME OF ORDER 1830 HOURS

LIST TIME ORDER NOTED AND SIGN

Admit to ICW1
Dx: Multiple corneal perf. OD
Multiple ant seg foreign bodies OU
Condition stable
Vitals routine
Diet Adv as tolerated
Act Bedrest up i assistance

PATIENT IDENTIFICATION

#[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER

AU MDDA HOURS

IV Ancef 1gm IV q8°
Cipro 400mg IV q12
Solumedrol 125mg IV qid
Zantac 150mg po bid
in am begin Pred Acetate 1 gtts OU q2°
Ocuflox 1 gtts OU qid

(b)(6)-2

[redacted]

PATIENT IDENTIFICATION

#[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER [redacted]

6D4 LTC

PATIENT IDENTIFICATION

#[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

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

MEDCOM - 24503

(b)(6)-2 unless otherwise indicated

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. 12 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 8	9	10	11	12	13	14	15	16	17	18		
	NIO	BRADEN SCALE	6	[redacted]	/	/	/	/	/	/	[redacted]	/	/	/	/	/
		EVAL	18	/	/	/	/	/	/	/	/	/	/	/	/	/
12NOV	[redacted]	VS: Routine	6	[redacted]												
			18	[redacted]												
13NOV	[redacted]	Reg Diet, AAT	6	[redacted]												
			18	[redacted]												
14NOV	[redacted]	ACT BR ↑ C Assit.	6	[redacted]												
			18	[redacted]												
15NOV	[redacted]	Pt. can shower	10	[redacted]												
			22	[redacted]												
4Dec	[redacted]	NIO: Braden Scale	6	[redacted]												
			18	[redacted]												

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: facial burns

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

(b)(6)-2 unless otherwise indicated

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. 11 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 15	16	17	18	19	20	21	22	23	24	25	26	27	28
14	[redacted]	PRED ACETATE 1 gtt OU	00	/	[redacted]												
		Q2°	02	/	[redacted]												
		(start 11/15 11 AM)	04	/	[redacted]												
			06	/	[redacted]												
			08	[redacted]													
			10	[redacted]													
			12	[redacted]													
			14	[redacted]													
			16	[redacted]													
			18	[redacted]													
			20	[redacted]													
			22	[redacted]													
14	[redacted]	OCUFLOX 1 gtts OU	6	[redacted]													
		QID	12	[redacted]													
			18	[redacted]													
			24	[redacted]													
18NOV	[redacted]	erythromycin opth.	06	/	—	—	/	[redacted]									
		ointment qid OU	12	/	—	[redacted]											
			18	/	/	[redacted]											
			24	/	/	[redacted]											
20NOV	[redacted]	Pred 40mg PO QD	08	/	/	/	/	/	/	[redacted]							11/27
20NOV	[redacted]	Atropine 1%	06	/	/	/	/	/	/	[redacted]							
		1 gtts OU TID	14	/	/	/	/	/	/	[redacted]							
			22	/	/	/	/	/	[redacted]								
11/27	[redacted]	Decrease Pred to	08	—	—	—	—	—	—	—	—	—	—	—	—	[redacted]	
		30mg qd															

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: brainfall / mult corneal perf OD mult ant seg FB OU

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO
PAGE NO. 2

PATIENT IDENTIFICATION:

(b)(6)-4

[redacted]

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

(b)(6)-2 except very bottom

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 15	16	17	18	19	20	21	22	23	24	25	26	27	28
15 DEC	-MA-	DECREASE PREDNISONE 20mg	08	[redacted]													
	-----	PO QD x 4 DAYS, THEN															
	-----	15mg PO QD x 4 DAYS,	08														
	-----	THEN 10mg PO QD	08														
	-----																
15 DEC	-MA-	TIMOPTIC ½ GTTS OD BID	10	[redacted]													
	-----	(OS/.)	22	[redacted]													

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: BURN FACE/MULT FB OU

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

DA FORM 1 FEB 79 4678 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

(b)(6)-2 except very bottom

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. Dec Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 10	11	12	13	14	15	16	17	18
13 NOV	[redacted]	Bacitracin to face	10	[redacted]								
	-----		22	[redacted]								
14 NOV	[redacted]	Zantac 150mg	10	[redacted]								
	-----	P.O. BID	22	[redacted]								
20 NOV	[redacted]	Atropine 1% 1 gtt OU	06	[redacted]								
	-----	TID	14	[redacted]								
	-----		22	[redacted]								
8 Dec	[redacted]	Pred acetate 1 gtt OU	08	[redacted]								
	-----	Q2° (no gtts 24-0600)	10	[redacted]								
	-----		12	[redacted]								
	-----		14	[redacted]								
	-----		16	[redacted]								
	-----		18	[redacted]								
	-----		20	[redacted]								
	-----		22	[redacted]								
12 DEC	[redacted]	Prednisone 20mg po	08	[redacted]								
	-----	QD ↑ to 40mg		[redacted]								
14	[redacted]	Ocuflox 1 gtt OU	06	[redacted]								
	-----	QID	12	[redacted]								
	-----		18	[redacted]								
	-----		24									
18	[redacted]	Erythromycin opth.	06	[redacted]								
	-----	ointment QID OU	12	[redacted]								
	-----		18	[redacted]								
	-----		24									

Rd 15 DEC 03 SEE NEXT SHEET

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Burn face/multi fb OU

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 1 FEB 79 4678 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

(b)(6)-2all

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. 12 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
19	[redacted]	Percocet 1-II po 9-4-6° pm	[redacted]
18	[redacted]	Ambien 10mg QHS po pm	
18	[redacted]	Tylenol 325mg II po 9-4-6° pm	

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

(b)(6)-2 except very bottom

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. 11 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 12	13	14	15	16	17	18	19	20	21	22	23	24	25
12	[redacted]	LR@ 125cc/hr	6	/	[redacted]												
		Heplock IV	18	[redacted]		/											
13NOV	[redacted]	HL IV	6	/	[redacted]												
			18	/	[redacted]												
13NOV	[redacted]	Ancef 1gm IVP Q8°	08	/	[redacted]												
		x3 doses	16		[redacted]												
			24		[redacted]												
13NOV	[redacted]	Bacitracin to face	10		[redacted]												
			22		[redacted]												
14NOV	[redacted]	Atropine 1 gtts OU	08														
		TID	16			[redacted]											
		~~Ocuflox 1 gtt OU~~	24														
		~~TID~~ ERROR (BR)	X														
14NOV	[redacted]	Ocuflox 1 gtts OU	08														
		TID	16			[redacted]											
			24														
14NOV	[redacted]	Ancef 1 gm IV Q8°	8	/	/	/	[redacted]										
			16	/	/	/	[redacted]										
			24	/	/	[redacted]											
14NOV	[redacted]	Cipro 400mg IV Q12°	10	/	/	/	[redacted]										
			22	/	/	[redacted]											
14NOV	[redacted]	Solumedrol 125mg IV	6		/	[redacted]											
		QID	12		/	[redacted]											
			18		/	[redacted]											
			24	/	[redacted]												
14NOV	[redacted]	Zantac 150 mg po BID	10		/	[redacted]											
			22		/	[redacted]											

D/C'd

AUTO D/C'd

20 Nov 03 D/C

ALLERGIES: ☐ YES ☒ NO	PRIMARY DIAGNOSIS:		ADDITIONAL PAGES IN USE: ☒ YES ☐ NO
NKDA	Burn face	mild corneal perf OD mild ant seg FB OU	PAGE NO. 1

PATIENT IDENTIFICATION:

(b)(6)-4

[redacted]

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

(b)(6) - 2 all

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 11 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												
15NOV	[redacted]	Percocet 1-2	17NOV 0910	18NOV 0080	19NOV 2100	20NOV 1200									
		PO q 4-6 PRN	2	2	1 tbs	1									
		PAIN			(R)										
18NOV	[redacted]	Ambien 10mg QHS	[redacted]	22NOV 2300											
		PO PRN	[redacted]	10mg 50											
18NOV	[redacted]	Tylenol 325mg 1	[redacted]	23NOV 1330											
		PO Q4-6° PRN	[redacted]	1 tbs											

Pevrl Hen
24 Nov 03

(b)(6)-2 except very bottom

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. 12 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 29	30	1	2	3	4	5	6	7	8	09	10	11	12
14	[redacted]	PRED ACETATE 1 gtt	00	[redacted]													
	-----	OU Q2°	02	[redacted]													
	-----		04	[redacted]													
	-----		06	[redacted]													
	-----		08	[redacted]													
	-----		10	[redacted]													
	-----		12	[redacted]													
	-----		14	[redacted]													
	-----		16	[redacted]													
	-----		18	[redacted]													
	-----		20	[redacted]													
	-----		22	[redacted]													
14	[redacted]	OCUFLOX 1 gtt OU QID	6	[redacted]													
	-----		12	[redacted]													
	-----		18	[redacted]													
	-----		24	[redacted]													
18	[redacted]	Erythromycin Opth.	06	[redacted]													
	-----	Ointment QID OU	12	[redacted]													
	-----		18	[redacted]													
	-----		24	[redacted]													
20	[redacted]	Atropine 1% 1 gtt OU TID	6	[redacted]													
	-----		14	[redacted]													
	-----		22	[redacted]													
27	[redacted]	Prednisone 30mg po	08	[redacted]													
	-----	QD	X	[redacted]													
02 Dec	[redacted]	Prednisone 20mg p.o	08	[redacted]													
	-----	QD															

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: BURN FACE / MULT. CORNEAL PERF OD, MULT ANT. SEG FB OU

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO. 2

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

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

DA FORM 1 FEB 79 4678 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

(b)(6) - 2 all

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 12 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
03 DEC	[redacted]	No drops 2400 - 0600	09	—		[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
15 NOV	[redacted]	Percocet T-II po q 4-6° pm	[redacted]												
18	[redacted]	Ambien 10mg QHS po pm													
18	[redacted]	Tylenol 325mg II po q 4-6° pm													

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

(b)(6)-2 except for very bottom

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. 11/12 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	29	30	1	2	3	4	05	6	7	8	9
13 Nov	[redacted]	HL IV	06	[redacted]													
	-----		18	[redacted]			D/C						27 Nov 03				
13 Nov	[redacted]	Bacitracin to face	10	[redacted]													
	-----		2	[redacted]													
14 Nov	[redacted]	Ancef 1 gm IV	08	[redacted]													
	-----	Q8°	16	[redacted]									Nov 03				
	-----		24	[redacted]													
14 Nov	[redacted]	Cipro 400mg	10	[redacted]													
	-----	IV Q12°	22	[redacted]													
14 Nov	[redacted]	ZANTAC 150mg	10	[redacted]													
	-----	P.O BID	22	[redacted]													
20 Nov	[redacted]	Atropine 1% 1 gtts OU	06														
	-----	TID	14														
	-----		22														
14 Nov	[redacted]	Pred Acetate 1 gt OU	06														
	-----	92° (no gtts 24-[illegible])	08														
	-----		10														
	-----		12														
	-----		14														
	-----		16														
	-----		18														
	-----		20														
	-----		22														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Burn face / Mult FB OU

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO. 1

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

DRM FEB 79 4678 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

(b)(6)-2 all

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. 11 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												
15 NOV	[redacted]	Percocet-5 - 1/2	[redacted]												
		P.O Q 4-6 prn													
18 NOV	[redacted]	Ambien 10mg QHS		30 NOV 2300 tpo	30 NOV 2330 tpo										
		P.O prn													
				(e)											
18 NOV	[redacted]	Tylenol 325 mg													
		1/2 P.O Q4-6													
		PRN													

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

(b)(6)-2 except very bottom

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 12	13	14	15	16	17	18	19	20	21	22	23	24
12	[redacted]	NPO	6	/	[redacted]	\										
			18	[redacted]		/		DIC								
12 14	[redacted]	VS: Routine	6	/	[redacted]											
			18	[redacted]												
13NOV	[redacted]	Reg. diet, AAT	6	/	[redacted]											
14NOV			18	/	[redacted]											
14NOV	[redacted]	ACT: BR, ↑ Cassist	6	/	/	/	[redacted]									
			18	/	/	[redacted]										
15NOV	[redacted]	Pt can shower	10	—	—	/	[redacted]									
			22	—	—	/	[redacted]									

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: Burn face / mult corneal perf OD, mult ant seg FB OU

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

(b)(6)-2 all

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 11 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
12	[redacted]	Admit IWN, stabize	12	—		[redacted]
12	[redacted]	To OR [redacted] 11/13	13	—		[redacted]
13NOV	[redacted]	Send pt to ~~ortho~~ ortho-clinic (coordi-	14NOV		1100	[redacted]
	----	nate time c [redacted]	/	/	/	/
14NOV	[redacted]	NPO	14NOV	ASAP 1100	1100	[redacted]
15	[redacted]	D/C Foley	15NOV	1600	—	[redacted]

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

(b)(6)-2 except very bottom

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. 11 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 25	26	27	28	29	30	1	2	3	4	5	6	7
12Nov	[redacted]	VS: Routine	6	[redacted]												
			18	[redacted]												
13Nov	[redacted]	Reg Diet, ~~AAT~~ AAT	6	[redacted]												
			18	[redacted]												
14Nov	[redacted]	ACT BRTC Assist	6	[redacted]												
			18	[redacted]												
15Nov	[redacted]	Pt can shower	10	[redacted]												
			22	[redacted]												
4 DEC	[redacted]	NIO: BRADEN SCALE	06	/			/	[redacted]	/					/	[redacted]	/
		Q 7 DAYS	18	/			/	[redacted]	/					/	[redacted]	/

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: FACIAL BURNS

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

(b)(6) - 2 all

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*				Mo 11 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
25 NOV	[redacted]	To elthaytham for eval.	25			

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

24

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: 14 Nov 02
Time In: 1640
Allergies: NKA
Pre-op V/S: 150/60 134
Procedures: bil. Schrapel to left
Anesthesia Type (Circle): General/Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1700 Colloid
OR Output: UOP 350 EBL NKA
Meds/Times: Fentanyl, MARCAINE-lyles

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

Pre Op Meds History

Time	1840	1855	1870	1905
SaO2	97	100	98	95
FiO2	RA	2L	2L	RA
Methods	M	M	M	FT
240				
220				
200				
180				
160				
140				
120				
100				
80				
60				
40				
20				
RR	24	18	22	16
T	97.6			

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1840	LR	300	L Arm	DC	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	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	1
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	8	9	9

Codes:
AIRWAY: A = Ambu, BB = Blow-by, M = Mask, FT = Face Tent, RA = RoomAir, NC = Nasal Cannula
V/S: X = A-line BP, * = Cuff BP, = Pulse
TEMP: S = Skin, O = Oral, A = Axillary, T = Tympanic, R = Rectal
LOS: C = Cervical, T = Thoracic, L = Lumbar, S = Sacral

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)

[redacted] (b)(6)-2 DEPARTMENT/SERVICE/CLINIC: PACU DATE: 14 Nov 02

PATIENT'S IDENTIFICATION (For 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

(b)(6)-2 all

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

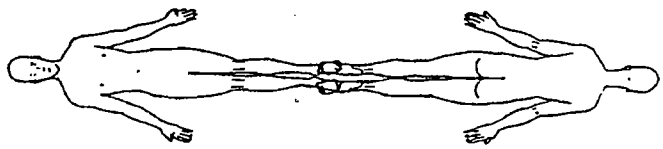
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	L eye	patch	—
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1915	Urine	Clear	200

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1840	SR	—	—

WAMC OP 173-E

NURSING NOTES

Pt to Urology room (Thomas) via gurney s/p Orbital bldg removal from both eyes. B/L eye patches intact. IV of LR infusing into (L) wrist. c/o s/s of headache d/t anesthesia. VSS. Will continue to monitor [redacted]

Discharge Criteria:
Date: 4/NOV **Time:** 1915 **PARS:** 9
BP: 127/72 **T:** 96.8 **HR:** 101 **RR:** 12 **Sa02:** 95
Pain Level at D/C (0-10):
Intake: 200 **Output:** 200
Additional Data:
Transferred To: [redacted]
Report Given To:
Transferred Via:
Transferred By:
Cleared IAW Recovery P
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: 11/13/03 Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block

Time In: 1030

Allergies: OR Intake: Crystalloid 1500 Colloid

Pre-op V/S: 110 80 12 NISO OR Output: UOP 450 cc EBL 210 cc

Procedures: WASH & DEBRIDE FACIAL BURNS Meds/Times: 10 cc FENTANYL

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

Pre Op Meds History

Time	1030	1035	1040	1045	1050
SaO2	98	100	100	99	100
FiO2	1/2	1	1	1	1
Methods	RA	OP	RA	NC	RA
240					
220					
200					
180					
160					
140					141
120	124	122	128	130	
100					
80					
			72	74	69
60	68	69			
40					
20					
HR	75	86	72	90	101
RR	18	15	15	20	16
T	96.5				

Pacu Intake					
Time	Solution	Amount	Site	By	Infused
1030	RL	475	R Arm	IV	50
X-rays:			Labs:		

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	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

Time									
Pain (0-10)									
LOS									

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

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 11/13/03

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

[redacted] (b)(6)-4

[redacted]

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

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

USAPPC V2.00

(b)(6)-2 all

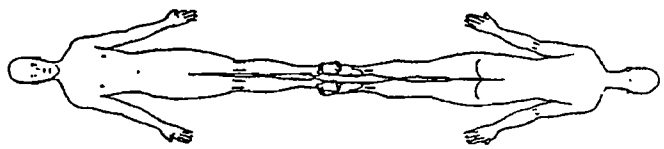
MEDICATIONS						
Allergies:						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR							
Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	[illegible]	[illegible]	[illegible]	P	B	C	PK
15'	[illegible]	[illegible]	[illegible]	P	B	C	PK
30'	[illegible]	[illegible]	[illegible]	P	B	C	PK
45'							
60'							
90'							
D/C	[illegible]	[illegible]	[illegible]	P	B	C	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 1030	FOREHEAD	PACKING	Q
30'			
60'			
D/C 1115			



PACU OUTPUT			
Time	Source	Color/Appearance	Amount
10:30	FOLEY.	YELLOW.	—
11:15	FEY.	YELLOW.	50cc

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1030	NSR	S1S2 PRESENT.	

WAMC OP 173-E

NURSING NOTES

1030 PT admitted to PACU on stretcher. PT has burn to ⓡ hand - 2nd degree. PT has shrapnel wounds about body, particularly face and ⓛ leg. PT unable to open eyes fully due to blast injuries. Has packing to shrapnel head wounds on forehead. Blast on ⓡ side has abrasion and injuries from shrapnel wounds. PT has good O2 perfusion; obeys verbal commands.

1115 PT follows verbal commands through interpreter. PT encouraged to deep breathe and remain awake. VS stable. Arrangements made to PACU. [redacted]

Discharge Criteria:
Date: 11/13/03 Time: 11:15 PARS: 10
BP: 142/88 T: HR: 76 RR: 15 Sa02: 99
Pain Level at D/C (0-10):
Intake: RL 50 Output: FOLEY 50cc
Additional Data: Q
Transferred To: TCW1
Report Given To: [redacted]
Transferred Via: W/C [redacted] Gurney Ambulance
Transferred By:
Cleared IAW Recovery [redacted]
Charge Nurse Signature [redacted] LE AW

AEROMEDICAL EVACUATION PATIENT RECORD

PATIENT IDENTIFICATION

1. NAME (Last, First, Middle Initial)	2. SSN	3a. STATUS	3b. SERVICE	4. PRECEDENCE U P R	5. GRADE
[redacted] (b)(6)-4					

6. AGE	7. SEX	8. WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A-5F)	11. ACCEPTING PHYSICIAN	12. CITE/AUTHORITY NO.
30	X Male / Female			AMBULATORY / X LITTER 2A		

13. APPT/SURG DATE	14a. ORIGINATING FACILITY	15a. DESTINATION FACILITY	16. NUMBER OF ATTENDANTS
	14b. ORIGINATING FACILITY PHONE NUMBER	15b. DESTINATION FACILITY PHONE NUMBER	16a. MEDICAL / 16b. NON MED

17. DIAGNOSIS

BURNS TO FACE AND EYES

18. BATTLE CASUALTY | DISEASE | NON-BATTLE INJURY

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

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

20. PHYSICIANS ORDERS

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

20d. DIET | REG | 3GM NA | CARDIAC | DIABETIC ____ CALS

- RENAL ____ Gm prot ____ Gm Na ____ Meq K ____ mg PO4
- TUBE ____ TYPE ____ cc/hr, 1/2, 3/4, FULL STRENGTH
- PEDIATRIC: AGE ____ | OTHER (Specify) ____
- TPN: Change to D10 at ____ cc/hr for max of ____ days
- TUBE FEEDING ____ at ____ strength at ____ cc/hr

20e. IV/BLOOD

20f. SPECIAL EQUIPMENT | TRACTION | ORTHOPEDIC BRACES

SUCTION	IV PUMP	CHEST TUBE/HEIMLICH
NG TUBE	TRACH	RESTRAINTS
STRYKER FRAME	MONITOR	OTHER (Explain in 23)
INCUBATOR	FOLEY	

O_2: | LITERS: | ROUTE:

VENTILATOR SETTINGS

20g. ALTITUDE RESTRICTION:

20h. RECORDS TO ACCOMPANY PATIENT

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

20i. MEDICATIONS/TREATMENTS

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE

30 yo F/W spinning via C-130 to [illegible] or [illegible] w/s. alert oriented. Very clear [illegible] resp. 80/m. [illegible] soft non tender. Eff [illegible] abrasion [illegible] Burns [illegible] not noted. Clear. [illegible] Burns [illegible] Transferred directly to [illegible] 28CSH via mil-ambulance [redacted] (b)(6)-2

23. ASSESSMENT/PROGRESS

DATE/TIME	NOTES
12NOV03	Pt received @ 1447 MASF via C-130 @ 1855(Z) / 2155(L). VS: BP 131/72 HR 114 RR 20 T 99.3 Pox 97% on RA. Pt strapped onto litter. Interpreter & SPTS @ bedside. Visible burns on face & shoulders. Kerlix dry cont (b) RA. multiple abrasions on (b) ↑ ext. (b) most eye patches OTA. Cont. to follow. [redacted] USAFNC. 2225(L) 1925(Z) (b) eye dsg changed. Saturated clean dsg c. NS. Paraffin ointment applied to lips & pt gargled c Chlorhexidine mouthwash. Pt restrapped to litter, awaiting transport [redacted] USAFNC.

24. STAMP AND SIGNATURE OF ATTENDING PHYSICIAN

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF FORM 3899, MAR 95

(b)(6)-2 unless indicated otherwise

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: **TRAUMA FLOWSHEET** — The proponent is Dept of Surgery

OTSG APPROVED *(Date)*: QI Appr 11 Jun 97

EMS REPORT

TIME: 1200 ETA: _____ UNIT: _____

MED COM: [Y] [N] _____

ARRIVAL STATUS

TIME 0005 ☐ IV x 1 ☐ O_2 _____ l/min ☐ C-Spine Immob

Meds: ☐ UKN ☑ None ☐ Yes: _____

Allergies: ☐ UKN ☑ None ☐ Yes: _____

Tetanus: ☐ UKN ☑ Current Last Meal/Fluid Intake _____ hrs

LMP: _____ ☐ _____

PRIMARY SURVEY

AIRWAY

☑ Natural Patient [Y] [N]

☐ ETT ____ ☐ _____

☐ Secretions _____

BRETHING

☐ Labored ☑ Unlabored ☐ Absent

TRACHEA: ☐ Midline ☐ Deviated [L] [R]

CHEST SYMMETRY: [L] > = < [R]

CIRCULATION

PULSE: ☑ Present ☐ Absent

BLEEDING: [Y] [N]

HEART TONES: ☐ Clear ☐ Muffled

SKIN: ☐ Warm ☐ Cool ☐ Hot

☐ Pink ☐ Pale ☐ Cyanotic ☐ _____

☐ Dry ☐ Moist ☐ Diaphoretic

SECONDARY SURVEY

DISABILITY

GCS: E _____ V _____ M _____

SPHINCTER TONE: ☐ WNL ☐ None

HEAD

PUPILS: ☐ Equal ☐ Fixed ☐ React ☐ Dilated [L] [R]

TM: ☐ Clear ☐ Blood [L] [R]

NECK

C-Spine Tenderness: [Y] [N]

Pain @ _____

JVD: [Y] [N]

HEART

RHYTHM: ☑ Regular ☐ _____

PULSES: ☐ Central ☐ Peripheral

LUNGS

BREATH SOUNDS: ☐ Bilat ☐ Equal ☐ Clear

Decreased [L] [R] Absent [L] [R]

Wheezes [L] [R] Crackles [L] [R]

ABDOMEN

☐ Soft ☐ Rigid ☐ Non-Tender

☐ Tender: _____

PELVIS

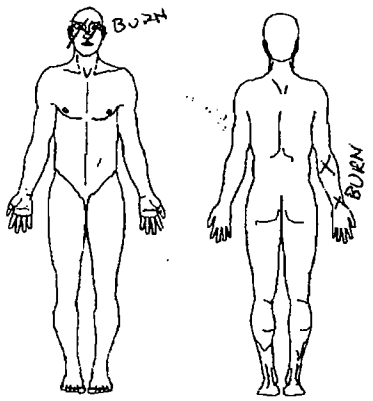
☐ Stable ☐ Unstable ☐ _____

Blood at meatus/vagina: [Y] [N]

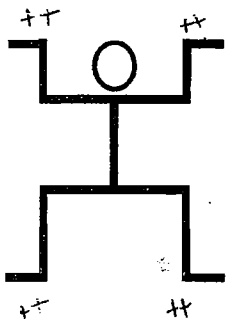
Heme +/- Prostate: ☐ WNL ☐ Abnl

USE DIAGRAM TO DOCUMENT INJURIES AND PAIN

(AB)rasion
(AMP)utation
(AV)ulsion
Battle's Signs
(BL)eeding
(B)urn
(D)eformity
(E)cchymosis
(F)oreign Body
(H)ematoma
(LAC)eration
(P)uncture (W)ound
(Pain)
(S)eatbelt (S)ign
(S)tab (W)ound
(GSW) Gun Shot Wound



VASCULAR ASSESSMENT



++ Strong	+ Palpable	D Dopler

RN: [redacted]

PHYSICIAN: [redacted]

(Continue on reverse)

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

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

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

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

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

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 **4700**

REQUIREMENT OF PRIVACY ACT OF 1974 IS COVERED BY DO FORM 2005. PREVIOUS EDITION IS OBSOLETE.

EAMC OP 503, 1 Dec 98

TIME	PROCEDURE	SIZE	SITE	BY	RESULTS
	ET Intubation		☐ Oral ☐ Nasal Teeth		☐ $ETCO_2$ Change ☐ BBS Post Int ☐ Post CXR
	Gastric Tube		☐ Oral ☐ Nasal		☐ Air ☐ Contents ☐ Verified_____ Suction: Y N
	Urinary		☐ Meatus ☐ Supra-Public		☐ Return_____cc ☐ Heme Dip: + - ☐ Secured
	DPL		☐ Opened ☐ Closed		☐ Grossly: + - Cell count Sent@_____
	Chest Tube #1		L R		☐ Air ☐ Blood ☐ Pleuravac____cm ☐ Autotransfuser
	Chest Tube #2		L R		☐ Air ☐ Blood ☐ Pleuravac____cm ☐ Autotransfuser
	12 Lead	Rhythm:		Comments	

ABG SITE	TIME	$\%O_2$	pH	BE	pCO_2	PO_2	O_2 Sat	HCO_3
1)								
2)								

LABS

TIME	LABS
	☐ D-stick_____ ☐ SHct_____
	☐ D-stick_____ ☐ SHct_____
	☒ CBC ☒ Chem ☒ PT/PTT
	☐ ETOH ☐ T&S ☐ T&C x_____
	☐ Tox Screen
	☒ UA ☐ HCG
	☐ OTHER
	☐ OTHER

X-RAYS

TIME	LABS
0015	☒ Chest Initial
	☐ Chest Post ET
	☐ Chest Post CT
	☐ C-Spine
	☐ Pelvis
	☐
	☐
	☐

TIME	PROCEDURE	ACCOMPANED BY	RETURN
	CT Scan: ☐ Contrast		
	☐ Head ☐ Abd ☐ Pelvis		
	☐ C-Spine ☐ T/L Spine ☐ Chest		
	☐		
	A-Gram Site:		

IV ACCESS & FLUIDS

TIME	#	GA	IAW SOP		SITE	IVF TYPE	AMT UP	AMT IN
ARRIVED WITH	1	7	(Y)	N	(L) FOREARM	SODIUM LACTATE	/<	
			Y	N				
			Y	N				
			Y	N				

MEDICATIONS

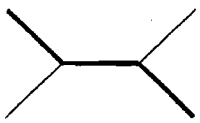
MEDICATION	TIME	DOSE	RTE	TIME	DOSE	RTE	TIME	DOSE	RTE
75 Fentanil	0009		IV						

BLOOD PRODUCTS

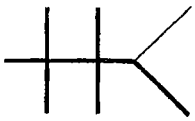
START	#	TYPE	UNIT#	AMT UP	AMT IN	END	INT

LAB RESULTS

CBC:



Chem:



INTAKE & OUTPUT

INTAKE	AMOUNT	OUTPUT	AMOUNT
IVF		Urine	
NGT		NGT	
Blood		EBL	
Other		Other	
TOTAL		TOTAL	

TRAUMA TEAM ARRIVAL

TITLE	NAME (Print)	PAGED	RESPONDED	ARRIVED
ED Phys				
Surgeon				
Anesth				
X-Ray				
RT				
Ortho				
Neuro				
Chaplain				

VALUABLES & CLOTHING

V	STATUS	C
	None Found	
	Given to Patient	
	Given to Family	
	Inventoried and Released to Patient Trust Fund/NCOD See DA Form 3696	
	Other: See Nursing Notes	

DISPOSITION

☐ Home ☐ _____

Admitted to_____

Report Called to_____

Time Transferred_____

Accompanied By_____

Via: ☐ Stretcher ☐ Wheelchair

As per ACLS Precautions: ☐ Yes ☐ No

(page 2)

VITAL SIGNS

Rectal Temp:

TIME	BP	HR	RHY	RR	SAO_2	FIO_2	MODE	GCS: E	V	M	T
0001	135/75	110		16	98						
0009	168/101	91		18	99						
0025	144/68	76		16	99						
	/										
	/										
	/										
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GLASGOW COMA SCALE

EYE OPENING	VREBLE RESPONSE	MOTOR RESPONSE
4 - Spontaneous	5 - Oriented	6 - Obeys Commands
3 - To Voice	4 - Confused	5 - Localizes Pain
2 - To Pain	3 - Inapp Words	4 - Withdraws to Pain
1 - None	2 - Incomp Speech	3 - Flexion to Pain
	1 - None	2 - Extension to Pain
		1 - None

TIME	PROCEDURE	PERFORMED BY:
	☐ Backboard Removed	BY:
	☐ Downgraded	BY:

NOTES

☆U.S.GOVERNMENT PRINTING OFFICE 1997-571-7000

29/10 5° ingi S/P (A bowls in BAS 28 Days

Ago. Sent to US. Pt AAOX3 on dismd

CPAN.

USIOR - only can see light.

9	10	11	12	13	14	15

NAME (Last, First, Middle Initial)

4. PAY GRADE: 16 | 17

5. SEX: 18

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

7. AGE AT ADMISSION: 27 | 28 | 29

8. RACE: 30

9. ETHNIC BACK-GROUND: 31

RELIGION

10. LENGTH OF SERVICE: 32 | 33 | 34

ETS

11. FMP: 35 | 36

12. SOCIAL SECURITY NUMBER: 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45

ORGANIZATION (Active Duty Only)

13. MARITAL STATUS: 46

HOUR OF ADMISSION

BRANCH / CORPS

14. FLYING STATUS: 47 | 48 | 49

15. BENEFICIARY CATEGORY: 50 | 51 | 52

16. ZIP CODE OF RESIDENCE: 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61

17. UNIT LOCATION (State or Country Code): 62 | 63

18. MOS: 64 | 65 | 66 | 67 | 68 | 69 | 70

19. TRAUMA: 71

PREV. ADMISSION

YEAR

☐ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 72

WARD

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION: 73 | 74

22. MTF TRANSFERRED TO: 75 | 76 | 77 | 78 | 79 | 80

23. DATE OF DISPOSITION (YYMMDD): 81 | 82 | 83 | 84 | 85 | 86

24. CLINIC SVC - ADMITTING: 87 | 88 | 89 | 90

25. MTF TRANSFERRED FROM: 91 | 92 | 93 | 94 | 95 | 96

26. DATE THIS ADMISSION (YYMMDD): 97 | 98 | 99 | 100 | 101 | 102

27. LOCATION OF OCCURRENCE (Battle Casualty Only): 103 | 104

28. MTF OF INITIAL ADMISSION: 105 | 106 | 107 | 108 | 109 | 110

29. DATE INITIAL ADMISSION (YYMMDD): 111 | 112 | 113 | 114 | 115 | 116

FOR LOCAL USE

Dx: 8715
94100
94303
36622
E9919

Pr: 8345
9513

Inj Training
4/43 1

ADMITTING OFFICER (Signature, as required)

SIGNATURE OF ADMITTING CLERK

DA FORM 2985, MAR 89 EDITION OF MAY 79 IS OBSOLETE USAPPC V1.00

Admission and Coding Information

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

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

2. MTF Location: IZ

3. Register Number: 0015232 00152556

Name (Last, First, MI): [redacted] (b)(6)-4

4. Pay Grade: FGN

5. Sex: M

6. DoB (YYYYMMDD): 1953-01-01

7. Age at Admission: 50Y

8. Race: X

9. Ethnicity: 9

Religion:

10. Length of Service:

ETS:

11. FMP: 99

12. Social Security Number: [redacted] (b)(6)-4

Organization (Active Duty Only):

13. Marital Status:

Hour of Admission: 18:20

Branch / Corps:

14. Flying Status:

15. Beneficiary Category: K78-PRISONER OF WAR/INTERNEES

16. Zip Code of Residence:

17. Unit Location:

18. MOS:

19. Trauma: DIS

Prev. Admission: NO

20. Source of Admission: Direct from ER

Ward: ICU2

Name / Relationship of Emergency Addressee:

Address of Emergency Addressee:

Telephone Number of Emergency Addressee:

Name and Location of Medical Treatment Facility: [redacted] No Install Provided (b)(2)-2

21. Type of Disposition: HOME

22. MTF Transferred To:

23. Date of Disposition (YYYYMMDD): 2003-11-21

24. Clinic Svc - Admitting: ABA - GENERAL SURGERY

25. MTF Transferred From:

26. Date this Admission (YYYYMMDD): 2003-11-19

27. Location of Occurrence:

28. MTF of Initial Admission:

29. Date of Initial Admission: 2003-11-19

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: FACAIL BURNS,MULT CORNEAL PERF OD

Procedure Narrative(s):

Cause of Injury Narrative:

Admitting Officer (Signature and Rank): [redacted] (b)(6)-2

Signature of Admitting Clerk: [redacted] (b)(6)-2

5179-1

Pre-operative Notes

		0015									
FENTANYL	100										
STP	300										
Roc	35										
MORPH		3									
	Time										
Chart Code	200										
	180										
Pulse ●	160										
	140										
Resp. ○	120										
B.P. V ^	100										
	80										
C.V.P. +	60										
	40										
Opn. ⊙	20										
FiO2		.35	.35	.35	.35	.35					
SpO2		99	99	99	99	99					
ET CO2		4.4	4.6	4.8	4.8	4.8					
Fluids	1			2							

Summary

18g LFA.

Pre O_2

IV induct Fent / STP / Roc

gel II intubat 8.0 RAE

IPPV Pneumpacl TSA O_2 / Air

① IVI CSC 1000

Signature (Anaesthetist)

[redacted]

(b)(6) - 2

MEDCOM [redacted]

Medical-in-Confidence

Anaesthetic Record

F/Med 245A
Revised 5/93

Operation Proposed				Surname and forenames		
FACIAL/EYE WOUND TOILET				[redacted] (6)(6)-4		
Date		Time		Service No.	Rank	Regt/Corps
12/11/03		0001		[redacted]	CIV	
Anaesthetist		Surgeon		Ship/Unit		Hospital No.
[illegible]		[redacted] / [redacted]				
Wt	Date of Birth	BP	Urine	Allergies/Sensitivities		
				Nil known		
Teeth	Smoking	Hb	LMP			

Preoperative Assessment

previously fit healthy.
- drugs / allergies
- prev GA.

involved in IED incident 16hrs ago.
Facial / Eye burns but prelim escam of mouth shows no oral mucosal burns

Drugs

Nil

Investigations/Results

ABG on air
pH 7.43
pO_2 14
pCO_2 4.8
BxS 2

Special Precautions

Intubation Score

MP III - painted with [illegible]

ASA

CL 1/2 : CP.

1

Record of Premedication/Effect

Nil by mouth from:

0600

Per-operative Complications

Anaesthetist/Grade

MED[redacted]M - 24531

F Med 245B
(Revised 7/95)

Surgical Operation Notes

Operation Performed		Surname and Forename(s)		
EUA, OPHTHALMIC TOILET BURNS TOILET BOTH LEGS & (R) ARM				
Operation Code		Service No.	Rank	Regt/Corps
Date	Time			
12/11/07		Ship/Unit		Hospital No.
Surgeon	Scrub Nurse			
[redacted]	(b)(6)-2			
Assistants		Tourniquet On		
[redacted]	(b)(6)-2	Tourniquet Off		

Operation Notes

(R) Eye – lids retracted much black debris adherent to lids, conjunctiva & sclera. ~~Cornea~~ Cornea opaque – No red reflex obtained. Much conjunctival oedema. One laceration to sclera at 9 O'clock close to pupil but not apparently perforating. Damage also involves contus to [redacted] sac.

(L) eye similar to (R). Cornea less opaque & weak red reflex obtained. One scleral laceration at 6 O'clock, close to cornea, again appears not to penetrate.

Thorough irrigation & cleaning of both eyes. Most but not all debris removed.

Chloramphenicol eye ointment.

Eye patches.

Rest of face scrubbed & cleaned. Most burnt area superficial, some tissue loss ?? dull blackness ~~burn~~ ~~to nose~~.

Cont.
A number of small perforations of skin – no metallic foreign body detected, all appear to penetrate only into soft tissues.
Liquid paraffin to face.
Both legs & Right arm thoroughly scrubbed.
Little superficial burns to both legs.
(R) arm all superficial burn ½–1% total.
Scrubbed. Small lacerations & perforations esp one over (R) middle finger – does not enter joint.
Para net vaseline gauze. [redacted] (b)(6)-2
Gauze + crêpe
Total burn area 3% [redacted]

(b)(6)-4 unless otherwise indicated

(Revised 12/95)

In-Patient Case Sheet

PPQ = 100

1. Full Service Number	2. Rank/Rating	7. Ship/Regt./Corps/RAF Station
[redacted]	CIV	

3. Surname	8. Branch/Trade	9. Religion
[redacted]		

4. Forename(s)	10. Theatre from which admitted	11. Time in10
[redacted]		

5. Hospital Number	6. Date of Birth	12. Type of Enlistment	13. Total Full Time Service
[redacted]	1973		

14. Name, address and relationship of person to be notified	15. Name and address of Doctor
Mr [redacted] (UNCLE) [redacted] (LOCAL PHONE)	

16. Name of Unit in which admitted	Ward	Date/Time in	Date out	No. of Days
Direct admission to [redacted] (b)(6)-2				
Transferred to WARD ONE				
Transferred to				

17. Final Disposal (Duty, Invaliding, Death)	To Unit	Number of days under treatment

Med Cat	No. of days recommended sick leave	Out-patient appointment

18. Principal diagnosis/injury — ICD CODES

BURNS TO FACE/(R) ARM / EYES.

19. Complications or sequelae

20. Secondary diagnoses unrelated to 18

21. Nature of operation/investigation

22. Special information in accordance with current instructions	23. Surgeon/Physician in charge

Injury and Wounded Cases only (to be completed by MO first seeing patient)

24. Enemy or Non-Enemy Action	25. Date of MOD Form 298	26. Nature of Weapon or cause of injury

27. Activity at time of injury — On ☐ Off ☐ Duty [✓ relevant box]

To MOIC [ ] Hospital/Ward

The patient named overleaf is referred to you for admission

Provisional diagnosis *(In cases of injury **Boxes 24-27** will be completed):*

Date	**Clinical Notes** *(To be signed by medical officers, giving rank/appointment/2nd name in **BLOCK CAPITALS** after the first entry).*
	Give (1) history of disability *(including* (a) *date and place of disability* (b) *personal and family history when relevant)* and (2) condition on examination.
11.11.03	30 ish yr old Iraqi Prisoner under armed guard.
22.30	Involved in IED incident 07.45 today
	Initially taken to Basra General Hospital
	transferred here this evening (no prior notice)
	Burns - mainly face
	swollen lips
	Airway - lips swollen but actual airway clear
	No suspicion of C-spine injury.
	↓ exp L=R=good
	BS vesic - nil added.
	P 100 BP 136/81 RR 14 O_2 sat 99%
	UUP → HS 1+11+0
	Abdo. soft.
	No suspicion of long bone fracture.
	Speaking with interpreter - A on AVPU
	CXR
	Airway assessed by anaesthetist - no immediate concerns.
	ABGs - NAD
	FBC / U+E
	burns estimation. max 5% - forehead full thickness
	unable to open eyes at present.
	catheterize.
	Seen by ENT - bilat bilat tymp membr perforation
	rhine -ve bilat.

(b)(6)-2 all

Dear Dr. [redacted]

I'm glad to hear from you again

This poor man had badly traumatized cornea, cataract & IOFB OD.. No evidence of RD. This eye needs a combined Keratoplasty and lensectomy as a first step, which we cannot afford for him because no donor cornea available

(L) eye has multiple intraconeal F.B.s. early traumatic cataractous changes., IOFB. & a flat retina. The IOFB.s. looks inert & the eye seems quiet that I prefer to observe him since there is no retinal damage.

Best regards.

[redacted]

(b)(6) - 2 all

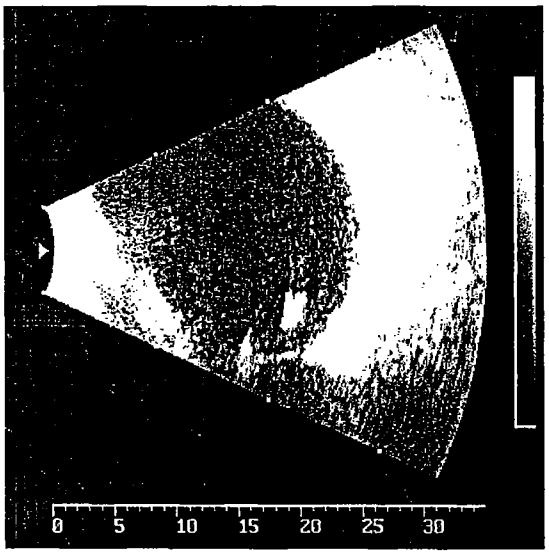
Printed: 05/12/00 00:01:54

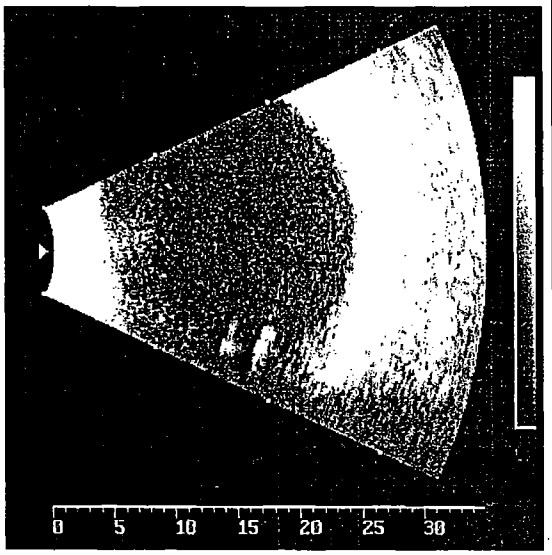
zain;mrem;fade;tara

Patient:

Physician: Dr.

Advent™ A/B SYSTEM





OD			OS		
	Gain: 85 dB			Gain: 85 dB	
	Freq: 12.5 MHz			Freq: 12.5 MHz	
05/12/00	Range: 35 mm	Gamma: linear	05/12/00	Range: 35 mm	Gamma: linear
00:00:51	TGC: vit/ret	Reject:off	00:01:30	TGC: vit/ret	Reject:off
	T.Avg: off	Vel: 1550 m/s		T.Avg: off	Vel: 1550 m/s

C — X 1c/11

u/s shows

echogenic cort. seq. opacity of Both eye.

OD

There is about 2 IOFB at inf. part of vit. Cavity.

OS

clear vit. Cavity but there is about 2 IOFB at inf. part of vit. Cavity.

NO R.D. in Both eye.

MENTOR OPHTHALMICS

[redacted]

00A000 TFQ292008

[redacted]

TPR and BP Chart

F/Med 13
Revised 8/90

Date: 12/11/03

Time: 6 10 14 18 22 | 6 10 14 18 22 | 6 10 14 18 22 | 6 10 14 18 22 | 6 10 14 18 22 | 6 10 14 18 22 | 6 10 14 18 22

Temperature: 41 40 39 38 37 36 35 34 33

Pulse / Blood Pressure (IN RED): 300 290 280 270 260 250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70

Respiration: 60 50 40 30 20 10 0

98° 99
4L

+

Special Checks (Black Ink)

Patient Label (b)(6) - 4

Name [redacted]

Rank CIV.

Number

Hospital Number [redacted]

Admission Date

Observation Chart

Date

Time: 02:00, 01:30, 03:00, 03:30, 03:40, 04:00, 05:00, 06:00

Temperature: 41, 40, 39, 38, 37, 36, 35, 34, 33

Pulse / Blood Pressure (IN RED): 200, 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40, 30, 20, 10, 0

Respiration: 300, 290, 280, 270, 260, 250, 240, 230, 220, 210, 200, 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40, 30, 20, 10, 0

SaO2	100	100	100	100	100	100	99	100
O2	4L	3L	3L	2L	2L	3L	3L	3L

+

Special Checks

Patient Label

Name

Rank

Number

Hospital Number

Special Instructions

Alternative Scale

MEDCOM - 24539

Drug Record

F Med 152
(Revised 6/91)
PPQ = 100

Patient Label

Surname	[redacted] (b)(6)-4	Allergies	HAY FEVER
Forename(s)	[redacted] (b)(6)-4	Ward	CARE
Service/Hospital No	[redacted]	Ht / Wt / SA	
Date of Birth	1973		
Consultant		Date of Admission	11 / 11 03.

Once Only and Premedication Drugs

Date	Once Only Drugs	Time	Dose	Route	Signature	Given Time	Given Sig
	BENZYL PENICILLIN		1.2 g	IV	[redacted]	2255	[illegible]
	FLUCLOXACILLIN		1 g	IV	[redacted]	2250	[illegible]
	TET TOX		0.5 ml	im	[redacted]	2245	[illegible]
	TET IMMUNOGLOBULIN		500 iu	im	[redacted]	2308	[illegible]
	MORPHINE	22-55	5 mg	IV	[redacted]	2255	[illegible]
	MORPHINE		3 mg	IV	[redacted]	2305	[illegible]
					(b)(6)-2		

General Instructions for Use

1. This record is valid for fourteen days from commencement. On expiry the patient's medication is to be reviewed by the doctor and a new record commenced if appropriate.
2. Only one prescription record is to be used at any time.
3. Only GENERIC names of drugs are to be used.
4. Prescriptions are to be clearly written in BLOCK CAPITALS.
5. Any alteration in drug therapy must be written as a new entry on the record.
6. Discontinue a drug as follows: ~~PENICILLIN~~ and a similar line through the remaining administration days.
7. Discontinuations of drugs must be signed and dated by the doctor.
8. REGULAR PRESCRIPTION times of administration must be inserted by a doctor.
9. The nurse (or doctor) must complete the record after administering the medication.
10. Special circumstances which cause a drug to be omitted or postponed require to be recorded as follows:
    a. Mark the appropriate box with an **x**.
    b. Enter the details in the section provided.
11. All Pre-Op and Post-Op medication must be prescribed on this record.
12. This record must accompany the p[illegible] theatre.

As Required Prescriptions

	Date	Time	Dose	Given	Date	Time	Dose	Given	Date	Time	Dose	Given
Drug: MORPHINE Dose: 10 mg Route: IM Freq.: 8° Signature/Date: [redacted] DIRECTIONS: b62												
Drug: VICHZINE Dose: 50 mg Route: IV/IM Freq.: 8° Signature/Date: [redacted] DIRECTIONS												
Drug: Co DYDRAMOL Dose: II Route: po Freq.: 6° Signature/Date: [redacted] DIRECTIONS												
Drug: DICLOFENAC Dose: 50 mg Route: po Freq.: 8° Signature/Date: [redacted] DIRECTIONS												
Drug: SOFT YELLOW PARAFFIN Dose: T Route: LIPS Freq.: PRN Signature/Date: 12/11/03 [redacted] DIRECTIONS												
Drug Dose Route Freq. Signature/Date DIRECTIONS												
Drug Dose Route Freq. Signature/Date DIRECTIONS												

OBSERVATIONS

Time												
hour	22	22	22	22	22	23	23	23	23	23	23	23
mins	35	40	45	50	55	00	05	10	15	20	30	40

BLOOD PRESSURE mmHg (230 – 30)

Temp°C (40 – 30)

PULSE RATE
• REGULAR
• IRREGULAR

CVP — CVP H_2O

RESPIRATORY RATE per min	16	15	16	16	16							16
O_2 SATURATION %	99	99	99	99	99	99	99	98	97	99	99	99
BM												4.8

GLASGOW COMA SCALE

EYES OPEN	spontaneously	4
	to speech	3
	to pain	2
	none	1
BEST VERBAL RESPONSE (In brackets for child < 4 years)	orientated (interacts)	5
	confused (inappropriate)	4
	inappropriate (moaning)	3
	incomprehensible sounds (irritable)	2
	none	1
BEST MOTOR RESPONSE	obeys commands	6
	localises pain	5
	normal flexion to pain	4
	abnormal flexion to pain	3
	extension to pain	2
	none	1
	TOTAL GCS	

Eyes closed by swelling =C

Endotracheal tube or Tracheostomy =E

Record the best limb response

Paralysed=P

PUPILS		
RIGHT	Size (mm)	
	Reaction	
LEFT	Size (mm)	
	Reaction	

+ =Reacts
- =No Reaction
C =Eye closed
SL =Sluggish Pu

LIMB MOVEMENTS		
ARMS	Symmetrical	
	Asymmetrical	
LEGS	Symmetrical	
	Asymmetrical	

REVISED TRAUMA SCORE ON ARRIVAL

PUPIL SCALE (mm) 7 6 5 4 3 2 1

REVISED TRAUMA SCORE	4	3	2	1	0
SYSTOLIC BP mm Hg	>89	76-89	50-75	1-49	0
RESPIRATORY RATE	10-29	>29	6-9		0
GLASGOW COMA SCORE	13-15	9-12	6-8	4-5	3

ACTIONS DURING RESUSCITATION

(b)(6) - 2 of 11

Date	Clinical notes: To be signed by Medical Officers, giving Rank and appointment.
	Capt [redacted] will review tomorrow to liaise with ward staff. [redacted]
12/4/03	02.00 - Pt admitted to the ward following [redacted] admission straight to theatre. Observations within normal limits, eye pads given and soaked in Normal, prior to application, no c/o pain. [redacted] 04.00 Pt's B.P. has been dropping over time, fluids from increased, sats, pulse, temp remain normal. Pt has not pee'd. [redacted] EN(G) CA. 04.00 Eye pads changed, [redacted] EN(G) CA.
12/4/03	WR Watkins / Hand Afebrile c/o sore throat + lips feels thirsty Rx free fluids [redacted] MO
12/4/03	Reviewed on the ward. Dressing to right eye was clean and intact - for change on Friday (on the ward) facial burn will require further cleansing with normasol as tolerated and re-application of liquid paraffin to keep skin moist. Discussed further chloramphenicol with GP and Whitfield - for review in 24°, trying to arrange transfer for opthalmic review. [redacted]
	Contacted by FLT/LT Cowell re: opthalmic review - trying to arrange with Americans. cc number for FLT/LT [redacted]

Clinical Continuation Sheet

(Rev.5/95)
PPQ = 100

To be used to continue the clinical notes from forms in the F Med series (ie Fs Med 1, 10, 19).
This form is to be securely attached to the original.

Continued from F Med	dated	Name including forenames [redacted] (b)(6)-4	
		Service No.	Rank/Rating MR.	Regt./Corps
Date	Clinical notes: To be signed by Medical Officers, giving Rank and appointment.	Ship/Unit/Station. Attach label if used.	Hospital No.

2NOV05.
1130HRS Showered with assistance. Dressing (RT) arm removed in situ. Facial burns cleaned with N/saline & liquid paraffin applied. Eye pads changed. Continues IV fluids. Re-contacted by FLT LT CORELL - explained that transfer to DSTC is urgent for further management. Awaiting further notice re: helicopter flight to ETA [redacted] ORSON/FCS ESC (MOB)

1200HRS Phone call from FLT LT CORELL Pt to be transferred by road to Basra by RAF uno/medic & RAF Police escort. For onward journey to Baghdad @ approx 1700HRS. [redacted] ACIN ORSON/998 ESC (MOB).

Medical in Confidence F/Med/827 (Revised)

R.N./ARMY/R.A.F.
Field Medical Card Continuation Sheet
Fiche Medical De L'Avant

(b)(6)-4

1. ~~Service~~ No. Numero Matricule	2. ~~Rank~~ or ~~Grade~~	3. Surname Nom [redacted]	4. Sheet No.
			1

Medical unit in which treated and Date	**Clinical Notes** (To be signed by M.O. giving rank and appointment)
IN FLIGHT: 2030hrs 12/11/03	IVI Continues - Hartmans ILT Analgesia Given - 2x paracetamol Passing urine well, Remains Comfortable No problems identified

Consent Form

F/Med 660 (Revised 9/92)

for medical or dental investigation, treatment or operation

Hospital			Hospital No.
Service No.	Rank/Title (b)(6)-4	Sex	Date of Birth
Surname [BLOCK CAPITALS] [redacted]		Forenames [redacted] (b)(6)-4	
Ship/Unit/Station/Address [redacted]			Service/Corps

This Part to be completed by the doctor or dentist. *[see notes on reverse of this form]*

Type of operation, investigation or treatment

Cleaning of wounds & burns to face & both eyes.

I confirm that I have explained the operation, investigation or treatment and such appropriate options as are available and the type of anaesthetic, if any (general/regional/sedation) proposed, to the patient in terms which in my judgement are suited to the understanding of the patient and/or to one of the parents or guardians of the patient.

Name of doctor/dentist [BLOCK CAPITALS] [redacted] (b)(6)-2

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

Date 11/11/03

Patient/Parent/Guardian

Please read this form and the notes overleaf very carefully.

If there is anything you do not understand about the explanation, or if you want more information, you should ask the doctor or dentist. Please check that all the information is correct. If it is, and you understand the explanation, then sign the form.

I am the patient/parent/guardian. *(delete as necessary)*

- ☐ **I agree**
  - ◆ to what is proposed which has been explained to me by the doctor/dentist named on this form
  - ◆ to the use of the type of anaesthetic that I have been told about.
- ☐ **I understand**
  - ◆ that the procedure may not be done by the doctor/dentist who has been treating me so far
  - ◆ that any procedure in addition to the investigation or treatment described on this form will only be carried out if it is necessary and in my best interests and can be justified for medical reasons.
- ☐ **I have told**
  - ◆ the doctor/dentist about any additional procedures I would **NOT** wish to be carried out straightaway without my having the opportunity to consider them first.

Name [redacted] Consent

Date

Address *(if not the patient)*

Witness [redacted]

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

Daily Fluid Balance Chart

F/Med 100
(Revised 6/91)

Post-op day	Date

Time	Intake: Oral mls	Intake: Oral Nature of Fluid	Intake: Intravenous mls	Intake: Intravenous Nature of Fluid	Intake: mls	Intake: Fluid	Output: urine mls	Output: mls	Output: mls	Output: mls	Tests
0100			2000	Hartmann infusion							
0200											
0300			1000	Hartmann (A)							
0400											
0500			1000	Hartmann (A)			✓ +++ (on floor).				
0600			1000	Hartmann (C)			300				
0700											
0800	100	Tea.					600				
0900							200				
1000	100	Tea.					300				
1100	200	Coke.					36				
1200							500				
1300											
1400			1000 (B)	NSAL (D) 1L							
1500											
1600											
1700											
1800											
1900											
2000											
2100											
2200											
2300											
2400											Estimated invisible losses
Totals											

Patient label

Name	[redacted] (b)(6)-2
Rank	CIVILIAN
Number	[redacted]
Hospital Number	[redacted]

Total in	
Total out	
Balance	

✓ box if form to be retained ☐

Special Instructions

MEDCOM - 24547

Pathology: 33 Field Hospital: BMH Shabiah: BFPO 645

PATIENT RESULTS

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

Rank: CIV Surname: [redacted] Forename: [redacted] DOB:

Ward: A+E Hospital/Reg No: [redacted] Lab No: 7174

Haematology

WBC:	12.3	4.0 – 10 x 10^9/L	Manual Diff	
RBC:	4.50	3.8 – 5.5 x 10^{12}/L	Neutrophil:	
Hb:	11.9	12.0 – 17 g/L	Lymphocyte:	
PCV:	0.364	0.36 – 0.60	Monocyte:	
MCV:	80.9	83 – 98 fL	Eosinophil:	
MCH:	26.4	27 – 32 pg	Basophil:	
MCHC:	32.7	31.5 – 34.5 g/dL	ICT Malaria:	NEG/POS
Platelets:	225	150 – 400 x 10^9/L	Monospot:	NEG/POS
Film Comment:				

Coagulation

PT:		13 – 17 secs
APTT:		30 – 41 secs

D-Dimer:	NEG/POS
FDP:	NEG/POS

Blood Gas 2235 hrs

pH:	7.447	7.36 – 7.44	pCO2:	4.98	4.8 – 5.9
PO2:	14.2	11.3 – 13.3	HCO3:	26	21 – 25
TCO2:	27	22 – 26	BE:	+2.0	-3.0 – +3.0
O2 Sats:	98				

Biochemistry

Sodium:	137	137 – 145	T Protein:		63 – 82
Potassium:	4.0	3.60 – 5.0	Albumin:		39 – 50
TCO2:		22 – 31	T Bilirubin:		2 – 23
Urea:	2.2	2.5 – 7.1	ALT:		8 – 61
Creatinine:		62 – 133	AST:		8 – 50
Glucose:		3.6 – 6.1	GGT:		8 – 78
Calcium:		2.10 – 2.54	ALP:		38 – 126
Phosphate:		0.81 – 1.45	CK:		30 – 170
Amylase:		30 – 110	CKMB:		
Serum Osmolality:		282 – 300 mOsm/kg	CKMB2:		
Urine Osmolality:		50 – 1200 mOsm/kg			

Date: Authorised by: [redacted] Name: [redacted]

Time taken: [redacted] Position: [redacted]

66-2

(b)(6)-2 except for top

ntravenous Fluid Prescription and Administration Record

Patient Label

Surname	[redacted] (b)(6)-4
Forename(s)	
Service/Hospital No.	[redacted]
Date of Birth	

Use of Chart

a separate IV continuation sheet is in use
is to be firmly attached to this chart.

Doctor's Prescription							Nursing Record of Administration				
Date	Nature of Fluid	Volume	Additive	Rate	Line No.	Doctor's Signature	Start Time	Signature: Nurse	Signature: Checked by	Time Comp.	Batch No.
03	HARTMANS	1L		1hr		[redacted]	2235	[redacted]			01H112
	~~[illegible]~~ MARTMANS	1L		1 hr		[redacted]	2313	[redacted]			01H112
	~~[illegible]~~ + REVIEW.					[redacted]	0				
	Hartmanns	1000		60			0315	[redacted]			01H112 EXP 02
	Hartmanns	1000		80			0830	[redacted]		1140	01H112-
12/4/03	N.SALINE	1L	20mmol	80			1140.	[redacted]			
2/4/03	-			80							

MEDCOM - 24549

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

YELLOW FIELDS MUST BE FILLED IN, IF APPLICABLE, UPON APPREHENSION

[ ] Offense against Civilian(s) [check one] If "Other" then describe:

- [ ] Arson (I.P.C. 342)
- [ ] Solicitation of Fornication/Prostitution (I.P.C. 399)
- [ ] Rape/Indecent/Sexual Assaults/Acts (I.P.C. 393-98, 402)
- [ ] Murder (I.P.C. 405)
- [ ] Aggravated Assault/Assault With Intent To Kill (I.P.C. 410)
- [ ] Maiming (I.P.C. 412)
- [ ] Simple Assault (I.P.C. 415)
- [ ] Kidnapping (I.P.C. 421)
- [ ] Burglary or Housebreaking (I.P.C. 428)
- [ ] Extortion/Communicating Threats (I.P.C. 430)
- [ ] Theft (I.P.C. 439)
- [ ] Destruction of Property (I.P.C. 477)
- [ ] Obstructing a Public Highway/Place (I.P.C. 487)
- [ ] Discharging Firearm/ Explosive in City/Town/Village (I.P.C. 495)
- [ ] Riot or Breach of Peace (I.P.C. 495(3))
- [ ] Other

[X] Offense against Coalition Forces [check one] If "Other" then describe: CAR Bomb Incident

- [ ] Violation of Curfew
- [ ] Illegal Possession of Weapon
- [ ] Assault/Attack on Coalition Forces
- [ ] Theft of Coalition Force Property
- [ ] Trespass on Military Installation or Facility
- [ ] Photographing/Surveiling Military Installation or Facility
- [ ] Obstructing Performance of Military Mission
- [ ] Other

Apprehending Unit: UK Contingent BASRA Location Grid:

Date of Incident: (D/M/Y)	Time of Incident:	Date of Report: (D/M/Y)	Time of Report:
11/1/03 to / /	hrs to hrs	/ /	hrs

Detainee #: (b)(6)-4	Key Connected Person: [ ] Victim [ ] Witness
Last Name: [redacted]	Last Name:
First Name [redacted] Given Name:	First Name: Given Name:
Hair Color: Scars/Tattoos/Deformities:	Hair Color: Scars/Tattoos/Deformities:
Eye-Color: Weight: lb Height: in	Eye-Color: Weight: lb Height: in
Address:	Address:
Place of Birth:	Place of Birth:
Ethn/Tribe/Sect: Sex: [X] M [ ] F Phone#: DOB D/M/Y: [ ] Mobile [ ] Regular	Ethn/Tribe/Sect: Sex: [ ] M [ ] F Phone#: DOB D/M/Y: [ ] Mobile [ ] Regular
[ ] Passport [ ] Dr. license [ ] Other (specify) Document #:	[ ] Passport [ ] Dr. license [ ] Other (specify) Document #:

Total Number of Persons Involved: (list names/identifying info on reverse under "Additional Helpful Information")

[ ] Vehicle Information Vehicle Number of Vehicle(s) Owner:

Make:	Color:	VIN:	
Model:	Type:	Plate No.:	Number of People in Vehicle:
Year:	Names of People in Vehicle:		
Contraband/Weapons in Vehicle:			

[ ] Property/Contraband [ ] Weapon Photo Taken of Suspect with Weapon/Contraband. Yes/ No

Type:		Model:	Color/Caliber:
Serial No.:	Quantity:	Make:	Receipt Provided to Owner Yes/ No
Other Details		Where Found:	Owner:

Name of Assisting Interpreter: Email, Phone, or Contact Info:

Detaining Soldier's Name (Print): British/UK Contingent BASRA	Supervisor Officer's Name (Print):
Last, First MI:	Last, First MI:
Signature: CPT [redacted] (b)(6)-2	Signature:
Email: (30th MP)	Email:
Unit Phone: 631-0106 Date: / /	Unit Phone: Date: / /

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM (b)(2)-2

Why was this person detained? Transferred to the [redacted] from the British Field Hosp in Basra. He was in the vicinity of a car bomb. His direct involvement

~~Who witnessed this person being detained or the reason for detention? Give names, contact numbers, addresses.~~

is unknown. He claims to be an policeman, but this information has not been verified.

How was this person traveling (car, bus, on foot)?

Who was with this person?

What weapons was this person carrying?

What contraband was this person carrying?

What other weapons were seized?

What other information did you get from this person?

Additional Helpful Information

Medical unit in which treated and date	**Clinical Notes** (To be signed by M.O. giving rank and appointment)				
Date: ...../...../.....	.....hrs	.....hrs	.....hrs	.....hrs	.....hrs
Resp Rate / min	.....	.....	.....	.....	.....
Pulse Rate / min	.....	.....	.....	.....	.....
Blood Pressure	...../.....	...../.....	...../.....	...../.....	...../.....
Capillary Refill	< 2 : > 2 sec	< 2 : > 2 sec	< 2 : > 2 sec	< 2 : > 2 sec	< 2 : > 2 sec
Cool / Clammy	Y : N	Y : N	Y : N	Y : N	Y : N
GCS EYES	.....	.....	.....	.....	.....
Verbal	.....	.....	.....	.....	.....
Motor	.....	.....	.....	.....	.....
Pupils	Rt Lt	Rt Lt	Rt Lt	Rt Lt	Rt Lt
(cumulative)					
Total IV Fluids	.....mls	.....mls	.....mls	.....mls	.....mls
Total Urine Vol	.....mls	.....mls	.....mls	.....mls	.....mls
Chest Rt	.....mls	.....mls	.....mls	.....mls	.....mls
Drainage Lt	.....mls	.....mls	.....mls	.....mls	.....mls
NM Drainage	.....mls	.....mls	.....mls	.....mls	.....mls

IV Fluid	Vol	Time Started

Involved in IED incident this morning at about 07.45 in Basrah city centre (Bafra. Red Zl & Sim 5).
Taken to General Hospital
? Given IV fluids & antibiotics here, but they were unable to tell me as there seemed to be no notes on him & a different doctor here now.
He doesn't complain of any pain.
He passed urine while I was at hospital (? how much as I didn't see).

No airway or resp probs
C → requires IV fluids & will require dressings & abx

* As he is suspected in IED which detonated prematurely therefore must be kept for further questioning when fit

Face & eyes to be cleaned, dressed etc asap.

IV Flask
Monitor BP & pulse

Imp - Dec '05 Zoy to blast

seen by → [redacted]
& I was asked to transfer him to BMH Shaibah asap

Medical In Confidence

RN./ARMY/R.A.F. Field Medical Card
Fiche Medical De L'avant

(?Poliomyelitis - Iraqi)

F/Med/826
Revised (7/94)

IRAQI

1. Service No. Numero Matricule	2. Rank or Grade	3. Surname Nom	4. Nationality Nationalite	5. Religion
		[redacted]	(b)(6)-4	

6. (a) Unit Unite	(b) Regt or Corps RN/RAF/Allied	7. Theatre/Fleet or Station in which admitted	8. Married/Single Widowed	9. Age
		BASRAH CITY CENTRE		

10. Date of Casualty or Illness Date de la Blessure ou Maladie	12. Diagnosis Diagnostic	13. Chemical casualty
11. Time of Wounding Heure	Type of casualty: Battle [ ] DNBI [ ] Stress [ ]	YES/NO OUI/NON

Redness

Full thickness burns to face

Charred right hand

Scattered small burns to both legs

Able to walk with help

BP = 120/80

○ Wound | Burn | Fracture | Δ HAEM

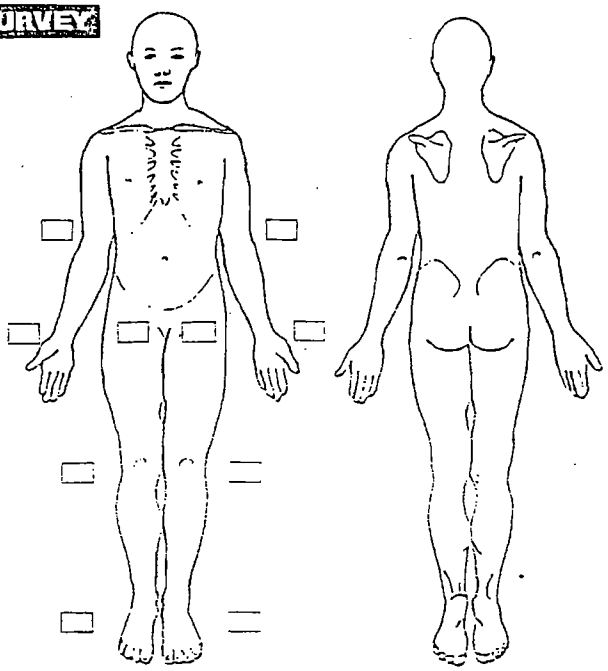
15. Treatment Given/ Traitement Donne	Dose	Time Given	Date	Dose	Time Given	Date	Dose	Time Given	Date
Morphia/ Morphine									
Antibiotic/ (a) Antibiotique									
(b)									
Atropine, Oxime/									
Tetanus/ Tetanos				16. Tourniquet Applied Garrot Place		YES/NO OUI/NON	Time Heure		Date

Principal Diseases, etc.

17. Final diagnosis or principal disease or injury leading to admission.

18. * Principal complication or sequel of 17	19. * Secondary disease(s) or injury(ies) aetiologically unconnected with 17.
*if these arise after admission, state date of onset.	
20. Nature of any surgical operations (Full details will be given in "Clinical Notes" but NOT here)	21. Special information in accordance with current instructions

SECONDARY SURVEY



LACERATION +++

FRACTURE #

BRUISING/ ABRASION ////

☐ Alcohol/Drug intoxication suspected
If yes, why?
.....

☐ LOG ROLL

☐ RECTAL EXAM.

X-RAYS

X-RAYS
- ☐ C-SPINE
- ☑ CXR
- ☐ PELVIS
- ☐ SPINE
- ☐ OTHER
- ☐ US
- ☐ CT

RESULTS:-

BLOODS

BM STICK _____ mmols/l

☐ Hb	☐ ABG pO2	
☐ WCC	pCO2	
☐ PLATELETS	pH	
☐ Na	BE	
☐ K	☐ CO	
☐ UREA	☐ AMYLASE	
☐ CREATININE	☐ ALCOHOL	
☐ BLOOD GLUCOSE	☐ TOXICOLOGY	

URINE

CATHETERISED
- ☐ URETHRAL
- ☐ SUPRAPUBIC

BLOOD	
KETONES	
SUGAR	
PROTEIN	
β – HCG	POS / NEG

PERITONEAL LAVAGE

PERFORMED BY _____

TIME _____

MICRO RBC ...../mm³

WBC ...../mm³

BACTERIA/FOOD Y / N

ALLERGIES _____ LAST ATE / DRANK _____

MEDICATIONS _____

PAST MEDICAL HISTORY _____

EVENTS _____

INCIDENT DETAILS

TYPE OF INJURY
- ☐ PENETRATING
- ☐ BLUNT
- ☐ BURN

☐ FALL ☐ >2m ☐ <2m
- ☐ RTA
- ☐ ASSAULT
- ☐ SPORT

RTA DETAILS:-
- ☐ DRIVER
- ☐ FSP
- ☐ RSP
- ☐ MOTOR CYCLIST
- ☐ PILLION

☐ INTRUSION
- ☐ EJECTION
- ☐ ENTRAPMENT
- ☐ DEATH OF ANOTHER
- ☐ SEAT BELT
- ☐ AIR BAG

FLUID INPUT

IV Site 1		IV Site 2		IV other		URINE OUTPUT		OTHER	
Time	Fluid	Volume	Fluid	Volume	Fluid	Volume	Time	Volume	Time	Volume
2215	HARTMANS	1L								
2310	HARTMANS	1L								
TOTAL		TOTAL		TOTAL		TOTAL		TOTAL		

TOTAL INPUT _____ TOTAL OUTPUT _____

DRUG TREATMENT

NAME	DOSE	ROUTE	DRs SIGNATURE	GIVEN BY	TIME GIVEN
TETANUS TOXOID 763283 EXP 12/03	0.5 ml	IM			2245
TETANUS IMMUNOGLOBULIN 5TONS521 EXP 12/03	250/500 I.U.	IM			2305
FLUCLOXACILLIN 2P4OHY EXP 9/05	500mg	IV			2250
ANTIBIOTICS BENZYL PENICILLIN 3119070 EXP 7/05	1.2g	IV			2255
morphine	5mg 3mg	IV IV			2255 2305

STAFF PRESENT DURING RESUSCITATION

	GRADE	TIME CALLED	TIME ARRIVED
☐ ACCIDENT AND EMERGENCY		: hrs	: hrs
☐ ANAESTHETIST		: hrs	: hrs
☐ GENERAL SURGEON		: hrs	: hrs
☐ ORTHOPAEDIC SURGEON		: hrs	: hrs
☐ OTHER		: hrs	: hrs

TEAM LEADER INITIALLY _____ FINALLY _____

DISPOSAL

☐ CT
☐ THEATRE
☐ ITU
☐ WARD _____
☐ TRANSFER TO _____
☐ OTHER _____

☐ PATIENT DIED TIME _____ hrs
☐ NEXT OF KIN INFORMED TIME _____ hrs

CHART COMPLETED BY

Nurse Sig. _____

Print Name _____

Doctor Sig. _____

Print Name _____

TUDOR TRAUMA CHART - (6)(6)-4 - - - - - - - - HOSPITAL

NAME [redacted] A&E NUMBER [redacted]

DATE OF ATTENDANCE 11 / 11 / 03 TIME 22 : 35 hrs

PRE-HOSPITAL CARE TIME OF ARRIVAL ON SCENE : hrs TIME LEFT SCENE : hrs

ON SCENE:- RR PULSE BP GCS

O_2 VIA MASK ☐ OROPHARYNGEAL AIRWAY ☐ NASOPHARYNGEAL AIRWAY ☐ ET TUBE ☐

IV CANNULA ☐ FLUIDS GIVEN mls CERVICAL IMMOBILISATION Y ☐ N ☐

SPINAL BOARD Y ☐ N ☐

ASSESSMENT

AIRWAY

☐ CLEAR GAG Y / N

☐ COMPROMISED

RESUSCITATION

☐ O_2 VIA MASK %

☐ OROPHARYNGEAL AIRWAY

☐ NASOPHARYNGEAL AIRWAY

☐ VENTILATED

☐ ET TUBE SIZE

☐ NG TUBE

C SPINE

☐ NORMAL ☐ SUSPECT INJURY ☐ SEMI-RIGID COLLAR ☐ IN LINE IMMOBILISATION

BREATHING

☐ SPONTANEOUS

☐ RESP. RATE

☐ Sa O_2 %

☐ BREATH SOUNDS NORMAL

☐ FLAIL SEGMENT R / L

☐ TENSION PNEUMOTHORAX R / L

☐ PNEUMOTHORAX OPEN/CLOSED R / L

☐ HAEMOTHORAX R / L

☐ CARDIAC TAMPONADE

VENTILATED Y / N

	L	R
NEEDLE THORACOCENTESIS		
CHEST DRAIN SITE		
SIZE		

CIRCULATION

SYSTOLIC BP ON ARRIVAL

HAEMORRHAGE

☐ EXTERNAL SITE

☐ INTERNAL

CHEST ☐

ABDO ☐

PELVIS ☐

☐ DIRECT PRESSURE

IV CANNULA 1 SITE DWRIST SIZE PINK

2 SITE AE SIZE PINK

IO LINE SITE

BLOOD ORDERED: TIME

O NEG UNITS

GROUP SPECIFIC UNITS

X MATCH UNITS

G & S

EXTERNAL CARDIAC MASSAGE

DISABILITY

ALERT ☐

EYES OPEN TO VERBAL STIMULUS ☐

EYES OPEN TO PAINFUL STIMULUS ☐

UNRESPONSIVE ☐

PUPILS EQUAL AND REACTIVE Y / N

☐ IN LINE STABILISATION OF WHOLE SPINE

EXPOSURE

FULLY UNDRESS ☐

MEDCOM - 24556

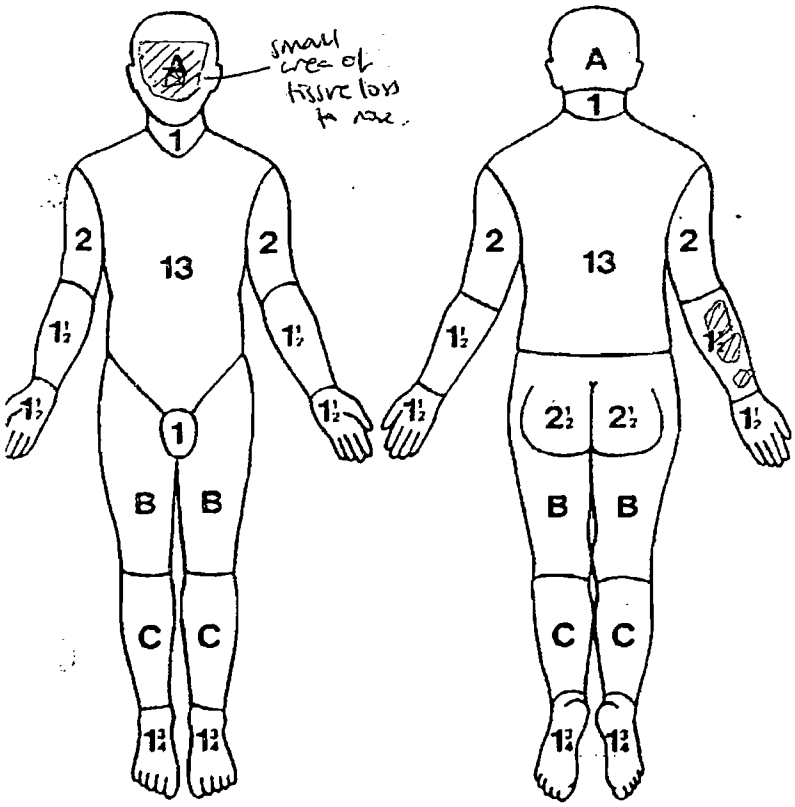
CHART FOR ESTIMATING SEVERITY OF BURN WOUND

(b)(6)-4

NAME [redacted] RD 1 NUMBER [redacted] DATE 11.11.03

AGE 30 ADMISSION WEIGHT _____

LUND AND BROWDER CHARTS



IGNORE
SIMPLE ERYTHEMA

Partial thickness loss (PTL)

Full thickness loss (FTL)

REGION	% PTL	% FTL
HEAD	2	
NECK		
ANT.TRUNK		
POST.TRUNK		
RIGHT ARM	1	
LEFT ARM		
BUTTOCKS		
GENITALIA		
RIGHT LEG		
LEFT LEG		
TOTAL BURN	3%	
	3%	

RELATIVE PERCENTAGE OF BODY SURFACE AREA AFFECTED BY GROWTH

AREA	AGE 0	1	5	10	15	ADULT
A=½ OF HEAD	9½	8½	6½	5½	4½	3½
B=½ OF ONE THIGH	2¾	3¼	4	4½	4½	4¾
C=½ OF ONE LEG	2½	2½	2¾	3	3¼	3½

For further supplies of this pad or of Flamazine* Cream for the prevention and treatment of infection in burns contact 0708 349333 or your Smith & Nephew Pharmaceutical representative.

*Trade mark

Smith & Nephew

MEDCOM - 24557 [redacted]

DEMOGRAPHICS

Military / Hospital No: [redacted]
Sumame [redacted] (b)(6)-4
DOB
FMed 830 No:

Rank CIV (b)(6)-4
First Name [redacted]
Regt/Corps

INJURY

Date & approx time (Delta) 11/11/03 2235
Mechanism BURNS - IED
Place DETAINEE CAMP
Type (Blunt/Penetrating) /
Seatbelt (Y / N)

Equipment (Helmet, CBA) N/A
Trapped Y (N) (N/A)
How long
Intent
Alcohol / Drugs

PRE-FD HOSP

Time of 1st med Tx (Delta) 0745
Est' of time at scene
Emergency care by USA SOLDIERS → BASRA HOSP
Pulse
Resps
BP
GCS ...../15

CPR Y N
Airway
Drugs
IV Cannula Y N
Fluid
Volume

FD HOSP RESUS

Date & Time (Delta) 11/11/03 2235
Transport
Airway CLEAR
Chest Drain (N) L R BL
Fluid Type
Volume
DPL ✗ (N) +ve / -ve
SonoSite Y N +ve / -ve

BP 135/75
Pulse 115
Resps 16
Temp
Time of Intubation /
X-ray
Disposal Theatre - WD1
Time to Theatre (<15 mins, <30, <45, <60, 60 mins)

Eye ...../4
Verbal ...../5
Motor ...../6
CPR Y / N

DIAGNOSIS / INJURIES (Written in text) & Red Cross wound classification (EXCFVM)

1 FACIAL BURNS 3% (Full thickness)
2 Deaf due to IED Blast
3 Superficial burns to (L) leg + (R) wrist
4
5
6
7
8

TREATMENT / OPERATIONS PERFORMED

Date 12/11/03 Procedure Irrigation + cleaning of eyes
Date Procedure
Date Procedure

DISCHARGE

RTU Y / N
DTG Aeromed requested
DTG Aeromed departed BMH
DTG Aeromed Arrived UK
Time of arrival at receiving Hospital / Unit

Transferred to:
Reason for Aeromed

NOTES

Drug Record

F Med 152
(Revised 6/91)
PPQ = 100

Patient Label (b)(6)-4

Surname	[redacted] (b)(6)-4	Allergies	HAY FEVER
Forename(s)	[redacted]	Ward	ONE
Service/Hospital No.	[redacted]	Ht / Wt / SA	
Date of Birth	1973	Date of Admission	11 / 11 / 03.
Consultant			

Once Only and Premedication Drugs

Date	Once Only Drugs	Time	Dose	Route	Signature	Given Time	Given Sig
	BENZYL PENICILLIN		1.2g	IV	[redacted]	2255	[redacted]
	FLUCLOXACILLIN		1g	IV	[redacted]	2250	[redacted]
	TET TOX		0.5ml	im	[redacted]	2245	[redacted]
	TET IMMUNOGLOBULIN		500iu	im	[redacted]	2300	[redacted]
	MORPHINE	22.55	5mg	IV	[redacted]	2255	[redacted]
	MORPHINE		3mg	iv	[redacted] (b)(6)-2	2305	[redacted]

General Instructions for Use

1. This record is valid for fourteen days from commencement. On expiry the patient's medication is to be reviewed by the doctor and a new record commenced if appropriate.
2. Only one prescription record is to be used at any time.
3. Only GENERIC names of drugs are to be used.
4. Prescriptions are to be clearly written in BLOCK CAPITALS.
5. Any alteration in drug therapy must be written as a new entry on the record.
6. Discontinue a drug as follows: ~~PENICILLIN~~ and a similar line through the remaining administration days.
7. Discontinuations of drugs must be signed and dated by the doctor.
8. REGULAR PRESCRIPTION times of administration must be inserted by a doctor.
9. The nurse (or doctor) must complete the record after administering the medication.
10. Special circumstances which cause a drug to be omitted or postponed require to be recorded as follows:
    a. Mark the appropriate box with an ✘.
    b. Enter the details in the section provided.
11. All Pre-Op and Post-Op medication must be prescribed on this record.
12. This record must accompany the pati[illegible] heatre.

Clinical Continuation Sheet

(Rev.5/95)
PPQ = 100

To be used to continue the clinical notes from forms in the F Med series (ie Fs Med 1, 10, 19).
This form is to be securely attached to the original.

Continued from F Med 10 dated 111103	Name including forenames [redacted] (b)(6)-4		
	Service No. [redacted]	Rank/Rating CIV	Regt./Corps —
Date	**Clinical notes:** To be signed by Medical Officers, giving Rank and appointment.	Ship/Unit/Station. Attach label if used.	Hospital No. [redacted]

2° survey - Nil else identified
· grazes/abrasions cut at legs
log rolled - nil on back.

morphine
tet tox + immunoglob.
benzyl. pen + flucloxx

Surgical cons. now present
Specialist burns nurse present. [redacted] (b)(6)-2

* Pt fasting no hot/eat since morning.

12/1/03 By Gp Capt WATKINS.
In view of serious eye involvement & inability to properly examine for eye toilet + burns toilet under GA. Consent ✓ (b)(6)-2

[redacted]

Post op
Eye pads.
Apply liquid paraffin to face 6 times daily.
4 hrly TPR
Dress to (R) arm in 2 days.

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

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

1. Register Nbr	2. Name	3. Grade	Admission Remarks
0015257	[redacted] (b)(6)-4	FGN	

4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm
M	11Y	X				NO

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

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

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	00:30	AAA - INTERNAL MEDICINE

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	TRF-OTH	2003-11-13

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-11-13	[redacted] (b)(6)-2

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
[redacted] (b)(2)-2	2003-11-13	

31. Selected Administrative Data

Marital Status: DoB: 1992-01-01

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

L ARM FRAGMENTS

884.1

35. Total Days This Facility

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

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0 (b)(6)-2	0	0

Signature of Attending M [redacted] Signatu [redacted] (b)(6)-2

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

PHYSICAL EXAMINATION

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

See ER evaluation form [redacted] 0/6-2

SIGNATURE OF PHYSICIAN	DATE	IDENTIFICATION NO.	ORGANIZATION

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

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

539-106

117

(b)(6)-2 except very bottom

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
13NOV03 @0130	Pt admitted from EMT, ambulatory, unknown security status (EPW vs CIV), currently in 2pt restraints $\bar{s}$ s/sx of skin or circulation compromise. VSS, speaking arabic, alert, c/o "little" pain, motrin given. (L) deltoid $\bar{c}$ sm frag wound, cleaned $\bar{s}$ dressed $\bar{c}$ 2x2 drsg. Pt refused food. H_2O provided, clean pjs provided. Interpreter explained restraints $\bar{s}$ plan of care. Plan: monitor (L) arm drsg, pain control, pr Abx. [redacted] Addendum: (+) CMS to LUE, neurovasc intact. [redacted]
13NOV @1100	Pt alo, VSS, ∅ c/o pain, 2x2 drsg over frag wound $\bar{c}$ ∅ drainage. Pt. to be d/c'd to camp @ 1130 today. — [redacted] 91WM6 SPC

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. ICW # 1

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	D/C Summary
13 AUG 03	
	Pt s/p GSW to (L) arm c̄
	resultant superficial soft tissue
	injury. ⊘ bone damage. Pt to
	be discharged to comp ō 7 days
	Abx + 8 ZZ dressing Δs until
	healed.
	(b)(6)-2
	[redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY																	
POST-	DAY																
MONTH-YEAR	DAY	13															
19	HOUR	00															
PULSE (0)	TEMP. F (•)	06															TEMP. C
	105°	09															40.6°
180	104°	15															40.0°
170	103°																39.4°
160	102°																38.9°
150	101°																38.3°
140	100°																37.8°
130	99°																37.2°
	98.6°																37.0°
120	98°																36.7°
110	97°																36.1°
100	96°																35.6°
90	95°																35.0°
80																	
70																	
60																	
50																	
40																	
RESPIRATION RECORD		18															
BLOOD PRESSURE		120/80															
		124/74															
HEIGHT:	WEIGHT →																
		98%															
		(RA)															

(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] (6)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

To Corp

[redacted]

(b)(6)-4

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

YELLOW FIELDS MUST BE FILLED IN, IF APPLICABLE, UPON APPREHENSION

☐ Offense against Civilian(s) [check one] If "Other" then describe:

- ☐ Arson (I.P.C. 342)
- ☐ Solicitation of Fornication/Prostitution (I.P.C. 399)
- ☐ Rape/Indecent/Sexual Assaults/Acts (I.P.C. 393-98, 402)
- ☐ Murder (I.P.C. 405)
- ☐ Aggravated Assault/Assault With Intent To Kill (I.P.C. 410)
- ☐ Maiming (I.P.C. 412)
- ☐ Simple Assault (I.P.C. 415)
- ☐ Kidnapping (I.P.C. 421)
- ☐ Burglary or Housebreaking (I.P.C. 428)
- ☐ Extortion/Communicating Threats (I.P.C. 430)
- ☐ Theft (I.P.C. 439)
- ☐ Destruction of Property (I.P.C. 477)
- ☐ Obstructing a Public Highway/Place (I.P.C. 487)
- ☐ Discharging Firearm/ Explosive in City/Town/Village (I.P.C. 495)
- ☐ Riot or Breach of Peace (I.P.C. 495(3))
- ☐ Other

☐ Offense against Coalition Forces [check one] If "Other" then describe: Mortars

- ☐ Violation of Curfew
- ☐ Illegal Possession of Weapon
- ☒ Assault/Attack on Coalition Forces
- ☐ Theft of Coalition Force Property (b)(2)-2
- ☐ Trespass on Military Installation or Facility
- ☐ Photographing/Surveilling Military Installation or Facility
- ☐ Obstructing Performance of Military Mission
- ☐ Other (b)(2)-2

Apprehending Unit: [redacted]		Location Grid: [redacted]	
Date of Incident: (D/M/Y) 12/11/03 / /	Time of Incident: 1823 hrs to hrs	Date of Report: (D/M/Y) / /	Time of Report: hrs

Detainee # (b)(6)-4		Key Connected Person: ☐ Victim ☐ Witness	
Last Name: [redacted]		Last Name:	
First Name: [redacted] Given Name:		First Name: Given Name:	
Hair Color: Black	Scars/Tattoos/Deformities:	Hair Color:	Scars/Tattoos/Deformities:
Eye-Color:	Weight: lb / Height: in	Eye-Color:	Weight: lb / Height: in
Address:		Address:	
Place of Birth:		Place of Birth:	
Ethn/Tribe/ Sect:	Sex: ☒ M ☐ F / Phone#: / DOB D/M/Y: / ☐ Mobile ☐ Regular	Ethn/Tribe/ Sect:	Sex: ☐ M ☐ F / Phone#: / DOB D/M/Y: / ☐ Mobile ☐ Regular
☐ Passport ☐ Dr. license ☐ Other (specify) Document #:		☐ Passport ☐ Dr. license ☐ Other (specify) Document #:	

Total Number of Persons Involved ____ (list names/identifying info on reverse under "Additional Helpful Information")

☐ Vehicle Information	Vehicle Number ____ of ____ Vehicle(s)		Owner:
Make:	Color:	VIN:	
Model:	Type:	Plate No.:	Number of People in Vehicle:
Year:	Names of People in Vehicle:		
Contraband/Weapons in Vehicle:			

☐ Property/Contraband	☐ Weapon	Photo Taken of Suspect with Weapon/Contraband. Yes/ No	
Type:		Model:	Color/Caliber
Serial No.:	Quantity:	Make:	Receipt Provided to Owner: Yes/ No
Other Details:		Where Found	Owner:

Name of Assisting Interpreter:	Email, Phone, or Contact Info.

Detaining Soldier's Name (Print):	Supervising Officer's Name (Print):
Last, First MI	Last, First MI
Signature:	Signature:
Email: (b)(2)-2	Email:
Unit Phone: [redacted] e. / /	Unit Phone: e. / /

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

[redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 0030 TIME OF ORDER 13 NOV 03 HOURS

LIST TIME ORDER NOTED AND SIGN (b)(6)-2

Admit to 7CW - [redacted]

Dx: ⊗ arm fracture right

Condition: stable

Vital: per routine

Allergy: NKDA

meds: 250 mg Keflex po QID

650 mg Tylenol po QID prn pain

noted NW 0115

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

NUTRIM 500 mg po TID prn pain

Diet: Regular

Activity: AS tolerated

plan: recheck in AM - Probable D/C

FU: ⊗

(b)(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

2 Nov

PATIENT IDENTIFICATION

DATE OF ORDER 13 NOV 03 TIME OF ORDER 1000 HOURS

(1) D/C to Comp [redacted]

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

(b)(6)-2 except for very bottom

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

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 12	13										
13	[redacted]	VS: routine	6	/	[redacted]										
			18	[redacted]											
13	[redacted]	DIET: regular	6	/	[redacted]										
			18	[redacted]											
13	[redacted]	ACT: as tol	6	/	[redacted]										
			18	[redacted]											

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
Darm fragmentation injury

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

(b)(6)-2 except for bottom

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 12	13
13	-hg-	Keflex 250mg po QID	6	/	[redacted]
	- - - - - -		12	/	
	- - - - - -		18	/	
	- - - - - -		24	[redacted]	
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ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: (1) arm frag injury

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

PATIENT IDENTIFICATION:

(b)(6)-4

[redacted]

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

(b)(6)-2 all

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
13	[illegible]	IV=Ø	[redacted]			
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
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	- - - - -					
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	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
13	[illegible]	Tylenol 650mg po QID pen pain	D/T													
- - - - -	- - - - -		D/T													
13	[illegible]	Motrin 800mg po TID pen pain	D/T	13NOV 0100												
- - - - -	- - - - -		D/T	800mg [redacted]												
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
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- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															

USAPA V1.00

1. Reporting MTF (b)(2)-2 [redacted]	2. MTF Location IZ	Admission and Coding Information For use of this form, see AR 40-400; the proponent agency is OTSG	
3. Register Number 0015257	Name (Last, First, MI) [redacted] (b)(6)-4	4. Pay Grade FGN	5. Sex M
6. DoB (YYYYMMDD) 1992-01-01	7. Age at Admission 11Y	8. Race X	9. Ethnicity 9	Religion
10. Length of Service ETS	11. FMP 20	12. Social Security Number [redacted] (b)(2)-2	
Organization (Active Duty Only)	13. Marital Status	Hour of Admission 00:30	Branch / Corps:
14. Flying Status	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES	16. Zip Code of Residence:	
17. Unit Location	18. MOS	19. Trauma DIS	Prev. Admission NO
20. Source of Admission Direct from ER	Ward: ICW1	Name / Relationship of Emergency Addressee Address of Emergency Addressee	
(b)(2)-2 Name and Location of Medical Treatment Facility: [redacted] Iraq; No Install Provided		Telephone Number of Emergency Addressee	
21. Type of Disposition TRF-OTH	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2003-11-13	
24. Clinic Svc - Admitting AAA - INTERNAL MEDICINE	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-11-13	
27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission 2003-11-13	

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: L ARM FRAGMENTS

Procedure Narrative(s):

Cause of Injury Narrative:

Admitting Officer (Signature, as requir [redacted] (b)(2)-2	Signature of Admitting Clerk [redacted] (b)(2)-2

ADMISSION · .D C ·ING INFORMATION

For use of this form, see AR 4 ., the proponent agency is OTSG

1. REPORTING MTF	2. ..F LOCATION (State or Country Code.)
1 2 3 4 5 6	
A	

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
9 10 11 12 13 14 15		16 17	18

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19 20 21 22 23 24 25 26	27 28 29	30	31	

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

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

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY		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	75 76 77 78 79 80	81 82 83 84 85 86

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
87 88 89 90	91 92 93 94 95 96	97 98 99 100 101 102

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: 8840
E9912

Inj Trauma
450 1

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

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

1. Register Nbr	2. Name	3. Grade	Admission Remarks
0015268	[redacted] (b)(6)-4	FGN	

4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm
M	22Y	X				NO

11. FMP	12. SSN	13. Organization	14. Ward
~~09~~ 20	[redacted]	(b)(6)-4	ICW2

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

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	14:00	AEA - ORTHOPEDICS

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	TRF-A	2004-01-29

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-11-14	[redacted] (b)(6)-2

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
[redacted] (b)(2)-2 Iraq	2003-11-14	

31. Selected Administrative Data

Marital Status:

In/Out Patient: Inpatient

DoB: 1981-10-12

MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

GSW R THIGH

Dx: 820.32
E991.2

Proc: 77.15
78.15
88.29

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	76	76

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	76	76

Signature of Attending Medical Officer [redacted] (b)(6)-2 [redacted] (b)(6)-2

Automated Facsimile - DA FORM 3647, May 79

MEDICAL RECORD | 1400 14 Nov **ABBREVIATED MEDICAL RECORD**

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

50 y/o GSW c/in post hx, pt a farmer
Med ō Allo ō Sh ō smoke
PMH ō known hxy
ō op

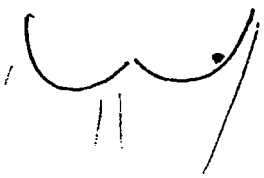
PHYSICAL EXAMINATION 130/70 108 99% O_2 sat

PERRL
teeth - poor dentition
chest - MRR, lungs clear
abd - soft ōm
genit - bil undescended testicle
rectal - good tone ō blood

back

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

ent -



~ 8x8 cm ant open wound (R) thigh
able to move toes bil
x LMT PT pulse in (R), DP on (L)
XR - prox femur fx (subtrochanteric)
P - ortho

SIGNATURE OF PHYSICIAN	DATE	IDENTIFICATION NO.	ORGANIZATION

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

[redacted] (b)(6)-4

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

539-108

MEDICAL RECORD	PROGRESS NOTES
DATE	
	Orth Op Note
14 NOV 03	
1705	Pre Op Dx - Grade III open (R) subtrochanteric femur fracture s/p GSW
	Post Op Dx - Same
	Procedure - (1) I+D (R) femur w/ Nailing
	(2) X-PIX (R) femur
	Surgeon - [redacted] / [redacted]
	EBL - 100 cc's
	Findings - Comminuted (R) subtrochanteric femur fracture, 3x3 mm posterior entrance wound, 5x5 mm exit wound. Lots of necrotic quadriceps muscle. X-PIX applied, good position under fluoroscopy. Calibrated, ready, nailing, placed along femur.
	PLAN - Repeat I+D in 18 NOV 03 OR sooner if necessary
	[redacted] (b)(6)-2
	[redacted]

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

13

PROGRESS NOTES

DATE	
18 NOV 03 1830	Nutrition Note: Pt appears thin, missing several teeth, remaining teeth appear decayed. Nsg reports poor po intake. Pt communicates through translator that his appetite is good, but he does not like American food. Pt is told he must eat to heal + upon encouragement, pt begins to eat bread, meat, rice. Recommend continuing regular diet c̄ lots of encouragement to ↑ po intake. [redacted] RD/LD (b)(6)-2

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

(b)(6) - 2 except for very bottom

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
24 JAN 04	(1100) ASSUMED CARE OF PT AT 0636. PT IS ALERT, & COMPLAINS OF PAIN + DISCOMFORT. LUNGS CTA, BOWEL SOUNDS ACTIVE X 4 QUADRANTS. DR [redacted] ORDERED 2 UNIT OF PRBC'S FOR PT. UNABLE TO START 18G IV ON PT. PT HAS STUCK 5X + ALL ATTEMPTS WERE UNSUCCESSFUL. DR [redacted] HAS CONTACTED AND HE STATED HE WOULD SEND SOMEONE FROM ANESTHESIA TO TRY. IV INFUSING IN R. LEG. NO S/S OF INFILTRATION. JEVITY INFUSING AT 75CC/HR. NO COMPLICATIONS NOTED. 2 POINT RESTRAINT INTACT. WILL CONTINUE TO MONITOR ——— [redacted]
24 JAN 04	PT HAS UNABLE TO RECEIVE HIS 0800 CARD DUE TO IV NOT RUNNING, BECAUSE OF INFILTRATION ——— [redacted]
25 Jan 04 0210	assumed care @ 2305. assumed care @ 2200. post transfusion vitals remain stable and remains afebrile. no S/S of reactive symptoms. dr BS0X3. Urinating clear yellow urine after been given lasix about 120cc since 2200. Lung sound are clear bilat. Extremities without edema. BS + in all quadrants and soft. Jevity @ 75/hr. Skin integrity in back and sacral area checked. no S/S of any decub ulcer present. ——— [redacted] OT. RN
	assumed care of pt @ 1900. VSS; pt is A+O x 3; no c/o pain or distress at this time; central line in place = Ø S/Sx of infiltration; central line running LR @ 75cc/hr; NG tube running Jevity @ 75cc/hr = Ø S/S of infection ——— [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

[redacted] (b)(6) - 4

(b)(6) - 2 of 11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
26 JAN 04 0720	assumed care of patient from night shift, patient assessment essentially unremarkable, pt had coarse lung sounds that cleared c̄ forceful cough instructed pt to use I.S. c̄ inspiration x10/1°, c-line intact c̄ LR @ 75cc/hr c̄ pato patent. Will continue to monitor for Also [redacted]
@1400	- OOB to BSC c̄ physical therapy assistance. MP's secured patient to chair patient tolerating well. [redacted] 9 WMC
@ 1530	pt returned to bed by PT & c/o pain received ⅡⅠ percocet. central line secured to @ [redacted] neck. will continue to monitor [redacted] 9 WMC.
27 Jan 04 @ 0200	Assumed care of pt @ 1900; VSS; A&O x3; Pt's central line was ~~at~~ falling down, secured ~~w~~ tape - kept on peeling off - will continue to monitor; IV NS was replaced c̄ a new bag & tubing this am; Ø c/o pn or discomfort @ this time; Jevity given thru NG tube @ 80cc/hr - need to locate more - supply room is out; Ø s/sx of infiltration or infection @ either sites — [redacted] WMC
27 JAN 04	assumed care of pt @ 0720. pt awakes easily and is oriented this a.m. talking with roommates. VSS lungs CTA & heart RRR. eating breakfast and tolerating well. Jevity continues NG & c/c intact ex-fix intact. [redacted] 9 WMC
28 Jan 04 @ 0400	Assumed care of pt @ 1900; VSS; A&O x3; pt's central line unchanged from yesterday - still falling off, even after reenforcement with tape; new IV NS was placed; Ø c/o pn or discomfort; [redacted]
28 Jan '04 @ 0315	Assumed care of pt @ 1900; VSS; A&O; c/o pn to @ LE - ⅡⅠ Percocet given - tol well; Central [redacted] line still falling - reinforced c̄ tape - still fell; central line is running LR @ 75cc/hr c̄ Ø s/sx of infiltration; pt needs to be reminded & encouraged to use IS 10x/hr while awake; Jevity & Dobhoff has been D/C'd per phy Sams orders; pt on restraints c̄ Ø s/sx of vascular compromise; will continue to monitor — [redacted] WMC
@0700	Pt c/o pn to @ LE. Requested that foot drop be removed. Once removed foot [redacted] in rt. Informed Charge Nurse & Wardmaster. Will cont. to monit [redacted]

STANDARD FORM 509 (REV. 5/1999) BAC

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
29 JAN 04	assumed care of pt, denies complaints & eating well. assessment done & ∅ significant changes noted. ex-fix-clean & intact. will continue to monitor SVT [redacted] given (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, print: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.
Pt # [redacted] (b)(6)-4		

PROGRESS NOTES
Medical Record

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

USAPA V1.00

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

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER: AMR

ARRIVAL — DATE: DAY 14, MONTH Nov, YR. 03 — TIME

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): [ ] PRIVATE VEHICLE [X] AMBULANCE [ ] OTHER (Specify)

CURRENT MEDS. (tetanus immunization and other data)

HISTORY OBTAINED FROM: [ ] PATIENT [ ] OTHER (Specify)

ALLERGIES: Ø

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)

SEX: ♂ AGE: 52

POSSIBLE THIRD PARTY PAYER? [ ] YES [ ] NO

TIME SEEN BY PROVIDER

VITAL SIGNS			
TIME	1400	1420	
BP	102/52	142/76	
PULSE	120	83	
RESP.	20	20	
TEMP.	96		
WT. (Child)	100%	100%	

CATEGORY (See reverse)
- [ ] EMERGENT
- [ ] URGENT
- [ ] NON-URGENT

ORDERS	INITS.	TIME
CBC/MET 8		
Tx Cuso x 4		
IM 350 mg Rocephin IV stat		
Ancef 1gm IV		
Tetanus 0.5 cc IM		

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)

50% ♂ Tirage shot in (R) thigh @ 2 T tirage

Ø other trauma

pt c/o

Pm Ø
PSH Ø
Soc Hx Ø
Meds Ø

O: Aox x4 in mod distress
HEENT: ↓ ↓ no clear/not m
Chest: CTA(B) —
CV: RRR ↑ ↑ ↑
Abd: soft, NT
rectal NL tone Ø gross blood
Ext: (+) entire (R) upper thigh post @ gluteal fold

Gu (B) cuts feet

Xrays: (+) ⊗ spasm

ASSESSMENT/DIAGNOSIS: Gsw (R) thigh

A/P (1) stable
open fx prox femur

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

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

SIGNATURE OF PROVIDER AND ID STAMP [redacted]

INSTRUCTIONS TO PATIENT (Include medication [redacted] and follow-up plans)

MEDICAL RECORD	INTRAOPERATIVE DOCUMENT For use of this form, see AR 40-407, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY Anesthesia

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

3. DATE 14 NOV 03 TIME PATIENT ARRIVED IN SUITE /

4. PATIENT IN ROOM TIME 1435 NUMBER 4

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: /

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: correct body alignment maintained, arms on padded armboards at less than 90°, position approved by surgeon + anesthesia

8. SKIN PREPARATION

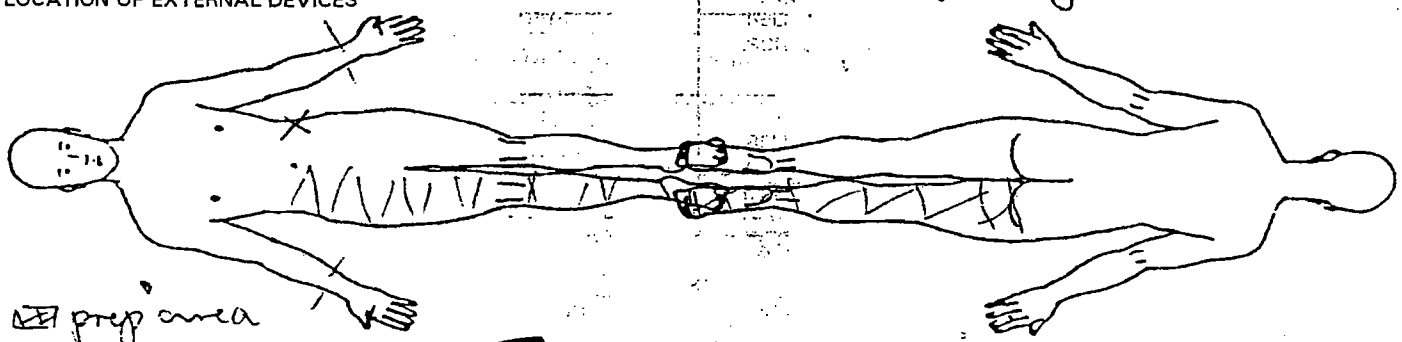
HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☒ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP

COMMENTS: no nicks or cuts noted

PREP SOLUTION *(Specify)* Betadine / Betadine Paint
SITE: (R) leg to umbilicus BY WHOM [redacted]
SITE: BY WHOM:

COMMENTS: no pooling or skin Δ's noted

9. LOCATION OF EXTERNAL DEVICES



☒ prep area

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

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB (b)(6)-2	CIRCULATOR (b)(6)-2
Sponge	☒ Yes	☐ No	/	/	C	[redacted]	[redacted]
Needle Sharp	☒ Yes	☐ No	/	/	C	↓	↓
Instrument	☐ Yes	☒ No	/	/	/		
Other	☐ Yes	☒ No	/	/	/		

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

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

[redacted] (b)(2)-2

14 NOV 03

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

30130

☒ ESU NO: Valleylab Force 4U RSE 105 305
GROUND PAD: BRAND VL Dual Pad Reflexive II
LOT NO: 70337 2005-05

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

Surgical Simplex® P

Howmedica Int. S. de R.L.
Raheen Business Park
Limerick, Ireland.

(A) Full Dose
REF 6191 0 001
LOT CLJ157

Surgical Simplex Bone Cement 4723-C-2007-10 Vacuum/C in Sp 02 Exp 01 MAR 06

13. PROSTHESIS, IMPLANTS ☒ YES ☐ NO

Hoffman II Set
CMS #[redacted]
Pins x 5 (5012-6-180)

MANUFACTURER

14. MEDI

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY
none		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	16F FIC *		
SITE	*Bladder		

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

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

*FIC placed in EMT
- DA 5179 initiated

20. OPERATION(S) PERFORMED
I+D (R) Femur Fx
Ex Fix Placement

21. PATIENT TRANSFERRED TO ICU3 (PACU) TIME see DA7389 METHOD PACU bed

22. REGISTERED NURSE SIGNATURE [redacted] CPT IAN

REVE[redacted] (b)(6)-2 MEDCOM - 24582 USAPA V1.00

(b)(6)-2 unless otherwise indicated

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
(b)(6)-4 [redacted]				1/25	HOURS	
			(1)	D/C Vanco		
			(2)	D/C Cipro		
				[redacted]		
NURSING UNIT	ROOM NO.	BED NO.		MA [redacted]		

NOTED [redacted] 25JAN'04 1800

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
				1/28	0715 HOURS	
				X-Ray - AP/Lateral (R) Femur		
				- D/C Tucity		
				+ D/C Dobhoff [redacted]		
NURSING UNIT	ROOM NO.	BED NO.				

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

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

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

☆U.S. GOVERNMENT PRINTING OFFICE: 2002-488-041

"USE BALL POINT PEN-PRESS FIRMLY I NO CARBON PAPER REQUIRED"

(b)(6)-2 except for very bottom

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: 14 NOV 03
Time In: 1703
Allergies: NKDA
Pre-op V/S: 112/58 80
Procedures: Left fix
Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 3500 Colloid
OR Output: UOP 300 EBL 400
Meds/Times: Fentanyl, MSO4

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds

History

Time	1700	1710	1715	1730	1745
SaO2	100	100	97	98	95
FiO2					
Methods	[redacted]				
240					
220					
200					
180					
160					
140					
120					
100					
80					
60					
40					
20					
RR	22	14	22	22	22
T	96				

Time										
Pain (0-10)										
LOS										

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1705	LR	1400	LH(2) AC	OL	3500

X-rays:

Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

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

(Continue on reverse)

[redacted] PK

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 14 Nov 03

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

[redacted] (b)(6)-4

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete USAPPC V2.00

(b)(6)-2 all

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	(R) Leg	WNL	+	+	B	C	PK
15'							
30'							
45'							
60'							
90'							
D/C							

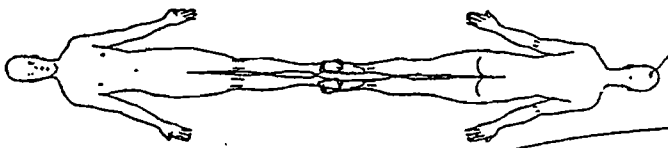
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(R) leg	All C lxt fix	-0
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1705	NSR	-0	-0

NURSING NOTES

Pt to recovery room from OR via gurney s/p (R) femur fx lxt fix. Placement ext fix c all. Wrap to (R) leg. NVS intact. Pt is walking into (L) & (C) c. Both dorsal patent. -0 S/S of hardness or swelling to calf site. VSS. Pain control to minimize + assess: [redacted], LPN

Discharge Criteria:
Date: 14 NOV 13 Time: PARS: 9
BP: 180/60 T: 98.3 HR: 76 RR: 6 Sa02: 97
Pain Level at D/C (0-10):
Intake: 200 Output: -0
Additional Data:
Transferred To: PACU
Report Given To:
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: [redacted]

WAMC OP 173-E

Admission and Coding Information

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

1. Reporting MTF (b)(2)-2 [redacted]	2. MTF Location IZ			
3. Register Number 0015268	Name (Last, First, MI) (b)(6)-4 [redacted]		4. Pay Grade FGN	5. Sex M
6. DoB (YYYYMMDD) 1981-10-12	7. Age at Admission 22Y	8. Race X	9. Ethnicity 9	Religion
10. Length of Service	ETS	11. FMP 99	12. Social Security Number (b)(6)-4 [redacted]	
Organization (Active Duty Only)		13. Marital Status	Hour of Admission 14:00	Branch / Corps:
14. Flying Status	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES		16. Zip Code of Residence:	
17. Unit Location	18. MOS	19. Trauma DIS	Prev. Admission NO	
20. Source of Admission Direct from ER	Ward: ICW2	Name / Relationship of Emergency Addressee		
		Address of Emergency Addressee		
Name and Location of Medical Treatment Facility: [redacted] Iraq; No Install Provided (b)(2)-2		Telephone Number of Emergency Addressee		
21. Type of Disposition TRF-A	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2004-01-29		
24. Clinic Svc - Admitting AEA - ORTHOPEDICS	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-11-14		
27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission 2003-11-14		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: GSW R THIGH

Procedure Narrative(s):

Cause of Injury Narrative:

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

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

Automated Facsimile - DA FORM 2985, MAR 2000

1316

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

YELLOW FIELDS MUST BE FILLED IN, IF APPLICABLE, UPON APPREHENSION

[ ] Offense against Civilian(s) [check one] If "Other" then describe:

- [ ] Arson (I.P.C. 342)
- [ ] Solicitation of Fornication/Prostitution (I.P.C. 399)
- [ ] Rape/Indecent/Sexual Assaults/Acts (I.P.C. 393-98, 402)
- [ ] Murder (I.P.C. 405)
- [ ] Aggravated Assault/Assault With Intent To Kill (I.P.C. 410)
- [ ] Maiming (I.P.C. 412)
- [ ] Simple Assault (I.P.C. 415)
- [ ] Kidnapping (I.P.C. 421)
- [ ] Burglary or Housebreaking (I.P.C. 428)
- [ ] Extortion/Communicating Threats (I.P.C. 430)
- [ ] Theft (I.P.C. 439)
- [ ] Destruction of Property (I.P.C. 477)
- [ ] Obstructing a Public Highway/Place (I.P.C. 487)
- [ ] Discharging Firearm/ Explosive in City/Town/Village (I.P.C. 495)
- [ ] Riot or Breach of Peace (I.P.C. 495(3))
- [ ] Other

[✓] Offense against Coalition Forces [check one] If "Other" then describe: Emplacing IED

- [ ] Violation of Curfew
- [ ] Illegal Possession of Weapon
- [ ] Assault/Attack on Coalition Forces
- [ ] Theft of Coalition Force Property
- [ ] Trespass on Military Installation or Facility
- [ ] Photographing/Surveilling Military Installation or Facility
- [ ] Obstructing Performance of Military Mission
- [✓] Other

Apprehending Unit: 2/319th AFAR		Location Grid: MB 41127912	
Date of Incident: (D/M/Y) 04/11/03 to / /	Time of Incident: 1945 hrs to hrs	Date of Report: (D/M/Y) / /	Time of Report: hrs

Detainee # FAOA-0011 (b)(6)-4			Key Connected Person: [ ] Victim [ ] Witness		
Last Name: [redacted]			Last Name:		
First Name [redacted]	Given Name:		First Name:	Given Name:	
Hair Color:	Scars/Tattoos/Deformities:		Hair Color:	Scars/Tattoos/Deformities:	
Eye-Color:	Weight: lb	Height: in	Eye-Color:	Weight: lb	Height: in
Address:			Address:		
Place of Birth:			Place of Birth:		
Ethn/Tribe/ Sect:	Sex: [✓] M [ ] F	Phone#: DOB D/M/Y: 6 Aug 81 [ ] Mobile [ ] Regular	Ethn/Tribe/ Sect:	Sex: [ ] M [ ] F	Phone#: DOB D/M/Y: [ ] Mobile [ ] Regular
[ ] Passport [ ] Dr. license [ ] Other (specify)			[ ] Passport [ ] Dr. license [ ] Other (specify)		
Document #:			Document #:		

Total Number of Persons Involved 3 (list names/identifying info on reverse under "Additional Helpful Information")

[ ] Vehicle Information	Vehicle Number ____ of ____ Vehicle(s)		Owner:
Make:	Color:	VIN:	
Model:	Type:	Plate No.:	Number of People in Vehicle:
Year:	Names of People in Vehicle:		
Contraband/Weapons in Vehicle:			

[ ] Property/Contraband	[ ] Weapon	Photo Taken of Suspect with Weapon/Contraband: Yes/ No	
Type:		Model:	Color/Caliber:
Serial No.:	Quantity:	Make:	Receipt Provided to Owner: Yes/ No
Other Details:		Where Found:	Owner:

Name of Assisting Interpreter:	Email, Phone, or Contact Info:

(b)(6)-2

Detaining Soldier's Name (Print): Last, First MI	Supervising Officer (Print): [redacted]
Signature:	Signature: [redacted]
Email:	Email:
Unit Phone: / /	Unit Phone: 582-5 Date: 14/11/03

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

Why was this person detained? He was emplacing an IED, IED detonated prematurely, he was ~~detained at the scene~~ I.D. at the scene and detained at Al Yarmook hospital

Who witnessed this person being detained or the reason for detention? Give names, contact numbers, addresses.

How was this person traveling (car, bus, on foot)? Car

Who was with this person? [redacted] (b)(6)-4

What weapons was this person carrying?

What contraband was this person carrying?

What other weapons were seized?

What other information did you get from this person?

Additional Helpful Information:

(b)(6)-2 unless otherwise indicated

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

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

1. Register Nbr	2. Name					3. Grade	Admission Remarks
0015270	[redacted] (b)(6)-4					FGN	
4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm	
M	22Y	X				NO	
11. FMP	12. SSN	13. Organization				14. Ward	
20	[redacted] (b)(6)-4					ICW1	
15. FlyStatus	17. Dept / Ben	18. BranchCorps	19. UIC / ZIP	20. Type Case			
	K78-PRISONER OF WAR/INTER			BC			
21. Source of Admission		22. Hour Of Adm:	23. Clinic Service				
Direct from ER		15:50	AEA - ORTHOPEDICS				
24. Name/Relation of Emergency Addressee		25. Type Disp	26. Date of Disp				
		TRF-OTH	2003-11-22				
27a. Address of Emergency Addressee		27b. Telephone No	28. Date This Adm:	AdmittingOfficer:			
			2003-11-14	[redacted]			
29. ReportingMTF	(b)(2)-2		30. Date Init Adm	32. Units Blood Components			
[redacted] raq			2003-11-14				

31. Selected Administrative Data

Marital Status: DoB: 1981-08-06

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

S/P HD MF SHRAPNEL WND R FA AND R 3RD FINGER

872.61
951.5
879.4
816.10
959.8
682.9
E991.2

79.34
86.22 x2

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	9	9

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	[redacted]	0	9	9

Signature of Attending Medical Offi [redacted] Signature of PAD or Medical Records Officer [redacted]

Automated Facsimile - DA FORM 3647, May 79

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

22 y/o blew self up 10 days ago setting IED.
Treated initially at Iraq hospital then transferred
to CFW CASP.

PMHx: ø
PSHx: ø
Meds: ø
Allergies: NKDA

PHYSICAL EXAMINATION

HEENT: [illegible]
Chest: [illegible]
Cor: S1 S2
Ext: medial & lateral wounds and [illegible] and
pharynx c̄ patient D/C

XR: Pr Fx

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

(A) Open (R) ~~Pr~~ Pr Fx chron
(P) Admit IPD

(b)(6)-2

[redacted]	DATE 11/14/03	IDENTIFICATION NO	ORGANIZATION
[redacted]		REGISTER NO	WARD NO

(Typed or written entries give Name last, first, middle, grade, date, hospital or medical facility)

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

24 Nov 03
2130

Orthe Op Note

Pre-Op Dx - Infected open (R) middle finger middle phalangeal fracture 2° GSW

Post-Op Dx - Same

Procedure - I&D (R) middle finger

Surgeon - [redacted]

ASA - MN FLUIDS - LR - 650

Findings - Grossly contaminated through and through wound for (R) MF, with necrotic debris, necrotic fat floating above fragments in wound, Extensor tendon with segmental loss, Radial digital artery and nerve disrupted.

Plan - IV abx, repeat I+D 16 Nov 03, possible amputation

(b)(6)-2

[redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
16 NOV 03	Ortho Op Note
1730	Pre-Op Dx - Displaced (R) medial malleolus fracture
	Post Op Dx - Same
	Procedure: I+D (R) medial fracture
	Surgeon: [redacted]
	SBL - min
	Findings - No gross. Minimal necrotic tissue
	Plan: Report I+D 18 NOV. Will either pin fx or do arthrodesis
	[redacted]
	(b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

(b)(6) - 2 except very bottom

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
14Nov03@1730	[redacted] Pt admitted to ICW1 from EMT via amb in stable condition; VSS, pt A&O speaking arabic; ⊕ cms, +2 PP, brisk cap Ref x4; S1S2, LS CTA ⊖ abd soft NTTP; pt voiding per urinal ∅ difficulty; PIV to ⓛ FA patent infusing D5½ NS@100 cc/hr ∅ s/sx infection/infiltration; Superficial shrapnel wounds RUQ, RLQ, & distal aspect of RUE; [redacted] 2nd finger to ⓡ hand wrapped c̄ kerlix; deep wound to medial aspect of finger & superficial wound to lateral aspect of finger; finger edematous & erythamous, [redacted] min. purulent drainage, ⊕ s/sx infection; pt remains NPO per MD; 2 point restraints in place, ⊕ circ, ⊖ skin breakdown; cont to monitor [redacted]
15Nov03@1730	Assumed care @ 0600; VSS, A&O speaking arabic; ⊖ c/o pain or discomfort @ this time; dsg to ⓡ hand CDI, ⊖ drainage; Superficial fragmentary wounds to ⓡ aspect of trunk & distal aspect of RUE OTA, ⊖ drainage, ⊖ s/sx infection; pt voiding QS per urinal; New PIV started in ⓛ FA, cont c̄ IV abx; pt TOI Reg diet well; Restraints in place, ⊕ circ ⊖ skin breakdown, cont to monitor [redacted]
15Nov03 2300	Pt resting in bed. VSS A&O Denies pain at this time. Drsg to ⓡ hand CDI. ⊖ Drainage. Multiple superficial wounds to ⓡ Torso & RUE. OTA. LS CTA ⊖ S/S, present ⊕ BS x4 quads. Will cont to Monitor [redacted] 9 WMG

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

[redacted] (b)(6) - 4

(b)(6)-2all

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
16 Nov 03 0900	Assumed care @ 0600. Pt A&O able to make needs known. Lungs CTA(B). Resp even/unlabored. (D) BS x4. Voiding clear yellow urine quantity sufficient per usual. ~~IV~~ Heplock flushed/patent per C&T. (R) hand drsg intact. Pt c multiple healing abrasions wounds to (R) torso area. Pt NPO since MN for OR today. 2 pt restraint s compromise to skin/circulation. Will continue to monitor. denies pain at this time. [redacted]
16 Nov 03 1245	Pt returned from PACU via gurney. A&O. No distress. Drsg to (R) middle finger CDI. Moves fingers s difficulty. Nailbeds pink c brisk capillary refill. Pt denies pain c requesting food. HL patent. Will continue to monitor c provide emotional support. Pt sitting in chair [redacted]
16 Nov 03	Assumed care of Pt @ 1800. Pt A&O. VSS LS CTA (B) HRRR (D) BS x4 quads. Drsg to (R) middle finger CDI. Will cont to monitor. [redacted] 11MA
17 Nov 03 1240	Pt AO x3 WC, c hx of DM pain at this time. Pt voiding dark yellow urine. Pt ambulates without difficulty. (R) middle finger drsg CDI. restraints x2 (D) circulation. [redacted]
17 Nov 03 1630	I concur c above assessment. Neurovascular intact. Will continue monitoring [redacted]

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

(b)(6)-2 all

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
18NOV03	(1420) Assumed care @ 0600. Pt alert, speaking Arabic rss. 0 c/o pain. Pt to OR this am for I/D. Pt. returned from OR in stable cond. via gurney. 0 c/o pain. Drsg to (R) 3rd finger CDI. Pt tol. reg diet well. IVFs [redacted] sld in IV in (L) forearm. 0 sgns infection/infiltration. Pt amb well in hallway. voiding w/ difficulty. 2 point restraints in place w/ sgns complications. Will cont. to monitor. [redacted]
18NOV03 2000	USS OOB → BR for shower per pt's request. (R) 3rd finger drsg covered w/ plastic prior to shower. Drsg remained dry & intact. Mult shrapnel wounds to (R) FA small w/ scabs. (L) FA saline lock patent & intact. 0 c/o pain noted. ~~[illegible]~~ +2 restraints in place without compromising circulation or skin integrity. Will continue care as planned. [redacted]
19NOV03 1506	Assume care of Pt @ 0600. Auto, USS 0 c/o pain today. Maintains a regular diet. Drsg to (R) 3rd finger is intact. Moved IV from lower (L) forearm to upper (L) forearm, due to being pulled out while performing personal hygiene. 2pt restraint without skin irritation. Will cont. to monitor. 9/USPC [redacted]
	(1700) I concur w/ above. [redacted]

STANDARD FORM 509 (REV. 5/1999) BACI
USAPA V1.0

(b)(6)-2 except for very bottom

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
17 Nov 03	Assumed care of Pt @ 1800. VSS A&O
2200	Denies pain. Drsg to (R) middle finger CDI. Tol PO well. Cont IV Antibiotics will continue to monitor [redacted] Sgt 91WM6
	(1120) Pt to OR via gurney in stable cond. [redacted]
18 Nov 03	(S) POD #1 OR ADMIT
1220	
	Pre-Op Dx: (R) MF Pa crushing for Injury
	Post-Op Dx: Same
	Procedure: OIF to (R) MF
	(2) longitudinal pinning of (R) MF
	Surgeon: [redacted]
	Findings: Wounds clean. Previous culture negative for Staphylococcus. Wound irrigated. Fixed with longitudinal .045 K-wire through P3 → P1 in good position, joint stable.
	Plan: Admit
	[redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.
#[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 V1.01

(b)(6)-2 all

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
(cont'd)	nsng to (R) 3rd finger CDI c (+) cap. refill. Good ROM to finger. IV HL (L) AC CDI (-) s/sx inf. flushes well. Two patient restraints in place c̄ compromise to skin/circulation. Will cont. to monitor pt. [redacted] I concur c̄ clin assessment [redacted]
21 NOV 03 0800	-Assumed care of pt. A+O x3. VSS sitting up at bedside eating breakfast. Lungs CTA HRRR Active BS x4 quads. Urinating spontaneously c̄ difficulty. AM shower care given. Wound to (R) hand middle digit healing dsg CDI. OK for discharge. Assessment WNL Will cont to monitor [redacted]
21Nov03@2045	Assumed care @ 1800; VSS, pt A&O speaking arabic; Ø c/o pain, pt in NAD; dsg to (R) finger CDI, (-) drainage noted; S,S2, LS CTA (R); (+) BSX4; pt voiding QS per urinal; Ø Δs in assessment; pt awaiting D/C; Restraints in place, (+) circ, (-) skin breakdown, cont to monitor [redacted]
22 NOV 03 0730	Assumed care of pt. A+O x3. VSS Ø c/o pain or discomfort @ this time Ambulated c̄ difficulty Lungs CTA. HRRR Active BS Urinating spontaneously PO intake well. (R) hand middle digit dsg CDI OK for discharge Will cont to monitor [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.0

(b)(6)-2 except for very bottom

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
19 NOV 03 1900	VSS. (L) FA Saline lock patent & intact OOB → BR. (R) 3rd finger dry dry & intact. Consumed 50% of regular diet for dinner. (P) FA c multi superficial shrapnel wounds c scabs & S/S of infection. Q C/O pain is disruptive. Will continue plan of care. +2 restraints in place without compromising circulation or skin integrity. [redacted] RN
20 NOV 03 1457	Pt A&O able to make needs known. VSS. (R) 3rd finger dry CSE. Pt moves finger purposefully. Multiple healing shrapnel wounds to RUE. Heplock patent to (L) AC. (P) BS x 4 quads. Voiding per urinal & BR clear yellow urine. Will continue monitoring & Abx therapy as ordered. 2 point restraint on 5 compromise to skin/circulation [redacted] RN
2010 –	Assumed care of pt. @ 1800. VSS A+O pt. speaking in arabic. LS CTA (B), Resp. even, unlabored, NSR, Abd. soft non-tender, BS x 4. voiding [redacted] clear yellow urine per urinal. →

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. ICW1

#[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

PREVIOUS EDITION IS USABLE

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2315	HPI. 20 YO I EPW S/P injury to (R) ARM 2° IED
	occurring 3 days prior to presentation. Seen
	@ Iraqi hospital and evacuated for intravenous
BP 142/86	Sensorimotor wound to (R) FA & sign injury to
PR 125	(R) 3rd finger. (+) HL
R 18	
Spo2 99	(-) on oxygen mask
T 97.6	HEENT: [illegible] (+) [illegible], [illegible], TTP only
	Neck supple
NEAR OPEN	(R) FA mild swell. erythema. min TTP. full compartment
	3rd finger joints, present, deformed w/ ROM.
	(+) TTP w/ flexor & volar compartments.
	CR 2 sec. sign TTP
	(R) TM (R) erythema, (L) hemotympanum. [illegible] 3rd MP Fx.
	A/P Sensorimotor wound (R) 3rd Finger w/ open fracture -
	Unasyn 3.0 g IV Rule Tetanus [illegible]
ALL. COWS	Toradol 30mg IV
Motile shrapnel	Soft tissue injury 2° shrapnel w/ mini cellulitis
Scattered throughout body w/ minimal pain	TO CSTL in ARM.
	(R) tympanic membrane rupture w/ Hearing loss.
	[redacted] b(6)-2
	[redacted]

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

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

REGISTER NO. | WARD NO.

[redacted] b(6)-4 EPW

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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

558-103 (See Instructions on Back of this Sheet) b(2)-2 NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT [redacted]
(Medical Record)

LOG NUMBER

ARRIVAL				TRANSPORTATION [redacted] (Attach care enroute sheet)	CURRENT MEDS. (tetanus immunization and other data)	HISTORY OBTAINED FROM
DATE			TIME	☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify)	Ø	☐ PATIENT ☐ OTHER (Specify)
DAY	MONTH	YR.				ALLERGIES
1Y	NOV	03	1600			Ø

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)

SEX	AGE	POSSIBLE THIRD PARTY PAYER?
M	22	☐ YES ☐ NO

TIME SEEN BY PROVIDER

VITAL SIGNS			
TIME	1600		
BP	118/70		
PULSE	100		
RESP.	16		
TEMP.	97.8		
WT. (Child)	97		

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)

CATEGORY (See reverse)

- ☐ EMERGENT
- ☐ URGENT
- ☒ NON-URGENT

ORDERS	INITS.	TIME

ASSESSMENT/DIAGNOSIS

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: LIST FACILITY HOLDING TREATMENT RECORD).

[redacted] EPM

b(6)-4

SIGNATURE OF PROVIDER AND ID STAMP

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

SKIN AND WOUND ASSESSMENT

MEDICAL RECORD **PROGRESS NOTES**

Admission Date: 14 Nov 03 Diagnosis: Shrapnel wounds HD: POD:

Braden Scale Evaluation (See Braden Evaluation Table for Details)

Sensory Perception	No impairment	4		**Mobility**	No limitations	4	
	Slightly limited	3			Slightly limited	3	
	Very limited	2			Very limited	2	
	Completed	1			Completely immobile	1	
Moisture	Rarely moist	4		**Nutrition**	Excellent	4	
	Occasionally moist	3			Adequate (Eats >50%)	3	NPO
	Moist	2			Adequate (Rarely eats)	2	
	Constantly moist	1			Very poor	1	
Activity	Walks frequently	4		**Friction and Shear**	No apparent problem	3	
	Walks occasionally	3			Potential problems	2	
	Chairfast	2			Problems	1	
	Bedfast	1					

Add the total score **Total Score** 19

Above 20	Low Risk
Between 16 and 20	~~Medium Risk~~
Between 11 and 15	High Risk
Below 10	Very High Risk

Note: A Braden Scale Score of less than or equal to 15 indicates **HIGH RISK** –Requires immediate Ulcer prevention program.

Surgical wound (s): Yes No Location:_____ Size: _____ Drainage: _____
Tubes: _____ Appearance:_____
Dressing change:_____

Pressure Ulcer (s): Yes No
Stage I, II, III, IV (Circle the one that applies and describe below)

Location:_____ Size: _____
Wound character: Pint_____ Moist _____ Dry _____ Granulation tissue _____ Yellow slough_____
Odor _____ Purulent discharge _____ Eschar _____ Exudates _____

Type of dressing change: Wet-to-dry_____ Comfeel dressing _____ Carrasyn V-Gel_____ Alginate _____

Physician notified/consulted for wound debridement: Yes_____ No_____
CNS notified/consulted for Stage II and greater: Yes_____ No_____
Nutrition Referral: Yes _____ No _____
Physical Therapy Referral: Yes_____ No _____
Action Taken: _____ Date & Time: _____

REGISTER NO.	WARD NO.

Patient's Identification (For typed or written entries give: Name-last, first, middle: Grade; rank; hospital or medical facilithy)

#[redacted]

b(6)-4

PROGRESS NOTES

Medical Record
STANDARD FORM 509

MEDICAL RECORD	PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT For use of this form, see AR 40-66; the proponent agency is The Office of the Surgeon General.
1. AGE: 30? HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): None 3. PREVIOUS SURGERY [ ] NO [ ] YES (type): ??

4. PROPOSED SURGICAL PROCEDURE:
(R) hand I?D

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

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL Potential for anxiety related to traumatic injury; language barrier; family separation; surgical environment	o Pt. verbalizes any specific anxiety. o Pt. exhibits relaxed body posture.	o Allow pt. to verbalize freely. o Explain OR environment and answer questions regarding surgery. o Offer comfort measures, (e.g., warm blanket, touch) o Explain all nursing procedures before they are done. o Remain with pt. whenever possible. o ~~Maintain family interface.~~
B. AERATION Potential for respiratory dysfunction due to sedation; positioning; injury	o PT. will be able to breathe without difficulty during immediate intra-operative phase.	o Offer to elevate head of litter or offer pillow. o Observe pt. while awaiting surgery for signs of distress o Assist anesthesia during intubation and extubation
C. INTEGUMENT Potential impairment of skin integuity due to bovie pad; position; fluid shift	o PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	o Utilize pressure preventing devices on OR table and accessories. o Check for proper positioning and support to maintain good body alignment. o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling.

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

[redacted] b(6)-4

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ___ Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; shock; previous surgery	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. ___ Potential impairment of mobility due to sedation; pain; injury E.2. ___ Potential discomfort due to injury; pain	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. ___ Disminished visual perception due to being injury; sedation; F.2. ___ Potential for decreased communictaion due to language barrier; sedation F.3. Potential injury due to dentures. ___	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from ___ side. o Validate pt.'s understanding of verbal communications. o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS. Or continuation of above interventions.

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

___ ___DATE

11. POSTOPERATIVE EVALUATION:

ABLE TO MOVE, awake, alert. able to follow directions (signals). Bowie cut clean, dry intact. Dressing dry and clean

POST

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)	13. PREOPERTIVE EVALUATION PREPARED (Signature and Title)
[redacted] DATE: 14NOV07 TIME: 2014 blw-2	[redacted] DATE: 14NOV07 TIME: 2113

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.01

b(6)-2 (A)
unless noted otherwise

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 TRANSEORTED TO OPERATING ROOM VIA: Litter BY ANESTHESIA

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] (Emergency)

3. DATE 14 Nov 03 TIME PATIENT ARRIVED IN SUITE 2016

4. PATIENT IN ROOM TIME 2016 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Pt able to follow commands, ? sedating. awake. able to move.

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MA [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) Pt placed in OR bed. anatomically aligned neutral.

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

COMMENTS: Arm on armboard, 290° Stretched ST RAO above knee 2H ALL PPP.

8. SKIN PREPARATION

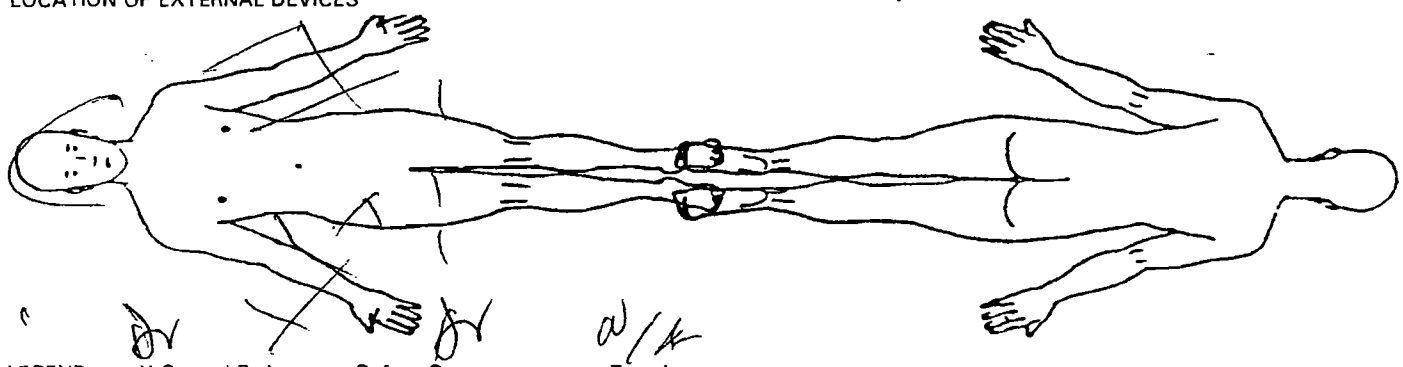
HAIR REMOVAL ☐ YES ☐ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION (Specify) BETA / BETA
SITE: (R) arm BY WHOM: [redacted]
SITE: ~~[illegible]~~ BY WHOM: [redacted]

COMMENTS: ↓ pooling of solution noted

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C = Correct I = Incorrect

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

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

[redacted]

b(6)-4

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

☑ ESU NO: Valleylab 40 Room 1 cut 30 coag 30
GROUND PAD: BRAND 3M 9165
LOT NO: 2005/11 LA.

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

☐ BIPOLAR NO: _____

MEDCOM - 24604

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

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☒ NO ☐ IF YES, SITE Arm (R) hand

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☒ NO ☐	NAME	NAME
NAME R middle finger Lacerated	NAME	NAME
NAME R middle finger Clean cut	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
Iodiform Gauze
fluff
Kerlix
Tubular Gauze

19. ADDITIONAL INFORMATION
S. ALBERTSON A. SMITH TYPE GETA

Bruise site clean, dry intact pre-post op
Dressing clean, dry intact.

20. OPERATION(S) PERFORMED
(R) hand I & D

21. PATIENT TRANSFERRED TO Plastic PACU TIME 2112 METHOD Litter

[redacted]GE SIGNATURE
[redacted]MAN

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

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA PACU bed BY Anesthesia

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

3. DATE 16 NOV 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 1135 NUMBER 4

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: ✓

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: correct body alignment maintained, (L) arm on padded arm board at less than 90°, (R) arm on 2 padded armboards for IV and table, position approved by anesthesiologist

8. SKIN PREPARATION

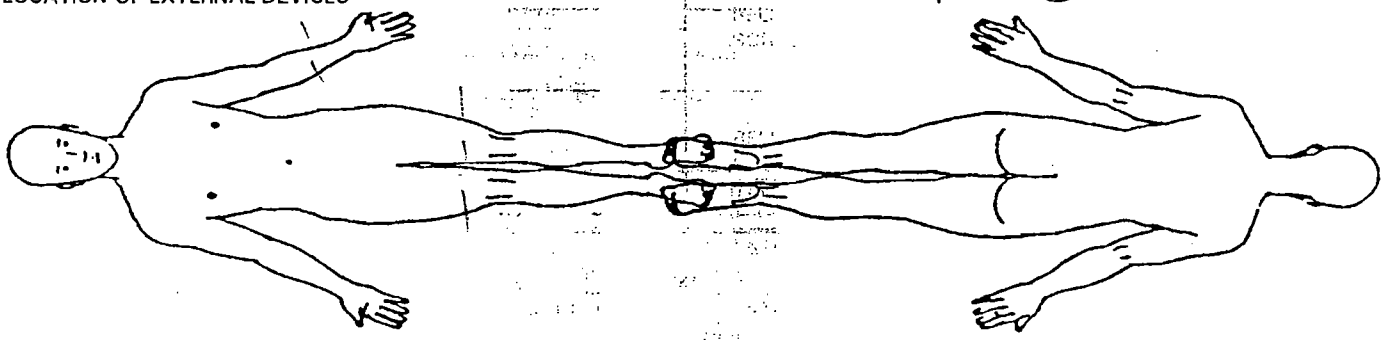
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine / Betapaint
SITE: (R) BY WHOM [redacted] b(6)-2
SITE: BY WHOM

COMMENTS: no problems or skin d's noted

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect b(6)-2

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

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

A [redacted] b(6)-4
[redacted] b(2)-2
16 NOV 03

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

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

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY
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. 1/4in Iodoform	2.	3.
SITE	1. (R) MF	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
~~Fluffs~~
~~Kerlix~~
Surgitube

19. ADDITIONAL INFORMATION
Surgeon: [redacted]
Anesthesia:
b(6)-2
-DA 5179 on chart, ØØ's noted

20. OPERATION(S) PERFORMED
I+D (R) MF

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU3 (PACU) b(6)-2	see DA7339	PACU bed

22. REGISTERED NURSE SIGNATURE
[redacted] (PACU)

MEDICAL RECORD — **INTRAOPERAT OCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA gurney BY Anesthesia

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

3. DATE 18NOV03 TIME PATIENT ARRIVED IN SUITE 1134

4. PATIENT IN ROOM TIME 1124 NUMBER 1-4

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: N/KA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SGT [redacted] 91D b(6)-2	RELIEF SCRUB	Ø
ASSIGNED CIRCULATOR	CPT [redacted] 66E	RELIEF CIRCULATOR	Ø

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt on padded OR Bed, Head on Foam doughnut, LUE extended out to side ~~on~~ < 90° in CAP, secured to padded armboard c̄ Safety

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

COMMENTS: Strap, RUE extended out to side < 90° prepped into sterile field, Folded Towel under heels. Correct Body Alignment Maintained

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

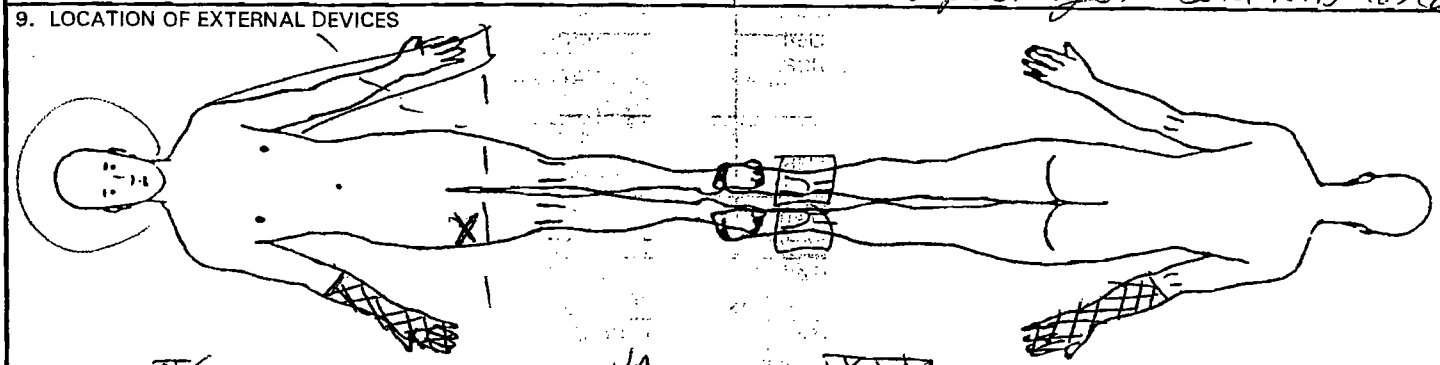
PREP SOLUTION *(Specify)* Betadine/Betadine

SITE: RUE BY WHOM: CPT [redacted]

SITE: (as below) BY WHOM: b(6)-2

COMMENTS: no pooling of solutions noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND TG X Ground Pad TG Safety Strap N/A = Tourniquet ▨ = prep

10. COUNTS — C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes	☒ No					
Needle Sharp	☒ Yes	☐ No	C		C	SGT [redacted]	CPT [redacted]
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ 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) ☒ YES ☐ NO

☒ ESU NO: R8B 105305 30/50 Blend 2 Spray

GROUND PAD: BRAND Valleylab Polyhesive II REM

LOT NO: 69441/2005-03

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

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

0.45 K-wire x1 from K-wire set CMS load# 0631206

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

0.9% NaCl - QS > 3000cc

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES [X] NO [ ] IF YES, SITE fluoro of RMF/Hand via C-arm

16. LABORATORY SPECIMENS

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

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

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

18. DRESSING/IMMOBILIZATION *(Specify)*

2x2 plain sponges Zeroform Gauze, Tubegauze.

19. ADDITIONAL INFORMATION

WC - IV

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

Anesthesia: Gen/Endo - MAJ [redacted] CRNA

Bovie pad site pre-op CDI - post-op CDI

20. OPERATION(S) PERFORMED

I+D + pinning of (R) MF

21. PATIENT TRANSFERRED TO PACU TIME 1235 METHOD gurney

b(6)-2

[redacted] OT/AW

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																			
POST-	DAY																		
MONTH-YEAR	DAY	14 Nov 03		15			16												
19	HOUR																		
PULSE (O)	TEMP. F (°)																		TEMP. C
	105°																		40.6°
180	104°																		40.0°
170	103°																		39.4°
160	102°																		38.9°
150	101°																		38.3°
140	100°																		37.8°
130	99°																		37.2°
	98.6°																		37.0°
120	98°																		36.7°
110	97°																		36.1°
100	96°																		35.6°
90	95°																		35.0°
80																			
70																			
60																			
50																			
40																			
RESPIRATION RECORD							100/62												
BLOOD PRESSURE		127/72	134/71				P 83												
							T 97.5												
HEIGHT:	WEIGHT →																		
		952	97%				SpO2 98												

(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.

b(6)-4

[redacted]

VITAL SIGNS RECORDS

Medical Record

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR NOVEMBER DAY 16 17 18 19 20

19 2003 HOUR 2 8 2 0 2

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

105° — 40.6°

180 — 104° — 40.0°

170 — 103° — 39.4°

160 — 102° — 38.9°

150 — 101° — 38.3°

140 — 100° — 37.8°

130 — 99° — 37.2°

98.6° — 37.0°

120 — 98° — 36.7°

110 — 97° — 36.1°

100 — 96° — 35.6°

90 — 95° — 35.0°

80

70

60

50

40

RESPIRATION RECORD 8 8 8 8 8

BLOOD PRESSURE 120/61 128/64 124/67 111/61 104/71 111/59 118/63 120/62

TEMP 98.8F 98.4 98.6 97.8

HEIGHT: WEIGHT TEMP 83 85

O2Sat 97% 99%(RA) 98% 96% 98% 99%

Source RA RA

O2Sat Source

pulse 85 pulse

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

EPW # [redacted]

b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

b(6)-2

Ward/Section: EMT	REQUESTING PHYSICIAN: Dr [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: 1316	DATE: 14 NOV 08 / TIME: 16:45	SSN/PSEUDO SSN: 1316

Hemoglobin/Hct

Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Color		N/A	RPR		Negative
App		N/A	Mono		Negative
Glu		Negative	Microbiology		
Bili		Negative	Source		
Ket		Negative	Gram Stain		
SG		N/A	Occ Bld		Negative
Bld		Negative	H. pylori		Negative
pH		N/A	Micro Parasites		
Prot		Negative	Malaria		
Urob		0.2-1.0	O & P		
Nit		Negative	Other		
Leuk		Negative	Microscopic Urinalysis		
HCG		Negative			

Spun Hematocrit		42-52% (M) 37-47% (F)	CSF	Blood Bank
Sed Rate			Cell Count	MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED
Other			Directigen	Negative	ABO/Rh

Coagulation Studies			Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)		
TEST	RESULT	REF. RANGE	UNIT	TYPE	CROSSMATCH
PT		9.8-13.6 secs			
APTT		21-34 secs			
D-Dimer		<500 ng/ml			
FDP		<10 ug/ml			

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

b(6) - 2

Ward/Section: EMT	REQUESTING [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: 1316	DATE: 14NOV03 / TIME: 1645	SSN/PSEUDO SSN: B16

(i-STAT)

TEST	RESULT	REF. RANGE
Na		135-146 mmol/L
K		3.5-4.9 mmol/L
Cl		99-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 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		3.5-5.5 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
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(2)-2

Microbiology Request Form

Preliminary Report

Last Name: [redacted]	Ward: ICW1
First Name: [redacted] b(6)-4	Room:
Patient # or SSN:	Bed:
	Physician:
Collected by: [redacted] b(6)-2	
Date: 14NOV03	Source: R hand wound
Time: 2030	Site: middle finger

Received by: rgc	Specimen #: W1216
Date: 14NOV03	
Time: 2120	

Preliminary Laboratory Results

no organisms seen (gram stain)

Reported	
Date: 14NOV03	
Time: 2140	
Tech: rgc	
Reviewer: [redacted] b(6)-2	Number of attached sheets:

Preliminary Report

MEDCOM - 24614

[redacted] b(2)-2

Microbiology Request Form

Last Name [redacted]
First Name: [redacted] b(6)-4
Patient # or SSN:

Collected by [redacted] b(6)-2
Date: 14 NOV 03
Time: 2030

Ward: ICW
Room:
Bed:
Physician:

Source: (R) hand. Wound
Site: middle finger

AEROBIC & GRAM STAIN

[redacted]

Received by [redacted]
Date: 14NOV03
Time: 2120

Specimen #: W 1210

Laboratory Results

No Growth

Reported
Date: 16 NOV 03
Time: 1000
Tech: IV [redacted] b(6)-2
Reviewer:

Number of attached sheets:

MEDCOM - 24615

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)	100	150	50
Fentanyl	50 µg/1 ml			
	( )			
	( )			
	( )			
	( )			
	( )			
VOLAT AGENT	Forane % del	3	2	1.5 1
	% e.t.			
AIR	L/Min			
N2O	L/Min			
O2 3	L/Min			

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

TOTALS	TOTAL EBL
	<5
	TOTAL URINE
	0

FLUIDS - SUMMARY
CRYSTALLOID- 600
COLLOID-
BLOOD-

FLUIDS

LINE site		
RL-100	☐ Warmed	100 RL
	☐ Warmed	600
	☐ Warmed	
	☐ Warmed	

LOSSES: EST BLOOD LOSS; URINE -

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: KG / LB

HEMATOCRIT:

INITIAL DATA:

BP- 111 / 64

HR- 106 98%

EQUIP CHECK

OK?- Y N

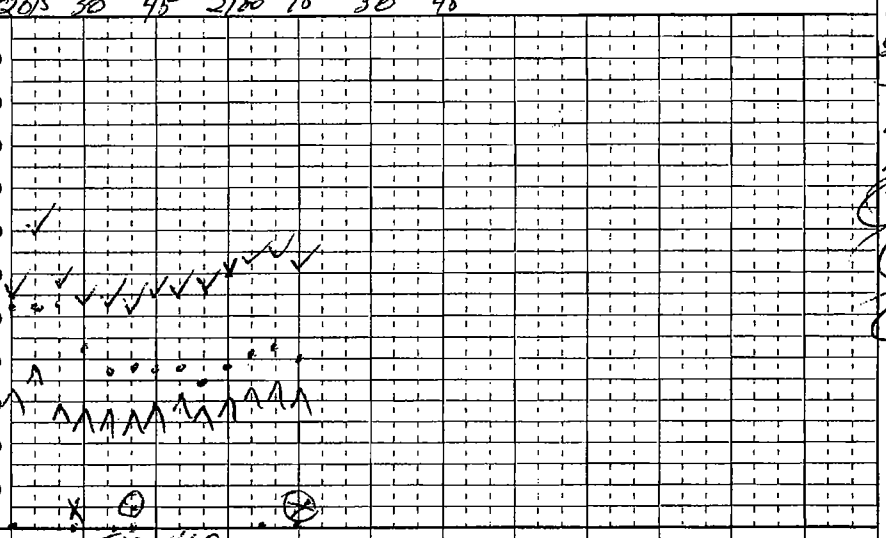
PATIENT RECHECK

OK for PROCEDURE?

TIME-

TIME → 2015 30 45 2100 15 30 45

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



VENTIL

VT - ml		510	460		
f - breaths/min		10	11	14	
Peak inf pres / PEEP		14	12	~~14~~	
MODE - S(pon), A(ssist), C(on)		CV	CV	AS	

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET-CO2 (torr)		40	42	48	
BP/oth	✓ FIO2 (Frac or %)		64%	63%	62%	
ART line	✓ SpO2 (%)		100	100	98	97
Steth- PC/ES	✓ ECG	ST	SR	SR	SR	
✓ Gas analyzer	TEMP-site					
	N-M Block (T/4)					
Warming blkt						
Conv warmer						

Mark with letters & symbols, explain under REMARKS — EVENTS Position: (1) (2) (3) (4) (5)

REMARKS

Code drugs with numbers, events with letters

(1) I/S Taken
(2) Induced w/ Fentanyl 100µgm Lidocaine 20mg Diprivan 160mg Anectine 60mg LMA inserted
(3) Procedure begun
(4) Procedure ended
(5) Breathing well, O2, LMA out
To recovery

RECOVERY AT
PACU ICU _____ (Specify)
OTHER
CONDITION: Stable
RESP- 16 SpO2- 97
BP- 122/73 HR- 79

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1951	2016	2114
PROC	Ready	Begin	End
	2037	2040	2107

PROCEDURES and CPT Codes: I&D (R) middle finger

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

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*: #5 LMA

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

#[redacted] D/W-4

SURG[redacted] D/W-2

[redacted] ANA

PROCEDURE LOCATION: OR

DATE: 14 Nov '03

PAGE 1 OF

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Iraqi ♂ PSH - IDrugs
① PMH NKDA

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)		1200													TOTALS
Fentanyl	(MCG)	50 100	100													250 mcg
Versed	(mg)	(5)														5 mg
propofol	(mg)	150	50													200 mg
	( )															
	( )															
	( )															
VOLAT AGENT	% del	2	3													
	% e.t.															
AIR	L/Min															
N2O	L/Min															
O2	L/Min	2	4	4												

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

TOTAL EBL: minimal

TOTAL URINE: Ø

FLUIDS - SUMMARY

CRYSTALLOID- 250 ml LR

COLLOID- Ø

BLOOD- Ø

FLUIDS

LINE site															
18GA (L) FA	☐ Warmed	LR	200												
	☐ Warmed														
	☐ Warmed														
	☐ Warmed														

LOSSES

EST BLOOD LOSS															
URINE -															

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 160 KG (LB)

HEMATOCRIT:

INITIAL DATA:

BP- 134/76

HR- 80

EQUIP CHECK

OK?- (Y) N

PATIENT RECHECK

OK for PROCEDURE? YES

TIME- 1140

TIME → 1200

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

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

VENTIL

VT - ml				
f - breaths/min				
Peak inf pres / PEEP	15	13	13	
MODE - S(pon), A(ssist), C(on)	SV	AV	SV	

MONITORS/ACCESSORIES

☒ BP/Auto Cuff	☒ ET CO2 (torr)	+	40	42	
BP/oth	☒ FIO2 (Frac or %)	60	60	60	99
ART line	☒ SpO2 (%)	98	99	99	
Steth- PC/ES	☒ ECG	SR	SR	SR	
Gas analyzer	TEMP-site	Axilla			
	N-M Block (T/4)				
Warming blkt	Room warmed				
Conv warmer					

Mark with letters & symbols, explain under REMARKS — EVENTS / Position → Supine (B) arms <90° abducted (+) Pneumatic tourniquet

REMARKS

Code drugs with numbers, events with letters

1100 #13/16
NPO > 10 hours
NKDA.

1135 O2 Rx
Monitors
1140 IVA
placed sincerely
1205 IVA removed
responding to
tactile stimulation
OTOT Rx
1206 90mm OPA
placed
1210 Report to
SSG Irby LPN
133/62 P74
R 22 T 94.5
PARG - 2 moved
- 1 airway
- 1 loc
1215 OPA
Removed by pt.

RECOVERY AT: PACU

(PACU) ICU 1200 (Specify)

OTHER

CONDITION: 94.5

RESP- 22 SpO2- 99%

BP- 133/62 HR- 74

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1120	1135	1215
	Ready	**Begin**	**End**
PROC	1140	1155	1200

PROCEDURES and CPT Codes:
I+D (R) middle finger

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
GAC IVA #4

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

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
ECG, Mask ventilation, Eyes taped closed.

[redacted] b(6)-2

[redacted] MAJ/CRNA

PROCEDURE LOCATION: OR#7

DATE: 16 Nov 03

PAGE 1 OF 1

MEDICAL RECORD - ANESTHESIA

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

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

DRUG (Units)			TOTALS	TOTAL EBL
Fentanyl / 50μg/cc	100			<25
( )				
( )				TOTAL URINE
Norcuron 1mg/cc				—
( )				
( )				
VOLAT AGENT Forane % del	3-2.25-1.5-1-1			FLUIDS - SUMMARY
% e.t.				CRYSTALLOID- 250
AIR L/Min				
N2O L/Min				COLLOID-
O2 3 L/Min		————————		
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS →				BLOOD-

FLUIDS

LINE site	Warmed	
RL 950	☐ Warmed	|-------------- (250)
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES — EST BLOOD LOSS; URINE -

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: KG / LB

HEMATOCRIT:

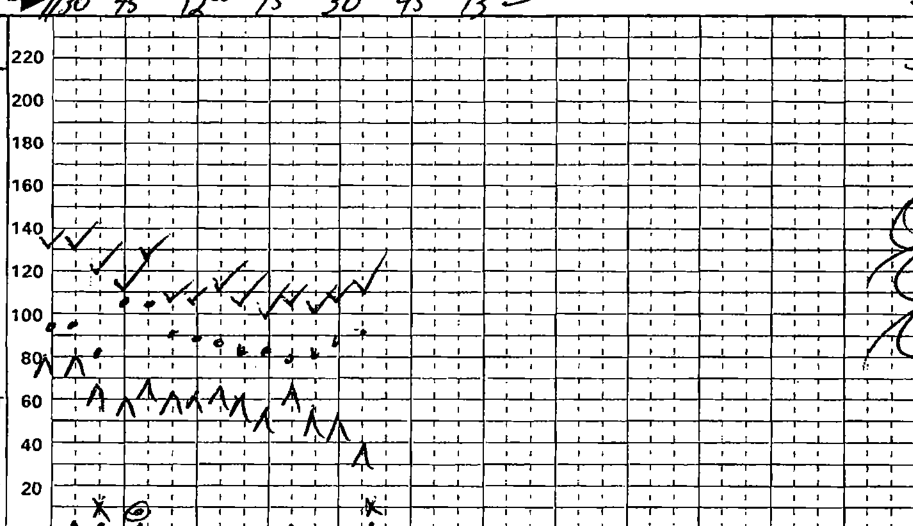
INITIAL DATA: BP- 130/79; HR- 94 96%

EQUIP CHECK — OK?- Y N

PATIENT RECHECK — OK for PROCEDURE? TIME-

TIME → 1130 45 1200 15 30 45 1300

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



REMARKS

Code drugs with numbers, events with letters

(1) V/S Taken
(2) Inducted c Lidocaine 20mg, Diprivan 160mg, Anectine 80mg, O2, Forane, LMA #4
(3) Procedure began
(4) Procedure ended
(5) NARCAN 0.4 O2, breathing
TO recovery

VENTIL

VT - ml		680	720
f - breaths/min		8	8
Peak inf pres / PEEP		14	14
MODE - S(pon), A(ssist), C(on)		CV	CV

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)		34	32
BP/oth	✓ FiO2 (Frac or %)		85	86
ART line	✓ SpO2 (%)	96	99	99
✓ Steth- PC/ES	✓ ECG		SR	SR
✓ Gas analyzer	TEMP-site			
	N-M Block (T/4)			
Warming blkt				
Conv warmer				

Mark with letters & symbols, explain under REMARKS — EVENTS Position: (1) (2) (3) (4) (5)

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

CONDITION: Stable

RESP- SpO2- 97

BP- 110/37 HR- 72

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1102	1124	1237
	Ready	Begin	End
PROC	1138	1148	1220

PROCEDURES and CPT Codes: W/O (R) Middle Finger c Pinning

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

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

[redacted]

b(6)-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* — #4 LMA

[redacted] b(6)-7

CRNA

PROCEDURE LOCATION: OR

DATE: 18 Nov 03

PAGE 1 OF

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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 1		

DATE OF ORDER 11-14-03 TIME OF ORDER 1630 HOURS

LIST TIME ORDER NOTED AND SIGN

- Admit ICW-1 Dr. [redacted]
- Stable
- Continue tests
- Bath or assist pt ≈ bath today
- IVF D5 1/2 NS @ 100 cc/hr
- Percocet 2 po q4hr

[redacted] b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

- Demerol 50 mg IV q4hr PRN breakthrough
- Phenergan 25 mg IVP q6hr PRN nausea
- Ambien 10 mg po q HS PRN
- NPO

[redacted] b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.
	[redacted]	

DATE OF ORDER 14 NOV 03 TIME OF ORDER 2100 HOURS

1. to ICW-1
2. S/P I+D (R) middle finger
3. US routine
4. VP 60 L/B per GPW routine
5. Nebulizer diet
6. IV-LR at 125 cc/hr. Heparin lock when tolerated PO
7. Ancef 1 Gram IVPB Q 8 hrs
8. Gentamicin 350 mg IVPB Q 24 hrs
9. Percocet 1-2 P.O. Q 4-6 hrs PRN
10. Tylenol 650 mg P.O. Q 4 hrs PRN
11. Phenergan 25 mg IVP Q 6 hrs PRN nausea
12. Ambien 10 mg P.O. Q HS PRN
13. NPO after midnight 15 Nov for OR 16 Nov 03

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

[redacted] b(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
b(6)-4 [redacted]				15 Nov 03	1650 HOURS	
				(1) NPO after midnight for OR tomorrow		
				b(6)-2 [redacted]		
NURSING UNIT [redacted]		BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
[redacted] b(6)-4				16 Nov 03	1200 HOURS	[redacted]
				(1) Resume Preoperative orders		
				(2) Regular diet		
				(3) NPO after midnight 17 Nov for OR 18 Nov		
NURSING UNIT	ROOM NO.	BED NO.		(4) Keep lock IV when taking PO Nov 23/24		
ICW						
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER [redacted]	
				b(6)-2 A1		
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

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

MEDICAL RECORD - DOCTOR'S ORDERS

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

DIRECTIONS: The provider will DATE, TIME, and SIGN each order or set of orders recorded. Only one order is allowed per line. Nursing will list the time the new order(s) are noted and initial in the column provided. Orders completed during the shift in which they were written do not require recopying. They may be signed off, as completed, in the far right column.

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
	POST ANESTHESIA ORDERS (circled Items)		
1	VS q 5 min X 15 min, then q 15 min until discharge.		
2	Supplemental oxygen. PRN		
3	Morphine / ~~Meperidine~~ 2-3 mg IV now and 2-3 mg q ~~3-5~~ 5-10 min prn pain for a		
	max dose of 10 mg.		
4	Zofran_____mg IV prn N/V q 15 min, may repeat x _____.		
5	Metoclopramide_____mg IV prn N/V x 1.		
6	Droperidol_____mg IV prn N/V x 1.		
7	Phenergan 25 mg IV prn N/V x 1.		
8	Benadryl 25-50mg IVP q1 hr prn, itching while in PACU.		
9	IVF: RL @ 125 cc/hr.		
10	Discharge from recovery status when PACU discharge criteria met.		
	[redacted] CRNA		
	Ondansetron 75 mcg IVP Q 3 hrs prn		
	[redacted]		
	b(6)-2		

PATIENT IDENTIFICATION

Complete the following information on page 1 only. Note any changes on subsequent pages.

Diagnosis: _____

Height: _____ Weight: _____ Diet: _____

Allergies: _____

Nursing Unit	Room No.	Bed No.	Page No.
PACU, 28th CSH			1 of 1

MEDICAL RECORD - DOCTOR'S ORDERS

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

DIRECTIONS: The provider will DATE, TIME, and SIGN each order or set of orders recorded. Only one order is allowed per line. Nursing will list the time the new order(s) are noted and initial in the column provided. Orders completed during the shift in which they were written do not require recopying. They may be signed off, as completed, in the far right column.

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS 11/18/03 1315	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
	POST ANESTHESIA ORDERS (circled Items)		
1	VS q 5 min X 15 min, then q 15 min until discharge.	[redacted] 11/18/03 1315	[redacted] 1315
2	Supplemental oxygen. PRN 5-0	[redacted] 1315	[redacted]
3	Morphine / ~~Meperidine~~ 4 mg IV now and 2-3 mg q ~~2-3~~ min prn pain for a	[redacted] 11/18/03 1315	[redacted] 1315
	max dose of 10 mg.		
4	Zofran_____mg IV prn N/V q 15 min, may repeat x _____.		
5	Metoclopramide_____mg IV prn N/V x 1.		
6	Droperidol_____mg IV prn N/V x 1.		
7	Phenergan_____mg IV prn N/V x 1.		
8	Benadryl 25-50mg IVP ql hr prn, itching while in PACU.		
9	IVF: LR @ 100 cc/hr.	11/18/03 1315 [redacted]	11/18/03 1317 [redacted]
10	Discharge from recovery status when PACU discharge criteria met.		
	[redacted]		

PATIENT IDENTIFICATION

#[redacted]

b(6)-4

Complete the following information on page 1 only. Note any changes on subsequent pages.

Diagnosis: _____

Height: _____ Weight: _____ Diet: _____

Allergies: _____

Nursing Unit	Room No.	Bed No.	Page No.
PACU, 28th CSH			1 of 1

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION b(6)-4 [redacted]

DATE OF ORDER 18 NOV 03 TIME OF ORDER 1220 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Resume previous order
(2) Regular diet
(3) Heparin lock IV when taking P.O. well; IV at 125 cc/hr.

b(6)-2 Noted [redacted]

NURSING UNIT [redacted] BED NO.

PATIENT IDENTIFICATION 2400 - 0200 DATE OF ORDER NOV TIME OF O[redacted] HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION DATE OF ORDER TIME OF ORDER HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION DATE OF ORDER TIME OF ORDER HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

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
b(6)-4 [redacted]				20 MAY 03	1120 HOURS	
			1	DISCHARGE TO EPW CAMP		
			2	LEVAQUIN 250 MG P.O. QDAY		
			3	FOLLOW-UP 1 WEEK		
NURSING UNIT		BED NO.				[redacted]
				24 0 ✓ 0800 DINNER		
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER b(6)-2	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

b(6)-4 [redacted] b(6)-2 [redacted] 1130

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

b(6)-2

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 11 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 14	15	16	17	18	19	20	21	22				
11/14	[redacted]	Routine Vitals	06 18	[redacted]												
			18 06													
11/14	[redacted]	Bath or assist pt	06 18	[redacted]												
		c̄ bath today	18 06													
11/14	[redacted]	NPO	06 18	[redacted]												
			18 06													
14	[redacted]	up ad lib per EPW	6	[redacted]												
		bottled	18													
11/18	[redacted]	Reg diet	6													
			18													

SDC ONE TIME ORDER

DC'd

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (SPHD MF) Shrapnel Wound (RHA & (R) 3rd Finger

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

b6-2A11

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo Nov Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
11/14	[redacted]	Admit ICW-1 - Dr Allerton	11/14			
11/14	[redacted]	Stable	11/14	noted		[redacted]
14	[redacted]	NPO p MN 15NOV for OR 16NOV	11/15	2359		[redacted]
15 NOV	[redacted]	NPO pMN for OR tom	16 NOV	0001		[redacted]
16 nov	[redacted]	Resume previous Orders	16 nov	noted		[redacted]
16 nov	[redacted]	NPO p mn 17 nov for OR	17 NOV	2400	—	[redacted]
	[redacted]	18 nov	/	/	/	[redacted]
18 NOV	[redacted]	Resume previous orders	18 NOV	—	—	[redacted]
20 NOV	[redacted]	D/C to EPW camp - F/U 1 week				

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

USAPA V1.00

b(6)-2

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo/ 11 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 14	15	16	17	18	19	20	21	22
11/14	[redacted]	IVF D5½ NS @ 100cc/h	[redacted]			D/C						
			20 06									
14/18	[redacted]	LR @ 125cc/hr	6	[redacted]								
		AL when tol po.	18									
14	[redacted]	Ancef 1 gm IVPB										
		Q8°										
14	[redacted]	Gentamycin 350mg	10	[redacted]								
		IVP QD										
14	[redacted]	Ancef 1 gm IV Q8°	6	[redacted]								
			14									
			22									
1												

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Phagnal Wound (RFA & (R) 3rd Finger

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

EPW # [redacted]

b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
11/16	[redacted]	keep heplock IV when taking	11/16	noted		[redacted]
		p.o. well				
20 NOV	[redacted]	levofloxacin 250mg po qday	20 NOV	Rx to pha		[redacted]
		D(c) - 2 A11				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
11/14	[redacted]	Percocet 11 po	Date	21NOV												
		q 4° prn	Time	1000												
			Dose													
			Initials													
			1/E													
11/14	[redacted]	Phenergan 25mg														
		IVP q 6° prn														
		nausea														
11/14	[redacted]	Ambien 10mg														
		po q HS prn														
14	[redacted]	Tylenol 650mg po	D4													
		q4° prn	D/1													

USAPA V1.00

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 14 NOV 03
Time In: 2127
Allergies: NKA
Pre-op V/S: _____
Procedures: I&D R) hand

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

OR Intake: Crystalloid _____ Colloid _____
OR Output: UOP _____ EBL _____
Meds/Times: _____

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds, History

Time	2127	2135	2212	2225												
SaO2	99	99	99	100												
FiO2																
Methods	RA	RA	RA	RA												
240																
220																
200																
180																
160																
	V	V														
140				V												
			V													
120																
	•															
100																
	^	^	^	^												
80																
60																
40																
20																
RR	10	14	16	14												
T	99															
Time																
Pain (0-10)																
LOS																

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: _____ Labs: _____

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	/	/	/
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	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 (Signature & Title) SGT [redacted] 9/C20

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 14 NOV 03

PATIENT'S IDENTIFICATION (For 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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
2130		Shivers Demerol 25mg	IVP		E	[redacted]

NEUROVASCULAR

Time 2112	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(R) hand	Limited	+	P	B	C	WNL
15'	(R) hand	Limited	+	P	B	C	WNL
30'	(R) hand	Limited	+	P	B	C	WNL
45'							
60'							
90'							
D/C	(R) hand	Limited	+	P	B	C	WNL

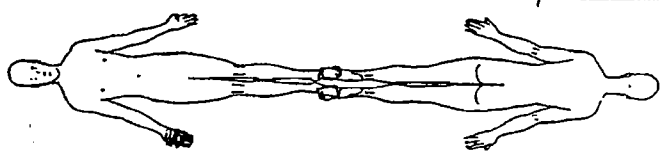
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 2121	(R) hand	Gauze	Ø
30' 2145	(R) hand	Gauze	Ø
60'			
D/C 2200	(R) hand	Gauze	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
2112	NSR	Ø	Ø

NURSING NOTES

21 15 Admitted from OR via gurney VSS - Alert x3. IV of LR to (R) FA is patent Perrl @ 4mm - HR - NSR S1S2 - Lungs CTABL resp even reg. BS (+) x4 quads - Pedal pulses +2 Radial +2 CMS >3 sec. color WNL Skin cool, DRSG of Gauze to (R) C/D/I. Ø c/o Pain or discomfort to (R) hand. Demerol 25mg IVP given for shakes, was effective in few minutes. -SG [redacted] 9/C20 b(6)-2

Discharge Criteria:
Date: 14 NOV 03 Time: 2200 PARS: 10
BP: 141/87 T: HR: 93 RR: 19 Sa02: 98
Pain Level at D/C (0-10): Ø
Intake: rock h2o Output: Ø
Additional Data: Ø
Transferred To: 1CW #1
Report Given To: SPL [redacted]
Transferred Via: W/C [redacted] Ambulance
Transferred By: SG [redacted] #C20
Cleared IAW Recover[redacted]
Charge Nurse Signatu[redacted] b(6)-2

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

LMA

OTSG APPROVED (Date)

Date: 16 Nov 03
Time In: 1210
Allergies: NKDA
OR Intake: Crystalloid 200 LR Colloid
Pre-op V/S: 134/76 80
OR Output: UOP Ø EBL min
Procedures: IND Ø made Eye
Meds/Times:

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

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds

History

Time	1210	1215	1220	1225	1240
SaO2	99	99	97	98	
FIO2	RA	6L	12 RA	RA	
Methods					
240					
220					
200					
180					
160					
140					
120	✓	✓	✓	✓	
100					
80					
60					
40					
20					
RR	22	20	24	22	20
T	97.4				

Time									
Pain (0-10)									
LOS									

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused

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	Ø	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	6	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

PREPAR[redacted] b(6)-2 SSG/CPN

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 16 Nov 03

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

[redacted]

b(6)-4

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

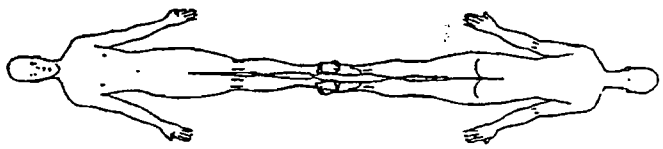
MEDICATIONS						
Allergies:						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

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

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

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

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



PACU OUTPUT			
Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

male Iraq admitted to PACU S/P ZID @ middle finger PSD, 95% RA. VSS Able to speak denies pain "Hole" IVLR @ TKO @ Arm @ DSD's CDI. — [redacted] SSG/CPM Gentamycin [redacted] OR — [redacted] SSG/CP. b(6)-2

Discharge Criteria:
Date: 16 NOV 03 Time: 1240 PARS: 10
BP: 135/91 T: HR: 95 RR: 20 Sa02: 98% RA
Pain Level at D/C (0-10):
Intake: <100 cc Output: Ø
Additional Data:
Transferred To: ICW [redacted]
Report Given To: Maj [redacted]
Transferred Via: W/C [redacted] Ambulance
Transferred By: SSG [redacted] b(6)-2
Cleared IAW Recovery Room [redacted]
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: 11/18/03 Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block

Time In: 1235

Allergies: 130/ OR Intake: Crystalloid 200 cc Colloid

Pre-op V/S: 137/75 OR Output: UOP EBL 100 cc

Procedures: ZTD Bunionectomy Meds/Times:

Accient Ropivacaine 1 Percent

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

Pre Op Meds / History

Time	1230	1240	1245	1300	1315	1245
SaO2	94%	96	90	100	98	98
FiO2	RA	RA	RA	RA	RA	RA
Methods						
240						
220						
200						
180						
160						
140						
120						
100						
80						
60						
40						
20						
RR	20	22	24	19	19	20
T	96.4				97.2	

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
1235	RC	1000	RA	[redacted]	100 cc

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	1	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	6	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 (S [redacted] b(6)-2

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 18 Nov 03

PATIENT'S ID [redacted] first, middle; grade; date; hos [redacted] Name – last,

[redacted]

b(6)-4

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

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

USAPPC V2.00

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1325	6	4mg morphine	IV			

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
	(R) HAND						
Adm	(R) middle finger	Limited	+		DSA	C	Pk
15'							
30'	(R) hand	+	+	P	DSA		Pk
45'	(R) middle finger	Limited	Limited				
60'							
90'							
D/C							

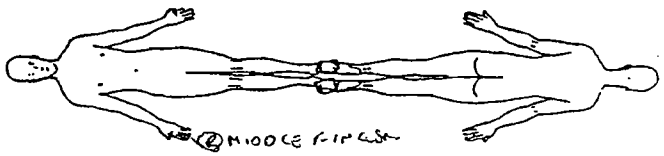
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 1235	(R) middle finger	knuckle	+
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1235			

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1235	S, R, +	No	

NURSING NOTES

1235 Male Iraqi admitted to PACU S/P ZHD (R) middle finger

1240 Pt in gurney, encouraged to cough and deep breathe. Pt alert and responsive to verbal and tactile stimuli. Pt has diminished chest noise and lung sounds clear. Bowel sounds present to 4. Radial pulses and pedal pulses present. No other signs of injury.

1255 Pt alert and response to verbal [redacted] b(6)-2

1325 Pt complained of pain. Medicated IVP 4mg Morphine, able to rest quietly.

1345 Pt able to rest quietly. No complaints at present. DSA on (R) middle finger dry. VS stable - Transferred on gurney to TCWI [redacted] b(6)-2

Discharge Criteria:
Date: 11/18/03 **Time:** 1345 **PARS:** 10
BP: 125/73 **T:** 97.6 **HR:** 89 **RR:** 19 **Sa02:** 97%
Pain Level at D/C (0-10): 0
Intake: 100 cc. **Output:** 0
Additional Data: —
Transferred To: TCWI
Report Given To: SPC [redacted]
Transferred Via: [redacted] Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Recovery [redacted]
Charge Nurse Signature: [redacted] b(6)-2

WAMC OP 173-E

Admission and Coding Information

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

1. Reporting MTF [redacted]	2. MTF Location IZ b(4)-4			
3. Register Number [redacted]	Name (Last, First, MI)		4. Pay Grade FGN	5. Sex M
6. DoB (YYYYMMDD) 1981-08-06	7. Age at Admission 22Y	8. Race X	9. Ethnicity 9	Religion
10. Length of Service	ETS	11. FMP 20	12. Social Security Number [redacted] b(4)-4	
Organization (Active Duty Only)		13. Marital Status	Hour of Admission 15:50	Branch / Corps:
14. Flying Status	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES		16. Zip Code of Residence:	
17. Unit Location	18. MOS	19. Trauma BC	Prev. Admission NO	
20. Source of Admission Direct from ER	Ward: ICW1	Name / Relationship of Emergency Addressee		
		Address of Emergency Addressee		
Name and Location of Medical Treatment Facility: [redacted] b(2)-2		Telephone Number of Emergency Addressee		
21. Type of Disposition TRF-OTH	22. MTF Transferred To 0607	23. Date of Disposition (YYYYMMDD) 2003-11-22		
24. Clinic Svc - Admitting AEA - ORTHOPEDICS	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-11-14		
27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission 2003-11-14		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: S/P HD MF SHRAPNEL WND R FA AND R 3RD FINGER

Procedure Narrative(s):

Cause of Injury Narrative:

Dx 81610 Proc 8604K
87261 7859
9032 Trauma 9
9553 Inj 599
09K

b(4)-2

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

Automated Facsimile - DA FORM 2985, MAR 2000

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

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

1. Register Nbr	2. Name	3. Grade	Admission Remarks
[redacted]	[redacted]	FGN	

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

11. FMP	12. SSN	13. Organization	14. Ward
20	[redacted]		ICW1

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

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	15:50	AEA - ORTHOPEDICS

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	TRF-OTH	2003-11-22

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-11-14	[redacted]

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
[redacted] b(2)-2	2003-11-14	

31. Selected Administrative Data

Marital Status: DoB: 1982-09-04

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

R ELBOW FX

812.43
958.3
E993

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	9	9

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	9	9

Signature of Attending Medical Officer [redacted]

b(6)-2

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

2/10 Dmg: 07 got exploded by IED 10 days ago. Originally treated at Iraqi hospital & then tx to Prem Care.

PMHx: -
PSHx: -
MOS 5
Allergies -

PHYSICAL EXAMINATION

HEENT: WNL
Chest: CTA
CVS: S1
Ext: (R) arm. non limited (ext/flex) by pain. b(6)-2
2 medial wounds, 1 lateral wound, serosanguinous drainage.
Ulnar nerve palsy

Rt: deep laceration medial condyle Ft
[redacted]

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

(A) Open (R) medial elbow epicondyle Ft (10 days out)
(P) Admit. IED, OR

b(6)-2

SIGN [redacted]	DATE 11-14-03	IDENTIFICATION NO	ORGANIZATION
PATIENT [redacted] *(Surname, middle initial, grade, date, hospital or medical facility)*		REGISTER NO	WARD NO

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FPMR 41 CFR 201-45.303

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13 Nov Cont'd	3) Evac to 2ND CSH in a.m. → ortho eval.
	4) Tylenol 325g 1-2 tabs @ 4-6h
	5) Motrin 800 → PO TID 10F
	6) Seen 2 Dr [redacted] → ER Physicians [redacted] b(6)-2
	b(6)-2 USA PMC

STANDARD FORM 600 (REV. 6-97) BACK

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	Fasciitis & Myositis infected, granulation wound, exhibiting charcoal packed appearance. Other exposed sharp Muscle debrided, closed with 6 sutures via prolene lavage Cultures taken Plan: DC wound w/ gentamycin Repeat I&D in 48 hrs. b(6)-2 [redacted]
15 NOV 03 1739	Assume care of PTO 0600. VSS, AOx3. went to surgery this afternoon for elbow. C/O ø pain. ⊖ new orders. Ambulate to bathroom without any assistance. In 2pt restraint without any skin breakdown. Splint on (R) elbow still intact, ø signs of bleeding. Will continue to monitor. b(6)-2 [redacted]
15 NOV 03 2000	VSS. AOO. OOB → AMB to BR. (R) UE c̄ splint + covered c̄ Ace wrap which is dry + intact. Radial (R) pulse +2. Capillary refill brisk to (R) fingers. Denies numbness/tingling to (R) UE per interpreter. +2 restraints applied without compromise circulation or skin integrity. Will continue care as planned. b(6)-2 [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
14NOV03	(1735) Pt admitted to unit from EmT, ambulatory, in stable cond. Pt alert, speaking Arabic. VSS. Ø c/o pain. Drsg/splint to RUE CDI. Pt able to move fingers. Shrapnel wounds noted on @ side of back and RLE. Ø sisx infection. Pt assisted c̄ bed bath. IVFs infusing into IV in @ forearm c̄ sisx infection/infiltration. Pt aware of NPO status. 2 point restraints in place c̄ s/s ~~infections~~ complications. Will continue to monitor. b(u)-2 [redacted] JAN
15NOV03	(0300). VSS. Ø c/o pain. Pt NPO for surgery in AM. (R) elbow in splint + wrapped. (+) pulse in (R) hand. Brisk cap refill. Pt able to move fingers. IVFS infusing into (L) FA. b(u)-2 [redacted] JAN
15NOV03	Pre-Op Dx: Infected (R) elbow medial epicondyle fracture Post-Op Dx: Same Procedure: 24615 (R) elbow. [redacted] b(u)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10
USAPA V1.0(