IN...IENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER (b)(6)-4	2. NAME (Last, First, MI) OD (b)(6)-4					3. GRADE —	ADMISSION REMARKS
4. SEX M	5. AGE —	6. RACE —	7. RELIGION muslim	8. LENGTH OF SVC —	9. ETS —	10. PREVIOUS ADMISSION —	
11. FMP 99	12. SSN (b)(6)-4		13. ORGANIZATION Iraqi Civilian			14. WARD IW1	
15. FLYING STATUS —	16. RATING/DSG —	17. DEPT./BEN —	18. BRANCH/CORPS —	19. UIC/ZIP —		20. TYPE CASE Inj	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Transfer				22. HOURS OF ADMISSION 1715	23. CLINIC SERVICE ABAA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE —			25. TYPE DISPOSITION Inj		26. DATE OF DISPOSITION 1 APR 03		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) —			27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION 30 mar 03		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1 IRAQ					30. DATE OF INTIAL ADMISSION		32. UNITS OF WHOLE BLOOD/COMPONENT TRANSPUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Anoxic encephalopathy - ~~348.3~~ 348.1

S/P GSW To (R) Leg S/P Traumatic Amputation

891.0 E991 84.15

897.4

Trauma	Inj
~~9~~	450
0	

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
3	3				3

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER (b)(6)-2 MH

SIGNA (b)(6)-2

DA FORM 3647 MAY 79

(b)(6)-2 MC

MEDCOM - 3773

INI ENT TREATMENT RECORD COVER SHEET

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

1.	2. NAME (Last, First, MI)		3. GRADE	ADMISSION REMARKS
(b)(6)-4	OD (b)(6)-4		—	
4. SEX / 5. AGE / 6. RACE	7. RELIGION	8. LENGTH OF SVC / 9. ETS	10. PREVIOUS ADMISSION	
M / — / —	Muslim	— / —	—	
11. FMP	12. SSN	13. ORGANIZATION	14. WARD	
99	(b)(6)-4	Iraqi Civilian	ICU	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
—	—	—	—	—	Inj
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION		22. HOURS OF ADMISSION	23. CLINIC SERVICE	
Transfer		1715	ABAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE		25. TYPE DISPOSITION	26. DATE OF DISPOSITION	
—		~~BAT~~ DOW	1 APR 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)		27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
—			~~30~~ Mar 03	
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY			30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1 IRAQ				

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Anoxic encephalopathy - 348.3

S/P GSW To ® Leg S/P Traumatic Amputation

891. E991 84.15

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a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
3	3				3

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER (b)(6)-2 MH

SIG (b)(6)-2

DA FORM 3647, MAY 79 EDITION OF 1 AUG USAPPC V1.10

(b)(6)-2

MEDCOM - 3774

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
29MAR03 1010Z	BRIEF OP NOTE: TRANSFER NOTE
	PROCEDURE: (R) LE TRAUMATIC AMPUTATION - I&D - MULTIPLE SHRAPNEL INJURIES (R) LE. (R) UE (L) PNEUMOTHORAX → CHEST TUBE
	PRE-OP DIAGNOSIS: (R) LE DISTAL FEMORAL CONDYLAR COMMINUTED AMPUTATION WITH PROXIMAL COMMINUTED FEMUR FX
	POST-OP DIAGNOSIS: SAME
	SURGEON: (b)(6)-2 ASSISTANT: (b)(6)-2
	EBL: 500 cc
	FLUIDS: 5000 cc, 1 UNIT PRBC's.
	UOP: 200
	TT: NONE
	POST-OP PLAN: REPEAT I&D; MAY NEED HIP DISARTICULATION AT NEXT LEVEL OF CARE - BASED ON DEGREE OF INJURY @ HIP LEVEL (UNABLE TO OBTAIN FILMS HERE). EVAC TO BAU CARE WITH STABLE (CSH)
	(b)(6)-2 UNIT MAC (b)(3)-1 COR

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
		LRMC

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.

LOG#:
SSAN#:
NAME:

(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

3-29-03

Pt EPW ī wound to (R) leg S/P (R) lower limb above the Knee Amputation. Patient stable during case. Noted difficulty ī oxygenation post op noted (L) Pneumothorax. Chest tube placed. 2 units of blood received. 2nd unit given after hypotensive episode sudden lost of pulse post unit transfusion? air embolism, coded ī response to epinephrine. Repeat FAST of Abdomen Neg. for free fluid. Noted SP changes in monitor. Transport to next echelon of care.

(b)(6)-2

(b)(6)-2 M.D., FACS (b)(6)-2

MAJ, MC, USA
General Surgeon

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
30 MAR 03 1015	PT TRANSFERED TO ICU 2 FROM [(b)(3)-1] PT SEDATED C ET TUBE IN PLACE, PT SPONTANEOUSLY BREATHING ON HIS OWN. RESP SUCTIONED THE PT, CLEARING A COPIOUS AMOUNT OF THICK WHITE SPUTUM, PT CONECTED TO VENT AND SETTINGS CONFIRMED C SSG [(b)(6)-2] VSS, SPO2 @ 99% C 10L VBM VENT, LUNGS SOUNDS RHONCHI AND RALES BILATERALLY, SINUS TACHY, ABDOMEN LARGE FIRM AND DISTENDED. (L) CHEST TUBE CONNECTED TO 20 cm WALL SUCTION, PLEU-EVAC TURNED IN TRANSPORT THEREFORE TOTAL OUT PUT MARKED IN ALL CHAMBERS. (L) HAND 18g C LR @ 120cc/0 LR. (R) FA GSW, 2 cm ENTRY WOUND & 2cm EXIT WOUND, +3 EDEMA IN (R) HAND AND WRIST. DOPPLER RADIAL PULSE, DRSNG Δ AND ARM ELEVATED. (R) SHOULDER SHRAPNAL INJURY DRSNG Δ, FOLEY TO GRAVITY DRAINING CYU. (R) AKA, STUMP DRSNG MODERATELY SATURATED, C SEROSANGUINEOUS DRAINAGE (R) FOOT DOPPLER PULSE. WILL CONTINUE TO MONITOR THE PT [(b)(6)-2]
30 Mar 03 1115	Resp Care Note pt. on mech vent as ordered, all settings checked & set properly All alarms set & working. Ambu bag @ bedside. BSS coarse SXN lg. thick white/yellow secretions. Vent Settings SIMV RR 12, V_T 750, Peep 5 cmH_2O, PIP 35, Exhaled V_T 747 mL, FIO_2 1 L/min Bleed in. SpO_2 96% [(b)(6)-2]
	NG IN (L) NARE NOT CONNECTED TO SUCTION. SGT [(b)(6)-2] 9/WMG
	1230 - 20G HEPLOCK PUT IN (L) UPPER FOREARM. SGT [(b)(6)-2] 9/WMG
~~1300~~	~~Pt. remains on mech vent~~ MG 1340 - 800cc CLEAR YELLOW URINE OUTPUT. Hct 21%, HB 7g/dL, PH 7.365, PaO_2 37.9 PO_2 93, 14/0 PT. PULSE TACHYCARDIA 500cc LR BOLUS GIVEN (R) AMPUTATION SITE DRESSING REINFORCED AND DR. NOTIFIED.
	SGT [(b)(6)-2] 9/WMG

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

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

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3/30/03 15:50	Resp Care Note: Vent settings ↓ RR 8, V_T 800 mL, Peep 5 cm H_2O, FIO_2 1/min Bleed in. PIP 38 cm H_2O, BBS Coarse soon small thick yellow secretions SpO_2 98%. (b)(6)-2 SIVSN
3/30/03	1615 - 1ST UNIT OF PRBC's STARTED WILL CONTINUE TO MONITOR PER TRANSFUSION PROTOCOL, SGT (b)(6)-2 SIVSN LPN 1825 - 1ST UNIT PRBC's FINISHED NO REACTIONS 1835 - 2nd UNIT PRBC's STARTED WILL CONTINUE TO MONITOR. 1845 - OUTPUT TOTAL - 1900 cc FOLEY FOR SHIFT. IV INTAKE 1850cc TOTAL FOR SHIFT. — SGT (b)(6)-2 SIVSN LPN

STANDARD FORM 600 (REV. 6-97) BACK

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
3-31	cont → @ 18g started - LR @ 125/HR, NEO at 50cc/HR @ FA decr for inhalers. P - monit B/P - Drsg c's CVL to eyes [redacted] SSG MS
3/31/02 1000	Resp Care Svc Note. Vent settings SIMV RR 10, Vt 800, Peep 5cm H2O FIO2 1/min Bleed in. HR 133, Ex Vt 791 PIP 29cm H2O Mean 14 cm H2O. SxN scant white secretions. [redacted]
3/31/02 1240	Resp Care Note: Vent settings: Mode SIMV, RR 10, Vt 800ml Peep 5 cm H2O, FIO2 2/min Bleed-in, PIP 29 cm H2O, Mean 14cm H2O HR 128, SpO2 98%. SxN scant yellow secretions. [redacted]
3/31/02 1330	pt care done, changed all dressing, foul smelling odor to stump smells like pseudomonas. IV LR @ 125/HR + NEO @ 110 MIC/MIN MAP ~~SBP~~ between 60-70, PAP between 24-30. [redacted] SSG MS
3/31/02 1520	Respiratory Care Note. Pt vent settings: Vt 800, SIMV RR 10 peep 5cm H2O, FIO2 2% bleed in. PIP 30, mean 15, Vte 298 mL. SxN scant thick white/yellow secretions. [redacted]
3-31/03 1535	Currently map between 58-62 - NEO @ 155 MIC/MIN, ST @ 140's MAP GS approx 200/HR, Pupils fixed, Reported to [redacted]
3-3/ 1630	NEO T 160 MIC/MIN, ST, GCS 1, map 60's, [redacted] LR bolus. [redacted] aware, Tmt to effect [redacted]
3/31 1745	↓ B/P 59/33 MAP 44 @ 190 MIC/MIN NEO, Report to [redacted]
3/31 1800	MD [redacted], cont aggressive measures per [redacted] Currently pt at 190 MIC/MIN of NEO, map 44's. T 99.5, RR 10 vent setting, HR 100's [redacted] ST, MAP GS @ 3380 [redacted] 2 L NS [redacted] 3500 in. [redacted]
2000	VS T 99.6 54/28 hr 95 No changes in condition, continue to monitor [redacted] q1 WNL

STANDARD FORM 600 (REV. 6-97) BACK

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
30MAR03	2100 hr 117 104/55 T 99.4
31MAR03	0324 suctioned pt. lt yellow secretions moderate amount. VS and I+O recorded hourly see flowsheet. Continue to monitor [(b)(6)-2] q1hrNC
31 Mar 03 0805	Resp Care Note: pt on mech vent as ordered. All settings checked + set properly. All alarms set + working. [(b)(6)-2] Ambu bag @ bedside. BBS fairly coarse SOM scant white secretions. Current vent settings SIMV RR 10, VT 800, Peep 5, FIO2 2/r, Bleed in, Exhaled VT 788 PIP 31, Mean 12. [(b)(6)-2] q1h3H
3-31 0830	↓ B/P @ 0730 87/60 HR 130, VO OR [(b)(6)-2] 500 CR NAD RT 0810 T B/P 100/52, HR 118, sats 100% RT SX VO Rate ↓ to 10 and TC q1h to 800 ov vent yesterday. 189 IV started (R) AC [(b)(6)-2]
0836	CT D/C'd by DR [(b)(6)-2] [(b)(6)-2]
0920	↓ B/P 60's sys, VO PR [illegible] T incr to 100's, mean Thirds map to 70 Rep to CV now sys 80's, also IL creased given to keep SysT B/P parameters could be set [(b)(6)-2]
1040	V- pupils 3+ fixed, GCS 1, moderately unresponsive to pain, R-sided VO, lungs TV 800, AC 22, VE 21.6 RR 12, FIO2, 8.0 cuff @ 23 on vip sats 100%. CV ST 130's, B/P 102/58 on NEO 50 mcg/min, good pulses upper extremities will be continued to (L) lower. GI absent BS next to (L) NG to LCS good placement xpo V, GU good UOP clear yellow about 100/HR, skin warm dry. (R) AK A stump with sutured fecal bag, (L) shoulder shrapnel wound, abdomen dry, (L) (R) pelvis dressing DTI, IV's (L) AC 20g, (L) Hand 20g cont

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

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

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

IORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
31 MAR 03	2106 VS T99.8 66/32 hr 95 97% SpO2 UOP 20 cc/hr. No significant Δ's in condition. Continue to monitor. (b)(6)-2 [redacted] 91W M6
2200	Cefazolin 16m IV, Clindamycin 900mg IV administered,
31 March 2003	
2354	Post Injury / Post op Day #2
	Pt 5 spontaneous movement. has been
	hypotensive. BP 68/34, HR100 on
	neosynephrine. 600cc V.O. / 8 hours
	On Cefazolin / Gentamicin / Clindamycin
	Pupils ~ 4mm - non responsive
	TMs intact
	lungs - course bilaterally
	ABD - soft; non tender
	wound examined ~ 1900 no evidence
	of sepsis
	CXR - no source of infection seen
	labs pending
	IMD: Hypotensive on broad spectrum
	coverage will add PCN.
	(b)(6)-2 [redacted]

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

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

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

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1 APR 03	0018 VS 90/45 hr 91 Spo2 99% T 98.8 (b)(6)-2 gwms
0020	2×10^6 units penicillin given IV (b)(6)-2 gwms
0100	pitressin 10u IV given. titrated neo down to 47 ml/hr to lower b/p. b/p now running 116/74. 1 unit PRBC being given now per dr. order. continue to monitor. (b)(6)-2 gwms
0143	titrated neo up to 57 cc/hr - b/p was down to 84/56. (b)(6)-2 gwms
0606	no changes in pt. status. continue to monitor. (b)(6)-2 gwms

STANDARD FORM 600 (REV. 6-97) BACK

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

ORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3/31/02	Resp Care Note. Vent settings. SIMV RR 10, Vt 800, Peep 5 cm H_2O
	EIO_2 21% PIP 28 cm H_2O, Mean 14 cm H_2O. SpO_2 98% BBS Coarse
	SXN scant thick yellow secretions: (b)(6)-2 [redacted] -SW3H
01 April 2003	Labs results
0022	171 130 133 - Yellow
	2.4 35 20 - BLW
	hab 6.0
	will give free fluid for hypernatremia (b)(6)-2 [redacted]
1 April 2003	Neurology note
0826	Pt seen, & evaluated. Pt purportedly had episode of pulseless V-tach, p̄ having several missile injuries, (L) pneumothorax, & traumatic amputation of (R) lower ext. Pt, now is on a ventilator — & is s̄ any sedation or paralytic meds.
	Exam - Comatose, pupils 5mm non-reactive bilat, no spontaneous movements, no movement to very deep painful stimulation; s̄ Doll's eyes
	Imp: Suspect pt is irreversible brain death.
	Recommend: Stop all paralytic & sedating drugs. ~~Hold vent~~ take vent tubing off for ± minutes, if no spontaneous movement then place back on vent. Repeat procedure @ 1400 — if no spontaneous breathing ⇒ pt is brain dead

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

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

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
01 APR 03	Pt CONNECTED TO VENT @ RESP 12, PEEP 5, FIO2 21%, TIDAL VOL 900, PUPILS
0800.	FIXED @ 6mm. UNRESPONSIVE TO PAINFUL STIMULI. ABSENT GAG REFLEX WITH SUCTIONING,
	VERIFIED @ DR. (b)(6)-2 THAT PT DID NOT SPONTANEOUSLY BREATH FOR 1 MIN WITH
	DISCONNECTED FROM VENT. WILL REPEAT AGAIN @ 1400, IN ORDER TO VERIFY BRAIN
	DEATH. NG. REMAINS @ LOW INT. WALL SUCTION, MODERATE AMOUNT OF BROWN
	DRAINAGE PRESENT. CONTINUE TO DEEP SUCTION Q 2° AND PRN. LUNGS SOUNDS R/L
	BILAT. (L) CHEST TUBE D/C'd 31 MAR. DRSNG C/D/I. ABSENT BS IN ALL 4 QUADS.
	SOFT SLIGHTLY DISTENDED ABD. FOLEY TO GRAVITY PRODUCING CYM QS.
	DRSNGS TO (R) AKA, (R) FA, (R) SHOULDER Δ AND C/D/I. CONT. ABX Tx AS
	ORDERED. WILL CONT TO MONITOR PT (b)(6)-2 KT/AN.
1000	NEOSYNEPHRINE DISCONTINUED PER V.O. FROM DR. (b)(6)-2 (b)(6)-2 KT/AN
1030	BLOOD PRESSURE CONTINUES TO FALL S/P D/C OF NEO. DR. (b)(6)-2 NOTIFIED. NO
	INTERVENTION ORDERED AT THIS TIME. ALL DRSNGS C/D/I. NO Δ IN NEURO STATUS
	GI, RESPIRATORY, GU, CONTINUE @ ABX Tx AND COMFORT CARE. COMPLETE
	BED BATH GIVEN. LACROLUBE APPLIED. 5mg of MSO4 ADMINISTERED FOR PAIN & COMFORT
	MEASURES. WILL CONTINUE TO MONITOR THE PT. (b)(6)-2 KT/AN
01 April 2003	
1130 ZULU	Expired 11:30 no respirations
	chaplain (b)(6)-2 at bedside
	(b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK

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

510-112 NSN 7540-00-634-4123

MEDICAL RECORD — NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
29 Mar 03		1900	Pt placed on Impact 754 Ventilator with initial Vent settings A/C mode, RR 12 bpm, FIO_2 .40, PEEP 5 cmH_2O, VT 700 ml, PIP 45 ET Tube [redacted] @ 22 cmH_2O at lips. Pt sedated bilateral B.S. rcvcal scattered rhonchi. Sx moderate amount thick yellow sputum. orders verified per Dr. [redacted] — Respiratory
29 Mar 03		2200	Started Versed + Sentanyl drip for severe agitation. C/in 30° pt calmed down. BP began to ↓ (MAP) in low 60's. talked c Dr [redacted] & will give 2u PRBC's for Hct in ER of 22. — [redacted] CPT AN. —
30 Mar 03	0130		2nd unit of blood complete — pt doing well — [redacted] CPT AN.
29 Mar 03	2030		Late entry: 2030 — advanced ETT by 3cm per Dr [redacted]. replaced OGT c NGT in (L) nare — good placement verified by air bolus, placed on LIS. took lab samples amylase & creatinine. — [redacted] CPT AN —

(Continue on reverse side)

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

EPW # [redacted]

REGISTER NO.

WARD NO.

NURSING NOTES
Medical Record

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

MEDICAL RECORD — INTRAOPERATIVE

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA
BY
3. DATE
TIME PATIENT ARRIVED IN SUITE

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

4. PATIENT IN ROOM
TIME 1030
NUMBER Somewhere in Iraq

5. PREOPERATIVE EMOTIONAL STATUS
☐ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☒ OTHER (Specify)
COMMENTS: ~~D~~ Responsive, to verbal stimuli.

6. NURSING PERSONNEL

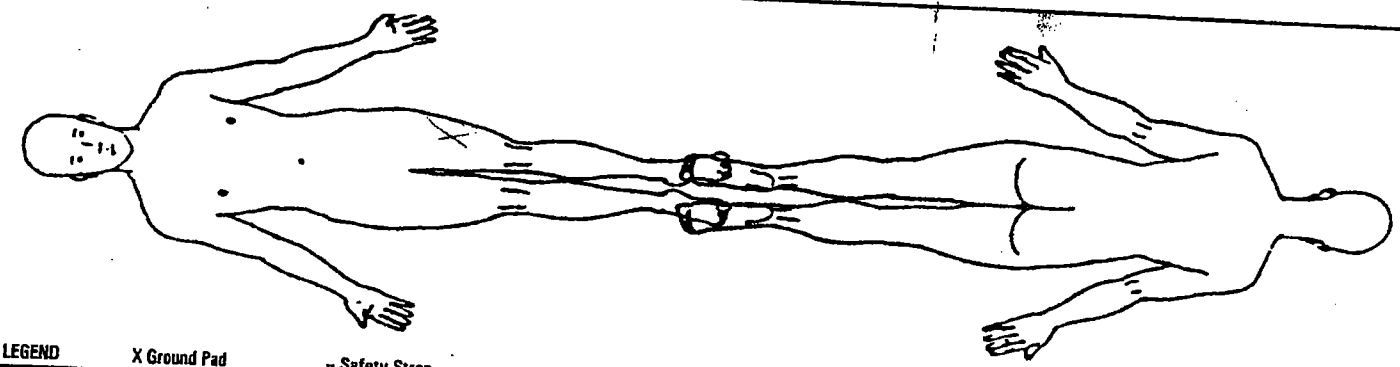
ASSIGNED SCRUB	Spc (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT (b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)
☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP
COMMENTS: on mesh gurney.

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

PREP SOLUTION (Specify) Betadine
SITE: Face
SITE: Groin
BY WHOM: (b)(6)-2
BY WHOM (b)(6)-2
COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap - - - Tourniquet

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes ☒ No				(b)(6)-2	(b)(6)-2
Needle Sharp	☒ Yes ☐ No			C		
Instrument	☐ Yes ☒ No			C		
Other	☐ Yes ☒ No				Spc	CPT

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

LOG# (b)(6)-4

SSAN#

NAME:

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

☒ ESU NO: Force 2 Valleylab
GROUND PAD: BRAND [illegible]
LOT NO: 021272

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NaCL

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE (b)(6)-2

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☐	NAME Rt. lower extremity (disposed in burn pit)	NAME
FROZEN SECTION (FS) YES ☐ NO ☐ X	NAME	NAME
CULTURE (C) YES ☐ NO ☐ X	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)* Rt. shoulder - 4x4 silk tape Rt. forearm - 4x4 silk tape Rt. leg - Kerlix, Ace wrap Rt. hip - 4x4

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. Kerlex Gauze	2.	3.
SITE	1. Rt. hip	2.	3.

19. ADDITIONAL INFORMATION

Surgeons: Dr. (b)(6)-2
Dr. (b)(6)-2
Dr. (b)(6)-2 irrigated Rt arm

LOG # (b)(6)-4
SSAN#
NAME:

20. OPERATION(S) PERFORMED

Above knee Amputation Rt. leg, I + D Rt. hip wound, I + D Rt. arm wounds

21. PATIENT TRANSFERRED TO	TIME	METHOD
(b)(3)-1 Post. op		Litter

22. REGISTERED NURSE SIGNATURE (b)(6)-2 Cpt AD

NSN 7540-00-634-4124

...L RECORD — VITAL SIGNS RECORD

...OSPITAL DAY		01 APR 03												
DAY														
...-YEAR	DAY	1000												
19	HOUR	1030												
PULSE (0)	TEMP. F (°)													TEMP. C
	105°													40.6°
180	104°													40.0°
170	103°													39.4°
160	102°													38.9°
150	101°													38.3°
140	100°													37.8°
130	99°													37.2°
	98.6°													37.0°
120	98°													36.7°
110	97°													36.1°
100	96°													35.6°
90	95°													35.0°
80														
70														
60														
50														
40														
RESPIRATION RECORD		58/29												
~~BLOOD PRESSURE~~ VENT		RR22												
HEIGHT:	WEIGHT →													
SAT.		91% 95%												
NG.		300cc												
INTAKE		DSW 125cc/0												
OUT PUT	Foley to gravity	1600 CYU												

(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.

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 3788

MEDICAL RECORD

VITAL SIGNS RECORD

3rd baby 1:30 PM

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY

19 HOUR

2300 2330 2345 2400 0100 0210 0231 0400 0600 0800 1000 1200 1315 1415 1615 1815 1935 2000 2106 2204 2303 0118 1140 145 219 0330 0345

PULSE (O) | TEMP. F (•) | TEMP. C

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

Pulse OR	96	97	97	94	96	95	94		96%	98%				95	97	97	99	99	97	97	100		
Input LR	125	125		125 125			125		500	3L					57 NeO 125 LR		57 125						
Output	400	510		400 700			400 800		1600 1800	3380					75	20	100	100					

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.

I 2,000

03400

STANDARD FORM 511 (REV. 7-95) BACK

*U.S.GPO:1996-404-763/40069

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY 30 MAR

19 HOUR

PRE TRANSFUSION 107/50 131 99.2

INSTRANSFUSION STARTED (1ST UNIT)

2nd UNIT

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

Record special data only when so ordered

~~BLOOD PRESSURE~~ RA	12/40						18	18	20							14/26			
HEIGHT: WEIGHT →																			
SPO2	98% VENT		99% VENT													93%	95%		
Outpoot																urine 600	600		
Input																125 LR	125		

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)-2

VITAL SIGNS RECORDS

Medical Record

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

Post Op Nsg Note / Code Summary

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	Crystalloid	5250	OR	EBL	500
OR	PRBCs (O+)	400	OR	Urine	200
PACU	hespan	500	PACU	Urine	250
↓	PRBCs (O-)	400			
↓	Crystalloid	3750			
TOTAL	+	10300	TOTAL	-	950

~~PACU NURSING NOTES: NURSING CARE PROBLEM NO.'S IDENTIFIED. Refer to FH MDA OP 39~~

~~NURSING CARE PROBLEMS: 1. RESP; 2. CIRC; 3. ACT; 4. LOC; 5. TEMP; 6. PAIN; 7. SAFETY; 8. ANXIETY; 9. EDUC; 10. OTHER~~

Post Op Nursing Note / Code Summary: ~~Sx completed~~ @ c. 1305 (L) pt became difficult to wean / extubate requiring frequent BVM support (c̄ No SpO_2 waveform / rdg avail) pressures remained 90s/50s. Pt then reqd fluid bolus for ↓ UOP c̄ min response + subsequent fluid boluses for hypotension; S-tach 130s throughout (Ø ectopy). After no improvement in oxygenation status pt recid 2nd of 2 units of PRBCs c̄ improvement in BP + SpO_2 (110/60s + SpO_2 as high as 95% on max FiO_2 (70%). Pt precipitously ↓ HR (40s) (approx 10 min p̄ PRBCs completed) c̄ noted ST ↓. Pt then became S-tachy + V tach'd s̄ pulse. CPR initiated 1 amp Epi + Atropine administered c̄ eventual ~~[illegible]~~ response; pt's rhythm converted to S-tach (130s c̄ bytrigeminy) + reqd ambu spt to ↑ SpO_2 to ≥90%, BPs 90/20-40s. Pt

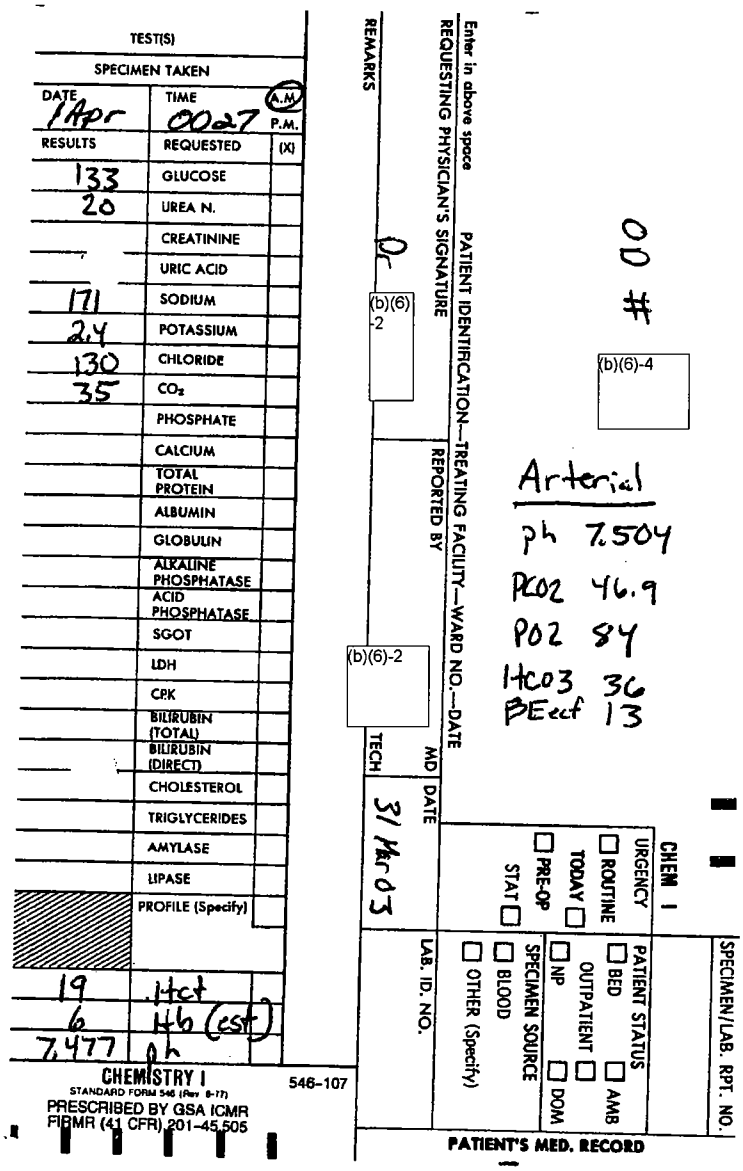
MEDICATION RECEIVED IN PACU (b)(6)-2

MEDICATION GIVEN BY: air-evacuated @ c. 1525 DRUG DOSE CPR EFFECTIVENESS (b)(6)-2

1g Ancef administered intra-Op @ c. 12 noon

DISPOSITION SUMMARY: Nursing Care Problems No.'s_____ Resolved; No.'s_____ Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status:_____ PAR Score_____ Safety Straps_____
Report given to_____. Patient released by Anesthesia_____
Time out_____. Nurses Signature:_____

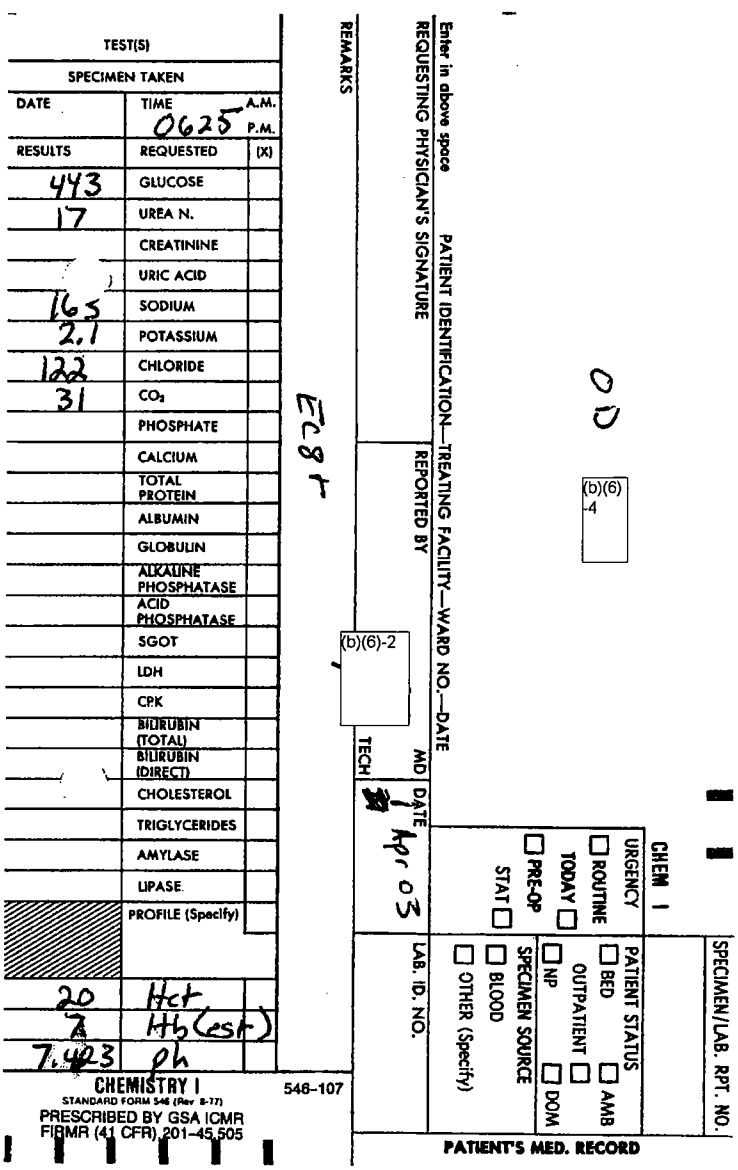
LOG#: (b)(6)-4 PT NA MEDCOM - 3791 PT SSAN#:



TEST(S)
SPECIMEN TAKEN
DATE 1 Apr
TIME 0027 A.M. P.M.
RESULTS | REQUESTED | (X)
133 GLUCOSE
20 UREA N.
CREATININE
URIC ACID
171 SODIUM
2.4 POTASSIUM
130 CHLORIDE
35 CO_2
PHOSPHATE
CALCIUM
TOTAL PROTEIN
ALBUMIN
GLOBULIN
ALKALINE PHOSPHATASE
ACID PHOSPHATASE
SGOT
LDH
CPK
BILIRUBIN (TOTAL)
BILIRUBIN (DIRECT)
CHOLESTEROL
TRIGLYCERIDES
AMYLASE
LIPASE
PROFILE (Specify)
19 Hct
6 Hb (est)
7.477 ph
CHEMISTRY I
STANDARD FORM 546 (Rev 8-77)
PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505
546-107

REMARKS
Dr (b)(6)-2
Enter in above space REQUESTING PHYSICIAN'S SIGNATURE
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE REPORTED BY
(b)(6)-2
TECH MD DATE 31 Mar 03
CHEM I
URGENCY ROUTINE TODAY PRE-OP STAT
PATIENT STATUS BED AMB OUTPATIENT NP DOM
SPECIMEN SOURCE BLOOD OTHER (Specify)
LAB. ID. NO.
SPECIMEN/LAB. RPT. NO.
PATIENT'S MED. RECORD

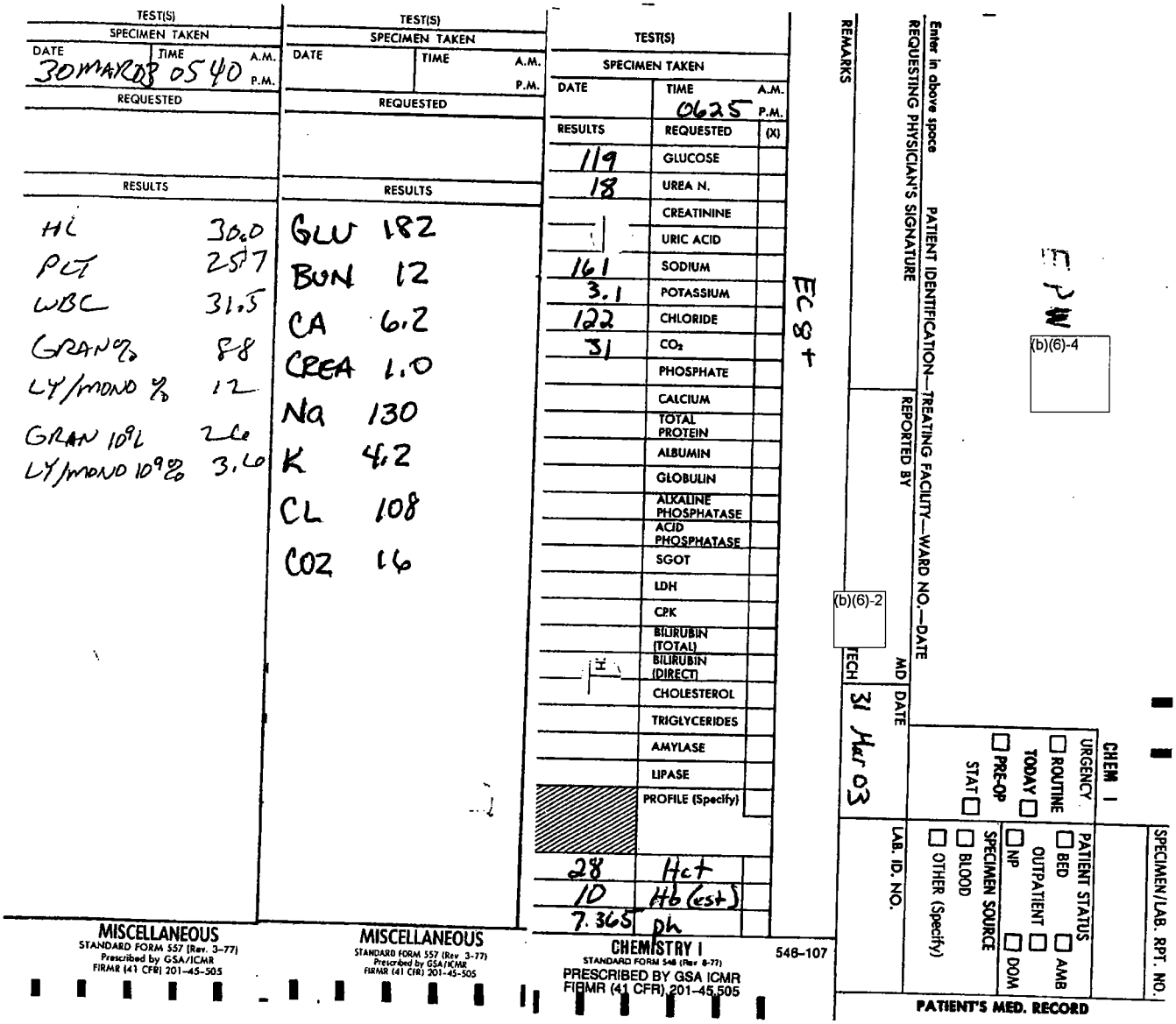
OD # (b)(6)-4
Arterial
ph 7.504
PCO2 46.9
PO2 84
HCO3 36
BEecf 13



TEST(S)
SPECIMEN TAKEN
DATE
TIME 0625 A.M. P.M.
RESULTS | REQUESTED | (X)
443 GLUCOSE
17 UREA N.
CREATININE
URIC ACID
165 SODIUM
2.1 POTASSIUM
122 CHLORIDE
31 CO_2
PHOSPHATE
CALCIUM
TOTAL PROTEIN
ALBUMIN
GLOBULIN
ALKALINE PHOSPHATASE
ACID PHOSPHATASE
SGOT
LDH
CPK
BILIRUBIN (TOTAL)
BILIRUBIN (DIRECT)
CHOLESTEROL
TRIGLYCERIDES
AMYLASE
LIPASE
PROFILE (Specify)
20 Hct
7 Hb (est)
7.423 ph
CHEMISTRY I
STANDARD FORM 546 (Rev 8-77)
PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505
546-107

REMARKS
EC8r
Enter in above space REQUESTING PHYSICIAN'S SIGNATURE
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE REPORTED BY
(b)(6)-2
TECH MD DATE 1 Apr 03
CHEM I
URGENCY ROUTINE TODAY PRE-OP STAT
PATIENT STATUS BED AMB OUTPATIENT NP DOM
SPECIMEN SOURCE BLOOD OTHER (Specify)
LAB. ID. NO.
SPECIMEN/LAB. RPT. NO.
PATIENT'S MED. RECORD

OD (b)(6)-4



TEST(S)
SPECIMEN TAKEN
DATE 30 MAR 08 TIME 0540 A.M. P.M.
REQUESTED
RESULTS
HCT 30.0
PLT 257
WBC 31.5
GRAN% 88
LY/MONO % 12
GRAN 10⁹/L 2.6
LY/MONO 10⁹/L 3.60

MISCELLANEOUS
STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45-505

TEST(S)
SPECIMEN TAKEN
DATE TIME A.M. P.M.
REQUESTED
RESULTS
GLU 182
BUN 12
CA 6.2
CREA 1.0
Na 130
K 4.2
CL 108
CO2 16

MISCELLANEOUS
STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45-505

TEST(S)
SPECIMEN TAKEN
DATE TIME 0625 A.M. P.M.

RESULTS	REQUESTED	(X)
119	GLUCOSE	
18	UREA N.	
	CREATININE	
	URIC ACID	
161	SODIUM	
3.1	POTASSIUM	
122	CHLORIDE	
31	CO_2	
	PHOSPHATE	
	CALCIUM	
	TOTAL PROTEIN	
	ALBUMIN	
	GLOBULIN	
	ALKALINE PHOSPHATASE	
	ACID PHOSPHATASE	
	SGOT	
	LDH	
	CPK	
	BILIRUBIN (TOTAL)	
H	BILIRUBIN (DIRECT)	
	CHOLESTEROL	
	TRIGLYCERIDES	
	AMYLASE	
	LIPASE	
	PROFILE (Specify)	
28	Hct	
10	Hb (est)	
7.365	ph	

EC 8+

CHEMISTRY I
STANDARD FORM 548 (Rev 8-77)
PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505
548-107

REMARKS

(b)(6)-2

TECH

MD

DATE 31 Mar 03

Enter in above space
REQUESTING PHYSICIAN'S SIGNATURE
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REPORTED BY

(b)(6)-4

CHEM 1

URGENCY: ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT

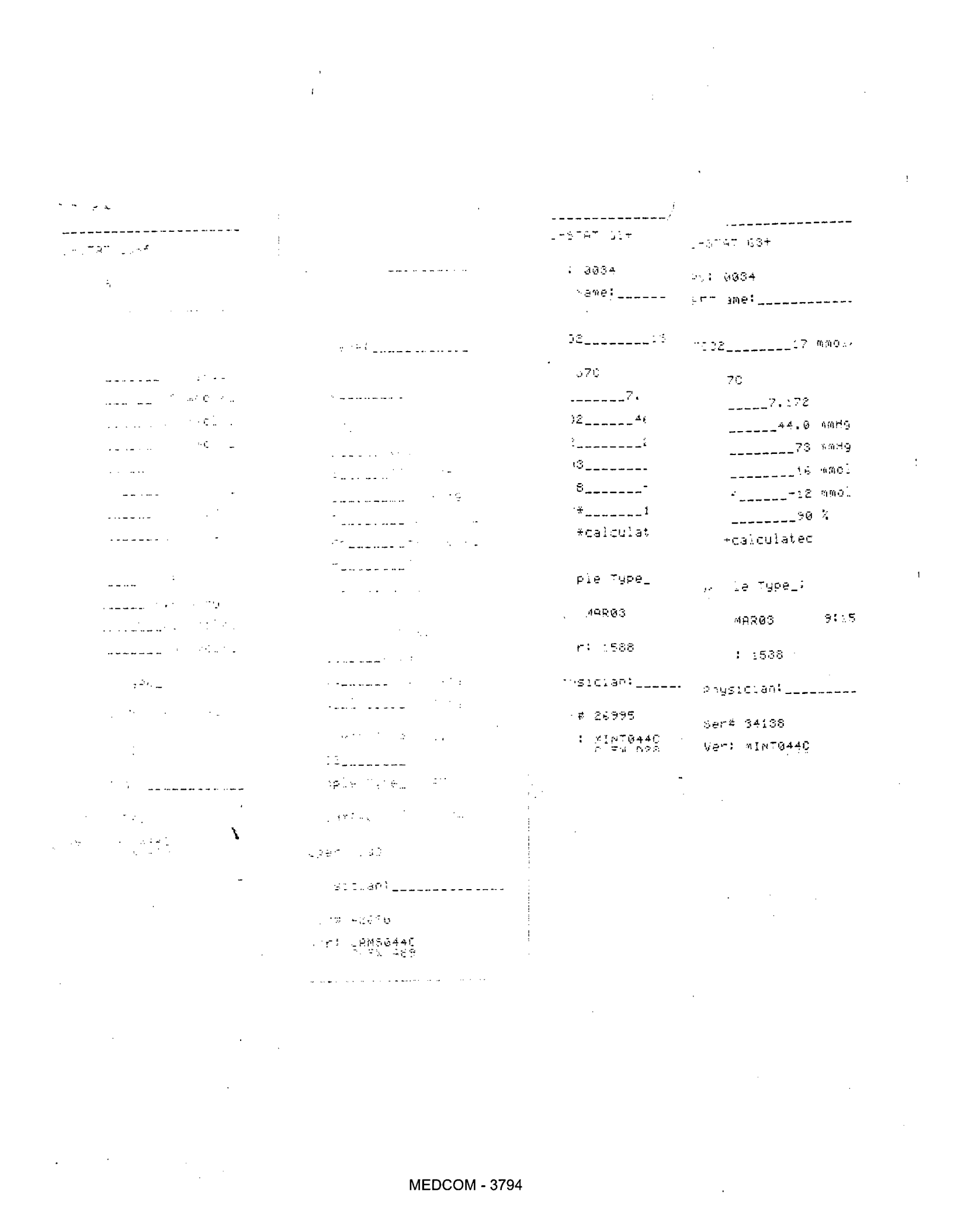
PATIENT STATUS: ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE: ☐ BLOOD ☐ OTHER (Specify)

LAB. ID. NO.

SPECIMEN/LAB. RPT. NO.

PATIENT'S MED. RECORD



MEDCOM - 3794

MEDICAL RECORD - ANESTHESIA

... 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; T=CONSTANT INFUSION

DRUG	(Units)												
STP	(ml)	12.5											
Fentanyl	(ml)												
KX/Vec	(ml)	120/5			1	0.5							
	( )												
	( )												
	( )												
VOLAT AGENT	730 % del		0.5	0.5	0.5								
	% e.t.												
AIR	L/Min		Drain over										
N20	L/Min												
O2	L/Min	5	5	5	5	5	5	5	5	10	10	5	5

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

FLUIDS

LINE site													
18g (A) LC	☐ Warmed	#1	NBF #1										
18g (B) LC	☐ Warmed	#1	100		200		275						
	☐ Warmed	#1	100		200		250						
	☐ Warmed												

LOSSES — EST BLOOD LOSS; URINE -

PHYS STATUS: 1 2 3 4 5 (E)

BODY WEIGHT: ~75 KG (LB)

HEMATOCRIT: 22

INITIAL DATA: BP- 116/44; HR- 112

EQUIP CHECK: OK? (Y) N

PATIENT RECHECK: OK for PROCEDURE? ✓; TIME-

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

TIME → 1030 X 1100 X 30 X 1130 X 30 X 1200 X 30

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

VENTIL

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

MONITORS/ACCESSORIES

X	BP/Auto Cuff	X	ET CO2 (torr)	40	42	39	43	49	⊕	⊕	⊕	⊕	
	BP/oth	X	FIO2 (Frac or %)	.70	.45	.45	.45	.45	.45	.45	.45	.45	.45
	ART line	X	SpO2 (%)	92	96	96	96	96	Unable	95	80	70	Unable
	Steth- PC/ES	X	ECG	ST	SR								
	Gas analyzer	X	TEMP-site/	35									
		X	N-M Block (TJ4)	1/4	1/1	1/4							
X	Warming blkt												
	Conv warmer												

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

TOTALS — TOTAL EBL: 500; TOTAL URINE

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

REMARKS (Code drugs with numbers, events with letters)

1. To OR, mo... IV, Intub x 2, ... 25 I ; I .

RECOVERY AT: PACU ICU (Specify); OTHER

CONDITION: RESP- SpO2- BP- HR-

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES		1030	
PROC	Ready	Begin	End
	1045	1050	1225

PROCEDURES and CPT Codes:

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

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

LOG # (b)(6)-4

SSAN#

NAME:

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

SURGEONS:

ANESTHETISTS:

PROCEDURE LOCATION:

DATE:

PAGE OF

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [x] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of ____ units)*
- [ ] CRYOPRECIPITATE *(Pool of ____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* ____

VOLUME REQUESTED *(If applicable)*
____ ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED
29 Mar 03

DATE AND HOUR REQUIRED

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: ____
HEMOLYTIC DISEASE OF NEWBORN? ____

REQUESTING PHYSICIAN *(Print)*
(b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE
R Leg amputation

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER
(b)(6)-2

DATE VERIFIED
29 Mar 03

TIME VERIFIED
0650

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.
(b)(6)-4

TRANSFUSION NO.

PATIENT NO.

DONOR
ABO A
Rh POS

RECIPIENT
ABO A
Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH

PREVIOUS RECORD CHECK:
- [ ] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE

REMARKS:

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*
(b)(6)-2

AT *(Hour)* 2355 ON *(Date)* 29MAR03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)*
(b)(6)-2
CPT AN

2nd VERIFIER *(Signature)*
(b)(6)-2
CPT AN

PRE-TRANSFUSION
TEMP. 36.4 PULSE 133 BP 98/56

DATE OF TRANSFUSION
30 Mar 03

TIME STARTED
0001

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

#
(b)(6)-4

POST-TRANSFUSION DATA

AMOUNT GIVEN
all ML

TIME DATE COMPLETED
0130/30 Mar 03

INTERRUPTED

REACTION
- [x] NONE
- [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER ____

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [x] NO
- [ ] YES *(Specify)* ____

SIGNATURE OF PERSON NOTING ABOVE
(b)(6)-2
CPT AN

SEX
M

WARD
ICU 3

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

- [x] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of ____ units)*
- [ ] CRYOPRECIPITATE *(Pool of ____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* ____

VOLUME REQUESTED *(If applicable)* ____ ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED: 29 March 03

DATE AND HOUR REQUIRED: ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: ____

HEMOLYTIC DISEASE OF NEWBORN? ____

REQUESTING PHYSICIAN (Print): (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: Rhes appetation

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER: (b)(6)-2

DATE VERIFIED: 29 March 03

TIME VERIFIED: 1650

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: (b)(6)-4

TRANSFUSION NO.

PATIENT NO.

DONOR: ABO A; Rh POS

RECIPIENT: ABO A; Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	COMP

PREVIOUS RECORD CHECK: [ ] RECORD [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED | DATE

REMARKS:

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*: (b)(6)-2

AT *(Hour)* 2225 ON *(Date)* 29 MAR 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

(b)(6)-2 CPT AN

(b)(6)-2 CPT/AN

PRE-TRANSFUSION

TEMP. 36² PULSE 136 BP 93/49

DATE OF TRANSFUSION: 29 Mar 03 TIME STARTED: 2240

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entri NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

EPW # (b)(6)-4

POST-TRANSFUSION DATA

AMOUNT GIVEN: all ML

TIME DATE COMPLETED: 0001/30 mar 03 ~~INTERRUPTED~~

REACTION: [x] NONE [ ] SUSPECTED

If reaction is suspected — IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER ____

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

- [x] NO
- [ ] YES *(Specify)* ____

SIGNATURE OF PERSON NOTING ABOVE: (b)(6)-2

WARD: ICU3

BLOOD OR BLOOD COMPONENT TRANSFUSION STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDCOM - 3797

MEDICAL RECORD COPY

518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)*: 450 ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [ ] TYPE AND SCREEN
- [ ] CROSSMATCH

DATE REQUESTED: 30 Mar 03

DATE AND HOUR REQUIRED: 30 Mar 03 1545

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)*: D (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

(b)(6)-4 1

(b)(6)-4

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION	
ANTIBODY SCREEN	CROSSMATCH
NA	NA

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [X] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST

DONOR	RECIPIENT
ABO O	ABO
Rh POS	Rh

- [X] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED — DATE 30 Mar 03

REMARKS:

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* (b)(6)-2

(b)(6)-2

AT *(Hour)* 1545 ON *(Date)* 30 Mar 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)*

(b)(6)-2 TCTAN

(b)(6)-2 91WMG/LPN

PRE-TRANSFUSION

TEMP. 99.2 | PULSE 131 | BP 107/50

DATE OF TRANSFUSION: 30 MAR03

TIME STARTED: 1615

POST-TRANSFUSION DATA

AMOUNT GIVEN: 450 ML

TIME/DATE COMPLETED/INTERRUPTED: 1825 3-30-03

REACTION

- [X] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
99.3	110	113/64

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

- [X] NO
- [ ] YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE

(b)(6)-2 CAN

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility)

SEX: Male

WARD: ICW II

EPW # (b)(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 3798

Medical Record Copy

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)* 450 ML

REMARKS:

TYPE OF REQUEST *(Check ONLY If Red Blood Cell Products are requested.)*

- [ ] TYPE AND SCREEN
- [ ] CROSSMATCH

DATE REQUESTED 30 Mar 03

DATE AND HOUR REQUIRED 30 Mar 03 1845

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* Dr (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6)-4

TRANSFUSION NO.

PATIENT NO.

DONOR

ABO O

Rh Pos

RECIPIENT

ABO

Rh

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	NA

PREVIOUS RECORD CHECK: [ ] RECORD [X] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST (b)(6)-2

[X] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED DATE 30 Mar 03

REMARKS:

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* (b)(6)-2

AT *(Hour)* 1840 ON *(Date)* 30 Mar 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)* (b)(6)-2

2nd VERIFIER *(Signature)* (b)(6)-2 91WM6 LPN

PRE-TRANSFUSION

TEMP. 99.3 PULSE 110 BP 113/64

DATE OF TRANSFUSION 3-30-03 TIME STARTED 1835

POST-TRANSFUSION DATA

AMOUNT GIVEN ML

TIME/DATE COMPLETED/INTERRUPTED

REACTION [ ] NONE [ ] SUSPECTED

TEMPERATURE

PULSE

BLOOD PRESSURE

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION

- [ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

[ ] NO [ ] YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility)

EPW # (b)(6)-4

SEX Male

WARD ICW II

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

Medical Record Copy

MEDCOM - 3799

518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)*: 450 ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [ ] TYPE AND SCREEN
- [ ] CROSSMATCH

DATE REQUESTED: 30 Mar 03

DATE AND HOUR REQUIRED: 30 Mar 03

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)*: Dr (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: S/P Amputee

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER: on File

DATE VERIFIED:

TIME VERIFIED:

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6)-4 | TRANSFUSION NO.

(b)(6)-4 | PATIENT NO.

DONOR	RECIPIENT
ABO O	ABO
Rh pos	Rh

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	NA

PREVIOUS RECORD CHECK: [ ] RECORD [X] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST

[X] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED | DATE 30 Mar 03

REMARKS: EXP: 4/09/03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY (Signature) (b)(6)-2

AT *(Hour)* 2305 | ON *(Date)* 30 Mar 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st (b)(6)-2

2nd VERIFIER *(Signature)*

PRE-TRANSFUSION: TEMP. 99.6 | PULSE 120 | BP 91/58

DATE OF TRANSFUSION: 30 Mar 03 | TIME STARTED: 2340

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility)

EPW # (b)(6)-4

POST-TRANSFUSION DATA

AMOUNT GIVEN: 340 ML

TIME/DATE (COMPLETED)/INTERRUPTED: 0150 31 MAR 03

REACTION	TEMPERATURE	PULSE	BLOOD PRESSURE
[ ] NONE [ ] SUSPECTED	99°	114	101/62

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION

[ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN

[ ] OTHER *(Specify)* N/A

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

[X] NO [ ] YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE: (b)(6)-2

SEX: Male | WARD: ICW II

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

Medical Record Copy

MEDCOM - 3800

518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

- [x] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)* 450 ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [ ] TYPE AND SCREEN
- [ ] CROSSMATCH

DATE REQUESTED 1 Apr 03

DATE AND HOUR REQUIRED 0100 1 Apr 03

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* Dr (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6)-4

TRANSFUSION NO.

PATIENT NO.

DONOR

ABO O

Rh POS

RECIPIENT

ABO

Rh

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	NA

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [x] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST

- [x] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 1 Apr 03

REMARKS:

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* (b)(6)-2 (b)(6)-2

AT *(Hour)* 0100 ON *(Date)* 1 Apr 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER (b)(6)-2 1 T/An

2nd VERIFIER *(Signature)* (b)(6)-2

PRE-TRANSFUSION

TEMP. 98.8 PULSE 95 BP 116/76

DATE OF TRANSFUSION

TIME STARTED

POST-TRANSFUSION DATA

AMOUNT GIVEN 347 ML

TIME/DATE COMPLETED/INTERRUPTED 0360

REACTION

- [x] NONE
- [ ] SUSPECTED

TEMPERATURE 99.4

PULSE 90

BLOOD PRESSURE 78/53

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)* NONE

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

- [x] NO
- [ ] YES *(Specify)*

SIGNATURE (b)(6)-2 2 T/An

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility)

OD (b)(6)-4

SEX Male

WARD ICU #2

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

Medical Record Copy

MEDCOM - 3801

519-302

NSN 7540-01-165-7294

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED

CXRAY in AM
0600.

AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
.	M		ICU 3	

FILM NO.

PREGNANT ☐ YES ☒ NO

REQUESTED BY (Print) (b)(6)-2

TELEPHONE/PAGE NO.

SIGNATURE OF REQUESTOR (b)(6)-2 CPT AM

DATE REQUESTED 29 Mar

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

lung - re-x pAmion.

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

RADIOLOGIC REPORT

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

EPW ft (b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

(b)(6)-4

NSN 7540-01-165-7294

519-302

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
AP chest					
	FILM NO.				PREGNANT ☐ YES ☐ NO
	REQUESTED BY (Print) (b)(6)-2				TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR (b)(6)-2				DATE REQUESTED 29 March 03

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

S/P chest tube for Pneumothorax, Fin placement

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*
29 March 03	29 March 03	29 March 03

RADIOLOGIC REPORT

(B) infiltrates Ø Pneumothorax c̄ (L) chest tube in place & directed Apically

ET tube at level T2 (Between clavicles)

Ø Shrapnel noted in (R) shoulder area.

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

EPW (b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

(b)(3)-1 IRQ.Q

SIGNATURE

(b)(6)-2

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

ID:

29-Mar-2003 17:29:14

(b)(3)-1

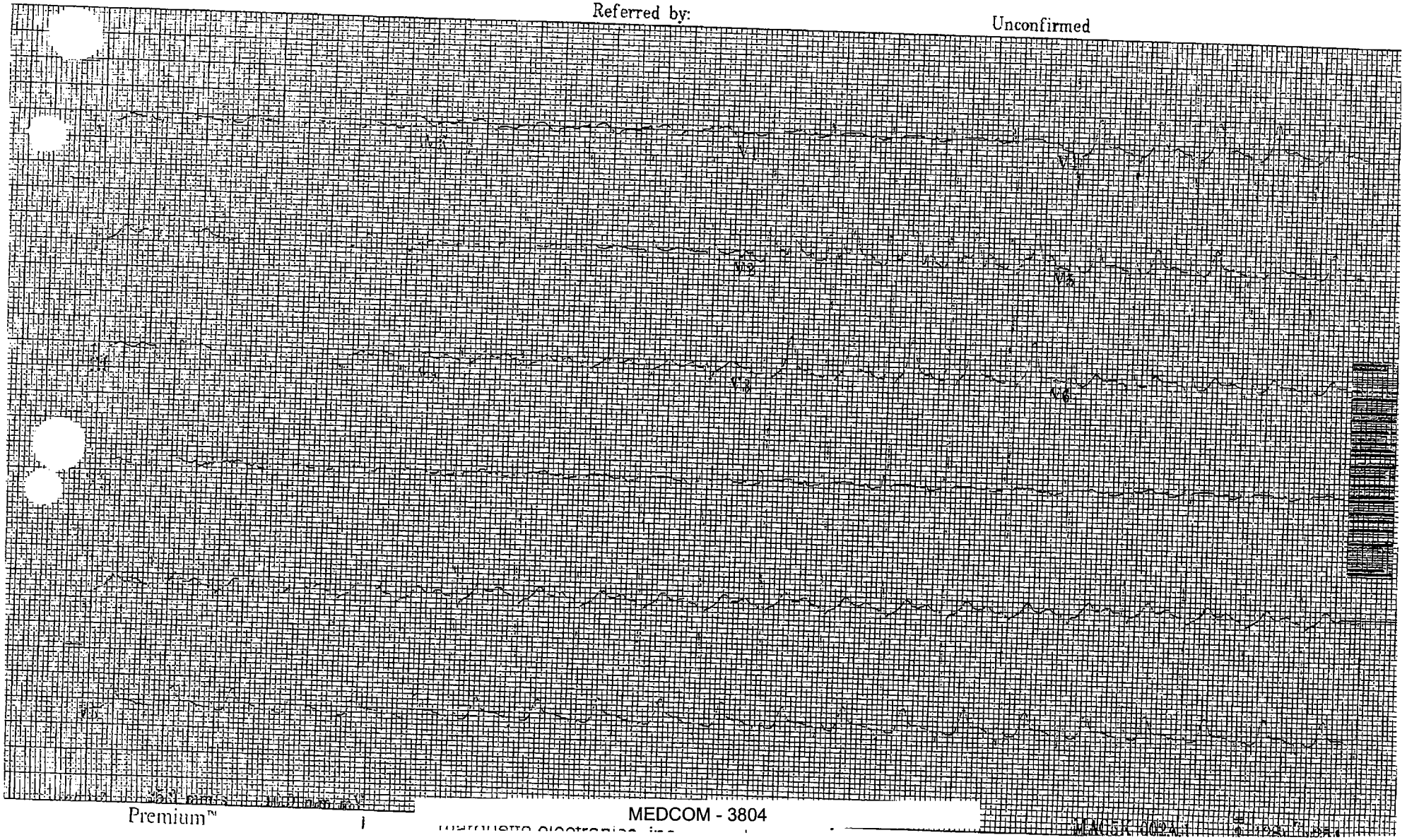
Ventricular rate	126 bpm
PR interval	172 ms
QRS duration	92 ms
QT/QTc	285/417 ms
P-R-T axes	51 -1 49

Sinus tachycardia
Possible Inferior infarct, age undetermined
Abnormal ECG

Technician:
Test ind:

Referred by:

Unconfirmed



Premium™

MEDCOM - 3804

ID:

29-Mar-2003 17:31:19

(b)(3)-1

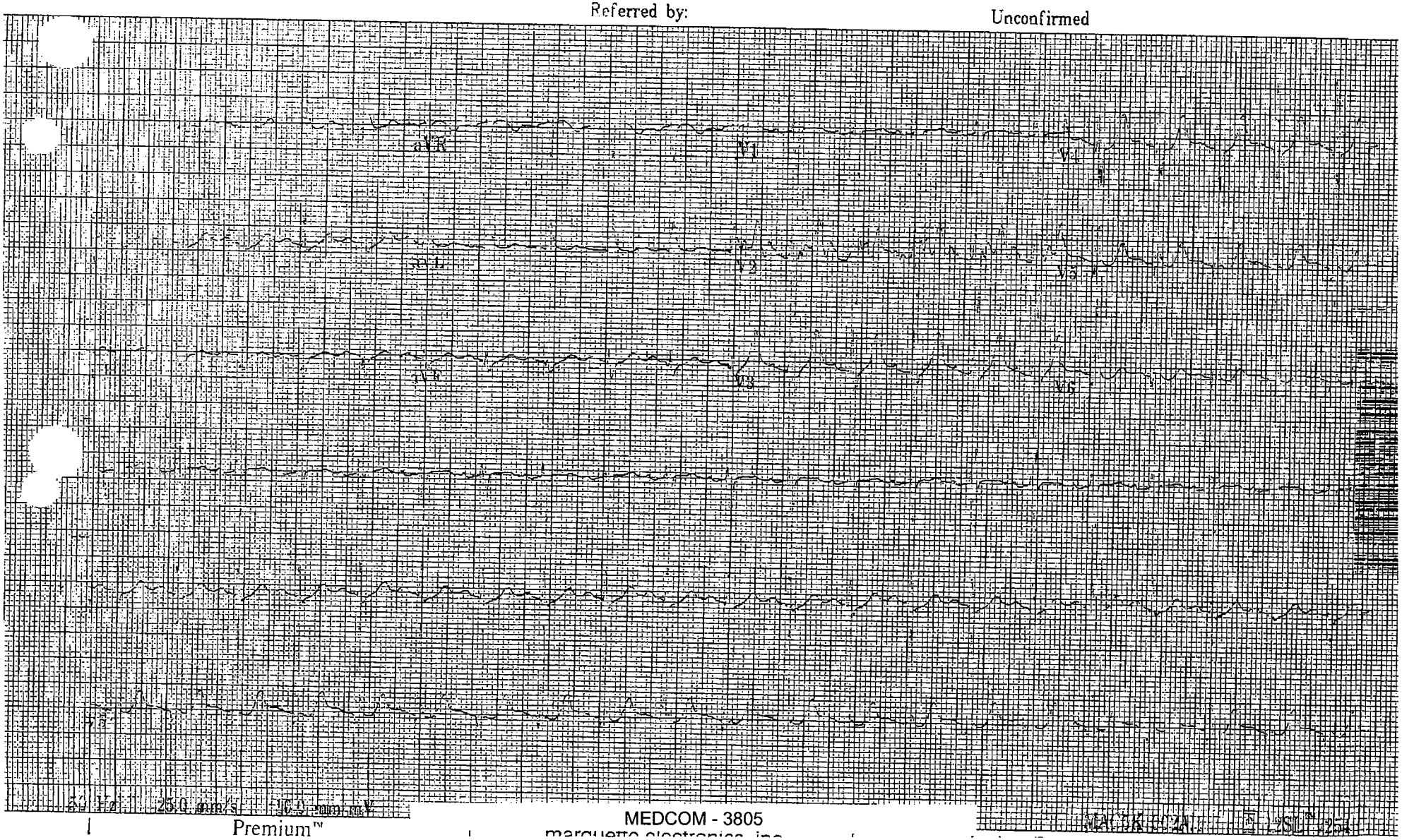
Vent. rate	126	bpm
PR interval	144	ms
QRS duration	92	ms
QT/QTc	286/414	ms
P-R-T axes	52 -3 47	

Sinus tachycardia
Possible Inferior infarct, age undetermined
Abnormal ECG

Technician:
Unconfirmed

Referred by:

Unconfirmed



Doctor's Orders—Post-OP

(b)(3)-1 OP 4256

Nurse Complete	Dr.'s Select	
		DATE: 29 MAR 03 1010Z TIME: 1010Z
☐	☑	1. Admit to: ☐ OR ☐ PACU ☑ ICW ☐ Patient Holding
☐	☑	2. Diagnosis: S/P (R) LE AMPUTATION
☐	☑	3. Condition: ☐ Critical ☑ Guarded ☐ Stable ☐ VSI ☐ SI
☐	☑	4. Allergies: See SF 558
☐	☑	5. Vitals: ☑ Unit SOP ☐ Notify Dr. for SBP < ___ or > ___, DBP < ___ or > ___, HR < ___ or > ___, RR < ___ or > ___, or Temp > ___
☐	☑	6. Activities: ☑ Bed Rest, ☐ BRP, ☐ OOB ASAP w/ assist, ☐ Sit up and dangle when stable ☐ Other:
		7. NRSG:
☐	☑	a. Propaq monitor w/ Pulse-ox
☐	☑	b. O_2 to maintain SAT's above 94%
☐	☐	c. Maintain Vent settings at MODE=_____ Vt=_____ RR=_____ PEEP= FIO_2=
☐	☑	d. ☑ Reinforce or ☐ Change dressing for bleed-through X1 then notify Dr.
☐	☑	e. I's & O's
☐	☑	c. Suction NT ETT PRN (IF PRESENT)
☐	☑	d. CT to ☐ H_2O seal or ☐ Suction at HEMILION DRAIN
☐	☑	8. Diet: ☑ NPO ☐ Clear fluids as tolerated ☐ Other:
☐	☑	9. IV: ☐ NS or ☑ LR TRA 50 cc/hr ☐ DEXTRAN or ☐ Hespan X 500 cc bolus titrated then _____ cc/hr ☐ Albumin 100cc X ____ TRA _____ cc/hr ☐ When tolerating PO fluids, complete current fluid then SL.
☐	☐	10. BLOOD: ☐ T&S or ☐ T&C _____ units ☐ Transfuse _____ units ☐ PRBCs or ☐ Whole Blood
		11. Medications:
☐	☑	a. Tobramycin 300mg IV Q12hrs X | e ☑ Ceftriaxone 750 mg IV
☐	☐	b. Clindamycin 600mg IV | f ☐ PEN G 2 million Units IV
☐	☐	c. Cefazolin 1 gram IV
☐	☐	d. Phenergan 12-25mg Titrate ☐ IV ☐ IM Q4hrs PRN nausea/vomiting
☐	☑	g. Droperidol 1mg ☐ IV ☐ IM X 1 PRN Nausea/Vomiting
☐	☐	h. MSO_4 1-3mg Titrate ☑ IV ☐ IM Q10min PRN Pain
☐	☐	i. Robinul 0.1mg IV X 1
☐	☐	j. Zantac 50 mg ☐ IV or ☐ IM or ☐ 6.25mg/hr infusion
☐	☐	k. Tetanus Immune Globulin
☐	☐	l. Toradol ☐ IV 30mg or ☐ IM 60 mg
☐	☐	m. Maintain sedation/paralysis w/ Rocuronium and MSO_4 PER SOP
☐	☐	12. LABS: a. iSTAT ☐ Glucose ☐ ABG ☐ BMP ☐ CMP
		13. Additional:
		Signatur (b)(6)-2

LOG# EBW # (b)(6)-4 PT NAME: (b)(6)-4 PT SSAN (b)(6)-4 N/A

Doctor's Orders—Post-OP

(b)(3)-1 OP 4256

Nurse Complete	Dr.'s Select	
☐	☑	DATE: TIME:
☐	☑	1. Admit to: ☐ OR ☐ PACU ☑ ICW ☐ Patient Holding
☐	☑	2. Diagnosis:
☐	☑	3. Condition: ☐ Critical ☑ Guarded ☐ Stable ☐ VSI ☐ SI
☐	☑	4. Allergies: See SF 558
☐	☑	5. Vitals: ☑ Unit SOP ☑ Notify Dr. for SBP < ___ or > ___, DBP < ___ or > ___, HR < 50 or > ___, RR < ___ or > ___, or Temp > ___
☐	☐	6. Activities: ☐ Bed Rest, ☐ BRP, ☑ OOB ASAP w/ assist, ☐ Sit up and dangle when stable ☐ Other:
		7. NRSG:
☐	☑	a. Propaq monitor w/ Pulse-ox
☐	☑	b. O_2 to maintain SAT's above 94%
☐	☐	c. Maintain Vent settings at MODE=_____ Vt=_____ RR=_____ PEEP= FIO_2=
☐	☑	d. ☑ Reinforce or ☐ Change dressing for bleed-through X1 then notify Dr.
☐	☐	e. I's & O's
☐	☐	c. Suction NT ETT PRN
☐	☐	d. CT to ☐ H_2O seal or ☐ Suction at ___
☐	☐	8. Diet: ☐ NPO ☑ Clear fluids as tolerated ☐ Other:
☐	☐	9. IV: ☑ NS or ☐ LR TRA ___ cc/hr ☐ DEXTRAN or ☐ Hespan X 500 cc bolus titrated then _____ cc/hr ☐ Albumin 100cc X ___ TRA _____ cc/hr ☐ When tolerating PO fluids, complete current fluid then SL.
☐	☐	10. BLOOD: ☐ T&S or ☐ T&C _____ units ☐ Transfuse ___ units ☐ PRBCs or ☐ Whole Blood
		11. Medications:
☐	☐	a. Tobramycin 300mg IV Q12hrs X
☐	☐	b. Clindamycin 600mg IV
☐	☑	c. Cefazolin 1 gram IV
☐	☐	d. Phenergan 12-25mg Titrate ☑ IV ☐ IM Q4hrs PRN nausea/vomiting
☐	☐	g. Droperidol 1mg ☐ IV ☐ IM X 1 PRN Nausea/Vomiting
☐	☐	h. MSO_4 1-3mg Titrate ☐ IV ☐ IM Q10min PRN Pain
☐	☐	i. Robinul 0.1mg IV X 1
☐	☐	j. Zantac 50 mg ☐ IV or ☐ IM or ☐ 6.25mg/hr infusion
☐	☐	k. Tetanus Immune Globulin
☐	☐	l. Toradol ☐ IV 30mg or ☐ IM 60 mg
☐	☐	m. Maintain sedation/paralysis w/ Rocuronium and MSO_4 PER SOP
☐	☐	12. LABS: a. iSTAT ☐ Glucose ☐ ABG ☐ BMP ☐ CMP
		13. Additional:
		Signature: (b)(6)-2

e ☐ Ceftriaxone 750 mg IV

f ☐ PEN G 2 million Units IV

L06#

PT NAME:

PT SSAN#: (b)(6)-4

AN03

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
	86 th Combat Support Hospital - EXTREMITY TRAUMA ORDERS		
	1. Diagnosis S/P (R) traumatic amputation, proximal femur, thorax		
	2. Vital signs Q 4 h		
	3. Diet as tolerated NG to intermittent suction		
	4. Lactated Ringers - 125 cc/hr		
	5. Cefazolin 1gm IV Q 8 h		
	6. Morphine sulfate 2 to 5 mg IV Q 1 hr prn pain		
	7. Activity Bedrest		
	Foley to gravity		
	8. Wound care		
	9. Drains Chest tube - wall suction		
	10. Evacuation - circle one		
	Priority Urgent Routine		
	Litter		
	DATE TIME 0823		
	30 March 03		
	[redacted] SIGNED		
	~~Vecuronium~~ ~~Pancuronium~~ 10mg IV Push Now > 1020 MB		
	Versed 1-2mg IV Push Q1° PRN SEDATION		
	[redacted]		
	I Stat [redacted] > 1340		
	ECG+ / 63+ MB		

PATIENT IDENTIFICATION

[redacted]

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.

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
	(b)(3)-1 VENTILATOR ORDERS		
	1. Mode SIMV		
	2. FiO2 60%		
	3. Rate 12		
	4. Volume 750		
	5. PEEP 5		
	6. Continuous SaO2 monitor		
	7. Wean O2 to keep SaO2 >94%		
	8. ABG Q AM or any signficant change in status		
	~~9. Weaning parameters Q AM~~		
	DATE TIME 0922		
	30 March 2003		
	SIGNED (b)(6)-2		
	500 cc CR bolus now		
	(b)(6)-2	1410 (b)(6)-2	
1	V.O. 500 cc CR Bolus x 1 now		
	Dr. (b)(6)-2 Sp (b)(6)-2		
	SIGNED		

PATIENT IDENTIFICATION

EPW (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.

CLINICAL RECORD - DOCTOR'S ORDERS

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

THE DOCTOR SHALL RECORD D/ ME AND SIGN EACH SET OF ORDERS. IF PROF ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLE. MBER IN COLUMN INDICATED BY ARROW BELO

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER ____ HOURS	LIST TIME ORDER NOTED AND SIGN
			25	NS/ LR bolus X	liters	
			26	Neuro checks q 1hr/ 2hr/ 4hr/ 6hr/ q shift		✓
			27	Vascular checks q 1hr/ 2hr/ 4hr/ 6hr/ q shift		
			28	Vent - AC c̄ TV 700, RR12, PEEP5, FiO2 40%		✓
NURSING UNIT	ROOM NO.	BED NO.	29	Lovenox ~~60mg~~ 30mg SQ Q12°		✓

Noted, CPT 29 Mar 03 1845

(b)(6)-2

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER ____ HOURS	
			30	ABG @ ~1830 hrs. ✓		
NURSING UNIT	ROOM NO.	BED NO.				

(b)(6)-2

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER 1906 HOURS	
				29 MAR 03		
				Fentanyl 100mcg FLP Yi		
NURSING UNIT	ROOM NO.	BED NO.				

Noted, CPT 29 Mar 03

(b)(6)-2

(b)(6)-2

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

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT	ROOM NO.	BE

PATIENT IDENTIFICATION

(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

CPT

Noted 29 Mar 03

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	29MAR03	1750 HOURS	
1	Admit Patient to ICU		
2	Diagnosis: S/P ACCS resusc / S/P (R) AKA for trauma		
3	Condition: Stable/Serious/Critical		
4	Allergies: NKDA/		
5	Vital signs q ~~hr~~/q2hr/q6hr/q8hr/q shift (Q ~~15mins~~ 30mins)		
6	Cardiac respiratory monitoring		
7	Diet: NPO / regular/ soft/ clear liquid		
	DATE OF ORDER	TIME OF ORDER HOURS	
8	Activity: AD LIB/ Strict BR/ BR with BSC/ NWB R or L LE		
9	HOB up 30 degrees		
10	Nursing I/O; CDB/ NG to LIS/ LCS		
11	Labs: Chem 7/ H/H/ PT/PTT/ CBC q AM/ 4 hrs/ 8 hrs/ BID		
12	EKG q AM		
	DATE OF ORDER	TIME OF ORDER HOURS	
13	PCXRAY q AM/QOD		
14	IVF NS/ LR/ D5NS/ D51/2NS To run @ 120cc/hr.		
15	Ancef 1 GM IV Q 8 hrs		
16	Gentamycin IV Q		
17	Cefoxitin 2gm IV q8hrs.		
18	O2 titrate to keep SPO2 >		
19	Versed gtt 1-10mg/hr IV titrate to		
	DATE OF ORDER	TIME OF ORDER HOURS	
	Ramsey Scale of		
20	Fentanyl gtt start at 50mcg/hr titrate for adequate pain control. MAX DOSE of		
21	Vecuronium 1mcg/kg/min		
22	MSO4 MG IV q HR PRN Pain		
23	Phenergan 12.5-25mg IV q 4-6hrs PRN N/V		
24	MOM 30cc PRN Gastric upset		

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 40-400; the proponent agency is the Office of The Surgeon General.

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

NURSING UNIT | ROOM NO (b)(6)-2 | BED NO. (b)(6)-2

DATE OF ORDER 29MAR03 TIME OF ORDER 2030 HOURS (b)(6)-2

LIST TIME ORDER NOTED AND SIGN

1. Fentanyl drip 1000mcg 50mcg - 150mcg/hr. titrate for sedation c:
2. Versed 1-4mg/hr titrate for sedation (b)(6)-2

PATIENT IDENTIFICATION (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 29MAR03 TIME OF ORDER 2100 HOURS

1. Clarify: fentanyl 1000mcg in 100ml NS run @ 50-150mcg/hr.
2. Versed 40mg in 50ml NS run @ 1-4mg/hr. titrate for sedation (b)(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
29 MAR 03	2230 HOURS	
(1) X-Match 2u PRBC each unit over ~ IV.		
(2) ~~Albumin~~ ~~over~~		
(3) HCT & ABG in a.m.		
(4) post CXR in a.m.		

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

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER _____ HOURS

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

DATE OF ORDER: 30 MAR 03 TIME OF ORDER: 1530 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Transfuse iii units PRBC's over 2° each
2. v HLH 2° after 3rd unit

(b)(6)-2 (b)(6)-2 (b)(6)-2 MAJ, MC

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 31 MAR 03 TIME OF ORDER: 0730 HOURS

1. CXR
   - (R) Forearm X-Ray
   - (R) Hip X-Ray
   - (R) Shoulder
2. NPO ↑ midnight
3. 500 cc LR IV now
4. Gentamicin 320g IVq24

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

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: TIME OF ORDER: HOURS

1. Neosynephrine 40 mcg/min titrate to MAP = 70 mm
2. CXR @ 1502 done

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

31 MAR 03/1545

Clindamycin 900g IVq8°

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

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 31 MAR 03 TIME OF ORDER: 2355 HOURS

lytes, BUN, glucose

ABG

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

Penicillin 2x10⁶ units IV Q4h

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION MEDCOM - 3814 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 _____ HOURS | LIST TIME ORDER NOTED AND SIGN

① change IVF to D5W at 125 cc/hour
01 April 03
0027
(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

② Pitressin 10 ~~[illegible]~~ units IV now
(b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER _____ HOURS

③ 1 unit PRBC
④ Lytes, BUN, Glucose, Hct AM
(b)(6)-2
01 April 03
(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER _____ HOURS

1 April 2003 | 0838

Disconnect vent tube for one minute, if no breathing place back on vent; repeat procedure @ 1400, if no spontaneous breathing pt is brain dead.
(b)(6)-2
LG/AN

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER (b)(6)-2 _____ HOURS

VO per LTC (b)(6)-2 DC
neosynephrine
1 April 03
1000
(b)(6)-2

Take pt off vent.
Pt is Brain dead
(b)(6)-2

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION MEDCOM - 3815

CLINICAL RECORD

THERA. ...TIC DOCUMENTATION CARE PLAN *(NON-M... ...CATION)*

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

Mo. 03 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 29	30
29 Mar	(b)(6)-2	Vital signs q ~~hr / q2hr / q6hr / q8hr /~~	07	/	
		~~q shift~~ q 30 mins	19	(b)(6)-2	
29 Mar		Cardiac Respiratory monitoring	07	/	
			19	(b)(6)-2	
29 Mar		Diet: NPO / Regular / Soft / Clear	07	/	
		Liquid	19		
29 Mar		Activity: Ad Lib / Strict BR / BR with	07	/	
		BSC / NWB R or L LE	19		
		HOB up 30 Degrees	07		
			19		
29 Mar		Nursing I/O, CDB / NG to LIS / LCS	07	/	
			19		
		Labs: Chem 7 / H&H / PT/PTT /	04		
		CBC q AM / 4 hrs / 8 HRS / BID	08		
			12		
			16		
			20		
			24		
29 Mar	(b)(6)-2	EKG q AM / QOD	06	/	
		PCXRAY q AM / QOD	06		
29 May 03		Neuro checks q 1hr / 2 hr / 4 hr / 6 hr /	07	/	
		q shift	19		
		Vascular checks q 1hr / 2 hr / 4 hr /	07		
		6 hr / q shift	19		
29 Mar	(b)(6)-2	Vent ACE TV 700	07	/	
		RR 12 Peep 5 FiO_2 40%	19		

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: (R) AKA

ADDITIONAL PAGES IN USE: ☐ YES ☒ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

EPW # (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

Treatment Facility: (b)(3)-1

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLA... (NON-MEDICATION)				Mo ____ Yr ____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
29 Mar	- - - - -	Admit Patient to ICU				(b)(6)-2
	- - - - -	Diagnosis: S/P ACLS rescue / S/P @ AKA d/t trauma				
	- - - - -	Condition: Stable (Serious) Critical				
	- - - - -	Allergies: NKDA				
29 Mar	(b)(6)-2	ABG x 1	29 Mar	1830	1900	(b)(6)-2
29 Mar		Hct + ABG in AM	30 Mar	0600		
29 Mar		PCXR in AM	30 MAR	0600		
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					

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

USAPA V1.00

CLINICAL RECORD — THER[A]PEUTIC DOCUMENTATION CARE PLAN (NON-[MEDICA]TION) — Mo. 03 Yr. 03

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

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 29	30
29 Mar 03	(b)(6)-2	IVF NS/ (LR) D5NS D5 1/2NS To run	07	/	
	------	@ 120 cc/hr	19	(b)(6)-2	
29 Mar 03	(b)(6)-2	Ancef 1 GM IV q 8 HRs	04	/	
	------		12	/	
	------		20	(b)(6)-2	
	------	Gentamycin IV Q			

	------	Cefoxitin 2 gm IV q 8hrs			

	------	02 titrate to keep SPO2 >	07		
	------		19		
29	(b)(6)-2	Versed gtt 1-4mg/hr titrate to ~~Ramsey~~	07	/	
	------	~~scale of~~ 10mg in 50cc NS	19	(b)(6)-2	
	------	~~Fentanyl gtt start at 50mcg/hr titrate for~~	07		
	------	~~adequate pain control MAX Dose of~~	19		
	------	Vecuronium 1mcg/kg/min	07		
	------		19		
29 Mar 03	(b)(6)-2	Lovenox 30mg SQ	08	/	
	------	q 12°	20	(b)(6)-2	
	------	Sentanyl 1000mcg in	07	/	
	------	100 cc NS @ 50-150	19	(b)(6)-2	
	------	mcg IV per Hour			

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: (R) AKA + Shrapnel wounds

ADDITIONAL PAGES IN USE: ☐ YES ☒ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

EPW (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

Treatment Facility: 212th Mobile Army Surgical Hospital

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PL (NON-MEDICATION)				Mo 03 Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
29 Mar	(b)(6)-2	Fentanyl 100mcg IVP x 1	29 Mar		1840	(b)(6)-2
29	-----	transfuse 2 u PRBC each over	29Mar	#1	2240	
	-----	10.		#2	0005	
28	(b)(6)-2	(b)(6)-2				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
-----	-----	Morphine Sulfate___mg IV q___hr PRN pain														
-----	-----	Phenergan 12.5-25mg IV q 4-6 hrs prn N/V														
-----	-----	MOM 30cc PRN Gastric Upset														
-----	-----	NS / LR bolus X ___liters														
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															

USAPA V1.00

CLINICAL RECORD

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

Mo.____ Yr.____

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 30 31 1 2
30MAR	(b)(6)-2	VS Q4°	06	(b)(6)-2
			10	
			14	
			18	
			22	
			02	
30MAR	(b)(6)-2	NG TO INTERMITTENT	06	
		SUCTION	14	
			22	
30MAR	(b)(6)-2	LR @ 125cc/HR	06	
			14	D/C'd 1 April 0100 (b)(6)-2
			22	
30MAR	(b)(6)-2	CEFAZOLIN 1GM IV	06	
		Q8°	14	
			22	
30MAR	(b)(6)-2	FOLEY TO GRAVITY	Q6	
			14	
			22	
30MAR	(b)(6)-2	CHEST TUBE TO WALL	Q6	
		SUCTION	14	D/C'd
			22	
31MAR03	(b)(6)-2	GENTAMYCIN 320 mg IV q 24°	10	
31MAR03	(b)(6)-2	Neosynephrine 40mic/min	06	✓
		titrate to map = 70 mmHg	14	✓ D/C'd
			22	✓
		Cleocin (clyodamycin) 900mg IVPB q8°	06	✓
			14	✓
			22	✓

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14

E 15 16 17 18 19 20 21 22

N 23 24 01 02 03 04 05 06

USTED

DA FORM 1 FEB 79 4678 EDITION OF

MEDCOM - 3820

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. _____ Yr. _____

Verify by Initialing						
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
30 MAR	(b)(6)-2	EC8+/63+ ISTAT NOW	3-30-03		1340	(b)(6)-2
30 MAR		VECURONIUM 10Mg IV PUSH NOW	3-30-03		1020	
30 MAR		500cc LR BOLUS NOW	3-30-03		1410	
30 MAR		TRANSFUSE III UNITS PRBC'S OVER 2° EACH	3/30/03		STARTED 1615	
30 MAR		V H/H 2° AFTER 3rd UNIT	3/30/03	—	(b)(6)-2	
30 MAR		TRANSFUSE III UNITS PRBC's	3/30/03	ASAP	~~ASAP~~ 31 MAR	
30 MAR		POST TRANSFUSION H/H	3/30/03	2° POST TRANS.	30 MAR	
30 MAR		CXR, (R) FA, HIP, SHOULDER X-RAY.	3/30/03	ASAP	(b)(6)-2	
31 MAR		NPO AFTER MIDNIGHT	3/31/03	4/01/03		
31 MAR		500cc LR IV NOW	3/31/03	3/31/03	3/31/03	
31 MAR		Pitress 10 units IV x1 now	3/31/03		NONE	
31 MAR		T Unit PRBC	3/31/03	01 AM	—	
31 AM		lytes bun glucose Hgb, Hct in AM	3/31/03	06 AM	—	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED															
30 MAR	(b)(6)-2	MORPHINE SULFATE	3/30 1315	3/30 1440	3/30 2155	01 APR 1033												
		2-5 Mg IV Q1° PRN PAIN	2MG	3MG	3MG	NS,												
30 MAR	(b)(6)-2	VECURONIUM 10Mg IV	3/30 1020															
		PUSH NOW	(b)(6)-2															
30 MAR	(b)(6)-2	VERSED 1-2Mg IV PUSH	3/30 1020	3/30 1300	2-30 1420	3/31 0328												
		Q1° PRN SEDATION	(b)(6)-2															

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

CLINICAL RECORD

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

Mo.____ Yr.____

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	MAR 31	APR 1	DATE DISPENSED
31MAR03	(b)(6)-2	Penicillin 2x10^6 units IV Q4h	06	✓	(b)(6)-2	
	-----		10	✓		
	-----		14	✓		
	-----		18	✓		
	-----		22	✓ HS		
	-----		02			
1Apr03	(b)(6)-2	D5W @ 125cc/hr	06		✓ (b)(6)-2	
	-----		14		✓	
	-----		22		✓	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14

E 15 16 17 18 19 20 21 22

N 23 24 01 02 03 04 05 06

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	
31MAR	(b)(6)-2	lytes, Bun, Glucose, ABG	31MAR	2355	2355	(b)(6)-2	
1 Apr		Pitressin 10 units IV now	31 Apr	100	100		
1 Apr		1 unit PRBC Now	1 Apr	0100	0100		
1 Apr		lytes Bun glucose Hct Am	1 Apr	0700	0625		
1APR		DISCONNECT VENT FOR 1 MIN, IF NOT BREATHING PLACE ON	1APR	—	0800		
	.....	VENT ; REPEAT @ 1400 IF NO SPONTANEOUS BREATHING PT REMAINS DOA	1APR	1400			
	.....						
	.....						
	.....						
	.....						
	.....						
	.....						
	.....						

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED														
.....	.....																
.....	.....																
.....	.....																
.....	.....																
.....	.....																
.....	.....																
.....	.....																
.....	.....																
.....	.....																
.....	.....																
.....	.....																
.....	.....																
.....	.....																

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

(b)(6)-4

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
ADULT TRAUMA FLOW SHEET

OTSG APPROVED (Date)

PREHOSPITAL INFORMATION

TRANSPORT TIME IN: _____

- ☐ Scene ☐ Police
- ☐ Auto ☐ Ambulatory
- ☐ Ambulance ☑ MEDVAC Unit: FST
- ☐ CCATT: Report From: _____
- ☐ Ref Hospital _____
- ☐ Ref Physician _____

MECAHNISM OF INJURY

- ☐ MVA: ☐ Driver or ☐ Passenger ☐ Front ☐ Back ☐ Seat Belt on
- ☐ MCA: ☐ Driver or ☐ Passenger ☐ Helmet worn ☐ Protective Clothing Worn
- ☐ Speed: _____ mph
- ☐ BCA: ☐ Front ☐ Back ☐ Helmet worn
- ☐ Pedestrian vs. Auto Speed: _____ mph
- ☐ Fall _____ ft ☐ Assault
- ☐ GSW ☐ Stab ☑ Frag wound ☐ Crush ☐ Burn
- ☐ Aircraft: Type _____
- ☐ Other _____

PREHOSPITAL TREATMENT

PROCEDURES PRIOR TO ARRIVAL

- ☐ Oral Airway ☐ Nasal Airway
- ☑ ET Tube # _____ ☐ NT Tube # _____
- ☐ Crico # _____
- ☐ O2 @ _____ L/min via _____
- ☐ Breath Sounds: LT: _____ RT: _____
- ☑ IV # _____: Peripheral Subclavian Femoral Intraossesous: Site _____
- ☑ Fluids: ☐ IV 1 2 3 4 5 (6) (7) ☑ Blood 1 (2) 3 4 5
- ☐ CPR: Time started _____ Stopped _____
- ☐ PASG Legs Abd
- ☑ Urinary Cath: Size _____ ☐ NG Tube ☐ OG Tube
- ☑ Chest Tube: ☐ RT ☑ LT ☐ Both
- ☐ Medication _____
- ☐ C-Collar ☐ Spine Immobilization Device Time On: _____
- ☐ Splints: _____ Type: _____
- ☐ Other: _____
- ☐ Tourniquet: Time On _____ Location: _____

AMPLE HISTORY

Allergies: Unknown / intubated

Medications: Fentanyl, Scopolamine Intraoperative Vec, Succinylcholine, Ancef, Ignoglycin

Past Illnesses: Unknown / Intubated

Last Meal: Unknown

Last Tetanus: Unknown

Events: Shrapnel Injuries S/P (R) AKA, post op pneumothorax with chest tube placed, coded Intraoperative to VTach + responded to Epinephrine

Pregnant: ☐ Yes ☐ No / LMP

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

DEPARTMENT/SERVICE/CLINIC (b)(3)-1 [redacted] BM

DATE 79 March 03

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

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

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

DA FORM 4700, MAY 78
MECU OP 36, 1 AUG 98
MRRC apprvl, 9 Jul 98

PAGE 1 of 4

MEDCOM - 3824

USAPPC V2.00

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

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

OTSG APPROVED *(Date)*

TRAUMA RESUSCITATION ORDERS

TIME	LABORATORY	TIME	X-RAYS	TIME	PROCEDURES
16:40	Type/Cross # 4 Units		Lateral C-spine		O2@L ~~mm~~ via:
	Type/Hold		Swimmers		(b)(6)-2 by:
	CBC HCT		Chest: Erect/Supine		NT# by:
	ETOH		Pelvis		Crico# by:
	Drug Screen		Thoracic Spine		Needle Thoracostomy by:
	PT/PTT		Lumbar Spine		Chest Tube# R L
	ABG		Odontoid		RT Return:
	Urinalysis		Skull		LT Return:
	DPL Fluid		Facial Series		ED Thoracotomy by:
	Pregnancy Test + -		Mandible		PIV: Size: Site:
	HIV + -		Abdomen		PIV: Size: Site:
	Chem 5		Extremity: LUE/RUE		PIV: Size: Site:
			Extremity: LLE/RLE		Arterial Line: Size: Site:
	Other:		Other:		Central Line: Size: Site:
			AP chest		Pericardiocentesis by:
			(B) infr/Hrdes		ECG: Sinus Tachycardia
			- ET between		NG # Return Color
			clavicular level		Rectal Tone: Retained Guaiac (+) Neg Colon Rhoid
			(T1-2)		Foley # Return Color
					Cath Urine Dip + -
					Spont Void Dip + -
					Suturing By:
					Restraints: UE LE Type:

FLUID INTAKE OUTPUT

INTAKE	OUTPUT
RL NS	Urine _____ ml
Total Prehospital _____ ml	NG _____ ml
ED: 1 2 3 4 5 6 7 8 9 10 _____ ml	Blood _____ ml
Blood Products	Stool/Diarrhea _____ ml
Total Prehosiptal _____ ml	
ED: PRBC's 1 2 3 4 5 6 7 8 9 10 _____ ml	
FFP: 1 2 3 4 5 6 7 8 9 10 _____ ml	Total Intake _____ ml
Platelets _____ ml	Total Output _____ ml

ABG

TIME	pH	PCO2	PO2	O2@LPM
	See Attached Reader			

MEDICATIONS

TIME	MED	DOSE	ROUTE	BY
	Tetanus			

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

Name —last,

EPW # (b)(6)-4

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

DA FORM 4700, MAY 78

MCEU OP 36, 1 Aug 98

MRRC apprvl, 9 Jul 98

MEDCOM - 3825

USAPPC V2.00

(b)(6)-4

NURSING FLOWSHEET

TIME	1680	1730								
CUFF B/P	107/60	143/61								
Pulse	120	123								
Rhythm	ST	ST								
Respiration	Intubated									
Temperature										
A-Line										
O2 Saturation	100%	100%								
End Tidal Co2										
CVP										
Urinary Output										
GLASCOW SCALE										
Eye Opening	Intubated									
Verbal Response										
Motor Response										
TOTAL GSC SCORE										
R Pupil size + react	Separated									
L Pupil size + react	Nonreactive									

MEDICATION DRIPS																				
1.																				
2.																				
3.																				
4.																				

Time	Notes
	Hostile: Shrapnel injury to (R) leg c Traumatic Amputation c approx 6" Femur Fx 5/c BKA @ FST. Intraoperative DX Hypotension c Exploratory laparotomy x 2 times in OR and (c) Chest tube placed c Intraoperative Code - VTach/Fibrillation c Epinephrine & Atropine & CPR x 3 rounds c Hemoglobin of 6.1 g/dl received 2U RBC & 6 units of FFP c 2L NS bolus. Last Sedative and Pain med on 11:30 (R) Shoulder shrapnel injury s/p I&D (L) Hand (6) stool tube entered (L) leg. AMP (D)s/p (2)ALIF (2) Femur Fx c injury (3)(R) Shoulder shrapnel s/p I&D (4) s/p Intraoperative Code (5) Hand (6) stool - Admit to ICU for continuous monitoring of vitals for further supportive and progressive care. Patient was Extubated

(b)(6)-2	Signature and Title: CPT
1 (b)(6)-2	
2	
3	
4	
5	
6	

Disposition: ☒ Alive Time Out: _____ To: ICU 3 floor
☐ Dead Time Out: _____
To: _____

Operative Permit Signed: ☐ Yes ☐ No ☐ NA
Valuables/Clothing: _____
Family Notified: ☐ Yes ☐ No ☐ NA
Chaplain Service Notified: ☐ Yes ☐ No ☐ NA

MECU OP 36, 1 Aug 98
MRRC apprvl, 9 Jul 98

3/29	0700	SIMV	12		710 ml		.40	5	45	1:2		checked		(b)(6)-2
3/29	0920	SIMV	12		0		.40	5	31	1:2		✓		
3/29	2305	SIMV	12		700		.40	5	32	1:2		✓		
3/30	0345	SIMV	12		710		.40	5	28	1:2		✓		
3/30	0600	SIMV	12		710		.40	5	26	1:2		✓		

b(6)-2

PREPARED BY (Signature & Title)
SSG [redacted] Respiratory Therapy

DEPARTMENT/SERVICE/CLINIC
Respiratory Care Service
Department of Medicine

DATE
29 Mar 03

(Continue on reverse)

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

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

DA FORM 1 MAY 78 4700 Previous editions are obsolete

*U.S. Government Printing Office: 1992 — 311-830/5

MED FC OP 12-1 (Rev), 1 Mar 95

FI (b)(6)-4

(b)(6)-4

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
ADULT TRAUMA FLOW SHEET

OTSG APPROVED *(Date)*

PREHOSPITAL INFORMATION

TRANSPORT TIME IN:_____

☐ Scene ☐ Police

☐ Auto ☐ Ambulatory

☐ Ambulance ☑ MEDVAC Unit: FST

☐ CCATT: Report From:_____

☐ Ref Hospital_____

☐ Ref Physician_____

MECAHNISM OF INJURY

☐ MVA: ☐ Driver or ☐ Passenger ☐ Front ☐ Back ☐ Seat Belt on

☐ MCA: ☐ Driver or ☐ Passenger ☐ Helmet worn ☐ Protective Clothing Worn

☐ Speed:_____mph

☐ BCA: ☐ Front ☐ Back ☐ Helmet worn

☐ Pedestrian vs. Auto Speed:_____mph

☐ Fall_____ft ☐ Assault

☐ GSW ☐ Stab ☑ Frag wound ☐ Crush ☐ Burn

☐ Aircraft: Type_____

☐ Other_____

PREHOSPITAL TREATMENT

PROCEDURES PRIOR TO ARRIVAL

☐ Oral Airway ☐ Nasal Airway

☐ ET Tube #_____ ☐ NT Tube #_____

☐ Crico #_____

☐ O2 @_____L/min via_____

☐ Breath Sounds: LT:_____RT:_____

☑ IV #_____: Peripheral Subclavian Femoral
Intraossesous: Site_____

☑ Fluids: ☐ IV 1 2 3 4 (6) (7) ☑ Blood 1 (2) 3 4 5

☐ CPR: Time started_____ Stopped_____

☐ PASG Legs Abd

☑ Urinary Cath : Size_____ ☐ NG Tube ☐ OG Tube

☑ Chest Tube: ☐ RT ☑ LT ☐ Both

☐ Medication_____

☐ C-Collar ☐ Spine Immobilization Device
Time On:_____

☐ Splints:_____ Type:_____

☐ Other:_____

☐ Tourniquet: Time On_____ Location:_____

AMPLE HISTORY

Allergies: Unknown / Intubated	Last Meal: Unknown
Medications: Fentanyl, Scopolamine Patch, Versed, Succinylcholine, Bactrim, Ciprofloxacin	Last Tetanus: Unknown Events: Shrapnel Injuries B/L (R) Arm, post op pneumothorax with chest tubes placed, Codes Pantaloon Vest to Wrist + responded to Epinephrine
Past Illnesses: Unknown / Patient Looks	Pregnant? ☐ Yes ☐ No LMP?

PREPARED BY *(Signature & Title)* (b)(6)-2 RN

DEPARTMENT/SERVICE/UNIT (b)(3)-1 ER

DATE 7 Nov 00

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

EPW (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

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

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

#(b)(6)-4

INITIAL ASSESSMENT

AIRWAY/BREATHING

☑ Patent ☐ Obstructed

☑ Symmetrical ☐ Asymmetrical

☐ Unlabored ☐ Labored Intubated + Bagg

☐ Trachea Midline ☑ Yes ☐ No

Breath Sounds:	R	L
Present	☑	☑
Clear	☐	☐
Decreased	☐	☐
Absent	☐	☐
Rales/Rhonci	☑	☐

Crepitus: ☐ Yes ☑ No

CIRCULATION

Skin/Mucous ☑ Pink ☐ Cyanotic

Membrane Color ☐ Flushed ☐ Ashen ☐ Pale

Pulses: ☐ Normal ☑ Weak ☑ Bounding ☐ Absent

Rate: 140

Rhythm: Tachycardia

Skin Temp: ☐ Warm ☐ Hot ☑ Cool ☐ Cold

Skin Moisture: ☑ Dry ☐ Moist

DISABILITY

Glascow Coma Scale

1. Eye Opening
   - Spontaneous 4
   - To Voice 3
   - To Pain 2
   - None 1
2. Verbal
   - Oriented 5
   - Confused 4
   - Inappropriate Words 3
   - Incomprehensive 2
   - None 1
3. Motor
   - Obeys Command 6
   - Purposeful Movement 5
   - Withdrawn 4
   - Flexion 3
   - Extension 2
   - None 1

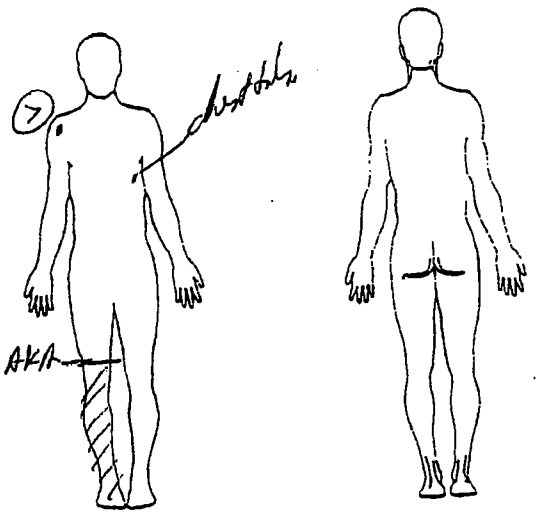
Total Score_____

Fixed + Symmetrical

Pupil Reaction	RT size	LT size
Brisk	☐____mm	☐____mm
Constricted	☐____mm	☐____mm
Sluggish	☐____mm	☐____mm
Dilated	☐____mm	☐____mm
Nonreactive	☐____mm	☐____mm

INDENTIFY INJURY SITE BY NUMBER

1. Laceration	2. Abrasion	3. Hematoma
4. Contusion	5. Deformity	6. Open Fx
7. GSW	8. Stab	9. Burn
10. Cold	11. Edema	12. Amputation
13. Avulsion	14. Frag Wound	15. Pain



HEAD Atraumatic

MAXILLOFACIAL Atraumatic

C-SPINE/NECK No step offs

CHEST (L) chest tube 4-5th DCS ØD/C
Rhonchi (R) chest clear (L)
Wound to (R) Axillary area

ABDOMEN Distended, soft

PERINEUM Dechymosis Heavy (R) stool

MUSCULOSKELETAL
As above.

MECU OP 36, 1 Aug 98
MMRC apprvl, 9 Jul 98

MEDICAL RECORD-SUPPLEMENTAL MEDICAL RECORD

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

REPORT TITLE	OTSG APPROVED DATE
CRITICAL CARE FLOWSHEET	

TIME	NURSING PROGRESS NOTES
0230	~~pt developed who by~~ pt developed a (L) sided body twitch - got Dr [b)(6)-2] who stated it was nothing & since pt is hemodynamically stable not to worry about it. [b)(6)-2] CP, N.
0300	changed dressings to (R) thigh.

[b)(6)-2] re & Title) CPT AN

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 30 Mar 03

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

EPW # [b)(6)-4]

- ☐ HISTORY/ PHYSICAL
- ☐ FLOWSHEET
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIAGNOSTIC STUDIES
- Supplement to SF 510
- ☐ TREATMENT

Date	ICU Day	Diagnosis/Surgery								Post Operative Day				
TIME		0100	0200	0300	0400	0500	0600	0700	0800	0900	1000	1100	1200	1300
VITAL SIGNS														
Temperature		96.7												
Heart Rate		125	119	122										
NBP		103/67	97/63	101/51										
NMAP		81	79	71										
ABP														
AMAP														
SpO2		98	98	99										
ICP/CPP														
CVP														
PAS/PAD														
PAWP														
PVR														
CO/CI														
SVR														
Cardiac Rhythm/ Ectopy			ST											
Circulation	RUE / LUE													
	RLE / LLE	A	A	A										
C N S	Responsiveness	Sed												
	Best eye opening													
	Best verbal response													
	Best motor response													
	Pupil Size & Reaction R/L													
PAIN ASSESSMENT														
Pain/discomfort scale: Denies 0 (no pain) – 10 (worst pain gets)		Sent												
Location:														
Quality: Sharp Dull Pressure Radiating to _____ Other _____														
Intervention: Medication Hotpack Coldpack Reposition Other _____														
Pain Reassessment: Denies 0 (no pain) – 10 (worst pain gets)														
RESPIRATORY														
Mode		SIMV												
Rate		12												
Tidal Volume		700												
FiO2		40												
Pressure Support/ PEEP		15												
INTAKE														
NS		120												
Versed		10												
Sentanyl														
IRRI gods		40												
TOTAL INTAKE														
OUTPUT														
Urine														
Stool														
NGT														
Flatw														
TOTAL OUTPUT														
COMMENTS **Nurse's Initials**		(b)(6)-2												

MEDCOM - 3831

MEDICAL RECORD-SUPPLEMENTAL MEDICAL RECORD

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

REPORT TITLE	OTSG APPROVED DATE
CRITICAL CARE FLOWSHEET	

TIME	NURSING PROGRESS NOTES
0001-0700	pt rec'd 2nd unit of Blood no reactions noted @ 0130 pt developed a twitch in (L) side of body mainly & not associated c̄ Ventilating; notified Dr (b)(6)-2 - who stated to monitor & told him if it got worse. @ 0500 - twitching had remained c̄ no ↑ or ↓. pt possibly by extubated & medevaced this AM. — (b)(6)-2 CPT AN

(b)(6)-2 (Title)	DEPARTMENT/SERVICE/CLINIC	DATE
CPT AN	ICU 3	30 Mar 03

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

EPW (b)(6)-4

- ☐ HISTORY/ PHYSICAL
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT
- ☐ FLOWSHEET
- ☐ OTHER (Specify)

Supplement to SF 510

FORM DA 1 MAY 78 4700

MCEUL OP 365 (Rev), 16 July 01
MRRC apprvl - 07 June 01

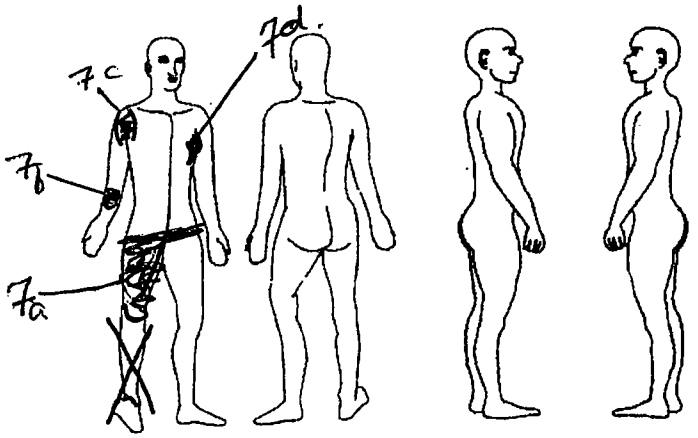
Date	ICU Day	Diagnosis/Surgery							Post Operative Day					
TIME		0100	0200	0300	0400	0500	0600	0700	0800	0900	1000	1100	1200	1300
VITAL SIGNS														
Temperature		96.7		96.9										
Heart Rate		125	119	122	116									
NBP		103/67	97/63	101/51	98/53									
NMAP		81	79	71	68									
ABP														
AMAP														
SpO2		98	99	99	98									
ICP/CPP														
CVP	Resp	22	24	26	24									
PAS/PAD														
PAWP														
PVR														
CO/CI														
SVR														
Cardiac Rhythm/ Ectopy		ST	ST	ST										
Circulation	RUE / LUE	2+ 2+	2+ 2+	2+ 2+										
	RLE / LLE	1+ 2+	2+	1+ 2+										
CNS	Responsiveness	Sed	Sed	Sed										
	Best eye opening	—	—	—										
	Best verbal response	Int	—	—										
	Best motor response	—	—	—										
	Pupil Size & Reaction R/L													
PAIN ASSESSMENT														
Pain/discomfort scale: Denies 0 (no pain) – 10 (worst pain gets)		on fentanyl drip												
Location:		—	—	—										
Quality: Sharp Dull Pressure Radiating to Other		—	—	—										
Intervention: Medication Hotpack Coldpack Reposition Other		—	—	—										
Pain Reassessment: Denies 0 (no pain) – 10 (worst pain gets)		—	—	—										
RESPIRATORY														
Mode		SIMV	—	—	—	—	—	—						
Rate		14	—	—	—	—	—	—						
Tidal Volume		700	—	—	—	—	—	—						
FiO2		40	—	—	—	—	—	—						
Pressure Support/ PEEP		5	—	—	—	—	—	—						
INTAKE														
LR		120	120	120	120	120	120	120						
Versed		10	10	10	10	10	10	10						
fentanyl		15	15	15	15	15	15	15						
Blood			350											
TOTAL INTAKE		145	640	783	930	1075	1220	1365						
OUTPUT														
Urine	—													
Stool														
Chest tube		13												
NGT		30												
TOTAL OUTPUT		43												
COMMENTS														
Nurse's Initials		(b)(6)-2												

TIME	0400											
[illegible] NCP [illegible] Initiated Ongoing Closed Priority #												
Method of Urination: Normal Foley Suprapubic Condom Cath In/Out Cath Ostomy Incontinent	F											
Urine Color: Yellow Amber Hematuria	Y											
Urine Character: Clear Cloudy Sediment Blood clots	CL											
Genital Edema: Y/N	N											
Genital Discharge: White Yellow Green Bloody None Menstruating	—											
SKIN WOUNDS NCP [illegible] Initiated Ongoing Closed Priority #												
Color: Pale Pink Mottled Dusky Cyanotic Jaundiced Flushed	NFR											
Temperature: Hot Warm Cool Clammy Diaphoretic	W											
Specialty bed Egg crate Other												

Code (Document by Numbers) with Time and Initials

1. Abrasions
2. Avulsion
3. Burn
4. Cast
5. Contusion
6. Decubitus
7. Dressing
8. Ecchymosis
9. Erythema
10. Incision
11. Laceration
12. Petechiae
13. Rash
14. Retention Sutures
15. Staples
16. Sutures
17. Tear
18. Wound
19. _____
20. _____

[ ] Clear except as otherwise indicated



Wound Location:	7A											
Approximated Sutured Staples Steri-strips Open to air Dsg Dsg Δ Reinforced D.C.I	DsgD											
Drain: JP Malencott Other _____	—											
Drainage: Serous Sanguineous Purulent None Other: _____	San											
Wound Location :	7b											
Approximated Sutured Staples Steri-strips Open to air Dsg Dsg Δ Reinforced D.C.I	D											
Drain: JP Malencott Other _____	—											
Drainage: Serous Sanguineous Purulent None Other:	San											
Wound Location :	7c											
Approximated Sutured Staples Steri-strips Open to air Dsg Dsg Δ Reinforced D.C.I	DsgD											
Drain: JP Malencott Other _____	—											
Drainage: Serous Sanguineous Purulent None Other:	San											
[illegible] NCP [illegible] Initiated Ongoing Closed Priority #												
Psycho-social: Calm & appropriate Anxious Angry Denial Coping Withdrawn Combative Restless	Sed											
Hygiene: Bath Oral Perineal Eye Cath Linen changed Shave	—											
Activity: Ambulate BR- bedrest BSC Chair ROM Turned (L eft Back Right) HOB Up Repositions Self Dangle	BR											
Call light within reach Side Rails up x ____ Y/N												
Patient teaching provided Y/N (See patient teaching flowsheet)												
Nurse's Initials	(b)(6)-2											

TIME	0400											
RESPIRATORY												
AIRWAY: NT-nasalpharyngeal [ ]R nare [ ]L nare Oralpharyngeal Tracheostomy Size____ ETT 2.5 cm @ ~~mouth~~ R [ ]L side of mouth Size____ cm @ nare [ ]R [ ]L nare Size____	ETT 2S											
RESPIRATIONS: Ventilated Regular Irregular	V											
EFFORT: Unlabored Labored SOB Tachypneic Dyspneic Accessory muscle use	U											
BREATH SOUNDS: Equal Unequal	E											
Clear Diminished Crackles Wheezing Rhonchi Stridor Absent *= Clears with suction/cough — RUL	R											
RML	R											
RLL	R-D											
LUL	R											
LLL	R-D											
COUGH: Productive Nonproductive	N											
SECRETIONS : Oral Nasal ETT Amount: Small Med Large	ETT-S O-S											
Color: Clear White Yellow Green Brown Tan Bloody Pink Cloudy Oral Nasal ETT	C											
Consistency: Thick Thin Oral Nasal ETT	T											
Pulmonary Toileting: IS-Incentive spirometry CPT-Chest PT Cough DB-Deep breath Suctioned	S											
Trach Care: Dsg Δ Inner cannula cleaned Trach ties Δ	—											
CHEST TUBE #1: Location	LMA											
Suction 20 cm H2O Water Seal												
Air leak: +/-	—											
Drainage: Serous Sanguineous SeroSang Purulent	S Sero											
Subcutaneous emphysema: +/- Site:	—											
CHEST TUBE#2 Location	=											
Suction cm H2O Water Seal	|										
Air leak: +/-	|											
Drainage: Serous Sanguineous SeroSang Purulent	|											
Subcutaneous emphysema: +/- Site:	|											
	|											
GI/GU												
ABDOMEN: Soft Firm Flat Round Distended Obese Tender Nontender Ascites	S D N											
BOWEL SOUNDS: Active Hyper Hypo Absent — RUQ / LUQ	Ab Ab											
RLQ / LLQ	Ab Ab											
TUBE: NG OG Dobhoff Peg	NG											
Tube location: Oral Nare[ ]R [ ]L Other	(L)											
Position checked Patent Feeding infusing Clamped LCS-low continous suction Gravity LIS- low intermittent suction Irrigated	Pa LIS											
RESIDUAL check ____ml	0											
Complains of Nausea Vomiting	|										
Tube Drainage: Amount Small Med Large	|										
Tube Drainage Color: Brown Green Yellow Clear Bloody	|										
STOOL: Continent Incontinent _____ostomy Rectal tube Diaper	|										
Ostomy Stoma : Pink Dusky Draining	|										
Stool Color/Consistency: Brown Green Bloody Yellow Black Formed Soft Loose	|										
DIET: _____	|										
Route: Oral NG -nasogastric OG- oralgastric Dobhoff Peg	|										
%Amt Consumed: Breakfast Lunch Dinner Supplements	|										
	|										

TIME	0400												
NEUROLOGICAL													
PUPIL SIZE/REACTION: R/L Brisk Sluggish Fixed	5/5												
RESPONSIVENESS: Alert Oriented X1 X2 X3 Disoriented Lethargic Sedated Sleeping Arousable Pain only Paralyzed Unresponsive	S												
BEST EYE OPENING: Spontaneously Or to: Speech Pain None	N												
BEST VERBAL RESPONSE: Oriented Confused Inappropriate words Incomplete sounds None Intubated Trach	Int												
BEST MOTOR RESPONSE: Obeys commands Moves all extremities Localizes pain Withdraws from pain Flexes to pain Extends to pain None	W												
MOTOR FUNCTION: Strong Weak UE R/L Purposeful Spontaneous None LE R/L	N N N N												
SENSATION: Intact Tingling UE R/L Numbness Absent LE R/L	A A A A												
MEMORY: Long +/- Short +/-	/												
NEURO BLOCKADE: Y/N Train of 4 __of 4 __mAMP													
VENTRICULOSTOMY: Monitor Open to drain Clamped													
Vent/drainage level: ___cm above: FOM-Foramen of Monro Other													
Zeroed ICP monitoring system at: FOM-Foramen of Monro Other													
CSF drainage: Serous Sanguineous Clear Purulent													
CARDIOVASCULAR													
RHYTHM: SR SA SB ST SVT VT VF JUNCT AFIB PAC AFL 1HB 2HB 2HB2 3HB PVC	ST												
HEART SOUNDS: S1 S2 S3 S4 Distant Murmur Rub	S1 S2												
PACER: Method Transvenous Tv Mode Transcutaneous Tc Rate Permanent (Implant) Output/ Sensitivity	— — —												
EDEMA: +1 Trace General +2 Minimal None +3 Moderate Pitting +4 Severe Pitting	RUE/LUE +2 +2 RLE/LLE — N Facial +2												
SCDs/TEDs On/Off	—												
JVD (+) (-) @ 30 degrees													
Homan's Sign (+) (-)													
CAP REFILL B< 3SEC S>3SEC RUE/LUE RLE/LLE	B B — B												
PULSES: Absent Doppler 1+ Faint 2+ Weak 3+ Normal 4+ Bounding Regular Irregular	Rad R/L 2+ 2+ PT R/L A 2+ DP R/L A 2+												
VENOUS ACCESS													

Appearance	Line Type	Site	Date Started	Size											
Dry Intact	(L) PAL	PIV	29 Mar	14G	DI										
Drainage Edema	(L) uint	PIV	29 Mar	18G	DS										
Erythema Dsg Δ															
Infiltrated Flushed															
Zeroed at Phlebostatic axis: Y/N															
Swan _____ cm @ hub															

MEDICAL RECORD-SUPPLEMENTAL MEDICAL RECORD

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

REPORT TITLE	OTSG APPROVED DATE
CRITICAL CARE FLOWSHEET	

TIME	NURSING
2000	See Nursing note for notes. (b)(6)-2 CPT AN

(b)(6)-2

(Signature & Title)	DEPARTMENT/SERVICE/CLINIC	DATE
CPT AN	ICU	29 MAR 03

IFICATION (For typed or written entries, give: Name-last, first, ..., hospital or medical facility)

EPW # (b)(6)-4

- ☐ HISTORY/ PHYSICAL
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT
- ☐ FLOWSHEET
- ☐ OTHER (Specify)

Supplement to SF 510

FORM
DA 1 MAY 78 4700

MCEUL OP 365 (Rev), 16 July 01
MRRC apprvl - 07 June 01

TIME	2000												
NEUROLOGICAL													
PUPIL SIZE/REACTION: R/L Brisk Sluggish Fixed	FHMA HMA F												
RESPONSIVENESS: Alert Oriented X1 X2 X3 Disoriented Lethargic Sedated Sleeping Arousable Pain only Paralyzed Unresponsive	P												
BEST EYE OPENING: Spontaneously Or to: Speech Pain None	N												
BEST VERBAL RESPONSE: Oriented Confused Inappropriate words Incomplete sounds None Intubated Trach	Int												
BEST MOTOR RESPONSE: Obeys commands Moves all extremities Localizes pain Withdraws from pain Flexes to pain Extends to pain None	W												
MOTOR FUNCTION: Strong Weak UE R/L Purposeful Spontaneous None LE R/L	SP SP N N												
SENSATION: Intact Tingling UE R/L Numbness Absent LE R/L	I I A I												
MEMORY: Long +/- Short +/-													
NEURO BLOCKADE: Y/N Train of 4 __of 4 __mAMP													
VENTRICULOSTOMY: Monitor Open to drain Clamped													
Vent/drainage level: ___cm above: FOM-Foramen of Monro Other													
Zeroed ICP monitoring system at: FOM-Foramen of Monro Other													
CSF drainage: Serous Sanguineous Clear Purulent													
CARDIOVASCULAR													
RHYTHM: SR SA SB ST SVT VT VF JUNCT AFIB PAC AFL 1HB 2HB 2HB2 3HB PVC	ST												
HEART SOUNDS: S1 S2 S3 S4 Distant Murmur Rub	S1S2												
PACER: Transvenous Tv Transcutaneous Tc Permanent (Implant) — Method													
Mode													
Rate													
Output/ Sensitivity													
EDEMA: +1 Trace General +2 Minimal None +3 Moderate Pitting +4 Severe Pitting — RUE/LUE	+2 +2												
RLE/LLE	/ N												
Facial	+2												
SCDs/TEDs On/Off	off												
JVD (+) (-) @ 30 degrees	—												
Homan's Sign (+) (-)	—												
CAP REFILL B< 3SEC S>3SEC RUE/LUE	B B												
RLE/LLE	— B												
PULSES: Absent Doppler 1+ Faint 2+ Weak 3+ Normal 4+ Bounding Regular Irregular — Rad R/L	2+ 2+												
PT R/L	A 2+												
DP R/L	A 2+												

INVASIVE LINES

Appearance	Line Type	Site	Date Started	Size												
Dry Intact Drainage Edema Erythema Dsg Δ Infiltrated Flushed	PIV	(R) AC	29	14G	NSG A											
	PIV	(L) wri	29	18G	DSG D.											
Zeroed at Phlebostatic axis: Y/N																
Swan _____ cm @ hub																

Physician | Allergies | Code status: Full DNI Chemical DNR

	1400	1500	1600	1700	1800	1900	2000	2100	2200	2300	2400
T					36	1				36.4	
HR					123	137	139	144	134	136	133
NBP					130/81	109/52	94/49	97/46	91/46	98/53	164/55
MAP					101	77	66	64	66	70	76
SPO_2					96	98	94	98	98	99	98
	H30	1530	1630	1730	1830	1930	2080	2130	2230	2330	0030
T											
HR					142	135	141	135	134	133	130
NBP					133/68	105/54	93/53	87/48	93/49	91/56	102/55
SPO_2					90	75	68	63	68	20	75
					95	96	98	98	97	98	99
					ST						
LR					200	120	120	120	120	120	120
Sent								10	10	10	10
Vene								5	5	5	5
Blood											350
					200	320	440	575	710	845	1230
									1000		
											1000

Reaction
Brisk
Sluggish
Fixed

Responsiveness
A-Alert
O-Oriented
D-Disoriented
L-Lethargic
P-To pain only
PR-Paralyzed
S-Sedated
U-Unresponsive
SL-Sleeping

Best Eye Opening
4-Spontaneous
3-To speech
2-To pain
1-None

Best Verbal Response
5-Oriented
4-Confused
3-Inappropriate
2-Incomprehensible
1-None, ETT, Trach

Best Motor Response
6-Obeys commands
5-Localized to pain
4-Withdrawl to pain
3-Flexion to pain
2-Extension to pain
1-None

Mode
V-Vent
TC-Trach collar
NC-Nasal Cannula
SM-Simple mask
VM-Venti mask
NRB-Non-rebreather mask
FT-Face tent

Ectopy
P-PVC
PA-PAC
M-Multifocal
N-None
F-Frequent >10/min
O-Occasional
R-Rare

Circulation
1+Faint
2+Weak
3+Normal
4+Bounding
A-Absent
D-Doppler

Cardiac Rhythm
SR-Sinus Rhythm
SA-Sinus Arrhythmia
SB-Sinus Bradycardia
ST- Sinus Tachycardia
SVT-Supra Ventricular Tachycardia
VT-Ventricular Tachycardia
VF-Ventricular Fibrillation
AF-Atrial Fibrillation
AFL-Atrial Flutter
1HB-First Degree Heart Block
2HB-Second Degree Heart Block Type I
2HB2-Second Degree Heart Block Type II
3HB-Third Degree Heart Block
JUN-Junctional
BI-Bigemeny
TRI-Trigemeny

Admission Wt	Ventilator Day
Today's Wt	Central Line Day Site:
Yesterday's Wt ~~1230~~	Arterial Line Day Site:
Difference +/- ~~+23~~	PIV Day Site:
Total Input 1230	PIV Day Site:
Total Output 1000	Foley Day
Difference +/- +230	

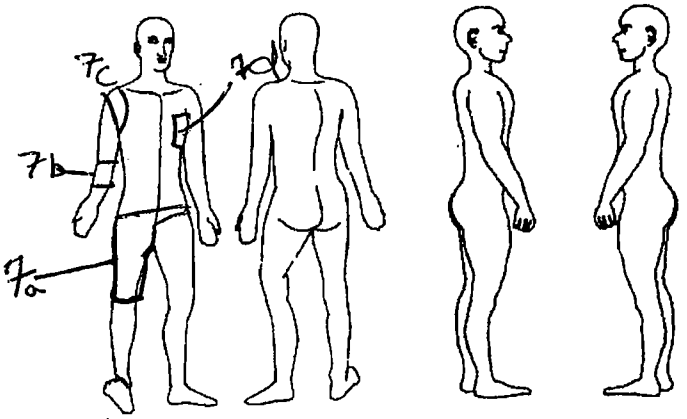
TIME	2000											
AIRWAY: NT-nasalpharyngeal [ ]R nare [ ]L nare Oralpharyngeal Tracheostomy Size___ ETT 25 cm @ [ ]R [ ]L side of mouth Size 8 cm @ nare[ ]R [ ]L nare Size___												
RESPIRATIONS: Ventilated Regular Irregular	V											
EFFORT: Unlabored Labored SOB Tachypneic Dyspneic Accessory muscle use	U											
BREATH SOUNDS: Equal Unequal	E											
Clear Diminished Crackles Wheezing Rhonchi Stridor Absent * = Clears with suction/cough — RUL	R											
RML	R											
RLL	R											
LUL	R											
LLL	R											
COUGH: Productive Nonproductive	N											
SECRETIONS : Oral Nasal ETT Amount: Small Med Large	E-S O-S											
Color: Clear White Yellow Green Brown Tan Bloody Pink Cloudy Oral Nasal ETT	E·T											
Consistency: Thick Thin Oral Nasal ETT	T											
Pulmonary Toileting: IS-Incentive spirometry CPT-Chest PT Cough DB-Deep breath Suctioned	S											
Trach Care: Dsg Δ Inner cannula cleaned Trach ties Δ	✓											
CHEST TUBE #1: Location	(L)mA											
Suction 20 cm H2O Water Seal												
Air leak: +/-	-											
Drainage: Serous Sanguineous SeroSang Purulent	Sm											
Subcutaneous emphysema: +/- Site:	—											
CHEST TUBE#2 Location												
Suction ___ cm H2O Water Seal												
Air leak: +/-												
Drainage: Serous Sanguineous SeroSang Purulent												
Subcutaneous emphysema: +/- Site:												
ABDOMEN: Soft Firm Flat Round Distended Obese Tender Nontender Ascites	D S N											
BOWEL SOUNDS: Active Hyper Hypo Absent — RUQ LUQ	Ab Ab											
RLQ LLQ	Ab Ab											
TUBE: NG OG Dobhoff Peg	NG											
Tube location: Oral Nare[ ]R [ ]L Other ___	(L)											
Position checked Patent Feeding infusing Clamped LCS-low continous suction Gravity LIS- low intermittent suction Irrigated	Pg LIS											
RESIDUAL check ____ml	I											
Complains of Nausea Vomiting	I											
Tube Drainage: Amount Small Med Large	S											
Tube Drainage Color: Brown Green Yellow Clear Bloody	CL											
STOOL: Continent Incontinent _____ostomy Rectal tube Diaper	T											
Ostomy Stoma : Pink Dusky Draining												
Stool Color/Consistency: Brown Green Bloody Yellow Black Formed Soft Loose												
DIET: _____ Route: Oral NG -nasogastric OG- oralgastric Dobhoff Peg												
%Amt Consumed: Breakfast Lunch Dinner Supplements												
	I											

TIME	2000											
GU/ SUPORT	**NOPE**	**Initiated**	**Ongoing**	**Closed**	**Priority**							
Method of Urination: Normal Foley Suprapubic Condom Cath In/Out Cath Ostomy Incontinent	F											
Urine Color: Yellow Amber Hematuria	Y											
Urine Character: Clear Cloudy Sediment Blood clots	CL											
Genital Edema: Y/N	N											
Genital Discharge: White Yellow Green Bloody None Menstruating	—											
SKIN/WOUNDS	**NOPE**	**Initiated**	**Ongoing**	**Closed**	**Priority**							
Color: Pale Pink Mottled Dusky Cyanotic Jaundiced Flushed	P											
Temperature: Hot Warm Cool Clammy Diaphoretic	W											
Specialty bed Egg crate Other	—											

Code (Document by Numbers) with Time and Initials

1. Abrasions
2. Avulsion
3. Burn
4. Cast
5. Contusion
6. Decubitus
7. Dressing
8. Ecchymosis
9. Erythema
10. Incision
11. Laceration
12. Petechiae
13. Rash
14. Retention Sutures
15. Staples
16. Sutures
17. Tear
18. Wound
19. _____
20. _____

[ ] Clear except as otherwise indicated



Wound Location:	7a	(b)(6)-4										
Approximated Sutured Staples Steri-strips Open to air Dsg Dsg Δ Reinforced D.C.I	DSG											
Drain: JP Malencott Other _____	—											
Drainage: Serous Sanguineous Purulent None Other:_____	San											
Wound Location :	7b											
Approximated Sutured Staples Steri-strips Open to air Dsg Dsg Δ Reinforced D.C.I	DSG Δ											
Drain: JP Malencott Other _____	—											
Drainage: Serous Sanguineous Purulent None Other:	San											
Wound Location :	7c											
Approximated Sutured Staples Steri-strips Open to air Dsg Dsg Δ Reinforced D.C.I	DSG Δ											
Drain: JP Malencott Other _____	—											
Drainage: Serous Sanguineous Purulent None Other:	San											
PSYCH/ADL	**NOPE**	**Initiated**	**Ongoing**	**Closed**	**Priority**							
Psycho-social: Calm & appropriate Anxious Angry Denial Coping Withdrawn Combative Restless	C											
Hygiene: Bath Oral Perineal Eye Cath Linen changed Shave	—											
Activity: Ambulate BR- bedrest BSC Chair ROM Turned (L eft Back Right) HOB Up Repositions Self Dangle	BR											
Call light within reach Side Rails up x— Y/N												
Patient teaching provided Y/N (See patient teaching flowsheet)		(b)(6)-2										
Nurse's Initials												

M. C... RECORD - SUPLEMENTAL MEDIC... DATA

r use of this form, see AR 40-66; the propone ...cy is the Office of the Surgeon General

[redacted]

EPORT TITLE

TRAUMA FLOWSHEET

OTSG APROVED *(Date)*

INITIAL ASSESSMENT | ☐ IMMEDIATE ☐ DELAYED ☐ MINIMAL

ate: 30 March Arrival Time: 0210 Sex: M F Age: _____ Wt: _____

llergies: _____ Tetanus Status: UTD Unknown

MP: Last Meal:

hief Complaint: S/P (R) leg amputee

MH: Medications:

reatments PTA:

ITAL SIGNS: BP: 117/31 P: 127 RR: Assisted vent @ TEMP: SAO2: 98% @ 10L

HEST RAUMA ☐YES ☐NO AIN ☐YES ☐NO OB ☐YES ☐NO UNG SOUNDS R L ☐ ☐ CLEAR ☐ ☐ WHEEZES ☐ ☐ DECREASED ☐ ☐ ABSENT

SKIN ☐ WARM ☐ DRY ☐ PALE ☐ DUSKY ☐ MOIST

ABDOMEN ☐ SOFT ☐ DISTENDED ☐ TENDER BOWEL SOUNDS ☐ YES ☐ NO GUIAC TEST ☐ POS ☐ NEG

NEURO BVM

PERRL ☐ YES ☐ NO R_____mm L_____mm

GLASCOW SCORE: _____

PUPIL SIZES: 2 3 4 5 6 7 8 9

GLASCOW COMA SCALE

1. EYE OPENING		2. VERBAL RESPONSE		3. MOTOR RESPONSE	
Spontaneous	- 4	Oriented	- 5	Obedient	- 6
To Voice	- 3	Confused	- 4	Purposeful	- 5
To Pain	- 2	Inappropriate	- 3	Withdrawal	- 4
None	- 1	Incomprehensible	- 2	Flexion	- 3
		None	- 1	Extension	- 2
				None	- 1

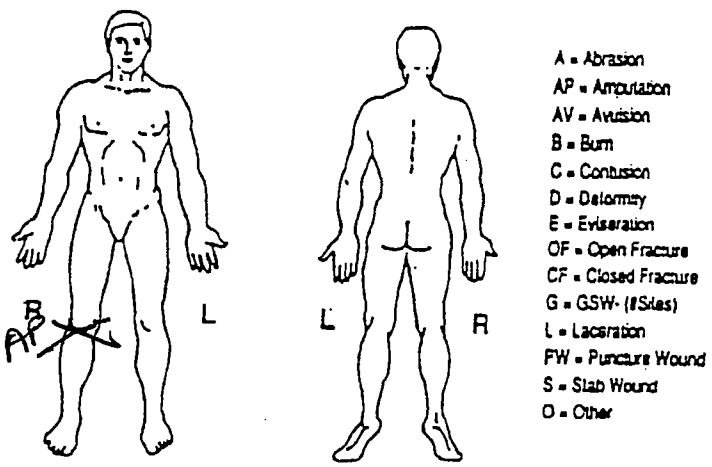
XTREMETIES
] DISTAL PULSES
] RT X 2 ☐ LT X 2
MOVES EXTREMETIES X 4
NO EDEMA
NO DEFORMITIES

XCEPTIONS TO BOVE ARAMETERS:

REATMENTS:

SPLINTS:

2: LPM NC MASK ORAL AIRWAY
TT # MM NASAL AIRWAY
ONITOR ☐Y ☐N EKG ☐Y ☐N
G TUBE #
OLEY: # DPL ☐ POS ☐ NEG
HEST TUBE ☐R ☐L CM H20



A = Abrasion
AP = Amputation
AV = Avulsion
B = Burn
C = Contusion
D = Deformity
E = Evisseration
OF = Open Fracture
CF = Closed Fracture
G = GSW (#Sites)
L = Lacsration
FW = Puncture Wound
S = Slab Wound
O = Other

(Continue on reverse)

REPARED BY *(Signature & Title)* | DEPARTMENT/SERVICE/CLINIC (b)(3)-1 | DATE

ATIENT'S IDENTIFICATION *(For typed or written ntries give: Name - last; first; middle; grade; date; ospital or medical facility)* OD [redacted] (b)(6)-4

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

A FORM 4700, MAY 78

[redacted]

		IV FLUID/BLOOD	AMOUNT INFUSED	OUTPUT
				CHEST TUBE:
				EMESIS:
				NG TUBE:
				URINE:
				EBL:
				OTHER:

TOTAL IN:_____ OUTPUT:_____

NURSING NOTES

TIME	B/P	P	RR	O2 SAT	NURSING ASSESSMENT

LABS: CBC T&S T & C # UNITS____ PT/PTT LYTES UA
OTHER:_____
XRAYS:

MEDICATIONS

TIME	MED	DOSE	ROUTE	INITIALS
0915	Versed	2mg	IVP	(b)(6)-2
0918	Versed	2mg	IVP	

PROCEDURES/PROGRESS NOTES

30 MAR 03 @ 2056 #Rs

(b)(6)-4

(b)(6)-4

AEROMEDICAL EVACUATION PATIENT RECORD

b6-4

PATIENT IDENTIFICATION

1. NAME (Last, First, Middle Initial): EPW [redacted]
2. SSN:
3a. STATUS:
3b. SERVICE:
4. PRECEDENCE: U / P / R — X
5. GRADE:
6. AGE: wk
7. SEX: X Male / Female
8. WEIGHT:
9. BLOOD TYPE:
10. CLASSIFICATION (1A-5F): AMBULATORY / X LITTER
11. ACCEPTING PHYSICIAN:
12. CITE/AUTHORITY NO.:
13. APPT/SURG DATE:
14a. ORIGINATING FACILITY: (b)(3)-1
14b. ORIGINATING FACILITY PHONE NUMBER:
15a. DESTINATION FACILITY: (b)(3)-1
15b. DESTINATION FACILITY PHONE NUMBER:
16. NUMBER OF ATTENDANTS: 16a. MEDICAL: Ø; 16b. NON MED: Ø

17. DIAGNOSIS

s/p RLE traumatic amputation
s/p pulseless V-tach c̄ resuscitation
~~s/p~~ (L) Pneumothorax c̄ chest tube

18. X 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.		X	HYPERTENSION	f.		X	MOTION SICKNESS	k.	X		AMBULATORY
b.	X		CARDIAC HX	g.		X	VISION IMPAIRED	l.		X	AMBULATORY AID
c.		X	DIABETES	h.		X	VOIDING PROBLEMS	m.		X	SELF-MEDS
d.	X		RESPIRATORY	i.		X	BOWEL PROBLEMS	n.		X	ADEQUATE SUPPLY OF MEDS
e.		X	EARS/SINUS	j.		X	SELF-CARE	o.		X	OTHER

20. PHYSICIANS ORDERS

20a. DATE: 24 MAR 03
20b. TIME: 1900
20c. ALLERGIES: NKDA
20d. DIET: REG / GEN NA / CARDIAC / DIABETIC / NPO / CALS
RENAL ____ Gm prot ____ Gm Na ____ Mg 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:
X SUCTION
X NG TUBE
STRYKER FRAME
INCUBATOR
TRACTION
IV PUMP
TRACH
X MONITOR
FOLEY
ORTHOPEDIC BRACES
X CHEST TUBE/HEIMLICH
RESTRAINTS
X OTHER (Explain in 23)

O2: LITERS: ROUTE:
VENTILATOR SETTINGS: TV 700 Rate 12 Peep 5 FiO2 40%

20g. ALTITUDE RESTRICTION:

20h. RECORDS TO ACCOMPANY PATIENT
OUTPATIENT RECORDS
X INPATIENT RECORDS
NARRATIVE SUMMARY
X X-RAYS
OB RECORDS
DENTAL RECORDS
FINANCIAL
OTHER (Specify)

20i. MEDICATIONS/TREATMENTS

Ancef ī gm IV Q8°
IVF LR @ 120 ml/hr
Fentanyl drip
Versed drip

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE

EPW s/p RLE traumatic amputation, seen @ prior facility, wnd washed out, intraop pt. c̄ desaturation (L) chest tube placed for presumed PTX, pt then developed pulseless v-tach, treated c̄ atropine & epinephrine + CPR. Pt currently hemodynamically stable. GCS 7t. Pt. for evac to EPW MTF.

23. ASSESSMENT/PROGRESS

DATE/TIME	NOTES
Ventilator	

(b)(6)-2

24. STAMP AND SIGNATURE OF FLIGHT SURGEON

A. FORM 3899, MAR 95

ADMISSION AND CO[illegible] INFORMATION

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

1. REPORTING MTF: (b)(3)-1
2. [illegible] TION (State or Country Code)
3. REGISTER NUMBER: (b)(6)-4
NAME (Last, First, Middle Initial): [illegible] (b)(6)-4 OD (b)(6)-4
4. PAY GRADE: E4
5. SEX: M
6. DATE OF BIRTH (Y Y Y Y M M D D):
7. AGE AT ADMISSION:
8. RACE: X
9. ETHNIC BACK-GROUND: 9
RELIGION:
10. LENGTH OF SERVICE:
ETS:
11. FMP: 99 20
12. SOCIAL SECURITY NUMBER: (b)(6)-4
ORGANIZATION (Active Duty Only): Iraq Civilian
13. MARITAL STATUS:
ADMISSION: 17 15
BRANCH / CORPS:
14. FLYING STATUS:
15. BENEFICIARY CATEGORY: K 7 8
16. ZIP CODE OF RESIDENCE: 0 9 3 3 0 0 0 0 0
17. UNIT LOCATION (State or Country Code):
18. MOS:
19. TRAUMA: INJ
PREV. ADMISSION: YEAR / NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 12 Direct
WARD: ICU 1
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE:
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code):
NAME AND LOCATION OF [illegible]: MTF (b)(3)-1 [illegible] IRAQ
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE:
21. TYPE OF DISPOSITION: 30 ~~4435~~ DOW
22. MTF TRANSFERRED TO:
23. DATE OF DISPOSITION (Y Y M M D D): 0 3 0 4 0 1
24. CLINIC SVC - ADMITTING: ATB A D
25. MTF TRANSFERRED FROM:
26. DATE THIS ADMISSION (Y Y M M D D): 0 3 0 3 0 3 30 mar 03
27. LOCATION OF OCCURRENCE (Battle Casualty Only): IZ Cause of Death
28. MTF OF INITIAL ADMISSION:
29. DATE INITIAL ADMISSION (Y Y M M D D): 0 3 0 3 0 3

FOR LOCAL USE

Dx
3481 8600
9971 8801
42789 8910
8972 E9912
82009
81380

S/P R LE Traumatic amputation
S/P pulseless V-tech & resuscitation
(L) pneumothorax & chest tube

Ins Trauma

Proc: 843 3404 8752
8604 9904 (G)

ADMITTING OFFICER (Signature, as required): (b)(6)-2 (b)(6)-2
SIGNATURE: (b)(6)-2

DA FORM 2985, MAR 89

EDITION OF MAY 79 IS OBSOLETE

(b)(6)-2

MEDCOM - 3845

ADMISSION AND CC ... INFORMATION

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

1. REPORTING MTF: 1 2 3 4 5 6 — (b)(3)-1
2. (State or Country Code): 7 8 — I A
3. REGISTER NUMBER: 9 10 11 12 13 — (b)(6)-4
NAME (Last, First, Middle Initial): OD — (b)(6)-4
4. PAY GRADE: 16 17 — CIV
5. SEX: 18 — M
6. DATE OF BIRTH (Y Y Y M M D D): 19 20 21 22 23 24 25 26
7. AGE AT ADMISSION: 27 28 29
8. RACE: 30 — X
9. ETHNIC BACK-GROUND: 31 — 9
RELIGION
10. LENGTH OF SERVICE: 32 33 34
ETS
11. FMP: 35 36 — 9 9
12. SOCIAL SECURITY NUMBER: 37 38 39 40 41 42 43 44 45 — (b)(6)-4
ORGANIZATION (Active Duty Only): Iraq Civilian
13. MARITAL STATUS: 46 — S
ADMISSION: 17 15
BRANCH / CORPS
14. FLYING STATUS: 47 48 49
15. BENEFICIARY CATEGORY: 50 51 52 — K 9 1
16. ZIP CODE OF RESIDENCE: 53 54 55 56 57 58 59 60 61 — 0 9 3 3 0 0 0 0 0
17. UNIT LOCATION (State or Country Code): 62 63
18. MOS: 64 65 66 67 68 69 70
19. TRAUMA: 71 — INJ
PREV. ADMISSION: YEAR ☐ NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 72 — 4 C — Direct
WARD: ICU 1
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: MTF (b)(3)-1 IRAQ
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
21. TYPE OF DISPOSITION: 73 74 — 3 0 — 1435 DOW
22. MTF TRANSFERRED TO: 75 76 77 78 79 80
23. DATE OF DISPOSITION (Y Y M M D D): 81 82 83 84 85 86 — 2003 04 01
24. CLINIC SVC - ADMITTING: 87 88 89 90 — A B A A
25. MTF TRANSFERRED FROM: 91 92 93 94 95 96 — (b)(3)-1
26. DATE THIS ADMISSION (Y Y M M D D): 97 98 99 100 101 102 — 2003 03 30 — 30 mon 03
27. LOCATION OF OCCURRENCE (Battle Casualty Only): 103 104 — I Z
28. MTF OF INITIAL ADMISSION: 105 106 107 108 109 110 — A 0 3 K
29. DATE INITIAL ADMISSION (Y Y M M D D): 111 112 113 114 115 116

FOR LOCAL USE

3481
Dx: 8910
8974
Dx: 8415
Trauma Inj
A0 450

S/P RLE Traumatic amputation
S/P pulseless V-tech & resuscitation
(L) Pneumothorax & chest tube

ADMITTING OFFICER (Signature, as required): (b)(6)-2 MD

SIGNATURE OF ADM... (b)(6)-2

DA FORM 2985, MAR 89 (b)(6)-2 EDITION OF MAY 79 IS OBSOLETE

MEDCOM - 3846

ADMISSION AND CODING INFORMATION

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

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

36. FIRST DIAGNOSIS (Principal Diagnosis)							
137	138	139	140	141	142	143	144
		3	4	8		3	

37. SECOND DIAGNOSIS							
145	146	147	148	149	150	151	152
		8	9	1			

38. THIRD DIAGNOSIS							
153	154	155	156	157	158	159	160
	E	9	9	1			

39. FOURTH DIAGNOSIS							
161	162	163	164	165	166	167	168

40. FIFTH DIAGNOSIS							
169	170	171	172	173	174	175	176

41. SIXTH DIAGNOSIS							
177	178	179	180	181	182	183	184

42. SEVENTH DIAGNOSIS							
185	186	187	188	189	190	191	192

43. EIGHTH DIAGNOSIS							
193	194	195	196	197	198	199	200

44. FIRST PROCEDURE (Principal Diagnosis)							
201	202	203	204	205	206	207	208
		8	4		1	5	

45. SECOND PROCEDURE							
209	210	211	212	213	214	215	216

46. THIRD PROCEDURE							
217	218	219	220	221	222	223	224

47. FOURTH PROCEDURE							
225	226	227	228	229	230	231	232

48. FIFTH PROCEDURE							
233	234	235	236	237	238	239	240

49. SIXTH PROCEDURE							
241	242	243	244	245	246	247	248

50. SEVENTH PROCEDURE							
249	250	251	252	253	254	255	256

51. EIGHTH PROCEDURE							
257	258	259	260	261	262	263	264

52. NUMBER OF DIAGNOSTIC FIELDS CONTAINING CODES		53. NUMBER OF PROCEDURAL FIELDS CONTAINING CODES		54. PRIMARY PROVIDER SPECIALTY CODE			55. BLOOD USAGE Y/N
265	266	267	268	269	270	271	272
0	3	0	1				

MEDCOM - 3847

CERTIFICATE OF DEATH *(OVERSEAS)*
Acte de décès *(D'Outre-Mer)*

NAME OF DECEASED *(Last, First, Middle)* Nom du décédé (Nom et prénoms)	GRADE Grade	BRANCH OF SERVICE Arme	SOCIAL SECURITY NUMBER Numéro de l'Assurance Sociale
(b)(6)-4	CIV	—	—
ORGANIZATION Organisation	**NATION** *(e.g., United States)* Pays: Iraq	**DATE OF BIRTH** Date de naissance: —	**SEX** Sexe: ☒ MALE Masculin ☐ FEMALE Féminin

RACE Race	MARITAL STATUS État Civil	RELIGION Culte
☐ CAUCASOID Caucasique	☐ SINGLE Célibataire	☐ PROTESTANT Protestant
☐ NEGROID Négroïde	☐ MARRIED Marié	☐ CATHOLIC Catholique
☐ OTHER (Specify) Autre *(Spécifier)*	☐ WIDOWED Veuf	☐ JEWISH Juif
	☐ DIVORCED Divorcé	☒ OTHER *(Specify)* Autre *(Spécifier)*: Muslim
	☐ SEPARATED Séparé	

NAME OF NEXT OF KIN Nom du plus proche parent	RELATIONSHIP TO DECEASED Parenté du décédé avec le susdit
STREET ADDRESS Domicile à (Rue)	**CITY OR TOWN AND STATE** *(Include ZIP Code)* Ville (Code postal compris)

MEDICAL STATEMENT Déclaration médicale

CAUSE OF DEATH *(Enter only one cause per line)* Cause du décès (N'indiquer qu'une cause par ligne)			INTERVAL BETWEEN ONSET AND DEATH Intervalle entre l'attaque et le décès
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH[1] Maladie ou condition directement responsable de la mort.[1]		anoxic encephalopathy	3 days
ANTECEDENT CAUSES Symptômes précurseurs de la mort.	MORBID CONDITION, IF ANY, LEADING TO PRIMARY CAUSE Condition morbide, s'il y a lieu, menant à la cause primaire	status post gsw shot wound to @leg, s/p traumatic amputation	3 days
	UNDERLYING CAUSE, IF ANY, GIVING RISE TO PRIMARY CAUSE Raison fondamentale, s'il y a lieu, ayant suscité la cause primaire	post operative cardiac dysrhythmia	
OTHER SIGNIFICANT CONDITIONS[2] Autres conditions significatives[2]			

MODE OF DEATH Condition de décès	AUTOPSY PERFORMED Autopsie effectuée ☐ YES Oui ☐ NO Non	CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES Circonstances de la mort suscitées par des causes extérieures
☐ NATURAL Mort naturelle	MAJOR FINDINGS OF AUTOPSY Conclusions principales de l'autopsie	
☐ ACCIDENT Mort accidentelle		
☐ SUICIDE Suicide	NAME OF PATHOLOGIST Nom du pathologiste	
☐ HOMICIDE Homicide	SIGNATURE Signature / DATE Date	AVIATION ACCIDENT Accident d'Avion ☐ YES Oui ☐ NO Non

DATE OF DEATH *(Hour, day, month, year)* Date de décès *(l'heure, le jour, le mois, l'année)*	PLACE OF DEATH Lieu de décès

I HAVE VIEWED THE REMAINS OF THE DECEASED AND DEATH OCCURRED AT THE TIME INDICATED AND FROM THE CAUSES AS STATED ABOVE.
J'ai examiné les restes mortels du défunt et je conclus que le décès est survenu à l'heure indiquée et à la suite des causes énumérées ci dessus.

NAME OF M... (b)(6)-2	TITLE OR DEGREE Titre ou diplôme
GRADE Grade: LTC	INSTALLATION OR ADDRESS ... (b)(3)-1
DATE Date: 01 April 2003	SIGNATURE Sig... (b)(6)-2

[1] *State disease, injury or complication which caused death, but not mode of dying such as heart failure, etc.*
[2] *State conditions contributing to the death, but not related to the disease or condition causing death.*
[1] *Préciser la nature de la maladie, de la blessure ou de la complication qui a contribué à la mort, mais non la manière de mourir, telle qu'un arrêt du coeur, etc.*
[2] *Préciser la condition qui a contribué à la mort, mais n'ayant aucun rapport avec la maladie ou à la condition qui a provoqué la mort.*

DD FORM 1 APR 77 2064 REPLACES DA FORM 3 ... JAN 72 AND DA FORM 3565-R(PAS), 26 SI ... WHICH ARE OBSOLETE.

HOSPITAL REPORT OF DEATH

FOR USE OF THIS FORM, SEE AR 40-2; THE PROPONENT AGENCY IS THE OFFICE OF THE SURGEON GENERAL.

NAME AND LOCATION OF HOS

Instructions - Medical Officer in attendance will:

Prepare, in one copy only, Items 1 through 10 and sign Item 11. Print or type entries.

Send form, without delay to the Registrar or Administrative Officer of the Day, for necessary action and for preparation of required number of copies.

SECTION A - ATTENDING MEDICAL OFFICER'S REPORT

PERSONAL DATA

1. PATIENT DATA *(Patient's ward plate will be used to imprint identifying data if available)* (b)(6)-4

OD

Patient's name (Last, first, middle initial), Grade, Social Security Account No., Register Number and Ward Number

2. TIME OF DEATH *(Hour-day-month-year)*

3. MEDICAL EXAMINER/ CORONER'S CASE ☐ YES ☐ NO

4. RELIGION Muslim

5. CHAPLAIN NOTIFIED ☐ YES ☐ NO

6. NAME, ADDRESS AND RELATIONSHIP OF RELATIVE OR FRIEND PRESENT AT DEATH

CAUSE OF DEATH

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7a. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury, or complication which caused death)*	DUE TO *(or as a consequence of)* anoxic encephalopathy	3 days
7b. ANTECEDENT CAUSES *(Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last)*	DUE TO *(or as a consequence of)* (1) post op cardiac dysrhythmia	
	(2)	
8. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	a. S/P GSW to (R) leg with	
	b. traumatic amputation	

9. DATE 01 April 2003

10. TYPED OR PRINTED NAME AND GRADE OF MEDIC (b)(6)-2

11. SIGNATURE OF MEDICAL OFFICER IN ATTENDANCE (b)(6)-2

SECTION B - ADMINISTRATIVE ACTION

TYPE OF ACTION	HOUR	DAY	MONTH	YEAR	INITIALS OF RESPONSIBLE OFFICER
12. TELEGRAM TO NEXT OF KIN OR OTHER AUTHORIZED PERSON					
13. POST ADJUTANT GENERAL NOTIFIED					
14. IMMEDIATE CO OF DECEASED NOTIFIED					
15. INFORMATION OFFICE NOTIFIED					
16. POST MORTUARY OFFICER NOTIFIED					
17. RED CROSS NOTIFIED					
18. OTHER *(Specify)*					
19.					

SECTION C - RECORD OF AUTOPSY

20. AUTOPSY PERFORMED *(If yes, give date and place)* ☐ YES ☐ NO

21. AUTOPSY ORDERED BY *(Signature)*

22. PROVISIONAL PATHOLOGICAL FINDINGS

23. DATE

24. TYPED NAME AND GRADE OF PHYSICIAN PERFORMING AUTOPSY

25. SIGNATURE OF PHYSICIAN PERFORMING AUTOPSY

26. DATE

27. TYPED NAME AND GRADE OF REGISTRAR

28. SIGNATURE OF REGISTRAR

DA FORM 1 OCT 72 3894

REPLACES DA FORM 8-257, 1 JAN 61, WHICH WILL BE USED.

*U.S. GPO: 1993-342-027/80481

CERTIFICATE OF DEATH *(OVERSEAS)*
Acte de décès *(D'Outre-Mer)*

NAME OF DECEASED *(Last, First, Middle)* Nom du décédé (Nom et prénoms)	GRADE Grade	BRANCH OF SERVICE Arme	SOCIAL SECURITY NUMBER Numéro de l'Assurance Sociale
(b)(6)-4	CIV	—	

ORGANIZATION Organisation	NATION *(e.g., United States)* Pays	DATE OF BIRTH Date de naissance	SEX Sexe
Iraqi Civilian			☒ MALE Masculin ☐ FEMALE Féminin

RACE Race	MARITAL STATUS État Civil		RELIGION Culte	
CAUCASOID Caucasique	SINGLE Célibataire	DIVORCED Divorcé	PROTESTANT Protestant	OTHER *(Specify)* Autre *(Spécifier)*
NEGROID Négroïde	MARRIED Marié		CATHOLIC Catholique	X Muslim
OTHER (Specify) Autre *(Spécifier)*	WIDOWED Veuf	SEPARATED Séparé	JEWISH Juif	

NAME OF NEXT OF KIN	RELATIONSHIP TO DECEASED Parenté du décédé avec le susdit
(b)(6)-4	SON

STREET ADDRESS Domicile à (Rue)	CITY OR TOWN AND STATE *(Include ZIP Code)* Ville (Code postal compris)
(b)(6)-4	

MEDICAL STATEMENT Declaration médicale

CAUSE OF DEATH *(Enter only one cause per line)* Cause du décès (N'indiquer qu'une cause par ligne)		INTERVAL BETWEEN ONSET AND DEATH Intervalle entre l'attaque et le décès
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH[1] Maladie ou condition directement responsable de la mort.[1] X	Pulmonary embolism	
ANTECEDENT CAUSES Symptômes précurseurs de la mort. — MORBID CONDITION, IF ANY LEADING TO PRIMARY CAUSE Condition morbide, s'il y a lieu, menant à la cause primaire X	Traumatic amputation	
ANTECEDENT CAUSES Symptômes précurseurs de la mort. — UNDERLYING CAUSE, IF ANY GIVING RISE TO PRIMARY CAUSE Raison fondamentale, s'il y a lieu, ayant suscité la cause primaire X		
OTHER SIGNIFICANT CONDITIONS[2] Autres conditions significatives[2]		

MODE OF DEATH Condition de décès	AUTOPSY PERFORMED Autopsie effectuée ☐ YES Oui ☒ NO Non	CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES Circonstances de la mort suscitées par des causes extérieures
NATURAL Mort naturelle	MAJOR FINDINGS OF AUTOPSY Conclusions principales de l'autopsie	Battle injury c̄ traumatic amputation prolonged checkout led it pulmonary embolism
ACCIDENT Mort accidentelle		
SUICIDE Suicide	NAME OF PATHOLOGIST Nom du pathologiste	
HOMICIDE Homicide	SIGNATURE Signature / DATE Date	AVIATION ACCIDENT Accident à Avion ☐ YES Oui ☐ NO Non

DATE OF DEATH *(Hour, day, month, year)* Date de décès *(l'heure, le jour, le mois, l'année)*	PLACE OF DEATH Lieu de décès
4/4/03 20 06	Iraq

I HAVE VIEWED THE REMAINS OF THE DECEASED AND DEATH OCCURRED AT THE TIME INDICATED AND FROM THE CAUSES AS STATED ABOVE.
J'ai examiné les restes mortels du défunt et je conclus que le décès est survenu à l'heure indiquée et à la suite des causes énumérées ci dessus.

NAME OF MEDICAL OFFICER (b)(6)-2	Militaire ou du médicin sanitaire	TITLE OR DEGREE Titre ou diplômé
	MD	

GRADE Grade	INSTALLATION OR ADDRESS Installation ou adresse
04	(b)(3)-1

DATE Date	SIGNATURE Signature
04/04/03	(b)(6)-2

[1] *State disease, injury or complication which caused death, ... ure, etc.*
[2] *State conditions contributing to the death, but not relate... h.*
[1] *Préciser la nature de la maladie, de la blessure ou de la complication qui a contribué à la mort, mais non la manière de mourir, telle qu'un arrêt du coeur, etc.*
[2] *Préciser la condition qui a contribué à la mort, mais n'... aucun rapport avec la maladie ou à la condition qui a p... ué la mort.*

DD FORM 1 APR 77 2064 REPLACES DA FOR... 5, 1 JAN 72 AND DA FORM 3565-R(PAS), ... 75, WHICH ARE OBSOLETE.

HOSPITAL REPORT OF DEATH

FOR USE OF THIS FORM, SEE AR 40-2; THE PROPONENT AGENCY IS THE OFFICE OF THE SURGEON GENERAL.

NAME AND LOCATION OF HOSPITAL

Instructions - Medical Officer in attendance will:

Prepare, in one copy only, Items 1 through 10 and sign Item 11. Print or type entries.

Send form, without delay to the Registrar or Administrative Officer of the Day, for necessary action and for preparation of required number of copies.

SECTION A - ATTENDING MEDICAL OFFICER'S REPORT

PERSONAL DATA

1. PATIENT DATA *(Patient's ward plate will be used to imprint identifying data if available)*

(b)(6)-4

Patient's name (Last, first, middle initial), Grade, Social Security Account No., Register Number and Ward Number

2. TIME OF DEATH *(Hour-day-month-year)*: 2006 / 4/4/03

3. MEDICAL EXAMINER/ CORONER'S CASE: ☐ YES ☒ NO

4. RELIGION: Muslim

5. CHAPLAIN NOTIFIED: ☒ YES ☐ NO

6. NAME, ADDRESS AND RELATIONSHIP OF RELATIVE OR FRIEND PRESENT AT DEATH

(b)(6)-4

CAUSE OF DEATH

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7a. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury, or complication which caused death)*	DUE TO *(or as a consequence of)*: Pulmonary embolism	
7b. ANTECEDENT CAUSES *(Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last)*	DUE TO *(or as a consequence of)*: (1) Traumatic amputation	
	(2)	
8. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	a.	
	b.	

9. DATE	10. TYPED OR PRINTED NAME AND GRADE OF MEDICAL OFFICER IN ATTENDANCE	11. SIGNATURE OF MEDICAL OFFICER IN ATTENDANCE
4/4/03	(b)(6)-2 MD O4	(b)(6)-2

SECTION B - ADMINISTRATIVE ACTION

TYPE OF ACTION	HOUR	DAY	MONTH	YEAR	INITIALS OF RESPONSIBLE OFFICER
12. TELEGRAM TO NEXT OF KIN OR OTHER AUTHORIZED PERSON					
13. POST ADJUTANT GENERAL NOTIFIED					
14. IMMEDIATE CO OF DECEASED NOTIFIED					
15. INFORMATION OFFICE NOTIFIED					
16. POST MORTUARY OFFICER NOTIFIED					
17. RED CROSS NOTIFIED					
18. OTHER *(Specify)*					
19.					

SECTION C - RECORD OF AUTOPSY

20. AUTOPSY PERFORMED *(If yes, give date and place)* ☐ YES ☐ NO	21. AUTOPSY ORDERED BY *(Signature)*

22. PROVISIONAL PATHOLOGICAL FINDINGS

23. DATE	24. TYPED NAME AND GRADE OF PHYSICIAN PERFORMING AUTOPSY	25. SIGNATURE OF PHYSICIAN PERFORMING AUTOPSY
26. DATE	27. TYPED NAME AND GRADE OF REGISTRAR	28. SIGNATURE OF REGISTRAR

DA FORM 1 OCT 72 3894

REPLACES DA FORM 8-257, 1 JAN 61, WHICH WILL BE USED.

*U.S. GPO: 1993-342-027/80481

(b)(6)-4

Born 1940

Positive i.d. by son (b)(6)-4

Local Phone # (b)(6)-4

(b)(6)-4

PATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4 (b)(6)-4	CW	

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M		Iraqi	Muslim	—	—	—

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99	—	—	ICU

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
—	—	—			Inj

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Trans	1130	ABAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
(b)(6)-4	DOW	4/4/03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
Tel (b)(6)-4		30 MAR 03	

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD; COMPONENT TRANSFUSED
(b)(3)-1		

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

War related

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

(1) s/p
(2) Traumatic Amputation - Knee 897.4
(2) Pulmonary Embolism 415.1

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER (b)(6)-2 MAJ, MC

SIGNA (b)(6)-2

(b)(6)-2 MD

DAY 79

EDITION OF 1 AUG 76 IS OBSOLETE

USAPPC V1.10

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4	CIV	

4. SEX	5. AGE	6. RACE	7.	LNGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M		Iraqi	muslim	—	—	—

11. PMP	12. SSN	13. ORGANIZATION	14. WARD
99	—	—	ICU

15. FLYING STATUS	16. RATING DSG	17. DEPT., BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
—	—	—	—		Inj

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Trans	1130	ABAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
(b)(6)-4	DOW	4/4/03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
Tel (b)(6)-4		30 MAR 03	

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1		

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

WDR related

34. DIAGNOSES OPERATIONS AND SPECIAL PROCEDURES

(1) s/p

(2) Traumatic Amputation - Knee 897.4 — Trauma — Inj. 959

(3) Pulmonary Embolism 415.19

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER (b)(6)-2 MAJ, MC SIGNA (b)(6)-2

(b)(6)-2 MD

AY 79 EDITION OF 1 AUG 76 IS OBSOLETE

J-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE

EPW arrives via transport from Blackhawk
PT MOI OSW (L) side of Thorax

28 Mar 03 1930 DS in OR for exlap. Start time 1940 end —
time: 2213. to ICU. [redacted] LCDR MC

Preop dx: Multiple GSW - chest (L) anterior, lateral laceration; GSW to abdomen x1 (+1 c̄ schrapnel); (R) LE GSW x2 c̄ lateral entry, medial exit c̄ laceration/hematoma, compartment syndrome vs vascular injury.

Procedure: Local exploration of GSW (Chest tube placed in SST; Ex. lap and large hematoma in rectus (small venous bleeding ligated c̄ omentum bleeding vessel), washout. (R) LE fasciotomy but when hematoma evacuated, obliteration of arteries/musculature @ the trifurcation: after consultation c̄ orthopedic surgeon, performed BKA amputation @ site of comminuted tibial fx.

Anesthesia: General.

GBL: 1500 (½ hematoma) Surgeons: [redacted]

Sely: 500 Pt has been hypotensive and is hypothermic, required

LR: 6000cc significant volume and pressors to maintain systolic pressures

Blood: 2 in OR, in 70-80's, but episodes in 60's for transient period

2 in SICU of time. Will proceed to SICU intubated for resuscitation

[redacted] 200 28% and warming

[redacted] LCDR MC

(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]

PROGRESS NOTES

Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE

3/30/03 - 0230 : Received from OR; pt sedated on ventilator see orders + anesthesia records. Abd dry c̄ minimal drainage/outlined; (D) LE stump dry C/D/I. Infused 1 unit PRBC, Pleurovac connected to suction, VSS, UOP adequate, see TPR record — (b)(6)-2

3/30/03 - 0245 : Rhonci to bilat lungs + diminished BS to bases bilat —

3/30/03 0255 Surgery —

(b)(6)-2

Intubated and sedated c̄ MSO4/Versed intermittent dosing. ~~As~~ Is hemodynamic stability improves today, may be able to lighten sedation to assess neurologic status. Hypotensive c̄ systolics in 80's - 90's ↓ pressors, but recently hypotensive episode in 60s systolics responded briskly to fluid bolus. Received 4 units total of pRBC's and is not clinically in DIC, only minimal drainage into dressings and tube sites. IVF is being warmed but he remains hypothermic axillary 93°. Will continue IVF @ current rate for perfusion and follow for ΔS. O_2 saturation 94 - 98% on 30% SIO_2. Lungs have sl + BS in (B) bases - dressings are intact over wounds and CT - CT ↓ output and ↑ AL. Will pull CT when off (F) pressure. Abd soft, dressings intact, nondistended. Maintain dressings and will reinforce as necessary. (b)(6)-2

UO remains brisk, unable to assess chemistries, but will dip to determine if any osmotic diuresis exists. Continue warming process and plans for medevac at earliest availability and pt's hemodynamic stability. (b)(6)-2

(Continue on reverse side)

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

REGISTER NO. b6-2 [redacted] no

WARD NO. (b)(6)-2

(b)(6)-4

PROGRESS NOTES

Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | NURSING ~~PROGRESS~~ NOTES

DATE	30 MAR 03 NOTES
0619	Assume care of (b)(6)-4 Pt intubated 8.0 approx 24cm @ lip, SIMV 10, 800, 5 c̄ PIPs of low 20s. LS c̄ bilateral rhonchi, O_2 sats 93-94% on FIO_2 30%. RR 10-12. Return TV 790-820. Neuro wise pt is sedated c̄ Valium & MSO4, PERL. ~~NOT to~~ error Nasal temp probe in place to left nares & does correlate c̄ thermometer. Temp 33.2 on initial assessment. Hot line immediately set up, extra blankets placed, temp now 33.8. HR 90-100 c̄ few multifocal PVCs, B/p hypotensive 70/40 c̄ initial assessment, 600cc LR bolus given. B/p now 106/63. Pulses palpable throughout, minus RLE. Ext cool to touch. Cap refill > 3sec. BS absent, ABD round. Foley draining clear yellow urine. (L) CT to 20cm sxn c̄ minimal bloody output. Drsg intact. (L) atest drsg intact c̄ some bloody drainage noted. RLE stump drsg intact. Midline ABD incision c̄ intact drsg ø drainage. 18g PIV in (L) AC c̄ LR @ 100cc°. Pt-Sp GSW to (L) atest, Sp ex lap for GSW to ABD, GSW to RLE Sp (R) BKA. Arrived to ICU @ 0153. (b)(6)-2
0715	Check pt stump notice excessive blood drainage, reinforce with kerlix bandages (b)(6)-2
0740	Dr (b)(6)-2 came by check (R) stump reinforce with ace wraps, kerlix bandages (b)(6)-2
0955	Pt prepared for medevac at this time. Metoxin 1cm IV given. TOTAL I&O for shift CT 20cc Foley 195cc IVF 2000L NOT placed to (R) nares 100cc of green gastric contents sxned (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES MEDS
3/30/03	0200 - Mefoxin 1 gm IV (b)(6)-2
	0300 - MgO4 2mg IVP
	0510 - MSO4 5mg IVP (b)(6)-2
	0510 - Valium 5mg IVP
	0715 - 4MG MORPHINE IVP (b)(6)-2
	0715 - 5MG VALIUM
	0829 - 5MG VALIUM (b)(6)-2
	0940 MSO4 3mg
	0945 Metoxin 10mIV
	1245 - ARRIVED AT ICU, VS. B/P 88/52, RR-12 (bb-2) (BAG VALVE MASK THEN VENTILATOR SETTINGS - SEE NOTE R/T) P. 109, T. 97.0, SATS 21% (FIO2 - 100%) LUNGS CLEAR, NG ON (R) NARE, CHECKED PLACEMENT C̄ LOUD ABD, GURGLING SOUNDS AND GASTRIC SECRETION UPON SUCTIONING C̄ TUMY SYRINE, CHEST TUBE (L) CHEST TO PLEURONIC ONLY C̄ INTERMIT. SUCTION, ABD DRESSING AND (L) UPPER THOMAX AREA DRESSINGS C̄ MINIMAL DRAINAGE (bb-2), AMPUTATION ON (R) LOWER NOT SURGICALLY REPAIRED YET, DR (b)(6)-2 AND COL (b)(6)-2 SAW WOUND AND DRESSING CHANGE WAS DONE, OTHERWISE GOOD DISTAL PULSES AND CAP. REFILL >2SEC x3, SOFT RESTRAIN ON UPPER EXTREMITIES PER DR. (b)(6)-2 AND VALIUM 2mg IV FOR ↑ AGITATION. (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

DATE	NOTES
30 March 03	15:00 PT EXTUBATED RR 20, SATS 100% c̄ NON-BREATHER
	10L/min, will wean off to keep SATS above 94%, P-116
	B/P-95/47 mean 71, lungs clear in all fields, AxO, able
	to verbalize, waiting for translator, will continue to monitor — AK
16:00	Anuf 16m given IV, PT on face mask 4l/min - SATS 95%
	stable, see VS flow sheet. (b)(6)-2
1700	Gentamycin 400mg IV given now, stable FM 4l/min RR 22 SATS 93%
31 Mar 03	Nursing: 2U Ot blood hung, Pre-med c̄ 650mg Tylenol PR and
0905	12.5mg benadryl IV. Baseline vitals T 99.9 AX P 130 R 18 B P 80/46 SAO2: 93%
	IV infiltrated restarted in ⓡ Bicep. Blood restarted. (b)(6)-2
Times	0940: VS T 99.8 P 128 R 13 BP 74/49 SPO2 98 6L Face mask
	1005 VS T 99.7 P 125 R 19 BP 80/51 SPO2 98 6L Face mask
	1030 VS T 99.3 P 104 R 15 BP 82/52 SPO2 98
	Second unit Hung @ 1105 see SF 518 for VS. (b)(6)-2 Sawyi
	1145 VS T 99.7 P 112 R 18 BP 88/53 SPO2 100 6L Face mask
	1225 VS T 99.6 P 112 R 15 BP 84/58 SPO2 98% 3L Face mask
	1255 VS T 99.2 P 114 R 14 BP 84/51 SPO2 99% 3L Face mask
	1325 Blood is finished flushed c̄ 500cc/NS. No adverse
	reaction VS T 99.3 P 111 R 17 BP 93/54 SAO2 98% 3L Face mask

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
30 mar 2015	- PT A&O X3, multiple abrasions on Head & ~~Face~~ Face 20 BPM, sating 99% on 3L O2 via simple mask & O2 concentrator. BS shallow c̄ audible snores & course when auscultated. BS diminished in (L) Lower lobe, cardio/ Normal Sinus tacky, cap ref <3sec, all pulses +3, central line on (L) inf 125cc/hr. Dressing on (R) chest, chest tube-removed CDI. Midline incision Dressing CDT. BKA sight has been bleeding Dressing reinforced. BS Hypo-active, no signs of Distention. Foley to Gravity QS. (b)(6)-2 Spc LPN
30 mar 03	0130 PT c̄ sawtooth rythm HR 170-200, called DR Smith, 5mg Labutolol, 1 unit Ot blood given. blood started @ 0131, no reaction, vitals remained stable, infusion complete @ 0238. Vitals @ Finish BP 102/60 HR 100 Temp 97.5 (b)(6)-2 Spc LPN (b)(6)-2
1 Apr 03 1600	Nursing VSS Active bowels sound. Stump has serous sequences drainage. Tolerates sips of water. Dr. Advance diet to Clear liquids. NG tube Dc'd. O2 Sats 95% on 3L Face mask. Midline drag is minimal through. Will Continue to monitor (b)(6)-2 SSG 9/Wm6

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

DATE	NOTES
17Apr03	Nursing – 2U of Blood started.
1800	1805 VS T 98.7 P 110 BP 130/75.
	1910 VS T 98.2 P 104 BP 132/80
	1825 VS T 99.2 P 109. BP 128/78
	1840 T 98.8 P 106 BP 130/76
	1850 2nd unit of Blood started. No adverse reaction noted
	O_2 SAT 97 @ 3L Face mask. Brief on Coming Shift. (b)(6)-2

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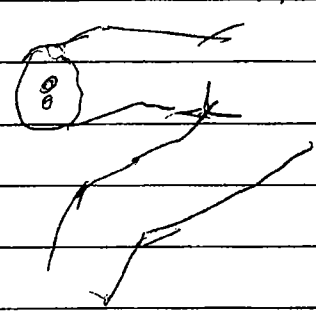
MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
30 March 2003	Pt is 50-60 yo Iraqi ♂ QD 71 who was wounded c̄ multiple missiles fragments; has the following
	(1) (R) BKA
	(2) Exp lap c̄ lignite of bleeding
	(3) chest wound s/p placement of chest tube
	(4) Hx of hypothermia
	Chest -
	Lungs - some coarse rhonchi thought all lung fields.
	Heart - RRR s̄ (m)
	Abdom - soft, tender, BS absent, abandage in place
	Ext. (R) LL has BKA s̄ flaps (wound not checked)
	
	A - as above
	P - per Dr [redacted] 66-2, needs debridement of amputation stump.
	CXR tomorrow to ✓ lung fields
	D. Anuf & gent.
	(b)(6)-2 [redacted] um LTC

RELATIONSHIP TO SPONSOR	SPON[redacted] LAST	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.
(b)(6)-4		

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

MEDCOM - 3862
509-114

DATE	NOTES
30 MAR 03	Recieved pt resting in bed. Pt is drowsy easily arousible. ~~Rates~~ dressing on (L) upper chest. dressing ~~[illegible]~~ dressing on abdomen (R) leg amputation. Reinforced dressing on stump. Pt had an uneventful night.

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MEDCOM - 3863

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
31 March 2003	Transfer note
1515	

Pt is 40ish y.o. Iraqi ♂ came to 86CSH, p̄ being operated on 29 March for missile wounds resulting in (R) BKA; abdominal wound c̄ exp lap; Pt, also had chest tube placed on (L), was intubated & noted to have hypothermia & hypotension. Both conditions improved c̄ treatment. Pt's resp status improved chest tube pulled. H/H @ 20/8 given 2 units of O+ blood.

A- (1) S/P BKA on (R)
(2) S/P GSW to chest & abdom
S/P ex lap. & chest tube placement & removal

P- Air Evac to definitive care facility
Continue MDI's & IV antibiotics
~~Gentamyc 400mg IV qd~~
~~Ancef 1gm~~

Rocephin 1gm IV qd

(b)(6)-2

(b)(6)-2

MD
LTC

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

MEDCOM - 3864

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
1 April 2003	
0140	Called to see pt in a wide complex tachycardia. Pt has cardiomegaly on chest xray — probably from long standing hypertension. Also, has fluffy infiltrate bilat. Pt recd 2 units of O+ blood yesterday & HCT went from 20 → 22. Pt's urine is very dark. O_2 sat >92. Propan shows — wide complex tachycardia.
	A — ① Wide complex tachycardia, probably SVT ② Cardiomegaly ③ fluffy infiltrate ? ards
	P — Labetal 2 mg IV q 2 - 6 H pm. Transfer c̄ 2 units O+ blood
	(b)(6)-2
1 April 2003	
16:57	BP 131/82 SPO2 87 HR 113
01 Apr 03	Pt Transferred from Stay via Sed — O2 @ 9L via mask — Sat 98-100% —
2015	① CL — CR @ 125 cc/h — CT D/C 3/30/03 — Pt has Aut SCD
	② Sed — occlusive Dry — Taper Coming loose — A'd, ASd — Mid ventral
	wet to Dry Dry A'd Foly c̄ D/C [illegible] NGT D/C'd [illegible] →

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

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(b)(6)-4		

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

DATE	NOTES
(cont)	(R) BKA – Ace wrap – @ dlc – remained, Pt wanted supper – test H + H 30/ Hgb? not found / to report for 02 – Pt wanted off – stayed around (L) Catheter open chest – ext to ch – Ad – SP Holter P-109 R 23 T 99.6 @ [redacted]
4/2 0200	Pt drinking / toleating / fluids –
0800	Pt AOX3, PERRL, (L) CHEST TUBE D/C'd DI APPLIED, DRSNG A C/D/I. EX LAP DRSNG D C/D/I MARGINS CLEAN NO ERYTHEMIA NOR DRAINAGE PRESENT, BED BATH GIVEN, PT ADVANCED TO REG DIET PT TOLERATED CRACKERS AND WATER WELL, ACTIVE BS IN ALL 4 QUADS. NON-DIST ENDED ABD SLIGTLY TENDER TO PALPATION, O_2 FACE MASK @ 4L SAT 92-98%. MEDS ADMIN AS ORDERED. LUNGS R/R, FOLEY TO GRAVITY DRAINING CYM. (R) BKA DRSNG C/D/I (L) DISTAL PEDAL PULSES +3, WILL CONTINUE TO MONITOR [redacted]
02 APR 03	s/p BKA, GSW abdomen + ex-lap (hemostasis examined) (surgery on 29 MAR 03) s/p 2u PRBC → H/H = 8/26 abx = cancel / Gent cont. to ↑ diet [redacted]
02 APR 03 1800	Assessment completed – CL (L) side patent – fair patent 2 DLC sutures intact, Dsg – MID ASD – (venting) c/d/i – (L) chest Dsg – intact (R) BKA Ace – c/d/i, (L) DP chk + 3 bot. (R) Cradle (L) open – Gom Loma – ↓ (R) Loma Seca, Pt calm – Sl guarded – O_2 @ 6Lpm via MASK – Sat 98%. Pt resting – family around – [redacted]
03 APR 03 0400	VS T 100.2 BP 87/63 P 140 R 20 POX 94. 1 P Dr [redacted] ordered NS 125 c/hr P 124 15 min later, SPC [redacted], A 91 W male
0800	VS T 100.5 BP 105/68 P 124 R 24 POX 96 SPC [redacted], A 91 W male
1500	VS T 100.9 BP 120/70 P 124 R 22 POX 95, given morphine 5mg prior to DSG change. Foley catheter DAD. SPC [redacted] remains

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
3 Apr	VSS pt has no % of SOB. cont on O_2 thru @ 5-8 2pm c Sats around 94-98% 3 O_2 ↓ to 80's. Will cont to monitor [redacted] (b)(6)-2 RT/SM
4 April 03 0538 SP	Nutrition – Patient with minimal intake since 29 March BKA. Will attempt to feed patient ensure, will enlist translators help to explain the need for calories & nutrients Would recommend at a TF if patient does not drink Ensure orally. [redacted] (b)(6)-2 MAT SPRD
0740	pt assessment completed bin and dressing Δ @ this time, wound is CDI he has no c/o pain @ this time dressing to (L) chest Δ pt has 2cm wound CDI, bin (R) leg stump dressing was Δ by night shift IV fluids @ 125/hr into (L) AC no S+S of infiltration, lung sound ETA c good breath sounds pt states SOB, but sats @ 98% resp @ 20 not using accessory muscles [redacted] (b)(6)-2 9 WMC RT
0800	pt tolerated H_2O well advanced to ensure [redacted] (b)(6)-2 9 WMC RT
0900	pt tolerated sips of ensure will encourage greater consumption. he has no c/o pain or SOB [redacted] (b)(6)-2 9 WMC RT
1300	Pt O_2 sats @ 79% BP taken 203/177 manual taken 98/68 confirmed by SS [redacted] (b)(6)-2, Dr. notified no action taken pt dressing on (L) axillary area off and drainage from that wound saturated bed wet to dry applied pt has returned to bed, pt on (R) side lotion & bed bath given [redacted] (b)(6)-2

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

DATE	NOTES
1530	pt desat to 72% and in tachy @ 138 Dr. notified O_2 applied rate
4-4-03	↑ to 96% on 6L (b)(6)-2 [redacted] 91 wmcm

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STANDARD FORM 509 (REV. 5-99) BACK

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
	Death Summary
4/4/03	40s Iraqi male admitted to (b)(3)-1
20 15 zulu	31 Mar 03. S/P (R) BKA (-) extap and chest tube for (L) PTX. Pt was intubated and redated on arrival. He was weaned with difficulty, had multiple cardiac arrhythmias (SVT) during his stay. Pt ultimately extubated 1 April c̄ slow improvement, remained O2 dependent. This evening he was found unresponsive. An airway was established and full effort at resuscitation proceeded per ATLS protocol. Despite maximal efforts, the pt remained in refractory EMD and expired at 20:06 zulu.
	(b)(6)-2 MD
	Maj USAR
	(b)(3)-1
	(b)(6)-2

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

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PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

29 MAR 03

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY | POST-OP DAY | MONTH-YEAR | DAY | 19 | HOUR

2215 · 30 · 45 · 2300 · 30 · 2400 · 30 · 0100 · 30

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

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

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

Fio2 100 100 100 100 100 100 100 100 100 100 100 100 100 100

SaO2 2 4 4 4 4 4 4 4 4 4 4 2 X

Pre-Op, Month

DLxT. 8.0 ETco2 %

(H) FTCO2 (H) IBW: 50

RESPIRATION RECORD

RBL 500 1000 1500

BLOOD PRESSURE Foley 100 200 500

1000 LR 3000 5000 6000

HEIGHT: | WEIGHT→

↑PRBC #1 → #2 — | 0215 | 2235 | 2235 | 0110 | 0130

Neo 100 100 | 25% Alb 100cc → #2 — 200cc

VERSED 2.5 | Scopolamine 0.4

FENTANYL 100

STT

Succ 150

Ket 150

Epi 100 100 100 100 100 100 100 100 100 100 100 100

Vec 2 1 7

IVs: 80, 99, 5%, SaO2/100

Record special data only when so ordered

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

REGISTER NO. (b)(6)-2 | CANA | WARD NO. T 31.9

(b)(6)-2 | LT | Fio2 50%

511-112

PT # (b)(6)-4

EBL 1500

LR 6000

Fluids PRBC 3U

Alb 200 25%

UOP 500

AL SIGNS RECORD

STANDARD FORM 511 (REV. 9-79)
Prescribed by GSA and Interagency Committee on Medical Records
FPMR (41 CFR) 101-11.806-8

Adult, male, Non-English speaker.

29 Mar 03

Ex-Lap, (R) ~~LF fasciotomy~~ (R) BKA

2448223 PRBC O+ unxmtch 2430

2448236 PRBC O100

1854003 PRBC O+ unxmtch @ 2445

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																
POST- DAY																
MONTH-YEAR	DAY	31														
19	HOUR	[illegible]														
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°		x													36.7°
			o													
110	97°															36.1°
100	96°															35.6°
90	95°															35.0°
80																
70																
			x													
60																
50																
40																
RESPIRATION RECORD			ϕ													
BLOOD PRESSURE			121/66													
HEIGHT: 5 ft	WEIGHT→		77%													
Carine			500													

(Centigrade Equivalents, for Reference only)

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

VITAL SIGNS RECORD

511-112

STANDARD FORM 511 (REV. 9-79)
Prescribed by GSA and Interagency Committee on Medical Records
FPMR (41 CFR) 101-11.806-8

1983-381-526/8361

511-118 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY															
POST- DAY		3/30/03													
MONTH-YEAR	DAY														
19	HOUR	953	0300	0400	0500	0600	0700	0800	0900	1000	1100	1800	1900	2000	2400
PULSE (O)	TEMP. F (°)														
	105°														
180	104°														
170	103°														
160	102°														
150	101°														
140	100°														
130	99°														
	98.6°														
120	98°														
110	97°														
100	96°														
90	95°														
80	94														
70	93														
60	92														
50	91														
40															

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

(Centigrade Equivalents, for Reference only)

FLUID BOLUS 600cc LR

AX 96°F

33.2 34.2 35.1 35.6

Mefoxin + gm Q8

0200, 1000, 1800

3/30

CBC ☐ in am.

NO LAB AVAIL @ this time

(b)(6)-2

ESPIRATION RECORD	12	12	12	12	12	10	10	14	10	23	23	27		25
BLOOD PRESSURES SpO_2	99	97	98	95	95	89	100	94	98	100	100	100		100
FiO_2	.50	.30	.30	.30	.30	.30	.40	.30	.35	BP	78/51	89/50		85/48
FMP @ 6L PIP	17	18	23	22	21	28	25	27	27	HR		114		117
HEIGHT: WEIGHT →	CHESTTUBE										20cc			
PRBC's	450	450												
Pleurovac	Ø	0	Ø	Ø	Ø	Ø	Ø	20	Ø					
IVF's	100	100	100	100	600 BOLUS	350/950	150/1100	130/1250	750/2000					
UO	50	50	175	450	100/100	75/175	10/185	10/195	195		150cc			

Record special data only when so ordered

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

(b)(6)-4

DAYSHIFT

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																
POST- DAY																
MONTH-YEAR	DAY	31 MAR		1 APR 03		1 APR 03		1 APR 03		1 APR 03		1000 1400		1 APR 03		
19	HOUR	0500	2200	0136	0141	0146	0151	0156	0201	0231	0400	[illegible]	18	1720	[illegible]	

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BP	85/54	109/60	91/55	87/58	90/60	93/60	97/50	94/57	102/60	105/68	104/64	120/74	113/70 350cc	130/77	23/21	
BLOOD PRESSURE HR	124	110	98	98	96	98	99	99	100	105	98	100	102	106	105	12/65
RR	19	20	12	14	20	20	23	16	12	14	20	20	18	20	25	
SaO2	100	95	99	99	96	98	12[illegible]	96	100[illegible]	98	93	94	97	94		
HEIGHT: WEIGHT →											urine 225/35					
urine	600cc										900cc					
											Total 510cc 7A-1P					

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7-95) BACK

*U.S. Government Printing Office: 1995 - 609-028

(b)(6)-4

MEDCOM - 3873

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY		2 Apr 03													
POST- DAY															
MONTH-YEAR	DAY					03 Apr	4 Apr	4 Apr							
19	HOUR	0300	0800	1130	1330 1630		0640	100 1300							
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		2	20	11	16	18									
BLOOD PRESSURE															
Spkr		96%	96%	98%	98%	90									
HEIGHT:	WEIGHT →	RA													
Intake		100				500 LR 4-4-02 0700		1000 4-4-03 1300							
Output		350cc CYU		650 CYU		1500									

(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

VITAL SIGNS RECORDS

Medical Record

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

Test(s) / Specimen taken	Slip 1	Slip 2	Slip 3	Slip 4
DATE	30MAR03	31MAR03	31Mar03	
TIME	20	0620	1610	1835 P.M.
GLUCOSE	204	168	154	226
UREA N.	28	33	31	24
CREATININE				
URIC ACID				
SODIUM	142	143	143	142
POTASSIUM	3.2	3.0	3.9	3.6
CHLORIDE	104	107	110	109
CO_2	26	26	26	26
PHOSPHATE				
CALCIUM				
TOTAL PROTEIN				
ALBUMIN				
GLOBULIN				
ALKALINE PHOSPHATASE				
ACID PHOSPHATASE				
SGOT				
LDH				
CPK				
BILIRUBIN (TOTAL)				
BILIRUBIN (DIRECT)				
CHOLESTEROL				
TRIGLYCERIDES				
AMYLASE				
LIPASE				
PROFILE (Specify)				
Hct	20	17	22	34
Hb / Hb (est)	7	6	7	12
pH	7.385	7.406	7.401	7.393

CHEMISTRY I
STANDARD FORM 546 (Rev 8-77)
PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505

546-107

REMARKS

Enter in above space
REQUESTING PHYSICIAN'S SIGNATURE

EC8

[redacted] (b)(6)-4

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

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

MD / TECH / DATE 1 Apr 03

CHEM I
URGENCY: ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT
PATIENT STATUS: ☒ BED ☐ AMB ☐ OUTPATIENT ☐ NP
SPECIMEN SOURCE: ☒ BLOOD ☐ OTHER (Specify)
LAB. ID. NO.
SPECIMEN/LAB. RPT. NO.
PATIENT'S MED. RECORD

SPECIMEN/LAB. RPT. NO.

CHEM I
URGENCY: ☒ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT
PATIENT STATUS: ☒ BED ☐ AMB ☐ OUTPATIENT ☐ NP
SPECIMEN SOURCE: ☐ BLOOD ☐ OTHER (Specify)
LAB. ID. NO.
PATIENT'S MED. RECORD

[redacted] (b)(6)-4

ICU 1
Bed #2

Enter in above space — PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE
Dr [redacted] (b)(6)-2

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

MD / TECH [redacted] (b)(6)-2 DATE 1 APR

REMARKS
Chem 8

Test(s) / Specimen taken	Result
DATE	01APR03
TIME	0550
GLUCOSE	153
UREA N.	30
CREATININE	
URIC ACID	
SODIUM	145
POTASSIUM	3.8
CHLORIDE	110
CO_2	—
PHOSPHATE	
CALCIUM	
TOTAL PROTEIN	
ALBUMIN	
GLOBULIN	
ALKALINE PHOSPHATASE	
ACID PHOSPHATASE	
SGOT	
LDH	
CPK	
BILIRUBIN (TOTAL)	
BILIRUBIN (DIRECT)	
CHOLESTEROL	
TRIGLYCERIDES	
AMYLASE	
LIPASE	
PROFILE (Specify)	
Hct	27
Hb (est)	9
ph	—

546-107
CHEMISTRY I
STANDARD FORM 546 (Rev 8-77)
PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505

518-124 NSN 7540-00-634-4159

MEDICAL RECORD | **BLOOD OR BLOOD COMPONENT TRANSFUSION**

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)* 450 ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [ ] TYPE AND SCREEN
- [ ] CROSSMATCH

DATE REQUESTED 31 Mar 03

DATE AND HOUR REQUIRED 31 Mar 03 0800

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* Dr (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE MULTI TRAUMA - GSW.

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.	TRANSFUSION NO.	TEST INTERPRETATION	
4636460	PATIENT NO.	ANTIBODY SCREEN: NA	CROSSMATCH: NA
DONOR	RECIPIENT		
ABO O	ABO		
Rh POS	Rh		

PREVIOUS RECORD CHECK: [ ] RECORD [X] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST

[X] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED DATE 31 Mar 03

REMARKS:

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* (b)(6)-2

AT *(Hour)* 0750 ON *(Date)* 31 Mar 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)* 1 LT (b)(6)-2

2nd VERIFIER *(Signature)* (b)(6)-2 SSG [illegible]

PRE-TRANSFUSION TEMP. 99.9 PULSE 129 BP 79/48

DATE OF TRANSFUSION 03/31/03 TIME STARTED 905

POST-TRANSFUSION DATA

AMOUNT GIVEN 450 ML

TIME/DATE COMPLETED/INTERRUPTED 1037 03/31/03

REACTION [X] NONE [ ] SUSPECTED

TEMPERATURE

PULSE 111

BLOOD PRESSURE 86/50

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION

- [ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

[ ] NO [X] YES *(Specify)* IV line changed to (R) BICEP 18G

SIGNATURE OF PERSON NOTING ABOVE 1LT (b)(6)-2

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade, rank, rate; hospital or medical facility)

(b)(6)-4

SEX Male

WARD ICU I

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 3876

Medical Record Copy

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)*: 450 ML

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [ ] TYPE AND SCREEN
- [ ] CROSSMATCH

DATE REQUESTED: 31 Mar 03

DATE AND HOUR REQUIRED: 31 Mar 03

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*:

REQUESTING PHYSICIAN *(Print)*: Dr (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: MULTI TRAUMA GSW

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER:

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

DATE VERIFIED:

TIME VERIFIED:

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. 463510

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	NA

PREVIOUS RECORD CHECK: [ ] RECORD [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST:

DONOR	RECIPIENT
ABO O	ABO
Rh POS	Rh

[X] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED — DATE 31 Mar 03

REMARKS:

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*: (b)(6)-2

AT *(Hour)*: 0103 ON *(Date)*: 31 Mar 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)*: 1LT (b)(6)-2

2 (b)(6)-2

55Q 9(W3M6

PRE-TRANSFUSION TEMP. 99.4 PULSE 112 BP 87/54

DATE OF TRANSFUSION: 03/31/03

TIME STARTED: 11:05 10/31/03

POST-TRANSFUSION DATA

AMOUNT GIVEN: 450 ML

TIME/DATE COMPLETED/INTERRUPTED: 03/31/03 13:20

REACTION [X] NONE [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
99.6	112	93/54

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION
- [ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [X] NO [ ] YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE: 1LT (b)(6)-2

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade, rank; rate; hospital or medical facility)

SEX: Male

WARD: Icu I

(b)(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 3877

Medical Record Copy

#3

518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)*: 450 ML

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [ ] TYPE AND SCREEN
- [ ] CROSSMATCH

DATE REQUESTED: 1 Apr 03

DATE AND HOUR REQUIRED: 1 Apr 03 0115

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*:

REQUESTING PHYSICIAN *(Print)*: Dr (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE:

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER:

DATE VERIFIED:

TIME VERIFIED:

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.	TRANSFUSION NO.	TEST INTERPRETATION	
1854363	PATIENT NO.	ANTIBODY SCREEN	CROSSMATCH
		NA	NA

DONOR	RECIPIENT
ABO O	ABO
Rh pos	Rh

PREVIOUS RECORD CHECK: [ ] RECORD [X] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST:

[X] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED — DATE 1 Apr 03

REMARKS:

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPEC (b)(6)-2

AT *(Hour)* 0115 ON *(Date)* 1 Apr 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)* (b)(6)-2 Spc LPN

2nd VF (b)(6)-2

PRE-TRANSFUSION

TEMP. 97.5 PULSE 98 BP 91/55

DATE OF TRANSFUSION: 1 Apr 03

TIME STARTED: 0131

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, r rate; hospital or medical facility)

(b)(6)-4

POST-TRANSFUSION DATA

AMOUNT GIVEN: 300 ML

TIME/DATE (COMPLETED)/INTERRUPTED: 1 Apr 03 0238

REACTION	TEMPERATURE	PULSE	BLOOD PRESSURE
[X] NONE [ ] SUSPECTED	97.5	100	102/60

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION

- [ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

- [X] NO [ ] YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE: (b)(6)-2 Spc LPN (b)(6)-2

SEX: Male

WARD: ICU F

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

518–124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)*: 450 ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [ ] TYPE AND SCREEN
- [ ] CROSSMATCH

DATE REQUESTED: 1 Apr 03

DATE AND HOUR REQUIRED: 1 Apr 03 1415

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: _____
HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)*: Dr (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.	TRANSFUSION NO.
1854329	PATIENT NO.

DONOR	RECIPIENT
ABO O	ABO
Rh pos	Rh

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	NA

PREVIOUS RECORD CHECK:
- [ ] RECORD
- [X] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST

[X] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED — DATE 1 Apr 03

REMARKS:

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*: (b)(6)-2

AT *(Hour)*: 1415 ON *(Date)*: 1 Apr 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)*: (b)(6)-2

2nd V

PRE-TRAN

TEMP. 98.8 PULSE 102 BP 113/70

DATE OF TRANSFUSION: 1 Apr 03 TIME STARTED: 1700

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, f rate; hospital or medical facility)

(b)(6)-4

POST-TRANSFUSION DATA

AMOUNT GIVEN: 450 ML

TIME/DATE COMPLETED/INTERRUPTED: 1850 1 APR 03

REACTION: [X] NONE [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
98.8	106	130/70

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION
- [ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [ ] NO [ ] YES *(Specify)*

SIGN (b)(6)-2

SEX: Male WARD: ICU 1

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9–92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201–9.202–1

MEDCOM - 3879

Medical Record Copy

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)*: 450 ML

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [ ] TYPE AND SCREEN
- [ ] CROSSMATCH

DATE REQUESTED: 1 Apr 03

DATE AND HOUR REQUIRED: 1415 1 Apr 03

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*:

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)*: Dr (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE:

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER:

DATE VERIFIED:

TIME VERIFIED:

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: 0758685

TRANSFUSION NO.:

PATIENT NO.:

DONOR: ABO O, Rh POS

RECIPIENT: ABO, Rh

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	NA

PREVIOUS RECORD CHECK: [ ] RECORD [X] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST:

[X] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED — DATE 1 Apr 03

REMARKS:

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED (b)(6)-2

AT *(Hour)*: 1415 ON *(Date)*: 1 Apr 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

(b)(6)-2

PRE-TRANSFUSION TEMP. 98.8 PULSE 106 BP 130/75

DATE OF TRANSFUSION: 1 Apr 03

TIME STARTED: 1845

POST-TRANSFUSION DATA

AMOUNT GIVEN: 450 ML

TIME/DATE COMPLETED/INTERRUPTED: 1

REACTION	TEMPERATURE	PULSE	BLOOD PRESSURE
[X] NONE [ ] SUSPECTED	98.2	106	130/77

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

[X] NO [ ] YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE: Transcribed from record

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility)

(b)(6)-4

SEX

(b)(6)-2

Tag #1

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | Doctors Orders ~~PROGRESS NOTES~~

29 30 MAR 03 2230

1. Admit to ICU
2. Dx: S/P Ex lap and ligation of bleeding vessels on abd wall, omentum; local exploration and irrigation of GSW to chest, (R) BKA.
3. Condition: guarded
4. Vitals q 1° per routine c continuous pulsox
5. MeSO4 1g IV q 8° (next @ 0200)
6. Nursing:
   - Strict I+O's
   - Sdy to gravity
   - Chest tube to -20 cm water suction
   - May reinforce BKA and other dressings ~~prn~~
7. Diet: NPO
8. IVF: LR @ 100 cc/hr.
9. MSO4 2-5 mg IV q 1° prn pain > titrate to (b)(6)-4
10. Versed 1-2 mg IV q 1°
11. CBC in AM
12. Vent setting → 100% SDO2 | SIMV | 10 | TV 800 | PEEP 5.
13. Call MO for T>101, R>40, SBP >160 <80, DBP >110 <50, HR >110, U.O. < 20 cc/hr over 2°

Thanks!

(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. (b)(6)-2

(b)(6)-4

~~PROGRESS NOTES~~ Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

PROGRESS NOTES

DATE	
3/30/03 12:45	Respiratory Care Note: Pt. on mech vent as ordered, all settings checked & set properly. All alarms set & working. Ambu @ bedside. Vent settings SIMV, RR 12, Vt 700, Peep 5, FIO2 2 L/min Blood in. Exp Vt 701, PIP 23 cmH2O, Mean 10 cmH2O, SpO2 100%. (b)(6)-2
3/31/03 15:05	Resp Care Note: pt. extubated placed on 10 L/min SM. (b)(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 30 MAR 03 — TIME OF ORDER: 1130 HOURS — LIST TIME ORDER NOTED AND SIGN

1. Admit ICU - Gen Surg (b)(6)-2
2. S/P Ex Lap / (R) BKA / (L) CT
3. Stable
4. VS q 3°, I & O's
5. NKDA
6. Bedrest
7. LR @ 125 cc/hr

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: — TIME OF ORDER: — HOURS

8. Foley → gravity
9. NG to LIWS ✓
10. CT to -20 cm H_2O suction ✓
11. CXR in AM
12. MSO_4 1-2 mg IV q 1-2° PPW pain
13. Versed 1-2 mg IV q 1-2° PPW sedation
14. Vent settings: SIMV Rate 12 TV 700 Peep 5 FiO_2 titrate for sats > 94%

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: — TIME OF ORDER: — HOURS

15. Albuterol MDI ~~PRN~~ per RT
16. Zantac 50 mg IVPB q 8°
17. Notify MD for T > 102 P > 120 < 60 SBP > 170 < 110 UOP < 30cc/hr x 2

(b)(6)-2 MD MAJ, MC Harris (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 30 March 2003 — TIME OF ORDER: 1405 HOURS

Restraints soft pm
Vacuronium 5-10 mg IV q 1-2 h pm ~~agitation~~
Valium 2-5 mg IV q 6 h pm
CXR (PA) in a.m.
~~Zantac~~
Suction to Y connector (2) (two) h low intermittent
M.S. 5-20 mg IV q 2 h pm (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

Noted Merry to CPT AND 3 [illegible]

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 30 March 2003 — TIME OF ORDER: 1407 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Gentamicin 400mg IV BID
2. Ancef T gm IV q 8 x 3 days
3. if pt is extubated start Albuterol nebs QID
4. Extubate if possible (RT)
5. Istat cum 8 ... gm.
6. V.S. q 4h ... LTC

noted 31 Mar 03 (b)(6)-2 CPT, AN

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER

Chart ✓ 31 Mar 03 (b)(6)-2 CPT, AN

31 March 2003 1535

△ Gentamicin to 400mg IV q 8h

Contin Ancef T gm IV q 8h x 2 days.

CXR (PA) (b)(6)-2

Done 31 MAR 03 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER — TIME OF ORDER

Istat 8 now — Done — HOURS

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

Chart ✓ 31 Mar 03 2200 (b)(6)-2 CPT AN

PATIENT IDENTIFICATION

DATE OF ORDER — TIME OF ORDER

1 April 2003 — 1 07 10 HOURS

1. Transfer c̄ T unit of O+ & the ~~...~~ T more ~~in~~ one hour later
2. ~~Lidocaine 100mg bolus IV over 2 minutes~~ (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH (b)(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4	1 April 2003 0220 HOURS	
	② Lubetol 5 mg slow IV push	voted 1 Apr 0545
	③ Can be repeated every hour pm wide complex tachycardia	(b)(6)-2
NURSING UNIT / ROOM NO. / BED NO.	(b)(6)-4	

PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER	
	1 April 2003 1620 HOURS	
	① Clear liquid diet (advance as tolerated)	1 APR 03
	② I stat @ 1800	noted
	③ D/C ~~[illegible]~~ Done	1700
	④ Transfer c̄ 2 unit of O+ blood,	(b)(6)-2
NURSING UNIT / ROOM NO. / BED NO.		

PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER	
	HOURS	
	1 Apr 03 (b)(6)-2 1700	
	① D/C NG Tube	
	V.O. Dr. (b)(6)-2	
NURSING UNIT / ROOM NO. / BED NO.		

PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER	
	03 APR 03 0546 HOURS	
	D/C Cordis, ↑ to P/V	
	D/C [illegible], Bent	
	D/C ALBUFORO (b)(6)-2	
	↑ diet as tolerated	
	(b)(6)-2	
NURSING UNIT / ROOM NO. / BED NO.	NS 125 c/c (D/C) (B) (Tyler) 03 APR 03 / 0810	

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

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.

MAR Mo. APR Yr. 03

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 30	31	01	02	03	04
30 MAR	[redacted]	VS q 4h 03	06	/					
		07	10	/					
		11	14	/					
		15	18	/					
		19	22						
		23	02						
	[redacted]	Stable	07						
			19						
		NKDA	07						
		16	19						
		Bedrest	07						
			19						
		Foley → gravity	07						
			19						
		NG to LIWS	07						
			19						
		Notify MD for T > 102°	07						
		P > 120 < 60, SBP > 170	19						
		< 110 UOP < 30 cc/hr x 2°							
30 mar 03	[redacted]	I and O	07-19						
			19-07						
30 mar 03	[redacted]	LR @ 125	07-19						
			19-07						
30 mar 03	[redacted]	OT to H2O Suction	07-19						
			19-07						
30 mar 03	[redacted]	Restraints Soft PRN							

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
S/P Ex Lap

ADDITIONAL PAGES IN USE: ☐ YES ☒ NO
PAGE NO. 1

PATIENT IDENTIFICATION:
[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	

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

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
30 MAR	(b)(6)-2	Isted chem 8 in am				
30 MAR		Admit ICU - Gen Surg/ (b)(6)-2				
30 MAR		S/P Lap/ (R) BKA/ (L) CT				
30 MAR		Stable				
30 MAR		~~NKDA~~				
30 mar		CXR in AM				
31 MAR		CXR (PA)	31 MAR 03	ASAP	3	(b)(6)-2
31 MAR		ISTAT 8 now	31 MAR 03	now	1600	
1 APR		ISTAT 8	1 APR 03	1800		

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED

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

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. MAR Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 30	31	1	2	3	4
30MAR03	(b)(6)-2	Gentamicin 400mg IV	06		(b)(6)-2				D'd QD 31MAR03
		BID	15 18						
30MAR		Ancef Tgm IV	3 06						
		q8 x3	11 14						
			22	(b)(6)-2					
30 MAR		If PT is extubated start albuterol mds QID	3 06		(b)(6)-2				
			9 12						D/c'd
			15 18						
			21 24	(b)(6)-2					
30 MAR		Zantac 50mg IVPB Q 8°	3 06		(b)(6)-2				
			11 14						
			19 22	(b)(6)-2					
31MAR03	(b)(6)-2	Δ Gentamycin to 400mg IVQ	06		(b)(6)-2				Dc'd 1APR03
31 MAR 03		Continue Ancef Tgm IV	06						
		q8h x 2 Days	14						Dc'd 1APR03
			22		(b)(6)-2				
1Apr03									

ALLERGIES: ☐ YES ☒ NO — Unk

PRIMARY DIAGNOSIS: S/P Exp Lap / (R) BKA

ADDITIONAL PAGES IN USE: ☐ YES ☒ NO

PAGE NO. 1

PATIENT IDENTIFICATION: (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.

MEDCOM - 3888

Medication

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
1 Apr 03	(b)(6)-2	~~CYR~~ Transfuse c̄ 2 units of O+ blood	1 Apr 03	Now	1800	(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
30 Mar 03	(b)(6)-2	MS04 1-2 mg W q 1-2° prn pain														
		MS 5-20 mg W q 2h prn	31 MAR 0130 5mg	31 MAR 0400 5mg	31 MAR 0620 8mg	31 MAR 0647 5mg	1 Apr 5mg 0040	1 Apr 5mg 0050	1 Apr 5mg 0945 TDT	1 Apr 10mg 1900	2 Apr 5mg 1000	2 Apr 5mg 1130	2 Apr 10mg IV 2237	3 Apr 5mg 1630	3 Apr 5mg 520 10mg SN	
30 Mar 03		Versed 1-2 mg W q 1-2 prn sed.														
30 Mar 03		~~Verovrom 5-10 mg W q 1-2h prn agitation~~														
30 Mar 03		Valium 2-5 mg q 6h prn W														
1 Apr 03		Labetal 5mg slow IV														
		Push; can be repeated														
		q hour prn for wide complex														

Tachycardia

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

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 04 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 1	2	3	4
1Apr03	(b)(6)-2	Diet: CL Diet (Advance as tole	07	(b)(6)-2			
	-----	tolerated.	19				
	-----		01				

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/p EXLAP/© BKA

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION

(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.

MEDCOM - 3890

MEDCOM - 3890

...DICAL RECORD - SUPLEMENTAL M... ...L DATA [redacted]

...r use of this form, see AR 40-66; t... ...onent agency is the Office of the Surgeon Ge...

EPORT TITLE: TRAUMA FLOWSHEET | OTSG APROVED (Date)

INITIAL ASSESSMENT | ☐ IMMEDIATE ☐ DELAYED ☐ MINIMAL

ate: _____ Arrival Time: _____ Sex: M F Age: _____ Wt: _____

llergies: _____ Tetanus Status: UTD Unknown

MP: Last Meal:

hief Complaint:

MH: | Medications:

reatments PTA:

ITAL SIGNS: BP: 96/63 P: 103 RR: BVM TEMP: SAO_2: 99

HEST
RAUMA ☐YES ☐NO
AIN ☐YES ☐NO
OB ☐YES ☐NO
UNG SOUNDS
R L
☐ ☐ CLEAR
☐ ☐ WHEEZES
☐ ☐ DECREASED
☐ ☐ ABSENT

SKIN
☐ WARM ☐ DRY ☐ PALE ☐ DUSKY ☐ MOIST

ABDOMEN
☐ SOFT ☐ DISTENDED ☐ TENDER
BOWEL SOUNDS ☐ YES ☐ NO
GUIAC TEST ☐ POS ☐ NEG

NEURO
PERRL ☐ YES ☐ NO R_____mm L_____mm
GLASCOW SCORE:_____

PUPIL SIZES: 2 3 4 5 6 7 8 9

GLASCOW COMA SCALE

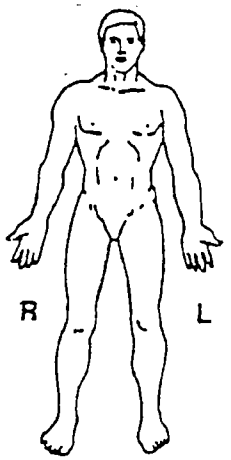
1. EYE OPENING		2. VERBAL RESPONSE		3. MOTOR RESPONSE	
Spontaneous	- 4	Oriented	- 5	Obedient	- 6
To Voice	- 3	Confused	- 4	Purposeful	- 5
To Pain	- 2	Inappropriate	- 3	Withdrawal	- 4
None	- 1	Incomprehensible	- 2	Flexion	- 3
		None	- 1	Extension	- 2
				None	- 1

XTREMETIES
] DISTAL PULSES
] RT X 2 ☐LT X 2
MOVES EXTREMETIES X 4
NO EDEMA
NO DEFORMITIES

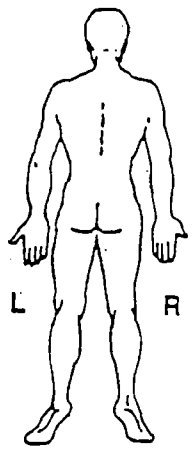
XCEPTIONS TO BOVE ARAMETERS:

REATMENTS:
2: LPM ☐NC BVM MASK
TT # MM
IONITOR ☐Y ☐N EKG ☐Y ☐N
IG TUBE #
OLEY: #
HEST TUBE ☐R ☐L

SPLINTS:
ORAL AIRWAY
NASAL AIRWAY
DPL ☐ POS ☐ NEG
CM H20



FRONT



BACK

A = Abrasion
AP = Amputation
AV = Avulsion
B = Burn
C = Contusion
D = Deformity
E = Evisaration
OF = Open Fracture
CF = Closed Fracture
G = GSW (#Sites)
L = Laceration
PW = Puncture Wound
S = Stab Wound
O = Other

(Continue on reverse)

REPARED BY (Signature & Title) | DEPARTMENT/SERVICE/CLINIC: 399th CSH | DATE

ATIENT'S IDENTIFICATION (For typed or written ...tries give: Name - last; first; middle; grade; date; ...spital or medical facility)
(b)(6)-4

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

☆U.S.GPO: [illegible] 318-678

PATI[illegible]VACUATION TAG – FICHE D'ÉVACUATION DE PATIE
[illegible]o this tag to patient – Attacher cette fiche au patient)

FROM *(Medical treatment facility)*
ORIGINE *(Installation de traitement médical)*
(b)(3)-1

NAME *(Last–first–middle initial)*
NOM *(Nom de famille–premier prénom–initiale deuxième prénom)*
(b)(6)-4 Elderly Benjamin M

SERVICE NUMBER NUMÉRO MATRICULE	RANK/RATING/GRADE GRADE	CATEGORY OF PERSONNEL *(Service or employer and nationality)* CATÉGORIE DE PERSONNEL *(Service ou employeur et nationalité)*

DIAGNOSIS
DIAGNOSTIC

CLASS–CLASSE		DISEASE MALADIE	BATTLE CASUALTY BLESSÉ AU COMBAT	INJURY BLESSURE
1A	2A			
1B	2B			
1C				
3	4			

VSI TRÈS GRAV. MAL. ☐ Yes Oui ☐ No Non	CABIN OR COMPARTMENT NO. NO. CABINE OU COMPARTIMENT	BUNK NUMBER NUMÉRO COUCHETTE
	BAGGAGE TAG NUMBER(S) NUMÉROS ÉTIQUETTES BAGAGE	

DESTINATION DESTINATION	SHIP/AC *(Number/type)* NAVIRE/AVION *(Matricule/type)*

TREATMENT RECOMMENDED EN ROUTE *(If no treatment is required a notation to this effect is made)*
TRAITEMENT RECOMMANDÉ EN ROUTE *(Indiquer si aucun traitement n'est nécessaire)*
(1)

SIGNA[illegible] SIGNA[illegible] (b)(6)-2 MD LTC	DATE DATE

REGUL[illegible] RÉGIME NORMAL	RÉGIME SPÉCIAL *(Description)*

SHIP'S RECORD OFFICE TAB – FICHE POUR ARCHIVES TRANSPORTS

FROM *(Medical treatment facility)*
ORIGINE *(Installation de traitement médical)*

NAME *(Last first–middle initial)*
NOM *(Nom de famille–premier prénom–initiale deuxième prénom)*

SERVICE NUMBER NUMÉRO MATRICULE	RANK/RATING/GRADE GRADE	CATEGORY OF PERSONNEL CATÉGORIE DE PERSONNEL

BAGGAGE TAG NUMBER(S) NUMÉROS ÉTIQUETTES BAGAGES	DATE OF SHIPMENT DATE DÉPART
DESTINATION DESTINATION	ARRIVAL DATE DATE ARRIVÉE

[illegible]ARKATION TAB – FICHE D'EMBARQUEMENT

Trauma Resuscitation Form

Name:	SSN:
Date and time of injury:	Date and time of arrival:

Chief complaint:

Pre-hospital information

Mechanism of injury:

- [x] Gunshot wound
- [ ] Stabbing
- [ ] Burn
- [ ] Chemical casualty
- [ ] Other:

Procedures before arrival

- [ ] Airway: type ____ size # ____
- [ ] O_2 @ 4 L/min via Face Mask
- [x] IV's: location and # AC Blat
- [x] Chest tube: location L size # 36F
- [ ] Splints: Type ____
- [ ] Medications: ____
- [ ] Chemical casualty:
  - [ ] Decontamination date/time: ____

	Dosage	Date/time
[ ] Atropine:		
[ ] 2-PAM:		
[ ] Other:		

- [ ] Other procedures: ____

AMPLE history

Allergies: NKA

Medications: NKA

Past illnesses: NKA

Last meal: NKA Last Tetanus: NKA

Events:

Initial assessment

Airway

- [x] Patent
- [ ] Obstructed

Breathing

- [ ] Normal
- [ ] Labored
- [ ] Symmetrical
- [x] Asymmetrical

Trachea midline? [x] Yes [ ] No

Breath sounds:	Right	Left
Present	[ ]	[ ]
Clear	[ ]	[ ]
Decreased	[ ]	[ ]
Absent	[ ]	[ ]
Rales/Rhonchi	[ ]	[ ]

Crepitus: [ ] Yes [ ] No

Initial assessment

Circulation

Skin/mucous membrane color:

- [x] Pink
- [ ] Flushed
- [ ] Pale
- [ ] Jaundiced
- [ ] Ashen
- [ ] Cyanotic

Skin temperature:

- [x] Warm
- [ ] Hot
- [ ] Cool

Skin moisture:

- [x] Normal
- [ ] Dry
- [ ] Moist

Pulses:

	Carotid		Radial		Femoral	
	R	L	R	L	R	L
Normal	[x]	[x]	[x]	[x]	[x]	[x]
Bounding	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Weak	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Absent	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

Disability

Glasgow Coma Scale (circle appropriate scores):

	Score:
1. Eye opening:	
Spontaneous	4
To voice	3
To pain	2
None	1
2. Verbal:	
Oriented	5
Confused	4
Inappropriate words	3
Incomprehensible words	2
None	1
3. Motor:	
Obeys commands	6
Localizes to pain	5
Withdrawls to pain	4
Flexion	3
Extension	2
None	1
Total GCS	13

Pupillary response

Pupil reaction:	Right	Left
Brisk	[ ]	[ ]
Constricted	[ ]	[ ]
Sluggish	[ ]	[ ]
Dilated	[ ]	[ ]
Nonreactive	[ ]	[ ]
Size	___mm	___mm

Trauma Resuscitation Form

Physical examination:

Age (years):_____ Height (inches):_____ Weight (kg's):_____

Head, eyes, ears, nose, throat:

Neck: NWI

Chest: GSW (L) side, chest tube

Back: NWI

Cervical/Thoracic/Lumbar spine:

Abdomen: tender

Perineum and rectum:

Extremity: No pulses R lower ext open wound

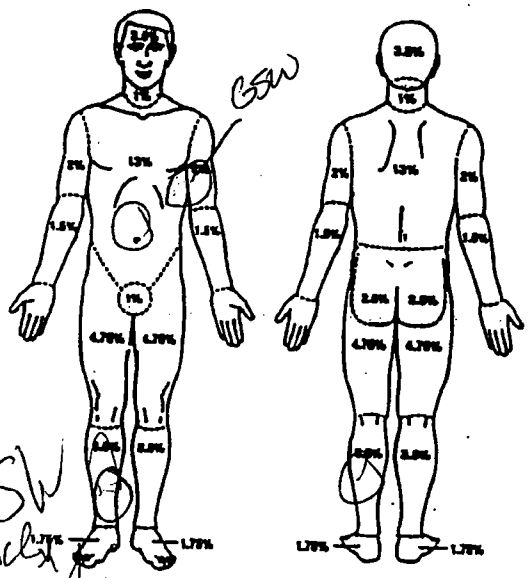
Skin:

Neurologic:

Other:

Diagram for documenting injuries
(Identify injury site by number)

1. Laceration
2. Abrasion
3. Hematoma
4. Contusion
5. Deformity
6. Fracture
7. GSW(s)
8. Stab wound(s)
9. Pain
10. Cold injury
11. Edema
12. Amputation
13. Avulsion
14. Burn
15. Other (Describe)



(With permission from JB Lippincott Company. After Deming RH. Burns. In: Greenfield LJ, Mulholland MW, Oldham KT, and Zelenock GB eds. Surgery: Scientific Principles and Practice. Philadelphia, JB Lippincott Company, 1993.)

Trauma Resuscitation Form

Procedures performed by trauma team		Medications			
Time:	Procedure:	Time:	Drug:	Dosage:	Route:
1854	Chest tube placement	1835	Ludocaine		(b)(6)-2 [redacted]
		1645	MSO4	6mg	

Trauma fluid resuscitation data

Estimated initial postburn IV fluid requirement

1. IV fluid of choice: Lactated Ringer's solution.
   (Use the following equations)
2. Total fluid requirement (TFR):
   TFR = 4 ml x wt (kg's) x % burn (2° and 3°)
   TFR = (4 x _____ x _____) = _____cc
3. Estimated fluid requirement 1st 8 hours post burn:
   (TFR/2) = _____cc
4. Estimated fluid requirement next 16 hours post burn:
   (TFR/2) = _____cc

Resuscitation area fluid intake and output

Intake:		Output:	
LR	_____ml	Blood	_____ml
PRBC	_____ml	Urine	_____ml
FFP	_____ml	NG tube	_____ml
Platelets	_____ml	Chest tube	_____ml
Other	_____ml	Other	_____ml
Total	_____ml	Total	_____ml

Vital signs

Time:								
BP:	98/60							
Pulse:	86							
Temp:								
Resp:	26							
GCS:								

Notes: GSW (L) Thorax ~~[illegible]~~ region

Impression: ~~Decreased breath sounds (L) side~~
GSW (L) Chest / Mid Abd / (R) TIB/Fi
compartment syndrome

Plan: O.R. / chest tube / Mefox2
MSO4

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

(With permission from the American College of Surgeons Committee on Trauma, Advanced T[redacted]

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF (1–8) (b)(3)-1 — F LOCATION (State or Country Code)

3. REGISTER NUMBER (9–15) (b)(6)-4 — (b)(6)-4

4. PAY GRADE (16–17): —

5. SEX (18): M

6. DATE OF BIRTH (Y Y Y Y M M D D) (19–26): 1 9 4 0 0 1 0 1

7. AGE AT ADMISSION (27–29): 6 3 Y

8. RACE (30): X

9. ETHNIC BACK-GROUND (31): 9

RELIGION: Muslim

10. LENGTH OF SERVICE (32–34): —

ETS

11. FMP (35–36): 9 9

12. SOCIAL SECURITY NUMBER (37–45) (b)(6)-4

ORGANIZATION (Active Duty Only): Iraqi Civilian

13. MARITAL STATUS (46): Z

HOUR OF ADMISSION: 1130

BRANCH / CORPS

14. FLYING STATUS (47–49): —

15. BENEFICIARY CATEGORY (50–52): K 9 1

16. ZIP CODE OF RESIDENCE (53–61): 0 9 3 3 0 0 0 0 0

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

18. MOS (64–70): —

19. TRAUMA (71): 9 INJ

PREV. ADMISSION: YEAR ☐ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72): 1

WARD: ICU

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE (b)(6)-4

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): (SON)

NAME AND LOCATION OF ADMISSION (b)(3)-1

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE (b)(6)-4

21. TYPE OF DISPOSITION (73–74): 3 0 DOW 2006HRS

22. MTF TRANSFERRED TO (75–80):

23. DATE OF DISPOSITION (Y Y M M D D) (81–86): 2 0 0 3 0 4 0 4

24. CLINIC SVC - ADMITTING (87–90): A B A A

25. MTF TRANSFERRED FROM (91–96):

26. DATE THIS ADMISSION (Y Y M M D D) (97–102): 2 0 0 3 0 3 3 0

27. LOCATION OF OCCURRENCE (Battle Casualty Only) (103–104): I Z

28. MTF OF INITIAL ADMISSION (105–110):

29. DATE INITIAL ADMISSION (Y Y M M D D) (111–116):

FOR LOCAL USE

Dx: 8970 41519 Trauma 9 Inj 459 S/P Fex Lap/ (R) BKA

(b)(6)-2

ADMITTING OFFICER (Signature, as required) (b)(6)-2 (b)(6)-4

MD MAJ, MC

DA FORM 2985, MAR 89

MEDCOM - 3896

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF (1–8) [redacted] (b)(3)-1 — F LOCATION (State or Country Code)

3. REGISTER NUMBER (9–15) [redacted] (b)(6)-4 — NAME (Last, First, Middle Initial) [redacted] (b)(6)-4

4. PAY GRADE (16–17)

5. SEX (18): M

6. DATE OF BIRTH (Y Y Y Y M M D D): 19 20 21 22 23 24 25 26 — 1 9 4 0 0 1 0 1

7. AGE AT ADMISSION (27–29): 6 3 4

8. RACE (30): X

9. ETHNIC BACK-GROUND (31): 9

RELIGION: Muslim

10. LENGTH OF SERVICE (32–34)

ETS

11. FMP (35–36): ~~9 9~~ 20

12. SOCIAL SECURITY NUMBER (37–45) [redacted] (b)(6)-4

ORGANIZATION (Active Duty Only): Iraqi Civilian

13. MARITAL STATUS (46): Z

HOUR OF ADMISSION: 1130

BRANCH / CORPS

14. FLYING STATUS (47–49)

15. BENEFICIARY CATEGORY (50–52): ~~K 9 1~~ K78

16. ZIP CODE OF RESIDENCE (53–61): 0 9 3 3 0 0 0 0 0

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

18. MOS (64–70)

19. TRAUMA (71): INJ

PREV. ADMISSION — YEAR — NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72): 0

WARD: ICU

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

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): (SON)

NAME AND LOCATION [redacted] (b)(3)-1

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

21. TYPE OF DISPOSITION (73–74): 3 0 — ~~DOW~~ 2006HRS

22. MTF TRANSFERRED TO (75–80)

23. DATE OF DISPOSITION (Y Y M M D D): 81 82 83 84 85 86 — 0 3 0 4 0 4

24. CLINIC SVC - ADMITTING (87–90): A B A A

25. MTF TRANSFERRED FROM (91–96)

26. DATE THIS ADMISSION (Y Y M M D D): 97 98 99 100 101 102 — 0 3 0 3 ~~3 0~~ 29

27. LOCATION OF OCCURRENCE (Battle Casualty Only) (103–104): I Z

28. MTF OF INITIAL ADMISSION (105–110)

29. DATE INITIAL ADMISSION (Y Y M M D D) (111–116)

FOR LOCAL USE

41519 Proc
82380
9588
8750
86399
8415
3401
3998
9671
9904 (6)

S/P Fex Lap/
(R) BKA
Ins Trauma
450 1

Death 1

ADMITTING OFFICER (Signature, as required) [redacted] (b)(6)-2 — 9912 — MD — MAJ, MC

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

MEDCOM - 3897

ADMISSION AND CODING INFORMATION

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

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

36. FIRST DIAGNOSIS (Principal Diagnosis)								37. SECOND DIAGNOSIS								38. THIRD DIAGNOSIS							
137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160
		8	9	7		Ø				4	1	5		1									

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

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

44. FIRST PROCEDURE (Principal Diagnosis)								45. SECOND PROCEDURE								46. THIRD PROCEDURE							
201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224

47. FOURTH PROCEDURE								48. FIFTH PROCEDURE								49. SIXTH PROCEDURE							
225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	2

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

52. NUMBER OF DIAGNOSTIC FIELDS CONTAINING CODES		53. NUMBER OF PROCEDURAL FIELDS CONTAINING CODES		54. PRIMARY PROVIDER SPECIALTY CODE			55. BLOOD USAGE Y/N
265	266	267	268	269	270	271	272
Ø	2						

MEDCOM - 3898

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)		3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4	(b)(6)-4		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M		IRAQI				NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
	(b)(6)-4		ICW2

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
					INJ

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct	0830	ABAN

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	Hans	5 Apr 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		31 Mar 03	

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1		

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW R Hand ~~882~~

~~III~~ 882.0 11040 E991.2

II 882.0 E991.2

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER		SIGN	RECORDS OFFICER
(b)(6)-2	(b)(6)-2 MAJ, MC	(b)(6)-2	

DA FORM 3647, MAY 79 EDITION OF 1 AUG 76 IS OBSOLETE USAPPC V1.10

PATIENT TREATMENT RECORD COVER SHEET

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

1. (b)(6)-4	2. (b)(6)-4	(b)(6)-4	3. GRADE	ADMISSION REMARKS
4. SEX: M	5. AGE	6. RACE: IRAQI	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION: NO
11. EMP	12. SSN: XXX-42-9901	13. ORGANIZATION	14. WARD: ICW2
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE: INJ
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct	22. HOURS OF ADMISSION: 0830	23. CLINIC SERVICE: ABAN
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION: Hans	26. DATE OF DISPOSITION: 5 Apr 03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION: 31 Mar 03	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW R Hand ~~892~~

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER (b)(6)-2 MD (b)(6)-2 MAJ, MC

SIG (b)(6)-2 RDS OFFICER

DA FORM 3647, MAY 79 EDITION OF 1 AUG 76 IS OBSOLETE USAPPC V1.10

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
3/31/03	Ortho Note
1630	Iraqi ↑ s/p GSW to (R) hand 4d ago c progressive pain + swelling
	O: 2.5cm dorsal entrance wound over thenar eminence ϕ exit
	diffuse palm swelling + pain c finger rom
	intact to LT throughout but sl ↓
	pain c passive finger extension, small ant purulence at entrance site
	Xray intact bullet over volar 5th MT ϕ fx
	A/P: GSW to (R) hand c early infection
	p/w I+D
	[redacted] MAJ MC

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]

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
31 MAR 03	PT ADMITED TO ICW-2 FOR EXCISION OF BULLET TO (L) HAND ON
1630	01 APR 03, NPO AFTER MIDNIGHT TONIGHT, VSS, LUNGS CTA, RRR, PERRL
	BS PRESENT IN ALL 4 QUAD. NON-TENDER NON DISTENDED, ABD. AMBULATES
	WELL W/OUT ASSISTANCE. (L) GSW ENTRY SITE HAS CLEAN MARGINS.
	IRRIGATED W/ IODINE/NS FLUSH. COVERED W/ 4X4 AND SAM. SPLINT APPLIED.
	(L) HAND WAS SWOLLEN, PALPABLE PULSES (RADIAL) BILAT, [redacted] ICT/MN.
1700	LR 500cc [redacted] ADMIN. [redacted] ICT/MN
31 mar 03	Assessment completed - Sm splint & Ace to (L) FA - (L) Ued (L) Hand
2015	Equipment to (L) Hand IV LR @ 150cc/h - (L) FA - ↑ 500cc @ 2045
01 APR 03	PT Conveyed mw. pain except when (L) Hand-finger palpated - [redacted]
0530	Ig Amp BUPs, PT wid XL qty stuff during nt. PT slept south. PT has been kept NPO for MIST for OR today. [redacted]
4/1/03	Post op Note
0900	Pre + post op dx GSW to (L) hand
	Procedure - I+D, FB removal through carpal tunnel incision
	Findings - bomb fx, fragment traversed from thenar eminence to ulnar palm through carpal tunnel
	Surg - [redacted]
	Plan - wound care, sutures out 7d.
	[redacted] MAJ MC

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

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

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1APR03	@900 PT. RTN FROM OR S/P I+D/BULLETECTOMY (L) HAND. DRESSING (L) HAND DRY AND INTACT, CAP REFILL < 3SEC. BP 135/68 P107 R18 POX 98% ON 8L SIMPLE FACE MASK. T 95.0. SGT [(b)(6)-2] -9IWMC
	@905-25mg DEMEROL GIVEN IV FOR POST OP PAIN. SGT [(b)(6)-2] 9IWMC
1Apr 03 1300	Returned to ward via gurney from OR. Bandage- C any diff. Bulky dsg to (R) hand dry & intact, < Refill < 2 sec O2 Sat 97%. IV to (R) arm patent & edema or erythema noted. — [(b)(6)-2] SSG 9IWMC30
1APR03 1900Z	AWAK, lays in bed. Denies c/o Pain, H/L (R) FA patient S/S infiltration or infect. Dsg To (L) Hand D+I, Cap refill <3sec. SAO2 98-99%, Able T, Move fingers. PT in NAD, assessment unchanged. Dsg [(b)(6)-2] -9IWMCH
1Apr 2250Z	Medicated c Vicodin PO for ch Pain — [(b)(6)-2] 9IWMCH
2APR 0300	PT slept p medication, assessment remains unchanged. Dsg remains D+I, able to move fingers. Cap refill < 3sec. [(b)(6)-2] Sgt 9IWMCH
02APR03 0530	A+OX3, (R) HL CDI, NV Finger dexterity slow, good cap refill. Maj Tyler stated that OD is ready for Minimal Care ward ASAP & D/C Amcef and Gent 04APR03. SPC [(b)(6)-2]
02April03 0600Z	BP 110/78 P-68 R-14 [(b)(6)-2] SGT 9IWMC
02Apr-03 1045Z	Morphine 4mg SIVP c/o PR — 1 Spc [(b)(6)-2]
02 APR03 1655Z	Theft c/o pain given Medcon 2 tabs. 9/5 BP [(b)(6)-2] T. 97.0 HR 86 [(b)(6)-2] 9CW
02APR03 2000Z	Amcef IM (R) deltoid — Spc [(b)(6)-2] 9CW
3APP03 0530	FPPN POD# 2 S/P GSW (L) hand (L) hand - CR < 2 sec. Spontaneous ROM all digits Tenderness - Hematoma to 2° GSW
Amcef x 7D	Plan - > Local wound care. Suture out 7D.
MSDP prn Vicodin prn 3April03 1200Z	[(b)(6)-2] [(b)(6)-2] IV Viccodin for Pain SGT 9IWMC

STANDARD FORM 600 (REV. 6-97) BACK

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
1100Z 3Apr03	1gram Ancef, 400mg Gent IV Hang, at Bedside to be administered over 1 hour. [redacted] SGT 91W20
1534OZ 03Apr03	Tylenol 650mg PO c/o minor pain - SGT [redacted] 91W
1630 Z 3 Apr 03	BP 110/60 P 68 T 98.5 R 18 [redacted] SGT 91W20M6
2000 Z 3Apr03	1 gram Ancef given IM (R) bicep [redacted] SGT 91W20M6
4 Apr 03	FP PN AF VSS
0600	(L) hand: Thenar eminence: Granulating exit wound ∅ s/sx infection
	Hypothenar: sutures c/D/I
	Imp: GSW c̄ (L) hamate fx POD # 3
	Plan: Local wound care, splint, prn pain control.
	Once daily dressing Δ [redacted]
4Apr03 0734Z	[redacted] CPT, MC
	136/84 R18 T99.1 P72 [redacted]
4Apr03 1530	Vicodin 1 PO 1 tab prn [redacted] 91W
4Apr03 1600	1 Vicodin PO for pain [redacted]
4APR03 2335	~~pt c/o~~ pt c/o pain given 800mg motrin [redacted] 91WS
5Apr03 0443Z	118/88 T96.8 R16 P76 [redacted]
5 Apr 03 0600 Z	AF, VSS. some c/o pain c̄ hand. TTP over thenar eminence & c̄ movement of thumb. Moves all fingers. Wound ∅ s/sx infx. min nec tissue @ distal edge. sutured area ∅ s/sx infxn. Cont wound dressings & suture removal 7Apr Swelling sig improved. [redacted]

.. (Continue on reverse side)

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

[redacted]

REGISTER NO.

PROGRESS NOTES

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

509-111

PROGRESS NOTES

DATE	
5 Apr 03 1435Z	C/o pain (L) hand 800 mg Motrin given. [redacted]
6 Apr 03	mo note: Ø complaints.
0430 Z	(L) hand: Sutures c/o/I. Thenar wound (+) Granulation s̄ d/c.
T 96.6	Imp: POD #5 s/p L hamate fx from GSW
BP 138/68	Plan: local wound care, pm pain control. [redacted]
P 76	6 apr 03 - 0930 2 u/d time - [redacted]
R 19	Dressing Δ done by Dr [redacted] wound s̄ s/s of infection. clean drsg c̄ post splint applied. [redacted]
6 APR 03 1037Z	800 mg Motrin for c/o pain. [redacted]
6 APR 03 2005 1705Z	BP 100/70 P 76 T 98.0 pt c/o of pain in (L) hand give 800 mg motrin [redacted]
2115/1815Z	Tylenol 1000 mg PO [redacted]
0740/0940Z 7 April 03	Tylenol 1000 mg PO [redacted] SGT 91W20
7 April 03	BP 120/80 T-98 P-64 R-12 [redacted] SGT 91W20
7 Apr 03	AFVSS. Ø complaints (L) hand thenar wound good Ø Sx infxn. Thumb N/V intact. swelling improved. Sutures removed from palm. looks good. may go self care [redacted]
7 APR 03 1625Z	pt c/o pain in (L) hand given 1000 mg Tylenol [redacted]
7 APR 03 1815Z	pt c/o pain given 1000 mg Tylenol [redacted]
7 April 0747/0447Z	BP 116/68 P-92 R-12 T 97.2 [redacted] SGT 91W20

☆U.S. GPO:1995-397-405

STANDARD FORM 509 BACK (Rev. 11-77)

PROGRESS NOTES

DATE	
8 Apr 03	FPPN: No complaints.
	(L) hand: Thenar eminence → granulating exit wound s/sx infection
	Hypothenar → sutures out; wound C/D/I. Strength 4/5
	Imp: GSW (L) hand c̄ hamate fx.
	Plan: D/C from 115th

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY		31 MAR		01 APRIL		1 APR 03									
POST- DAY		1634/2030				1 8 0 2									
MONTH-YEAR	DAY														
19	HOUR			0600	0800	0800	0800								
PULSE (O)	TEMP. F (•)														TEMP. C
	105°														40.6°
180	104°														40.0°
170	103°														39.4°
160	102°														38.9°
150	101°														38.3°
140	100°														37.8°
130	99°														37.2°
	98.6°														37.0°
120	98°														36.7°
110	97°														36.1°
100	96°														35.6°
90	95°														35.0°
80															
70															
60															
50															
40															

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

~~BLOOD PRESSURE~~ RR		14	14	18/16	16/18	18	16								
PSO2 SAT			95%	96%	98/98	98	96								
HEIGHT:	WEIGHT →														
INTAKE		100% DINNER TRAY .05L ORALLY		NPO 6 MIN 1400											
OUTPUT				voided 1000cc											

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

VITAL SIGNS RECORDS

Medical Record

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

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974 - AS A CLINICAL RECORD FORM, IT IS COVERED BY DD 220

ANESTHESIA RECORD

Page 1

ART	IN OR	ANES. END	DATE
35	0738		1 APR 03

OPERATION PERFORMED: HD (L) Hand

SUR (b)(6)-2

TOTS	SURG START	DRESSING	OR NO
0745	0750	0838	

PREOPERATIVE

- ☐ IDENTIFIED ☐ ID BAND ☐ QUESTIONING
- ☐ CHART REVIEWED ☐ NPO SINCE
- ☐ PRE-OP MEDICATION:

Drug	Dose	Route	Time
Midaz	2.5	IV	0730

Pre-Anesthetic State: ☑ AWAKE ☐ SEDATE ☐ UNRESPONSIVE ☑ CALM ☐ APPREHENSIVE

MONITORS AND EQUIPMENT

- ☑ ANES. MACHINE # ____ & EQUIP. CHECKED
- ☑ NON-INV. B/P ☐ PNS
- ☑ CONT. EKG ☐ V LEAD EKG
- ☑ ESOPH. STETH. ☐ PRECORD STETH.
- ☑ PULSE OXIMETER ☑ O2 ANALYZER
- ☑ END TIDAL CO2 ☐ MASS SPEC.
- ☐ TEMPERATURE
- ☐ WARMING BLANKET ☐ FLUID WARMER
- ☐ AIRWAY HUMIDIFIER
- ☐ N / G TUBE ☐ O /G TUBE
- ☑ IV(s) PIV
- ☐ ARTERIAL LINE
- ☐ CENTRAL LINE
- ☐ SWAN-GANZ
- ☐ FOLEY INSERTED: ☐ O.R. ☐ FLOOR
- ☐ EYE CARE
- ☐ PRESSURE POINTS CHECKED / PADDED

ANESTHETIC TECHNIQUE

- ☑ GENERAL ☐ LOCAL / MAC
- ☐ REGIONAL ☐ NERVE BLOCK
- ☐ mask

INDUCTION

- ☐ PREOXYGENATION ☐ INHALATION
- ☐ RAPID SEQUENCE ☐ INTRAMUSCULAR
- ☐ INTRAVENOUS ☐ RECTAL

AIRWAY MANAGEMENT

- ☐ INTUBATION ☐ ORAL ☐ NASAL
- ☐ DIRECT VISION ☐ BLIND ☐ AWAKE
- ☐ FIBER OPTIC ☐ STYLET USED
- ☐ ATTEMPTS x ____ ☐ BLADE
- ☐ ETT SIZE ____ ☐ DOUBLE LUMEN
- ☐ STRAIGHT ☐ RAE ☐ ANODE
- ☐ CUFFED ____ ML AIR INJECTED
- ☐ UNCUFFED, LEAKS AT ____ CM H2O
- ☐ ETT SECURED AT ____ CM
- ☐ BREATH SOUNDS
- ☐ AIRWAY ☐ ORAL ☐ NASAL ☐ NATURAL
- ☑ MASK CASE ☐ VIA TRACHEOSTOMY
- ☐ NASAL CANNULA ☐ SIMPLE O2 MASK
- ☐ LMA SIZE

RECOVERY

TIME IN PACU	CONDITION
0844	Stable

B/P	PULSE	RESP	02 SAT
	122	18	93

REMARKS | TEMP

REPORT TO: PARRS:

IN FLUIDS TOTALS OUT

Crystalloid 500	EBL [illegible]
	Urine NM
Blood Ø	Gastric

TOTAL

0730 x 0800 x 30 x 0900

AGENTS						
	Ketamine	100	50			
	MSO4		4			
	Robinul		.2			
	N2O L/min					
	O2 L/min	4	4	4	4	4
FLUIDS	LR				500	
	Urine	N				
	EBL	MM				
MONITORS	EKG	ST	ST	ST	ST	ST
	% O2 Inspired	1.0	1.0	1.0	1.0	1.0
	O2 Saturation					
	End Tidal CO2					
	Temperature					
	PNS					

TIME 0730 x 0800 x 30 x 0900

VITAL SIGNS

PRE-OP VALUES	
B / P	200 / 180 / 160 / 140
P	120 / 100
R	80 / 60
SAT	40 / 20
H / H	

RESP					
Tidal Volume	SV	SV	SV	SV	SV
Resp Rate	16	18	14	18	16
Peak Pressure					

Symbols for Remarks

Position

SYMBOL X ANESTH ◉ OPERAT V ^ B/P CU PRESSU ⊥ T ARTER LINE PRESSU ● PULS ○ SPONT/ OUS RE ¢ ASSIST RES ⊗ CONTRO RES T TOURNI F CRYST LOID F B BLOC

REMARKS: ☐ Patient reevaluated. No change from preop plan / evaluation. ☐ Significant changes from preop plan / evaluation.

Tourniquet Time:

(b)(6)-2

PHYSICIAN / CRNA

PATIENT'S IDENTIFICATION

(b)(6)-4

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

(TIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

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

3/31/03

Admit - ICW (ORTHO)

Diagnosis - GSW to hand

Condition - stable

Vitals - per routine

Allergies - ?

Nursing - per routine

Diet - NPO ~~until further notice~~

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

IVF - 1L LR 500cc bolus then LR 150 cc/hr

Special - clean wound, apply dsg (bulky)

Meds - Ancef 1g IV Q8 } start now

Gentamicin 400 mg IV QD }

Activity - may ambulate as able

Vicodin ~~1-2~~ PO q 4-6° p.r.n pain

[redacted]

CPT (b)(6)-2 (b)(3)-1

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

4/1/03 0930

✓ Admit to ward

✓ GSW ⓛ hand

✓ stable

✓ V. tabs routine

✓ Art - elevate ⓛ hand as tol up ad lib

✓ Diet - reg

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

✓ IV - 50 cc LR/hr, heplock if good po

✓ Meds Vicodin 1-2 q 4° p.r.n

MSO4 2-4 mg IV q 2° p.r.n

Combo 1 q 10 q 4° p.r.n x 720

✓ NKDA (b)(6)-2 MJMC

OD 429901 Accel STARTED 0622 1 APR AND 2000 3 APR

NURSING UNIT | ROOM NO. | BED NO.

...WHICH MAY BE USED.

4256 REPLACE

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	1 APR 03 0850 DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
	POST ANESTHESIA CARE UNIT ORDERS		
1	OXYGEN: 8 litres via Mask /Prongs to maintain O2 Sats greater than 94%;		
	Wean to room air.		
2	IVF: LR @ 150 cc/hr, bolus _____ cc x 1		
3	MORPHINE: 2-4 mg IV q 5-10 minutes PRN pain. MAX dose of 10 mg		
4	DEMEROL: 25 mg IV q 5-10 minutes PRN pain. MAX dose of 50 mg		
5	~~ZOFRAN: Give 4 mg~~ IV PRN nausea. May repeat after 10 minutes X 1		
6	~~DROPERIDOL: 0.625 mg (1/4 cc) OR~~ 1.25 mg (1/2 cc) IV PRN Nausea X 1		
7	REGLAN: Give 10 mg IV PRN nausea X 1		
8	Release from "PACU" when Aldrete score is 9 or greater		
9	Call Anesthesia for any questions or concerns		
10	Phenergan 12.5 mg IV q 6° PRN nausea		
	SIGNED		

PATIENT IDENTIFICATION

(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.

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				02 APR 03	0530 HOURS	
			①	Admit to Minimum care word		
				-tent 3		
			②	Maintain Current orders		
			③	D/C Ancef + Gent 04 APR 03		
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.				

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.

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

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. Mar Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 31	01	02	03
	(b)(6)-2						
31 MAR		ANCEF 1 GM IV Q 8° Z02	06				
		resund 1 April 03 Z10	14				
		X 72° Z18	22				
31 MAR		GENTAMYCIN 400mg IV QD	18				D/C'd
31 MAR		LR 150cc/° Δ 1 April 03 Z03	07				
		LR @ 50 - then Heplock @ Z15	19				
		↑ PO Intake					
31 Mar		VS q shift Z02	06				
		Z10	14				
		Z18	22				
31 Mar		NPO after MN	24				DC 1 April 03
1 April 03		Diet - Reg	07/19				
			19/07				
1 April		Activity - up ad lib	7/19				
			19/7				
1 April		Elevate L hand as tol	7/19				
			19/7				

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS:

GSW ® Hand - Condition Stable

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*				Mo MAR Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
31MAR	(b)(6)-2	ADMIT TO ICW-2 (ORTHO)	31 MAR	ASAP	1600	(b)(6)-2
31MAR		Dx - GSW TO (L) HAND	31 MAR	ASAP	1600	
31MAR		CONDITION STABLE	31 MAR	ASAP	1600	
31MAR		VS Q SHIFT	31 MAR	ASAP	1600	
31MAR		NKDA ?	31 MAR	ASAP	1600	
31MAR		DIET NPO AFTER MIDNIGHT ON 01 APR 03	31 MAR	31MAR	b6-2 [redacted]	
31MAR		ACTIVITY AD LIB	31 MAR	ASAP	1600	
31MAR		CLEAN WOUND / APPLY BULKY DRSNG/SPLINT	31 MAR	ASAP	1630	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
			[redacted] b6-2													
31MAR	(b)(6)-2	Δd 1 APRI VICODIN 10/11 PO Q4° PAIN	4/2 22 30 11 KAD	02 APR 11 0600	02 APR 11 1650Z											
-----		MSO4 2-4mg IV q														
-----		q 1-2° PRN - Pain														
~~02 APR~~		~~VICODIN 11~~ [redacted] b6-2														
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															

USAPA V1.00

1. LAST NAME, FIRST NAME / NOM ET PRÉNOM	RANK / GRADE	✓ MALE / HOMME
RAQI SOLDIER		FEMALE / FEMME
SSN / NUMÉRO MATRICULE	SPECIALTY CODE / GPM	RELIGION / RELIGION

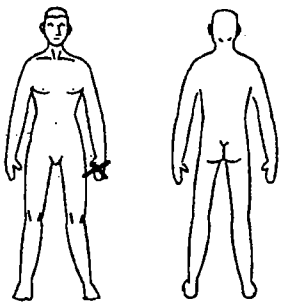
2. UNIT / UNITÉ

FORCE / ÉLÉMENT				NATIONALITY / NATIONALITÉ
A/T	AF/A	N/M	MC/M	
	BC / BC		NBI / BNC	

	DISEASE / MALADIE		PSYCH / PSYCH

3. INJURY / BLESSURE

FRONT / DEVANT — BACK / ARRIÈRE



	AIRWAY / TRACHÉE
	HEAD / TÊTE
✓	WOUND / BLESSURE
	NECK/BACK INJURY / BLESSURE AU COU/AU DOS
	BURN / BRÛLURE
	AMPUTATION / AMPUTATION
	STRESS / TENSION
	OTHER (Specify) / AUTRE (Spécifier)

- SHRAPNEL WOUND (L) HAND

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE

✓	ALERT / ALERTE	✓	PAIN RESPONSE / RÉPONSE À LA DOULEUR
✓	VERBAL RESPONSE / RÉPONSE VERBALE		UNRESPONSIVE / SANS RÉPONSE

5. PULSE / POULS	TIME / HEURE	6. TOURNIQUET / GARROT	TIME / HEURE
80	0700	✓ NO / NON ☐ YES / OUI	

7. MORPHINE / MORPHINE	DOSE / DOSE	TIME / HEURE	8. IV / IV	TIME / HEURE
✓ NO / NON ☐ YES / OUI				

9. TREATMENT / OBSERVATIONS / CURRENT MEDICATION / ALLERGIES / NBC (ANTIDOTE)
TRAITEMENT / OBSERVATIONS / PRÉSENTE MEDICATION / ALLERGIES / ANTIDOTES

- IRRIGATE & DRSG (L) HAND
- PERCOCET x 2 PO@0715
- CIPRO 500 MG PO@0715
- MOTRIN 800 MG PO @ 1000

10. DISPOSITION / DISPOSITION		TIME / HEURE
	✓ RETURNED TO DUTY / RETOUR À L'UNITÉ	1030
	EVACUATED / EVACUÉ	
	DECEASED / DÉCÉDÉ	

(b)(6)-2

	DATE/DATE (YYMMDD)
PAC	3/29/03

DEC 91 of DD Form 1380 and DD Form 1380 (TEST), which are obsolete.

U.S. FIELD MEDICAL CARD
FICHE MÉDICALE DE L'AVANT ÉTATS-UNIS

1. REPORTING MTF (b)(3)-1 | MTF LOCATION (State or Country Code)

ADMIS[illegible] AND [illegible]NG INFORMATION

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

3. REGISTER NUMBER (b)(6)-4 | NAME (Last, First, Middle Initial) (b)(6)-4 | 4. PAY GRADE | 5. SEX

9	10	11	12	13	14	15	16	17	18
(b)(6)-4							—		M

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

19	20	21	22	23	24	25	26	27	28	29	30	31
1	9	6	8	0	1	0	1				[illegible]	9

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
—			2	0	(b)(6)-4								

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

46	0830
Z	

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

47	48	49	50	51	52	53	54	55	56	57	58	59	60	61
—			K	7	8	0	9	3	3	0	0	0	0	0

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
—		—	—	—	—	—	—	—	9	~~DIS~~ INJ	☒

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

72	73	74	75	76	77	78	79	80	81	82	83	84	85	86
[illegible]	1								2	0	3	0	4	0	5

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCAT (b)(3)-1 | 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
0	5							2	0	3	0	4	0	5

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
A	B	A	A							2	0	3	0	3	1

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
I	Z												

FOR LOCAL USE

DX: 81510
E9912

Trauma Inj
1 450

Shrapnel wound.
GSW (R) Hand

Px: 7963

ADMITTING OFFICER (Signature, as required) (b)(6)-2 | SIGNA (b)(6)-2

(b)(6)-2 MD MAJ, MC

DA FORM 2985, MAR 89 EDITION OF MAY 79 IS OBS

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF LOCATION (State or Country Code): 1 2 3 4 5 6 7 8 — (b)(3)-1

3. REGISTER NUMBER: 9 10 11 12 13 14 15 — (b)(6)-4

NAME (Last First Middle Initial): (b)(6)-4 — (b)(6)-4

4. PAY GRADE: 16 17

5. SEX: 18 M

6. DATE OF BIRTH (Y Y Y Y M M D D): 19 20 21 22 23 24 25 26

7. AGE AT ADMISSION: 27 28 29

8. RACE: 30 Black

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 — (b)(6)-4

ORGANIZATION (Active Duty Only)

13. MARITAL STATUS: 46

HOUR OF ADMISSION: 0830

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 DS INJ

PREV. ADMISSION: YEAR — NO ☒

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 72 D

WARD: DW 2

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOC (b)(3)-1

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF [illegible]: 73 74 TRANS

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

23. DATE OF DISPOSITION (Y Y M M D D): 81 82 83 84 85 86 — 0 3 0 4 0 5

24. CLINIC SVC - ADMITTING: 87 88 89 90 — A B A A

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

26. DATE THIS ADMISSION (Y Y M M D D): 97 98 99 100 101 102 — 0 3 0 3 3 1

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

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

29. DATE INITIAL ADMISSION (Y Y M M D D): 111 112 113 114 115 116

FOR LOCAL USE

Shrapnel wounds
GSW ® Hand...

ADMITTING OFFICER (Signature, as required): (b)(6)-2 — (b)(6)-2 MD MAS, MC

SIGN (b)(6)-2

DA FORM 2965, MAR 89 — EDITION OF MAY 79 IS OBSOLETE

ADMISSION AND CODING INFORMATION

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

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

36. FIRST DIAGNOSIS (Principal Diagnosis)								37. SECOND DIAGNOSIS								38. THIRD DIAGNOSIS							
137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160
		8	8	2																			

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

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

44. FIRST PROCEDURE (Principal Diagnosis)								45. SECOND PROCEDURE								46. THIRD PROCEDURE							
201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224

47. FOURTH PROCEDURE								48. FIFTH PROCEDURE								49. SIXTH PROCEDURE							
225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	2

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

52. NUMBER OF DIAGNOSTIC FIELDS CONTAINING CODES		53. NUMBER OF PROCEDURAL FIELDS CONTAINING CODES		54. PRIMARY PROVIDER SPECIALTY CODE			55. BLOOD USAGE Y/N
265	266	267	268	269	270	271	272
0	1						

MEDCOM - 3917

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)		3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4	(b)(6)-4		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	18 Y	IRAQI				

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99	(b)(6)-4		FCW 1

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
					INJ

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct		AEDA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
		10 APR 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		6 APR 03	

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1		

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

① Tib/Fib Fx ~~X23.01~~

III
823.82
27530

II
823.82

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNAT (b)(6)-2

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER (b)(6)-2

DA FORM 3647, MAY 79 EDITION OF 1 A

USAPPC V1.10

IN ENT TREATMENT RECORD C E

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)		3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4	(b)(6)-4		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	18 Y	[illegible]				

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99	(b)(6)-4		FCW 1

15. FLYING STATUS	16. RATING/DSG	17. DEPT./BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
					INJ

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct		AEDA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
		10 APR 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		6 APR 03	

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1		

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

① Tib/Fib Fx ~~X23.01~~

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNA (b)(6)-2

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER (b)(6)-2

DA F [illegible] OF 1 A

USAPPC V1.10

Victim provided first aid near uncle's house at NV96594 40924 on 22 MAR03.

Former CP location of [redacted] (Aff. to [redacted]

[redacted]

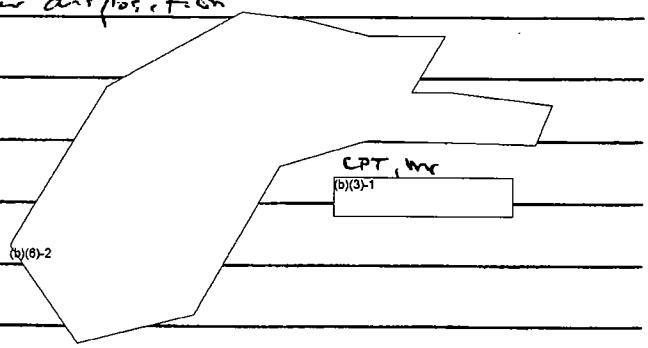
MAJ [redacted] Civil Affairs DST 4

for LTC [redacted]

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
23 Mar 03	~18 y/o Iraqi D→ civilian s/p closed (L) mid shaft
	fib-fib fx received closed reduction + long leg cast this
	Am by MAJ (b)(6)-2 of (b)(3)-1
BP 107/54	PMH: unknown
P80	P.E. GCS 15
	HEENT: NCAT
	Chest: CTA (B)
	CV: RRR 5m
	Abd: S/NT/ND (+) BS ØR/G
	Back: Ø/lesions/wounds
	Ext: (L) long leg cast
	Distal toes exposed → FROM, Ø edema, CR < 2 sec
A/P	(L) Tib/fib mid shaft fx s/p closed reduction
	- Pain Control Im Demerol / p.o T³ prn
	- await CA guidance on further disposition
	CPT, Mr (b)(3)-1
	(b)(6)-2



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

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

(b)(6)-4

REGISTER NO.	WARD NO.

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

MEDICAL RECORD	PROGRESS NOTES

DATE

26 MAR PT ABC's WNL, unable to assess pulse on (L) foot due to casting (+) Cap refill 22sec (+) PN c̄ radiation to upper thigh no apparent other injury's ((L) Tib Fib Fx) PT recieved T 800mg motrin po @ 1710

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

7300 Pt Sleeping USS NO Dis Conjunct Disj CDI [redacted] (b)(6)-2

1330 Pt arrive in new location no change in condition [redacted] (b)(6)-2

1600 Vs taken 128/78 P 68 T 96.1 Pt complaints on being hungry [redacted] (b)(6)-2

2411 VS 120/62 P 65 T 96.1 pt resting, no apparent signs of distress. repositioned L. leg placed rolled blanket under for support. pt stated "yes, thank you". [redacted] (b)(6)-2 91WM6

1305 No changes from previous exam continue to monitor. [redacted] (b)(6)-2 91WM6

28 MAR 03 MD ORDERS

0925 (L) TIB / fib X-RAY tomorrow (29 MAR 03)

[redacted] (b)(6)-2

28 MAR 03 pt c/o of pain on (L) leg. Give motrin 800 mg po for this #6/10 pain [redacted] (b)(6)-2 Maj, AN FNP

(Continue on reverse side)

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

(b)(6)-4 [redacted]

REGISTER NO.	WARD NO.

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

509-111

PROGRESS NOTES

DATE	
28 Mar 03	
1611	VS BP 91/41 P 87 R 16 sp O2 98% T
20 mar 03	2045. PT sleeping, awakes when spoken to. Fx to Tib Fib, closed Fixation, Cast from ankle to upper thigh. No drainage. Cms distal to wound intact. (b)(6)-2 [redacted] SPC LPN
28 MAR 03	VS BP 108/74 P 79 R T 99.2 SPO2 99%
29 MAR 03	(L) TIB/FIB FX
1225	Doing well
	need X-ray
	Confer to ORTHO
	(b)(3)-1 [redacted]
	(b)(6)-2 [redacted]
29 Mar 03	(L) Tib Fib fx cast to hip. Pt voiding well. BP - 116/78,
2150	P - 73y RR - 18, Temp - 96.8, Sats - 99% via RA.
	(b)(6)-2 [redacted] SSG/LPN
30 Mar 03	BP - 112/78 RR - 14 Sats - 98% via RA
0620	P - 77 Temp - 97 (b)(6)-2 [redacted]. SSG/LPN
30 mar 03	Pt. c/o of (R) leg pain. Toes cool, -0 edema, ~~[illegible]~~ capillary (b)(6)-2 [redacted]
1000	refill at 2 sec. (b)(6)-2 [redacted] Adj. Ad Tab
30 mar 03	(L) TIB/FIB FX 8 days post injury
1645	X-ray yesterday - significant angulation
	D/W Nielsen/ORTHO
	Await definitive care (b)(6)-2 [redacted]

☆U.S. GPO:1995-397-405

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1845 30 Mar 03	BP 102/68 P64 Temp 98.4 R18 — SPC [redacted] 9/W
2100	BP 98/64 - 64 - T 98° - R-18 — [redacted]
2100	pt assessment complete - ø s/s of compartment syndrome - [redacted]
31 Mar 03	(L) tib/fib ≡ angulation. Ortho aware.
	Long leg cast. Toes equal bilat warm, Neurovasc intact. No c/o pain
	(P) awaiting ortho intervention. [redacted] MD
31 Mar 03 0850	ø c/o pain. (L) leg elevated in long leg cast.
	NVWNL. slow cap refill 3-5. will continue
	to monitor. (F) sensation. [redacted] WTAW
31 Mar 03 0930	BP 108/78 P-88 R-18 [redacted] SGT 9/W20
31 Mar 03 1620	PT c/o Pain Given 800mg Motrin [redacted]
	[redacted]
31 Mar 03 2201	T 98.3 B/P 90/60 P84 [redacted] SGT 91'W
0600	pt slept through night - ø change from above — [redacted]
1 Apr 03	AF VSS no complaints. Toes N/V intact. Plan evac today
	for ortho [redacted] MD
1 April 03	BP 102/66 P-90 R-16 [redacted] SGT 91W20

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART[redacted]	[redacted]ED 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]

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1 Apr 03 1100	NVV WNL ↓ movement from yesterday ↑ pain c movement. ∅ c/o pain otherwise awaiting evac [redacted] (b)(6)-2
1 April 03 1958	Pt Given 975 mg Tylenol For Pain [redacted] BP 90/7 HR 92 T 98.5 [redacted]
2 Apr 03	AF, will repeat vitals. alert & awake. No Δ in status, awaiting evac [redacted] (b)(6)-2 MO
2 Apr 03 0550 7	Motrin 800 mg given for c/o throbbing pain to (L) leg [redacted] (b)(6)-2
0600 Z 2 April 03	BP 98/62 P 74 R-14 Temp 98.1 - SPC [redacted] (b)(6)-2
02 APR 03 1510 Zulu	MOTRIN 800 mg given for c/o throbbing PN to (L) leg [redacted] (b)(6)-2
03 April 03 0600 (2)	B/P 98/42, P-76, R-16, Temp 97.9, Pulse Ox, 98% - SPC [redacted]
1122 Z 4/3/03 1215 Z	1 Vikiding given for pain Crystal [redacted] (b)(6)-2 G/W — (L) TIB / Fib fx ō Angulation in long cast D#13 VSS/AF EVAC Priority [redacted] (b)(6)-2
4/3/03 1545 Z	Condition ~~[illegible]~~ Pt stable and unchanged from early day [redacted] (b)(6)-2
4/3/07 1700 Z	no Δ's from previous exam, CTA, ⊕ BS [redacted] (b)(6)-2 1LT/AN FND
4/3/07 1701 Z	VS 106/49, P 84, R 20, T 98.6, O2 99% [redacted] 1LT/AN

D FORM 600 (REV. 6-97) BACK
*U.S. GPO: 2002 - 491-600/50618

MEDCOM - 3925

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
4/4/03	(L) TIB / fib fx c̄ Angulation
	Long cast D#14
	Evac ? when ? [redacted] (b)(6)-2
	Repair ? when ?
	b6-2
4Apr03 -	B/P [redacted], P-90, R-18, Temp 99.8, Pulse Ox 98%
	B/P - 100/60 ——— Spc [redacted] (b)(6)-2
2220Z 4APR03	Vicodin 2 tabs PO for pain given. CP [redacted] AN
4/5/03	(L) TIB / FIB fx c̄ Angulation
0605Z	Long cast D#14
	NPO P̄ MN
	Recast tommonow [redacted] (b)(6)-2
	EMT
	↳ Bivalve Cast Today — Done 1100
4/5/03 1300	Pt c/o Pain Given Two T#3 PO [redacted] (b)(6)-2
5APR03 1700Z	Pt lying quietly in bed watching others. BP 92/44 HR 88 RR 16 SpO2 9
	T = 99.0. Pt states he's hungry. ~~BP 92/44 H~~ [redacted] b6-2 Lungs clear, BS+
	peripheral pulses palpable and correspond c̄ heart sounds. CP [redacted] (b)(6)-2 AN

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONS (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.

(b)(6)-4 [redacted] (b)(3)-1 [redacted]

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11 203(b)(10)

DATE	NOTES
5APR03 1715Z	Benadryl 25 mg P.O. for sleep aid CP [redacted] (b)(6)-2
6apr03	Vitals = 98 sp02, 101 pulse, 22 rr, 98.8 temp,
5:18Z	115/70 BP [redacted] (b)(6)-2 91W
4/6/03	(L) TIB/FIB fx c Angulation Long Cast D#15
0650	Recast today [redacted] (b)(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
6 Apr 03	Post op Note
1500	Pre/post op dx (L) tib fib fx
	Procedure closed reduction + cast
	Surg - Searle
	Findings - post cast Xrays ~3° procurvation, some valgus
	(b)(6)-2 [redacted] MAJMC
06 APR 03	
1205 Z	
TEMP 97.1, HR 88, BP 101/59, SPO2 94% RA, RR 14. PT SEDATED C̄ KATAMIE 150 mg and MSO4 10 mg IV. S/P RESET/RECAST	
	(L) TIB FX, LAST DOSE OF MSO4 @ 1400, LAST DOSE OF KATAMIE WAS 1430. PT DENIES PAIN. PT AWAKE
	BUT NOT ORIENTED R/T OP MEDS. PERLL, LUNGS CTA, ACTIVE BS IN ALL 4 QUAD C̄ NON-
	DISTENDED NON TENDER ABD, NEUROVASCULAR INTACT, IN OPERATIVE (L) LE. SECOND SET OF
1209	POST-OP VS T-97.3, 100/49, HR 88, 95% RA, 14 RR, LR INFUSING @ 125 cc/° WILL CONTINUE TO
	MONITOR PT POST-OP, ONCE POST-OP CRITERIA MET, TRANSFER TO MCW. (b)(6)-2 [redacted] LT
1220	PT TO BE ADMITED TO ICW 2 PER PHYSICIANS ORDERS. VS 100/50, T 97.3, 86 HR, RR 15, PSO2 96% RA.
1225	VS. 99/49, T 97.4, RR 15, 96% RA, HR 89. (b)(6)-2 [redacted] LT/AN
1230	VS 96/51, HR 85, 97% RA, RR 14, T 97.4. NO ESSENTIAL Δs FROM POST-OP ASSESSMENT, WILL CONT
	TO RECOVER THE PT. STATUS STABLE. (b)(6)-2 [redacted] LT/AN
1240	101/53, SPO2 97% RA, HR 84, 97.4, RR 15 (b)(6)-2 [redacted] LT/AN.

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.
(b)(6)-4 [redacted] (b)(3)-1 [redacted]		

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
6 Apr 2003	Pt returned to MCW #1. S/P (L) tib/fib fx cast. See
1340 Z	orders. [redacted] LTC, AN FNP
6 Apr 2003	Pt. returned and now c/o of nausea. Phenegrass 12.5 mg IVP for
1500	this.
1700Z	Pt sleeping, BP 90/54 HR 64 RR 16 T 98.3 (-) assessment.
	[redacted] AN
7Apr03	Vitals = 97.7 temp 99 Spo2, 88 pulse 22 rr
4:30Z	90/43 BP [redacted] 9LW
0600	IV Dced from (R) arm. + phlebitis good oral
	intake, alert + oriented [redacted] maj AN
4/7/03	(L) TIB/Fib FX
0800Z	S/P closed reduction (4/6/03)
	AF/USS
	Cast C/D/I
	P) long leg cast x 6wks
	weekly X-rays
	next X-ray 13 APR03
	[redacted]
4/8/03	(L) TIB/FIB FX
0740Z	S/P Close Reduction (4/6/03)
	NEXT X-ray 13 APR03

RELATIONSHIP TO SPONSOR | SPONSOR | LAST | FIRST

Shelton CAST - ~ 5/20/03

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY

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

(b)(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

DATE	NOTES
7Apr03	Vitals= 99.3 temp, 98 SpO2, 94 pulse, 22rr
13:13Z	115/50 B/P [redacted] 9kw
8APR03	VITALS - 98% SpO2, Pulse 89, Temp 98.7
0400Z	RESP 20, B/P 110/56 [redacted]
0900Z	Pt complains of headache. Given one tylenol 3 for
	PAIN control [redacted]
1500	Pt.'s Condition has been stable + % as of 0900. Has
	ambulated. Socialized with tent mates [redacted]
1635Z	Pt in bed, talking c̄ others. BP 98/54 HR 72 RR 14 T=99. No % pain.
	[redacted]
9 April 03 0410	- HR 72, Resp 16, BP 95/56, Tem 97.6 [redacted]
4/9/03	(L) TIB/Fib Fx S/P closed reduction ; CAST 06APR03
	STABLE
	NEXT X-RAY 13APR03
	X-RAY @ WK
	Shorter cast 20 May 03?
	[redacted]
09 Apr 03 1233Z	Tylenol 650 mg PO / C/O Headache — SPC [redacted] 9kw
09 Apr 03 1606	Vitals: Temp 98.4 Pulse ox 68/86 BP 132/36. Pt vitals are
	good Pt HAS NO complaints of Pain.
10 April 03 Z 0500	VS BP 120/66 P64 T 97.5 [redacted]
4/10/03	(L) TIB/Fib Fx S/P closed reduction / CAST 06APR03
0525Z	STABLE
	Desires discharge home
	✓ c̄ PAD / Civilian Affairs [redacted]

FPI LEX Printed on Recycled Paper

STANDARD FORM 509 (REV. 5-99) BACK

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
4/10/03	TEMP 98.7 PULSE OX ~~95~~ 99% HEART RATE 82 BP 122/42
	NO C/O Pt good condition.
11 Apr 03 @ 0428	bp 118/82 p80 T-96.5 RR-16
4/11/03 0635	D/C TO CN AFFAIRS?
	(L) TIB/FIB FR
	weekly X-rays next 4/13/03
	Remove CAST mid May 03
	(b)(6)-2
11 APR 03 1700Z	Pt resting quietly in bed. Benign assessment BP 112/60 HR 68 RR 14 Refuses Temp. Requesting sleep aid, Benadryl 50mg PO given. Pt asking about hospital in a.m. Referred to MD. CPT (b)(6)-2 -AN
12 Apr 03	Bp 110/64 p 93 T 97.2 RR 12 (b)(6)-2 SGT Wilson
4/12/03	PATIENT left AMA. EXPLAINED TO PATIENT via Arabic interpreter b6-2 [redacted] - that failure to receive adequate medical care could result in loss of function of (L) leg. He understands the risks.
	(b)(6)-2

RELATIONSHIP TO SPONSOR | LAST | NUMBER

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)*

(b)(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

ME[illegible]L RECORD – S[illegible]PPLEMENTAL MED[illegible] DATA

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

REPORT TITLE: **24 - HOUR COMPREHENSIVE CARE RECORD Part 1**

OTSG APPROVED *(Date)*

DATE: 22 Mar 03

HOSPITAL DAY NO. _____

POST OP DAY NO. _____

ISOLATION DAY NO. _____

ALLERGIES _____

LAB STUDIES

TIME										
TIME										
HCT										
GLU										
pH										
PO_2										
PCO_2										
HCO_3										
BE										

TOTAL OUTPUT

TOTAL INTAKE

VITAL SIGNS

TEMPERATURE (O) - ORAL (A) - AXILLARY (R) - RECTAL

PULSE ● = RADIAL ▲ = APICAL V = SYTOLIC ^ = DIASTOLIC

WEIGHT lbs.

RESPIRATIONS

BLOOD PRESSURE

SaO_2

TIME 01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24

MISC

INTAKE

ORAL

TUBE FEEDING

IV NUMBER #1 NS (TKO)

IV NUMBER #2

IV PB

CUMULATIVE TOTAL INTAKE

BLOOD

TOTAL # Units BLOOD Given

OUTPUT

URINE

NASOGASTRIC

EMESIS

CHEST TUBE

STOOL - LIQUID

CUMULATIVE TOTAL OUTPUT

BOWEL MOVEMENT

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC

DATE

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

(b)(6)-4

(b)(3)-1

DIAGNOSIS: (L) Tib/Fib Fracture

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

24 - HOUR COMPREHENSIVE CARE RECORD Part 2

	0700-1900	1900-0700
ACTIVITY BR - D - AA - A		
BATH B - P - S		
FOLEY / PERI CARE		
ORAL CARE		
ENDOTRACHEAL TUBE CARE		
ORAL / ET SUCTION		
OXYGEN VIA AT LPM		
VENTILATOR		
Fi O2 ____		
RATE: ____		
TIDAL VLOUME ____		
PEEP ____		
DIET: ____		
DRESSING CHANGE		
		INITIAL
(b)(6)-2 [redacted]	MAT/HV	TZ

TIME

NEURO GUIDE
- ✓ Normal
- – Sluggish
- + Fixed
- C Eyes Closed by Swelling

PUPIL SIZE
- 2 mm
- 4 mm
- 6 mm
- 8 mm

COMA SCALE

PUPILLARY REACTION	RIGHT SIZE	
	REACTION	
	LEFT SIZE	
	REACTION	
EYES OPEN	SPONTANEOUS	4
	TO SPEECH	3
	TO PAIN	2
	NONE	1
BEST MOTOR RESPONSE	EYE COMMANDS	6
	PULLS TESTERS HAND AWAY WHEN PINCHED	5
	FLEXION WITHDRAWAL	4
	DECORTICATE POSTURING	3
	DECEREBRATE POSTURING	2
	NONE	1
BEST VERBALE RESPONSE	ORIENTED	5
	CONFUSED	4
	INAPPROPRIATE	3
	INCOMPREHENSIBLE SOUNDS	2
	NONE	1
TOTALS		

BR - BEDREST D - DANGLE AA - AMBULATE WITH ASSISTANCE A - AMBULATORY B - BED P - PARTIAL S - SHOWER

TIME	NARRATIVE NOTES
2100	A received from EMT section. VSS, unable to verbalize c/o pain. In no apparent distress. (L) FA c̄ 18 G angiocath infusing NS @ TKO. IV site c/o I c̄ S/S/S infection/infiltration. (L) LE c̄ cast. Cap. refill < 3 sec. Bilat breath sounds clear. S1S2. Will monitor for Δ's. (b)(6)-2 [redacted] MAT/HV
0100	A sleeping. Ø c/o discomfort or pain. (L) LE continues to be elevated. Ø Δ's noted. (b)(6)-2 [redacted] MAT/HV

Recurrent Medications and Treatments		date	23rd	24	26	27
Vital signs						
	4					
9	8	P80 0630 B/P 107/54	115/65 t.99 96% p.90 R24			
	12	0 R23 130/80		10t/30 98% P97 R14 98.6°	T97.5 P85	110/72
	16		p105 SpO2 97% T101 BP 110/62			
	20	96%	108/66 20 100.8 96		T98.3 P81	112/74
	24					
PRN Medications and Treatments						
Demerol 50mg c̄ Phenergan 25mg IM	d/t amt/int	23 March 03 @ 0630				
q 4° prn pain	d/t amt/int					
T#3 1/1 - 1/1 po Φ 4-6° prn pain	d/t amt/int					
Motrin 800mg po TID	d/t amt/int		24 March 03 1270 SP	11 @ 2015 24 March 12	25 March 03 @ 1670 SP	27 MAR 03 1730 I 6M
	d/t amt/int	25 March 07 2100 SP				
	d/t amt/int					

Name (b)(6)-4

Dx: Tib/FibFx

Diet: Regular

SSN:

All:

Unit: CIV

Blood type:

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974 - AS A CLINICAL RECORD FORM, IT IS COVERED BY DD 220

ANESTHESIA RECORD

Page 1 of

START	IN OR	ANES. END	DATE
1400	1405		6 APR 03

OPERATION PERFORMED: (L) leg cast change

SURGEON(S): [redacted] 662

TOTS	SURG START	DRESSING	OR NO
1403	1410	1445	150

PREOPERATIVE

- ☐ IDENTIFIED ☐ ID BAND ☐ QUESTIONING
- ☐ CHART REVIEWED ☐ NPO SINCE
- ☐ PRE-OP MEDICATION:

Drug	Dose	Route	Time
Midaz	2.5mg	IV	1400

Pre-Anesthetic State: ☑ CALM ☐ APPREHENSIVE ☐ AWAKE ☐ SEDATE ☐ UNRESPONSIVE

MONITORS AND EQUIPMENT

- ☑ ANES. MACHINE # ____ & EQUIP. CHECKED
- ☐ NON-INV. B/P ☐ PNS
- ☐ CONT. EKG ☐ V LEAD EKG
- ☐ ESOPH. STETH. ☐ PRECORD STETH.
- ☐ PULSE OXIMETER ☐ O2 ANALYZER
- ☐ END TIDAL CO2 ☐ MASS SPEC.
- ☐ TEMPERATURE
- ☐ WARMING BLANKET ☐ FLUID WARMER
- ☐ AIRWAY HUMIDIFIER
- ☐ N / G TUBE ☐ O/G TUBE
- ☐ IV(s) 18g (R) FA
- ☐ ARTERIAL LINE
- ☐ CENTRAL LINE
- ☐ SWAN-GANZ
- ☐ FOLEY INSERTED: ☐ O.R. ☐ FLOOR
- ☐ EYE CARE
- ☐ PRESSURE POINTS CHECKED / PADDED

ANESTHETIC TECHNIQUE

- ☐ GENERAL ☐ LOCAL / MAC
- ☐ REGIONAL ☐ NERVE BLOCK
- ☑ IV sedation

INDUCTION

- ☐ PREOXYGENATION ☐ INHALATION
- ☐ RAPID SEQUENCE ☐ INTRAMUSCULAR
- ☐ INTRAVENOUS ☐ RECTAL

AIRWAY MANAGEMENT

- ☐ INTUBATION ☐ ORAL ☐ NASAL
- ☐ DIRECT VISION ☐ BLIND ☐ AWAKE
- ☐ FIBER OPTIC ☐ STYLET USED
- ☐ ATTEMPTS x ____ ☐ BLADE
- ☐ ETT SIZE ____ ☐ DOUBLE LUMEN
- ☐ STRAIGHT ☐ RAE ☐ ANODE
- ☐ CUFFED ____ ML AIR INJECTED
- ☐ UNCUFFED, LEAKS AT ____ CM H2O
- ☐ ETT SECURED AT ____ CM
- ☐ BREATH SOUNDS
- ☐ AIRWAY ☐ ORAL ☐ NASAL ☑ NATURAL
- ☐ MASK CASE ☐ VIA TRACHEOSTOMY
- ☐ NASAL CANNULA ☐ SIMPLE O2 MASK
- ☐ LMA SIZE

RECOVERY

TIME IN PACU	CONDITION
1457	Stable

B/P	PULSE	RESP	O2 SAT
101/59	93	14	96

REMARKS

TEMP 97

REPORT TO: PARRS:

IN FLUIDS TOTALS OUT

Crystalloid	EBL 0
	Urine NM
Blood 0	Gastric NM

AGENTS

1400 x 30 x 1500

MS04 (10)
Ketamine 100, 50
Robinul 2mg

N2O L/min
O2 L/min RA RA RA

FLUIDS

NS

Urine
EBL

MONITORS

EKG				
% O2 Inspired				
O2 Saturation	98	96	96	98
End Tidal CO2				
Temperature				
PNS				

TIME

1400 x 30 x 1500

VITAL SIGNS

PRE-OP VALUES

B / P
P
R
SAT
H / H

200, 180, 160, 140, 120, 100, 80, 60, 40, 20

RESP

Tidal Volume	SV	SV	SV	SV
Resp Rate	14	12	12	12
Peak Pressure				

Symbols for Remarks

Position

SYMBO
X ANESTH
OPERAT
B/P CU PRESSI
ARTER LINE PRESSI
PULS
SPONT OUS R
ASSIS RES
CONTRO RES
T TOURNI
F CRYS LOID F
B BLO

REMARKS: ☐ Patient reevaluated. No change from preop plan / evaluation.
☐ Significant changes from preop plan / evaluation.

1455 - out OR to ICU - 2 stable

Tourniquet Time:

(b)(6)-2

PHYSICIAN / CRNA

PATIENT'S IDENTIFICATION

(b)(6)-4

MCEUH OP 100, APR 00(Rev) (MRRC APPROVED: 29 M

MEDCOM - 3935

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 CARE UNIT ORDERS		
1	OXYGEN: 8 litres via Mask /Prongs to maintain O2 Sats greater than 94%;		
	Wean to room air.		
2	IVF: NS @ 125 cc/hr, bolus ~~cc x 1~~ →		
3	MORPHINE: 2 mg IV q 5-10 minutes PRN pain. MAX dose of 10 mg		
4	DEMEROL: 25 mg IV q 5-10 minutes PRN pain. MAX dose of 50 mg		
~~5~~	~~ZOFRAN: Give 4 mg IV PRN nausea. May repeat after 10 minutes X 1~~		
6	DROPERIDOL: 0.625 mg (1/4 cc) OR 1.25 mg (1/2 cc) IV PRN Nausea X 1		
7	REGLAN: Give 10 mg IV PRN nausea X 1		
8	Release from "PACU" when Aldrete score is 9 or greater		
9	Call Anesthesia for any questions or concerns		
	SIGNED (b)(6)-2		

PATIENT IDENTIFICATION

(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.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

T IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4	1225 / 29 MAR 03	HOURS	
	① TIB/FIB X-RAY (AP/LAT) (L) LEG		
(b)(6)-2		(b)(6)-2	

SING UNIT	ROOM NO.	BED NO.
	14:30 25 Mar 03	

IENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER
	4/6/03	HOURS
	① Vicoden i - ii Tabs ( ) 4-6° PIN PO Pain	
		(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER
	4/5/03	HOURS
	① NPO P MN	
	② Recast Tomorrow	
	③ Bivalve Cast Today	
Done		(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER
		HOURS

NURSING UNIT	ROOM NO.	BED NO.

REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

DA FORM 1 APR 79 4256

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

TIENT IDENTIFICATION

(b)(6)-4 (b)(3)-1

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 4/6/03 TIME OF ORDER 1500 HOURS

~~As~~ Admit to ward
S/P (L) tibia fx cast
stable
Vitals routine
Act - NWB on (L)
elevate (L) leg as able
Diet reg

LIST TIME ORDER NOTED AND SIGN

noted (b)(6)-2 MAJ, AN JNP

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

IV D5LR @ 70 cc/hr ✓
Leplock ē good po
Meds Vicodin ē ~~vii~~ po q 4° pm ✓
MSO4 2-4 mg IV q 2° pm ✓
Phenergan 12.5-25 mg IM q 6° pm

(b)(6)-2 MAJ MC

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 6 Apr 03 TIME OF ORDER 1340 Z HOURS

1 Admit to MCW#1 - continue previous orders.
2 Stable

(b)(6)-2

LTC, AN, JNP

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

DA FORM 1 APR 79 4256

MEDCOM - 3938

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*

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

Mo. ____ Yr. ____

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED
6 Apr 03	(b)(6)-2	dv NS @ 70cc/hr-heplock c̄ good pr		Dced 0600, good intake, no meds

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

(b)(6)-4

(b)(3)-1

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.

MEDCOM - 3939

USAPA V1.00

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo _____ Yr _____

Verify by Initialing

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
06 APR	(b)(6)-2	ADMIT TO ICU Z				
	-----	Dx S/P (L) TIBIA Fx CAST				
	-----	CONDITION STABLE				

INITIAL PROPER COLUMN FOLLOWING COMPLETION

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	TIME/DATE COMPLETED 6	7	8	9	10	11	12	1	2	3				
06 APR 05 -----	(b)(6)-2	VICODIN #I, II PO Q4° PRN PAIN														
06 APR -----		MSO4 2-4mg IV Q2° PRN PAIN														
06 APR -----		PHENERGAN 12.5-25mg IV Q6°	1500 PL													
-----	-----	PRN N/V														
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															

USAPA V1.00

ADMISSIC... ODING INFORMATION

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

1. REPORTING MTF	(b)(3)-1
...ATION (State or Country Code)	
3. REGISTER NUMBER	(b)(6)-4
NAME (Last, First, Middle Initial)	(b)(6)-4
4. PAY GRADE	
5. SEX	M
6. DATE OF BIRTH (Y Y Y Y M M D D)	1985 01 01
7. AGE AT ADMISSION	184
8. RACE	X
9. ETHNIC BACK-GROUND	9
RELIGION	
10. LENGTH OF SERVICE	
ETS	
11. FMP	20
12. SOCIAL SECURITY NUMBER	(b)(6)-4
ORGANIZATION (Active Duty Only)	
13. MARITAL STATUS	Z
HOUR OF ADMISSION	1500
BRANCH / CORPS	
14. FLYING STATUS	
15. BENEFICIARY CATEGORY	K78
16. ZIP CODE OF RESIDENCE	09330000
17. UNIT LOCATION (State or Country Code)	
18. MOS	
19. TRAUMA	9 BNJ
PREV. ADMISSION	YEAR ☐ NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	1 DHR
WARD	MCW 1
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	(b)(3)-1
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE	
21. TYPE OF DISPOSITION	22
22. MTF TRANSFERRED TO	(b)(3)-1
23. DATE OF DISPOSITION (Y Y M M D D)	200304 10
24. CLINIC SVC - ADMITTING	AEAA
25. MTF TRANSFERRED FROM	
26. DATE THIS ADMISSION (Y Y M M D D)	200304 06
27. LOCATION OF OCCURRENCE (Battle Casualty Only)	IZ
28. MTF OF INITIAL ADMISSION	
29. DATE INITIAL ADMISSION (Y Y M M D D)	

FOR LOCAL USE

① Tib/Fib Fx

Trauma 9

Inj 999

DX: 82322
E9889
Px: 7906

ADMITTING OFFICER (Signature, as required) (b)(6)-2

SIGNATURE OF ADMITTING CLERK (b)(6)-2

DA FORM 2985, MAR 89 EDITION OF MAY 79

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF | 2. MOBILIZATION (State or Country Code)

1	2	3	4	5	6	7	8
(b)(3)-1							

3. REGISTER NUMBER

9	10	11	12	13	14	15
(b)(6)-4						

NAME (Last, First, Middle Initial) (b)(6)-4

(b)(6)-4

4. PAY GRADE

16	17

5. SEX

18
M

6. DATE OF BIRTH (Y Y Y Y M M D D)

19	20	21	22	23	24	25	26

7. AGE AT ADMISSION

27	28	29
0	1	8

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
(b)(6)-4								

ORGANIZATION (Active Duty Only)

13. MARITAL STATUS

46

HOUR OF ADMISSION: 1500

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
BNJ

PREV. ADMISSION

YEAR

☐ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION

72
DHR

WARD: MCW 1

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME (b)(3)-1

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 (Y Y M M D D)

81	82	83	84	85	86
0	3	0	4	1	0

24. CLINIC SVC - ADMITTING

87	88	89	90
A	B	A	A

25. MTF TRANSFERRED FROM

91	92	93	94	95	96

26. DATE THIS ADMISSION (Y Y M M D D)

97	98	99	100	101	102
0	3	0	4	0	6

27. LOCATION OF OCCURRENCE (Battle Casualty Only)

103	104

28. MTF OF INITIAL ADMISSION

105	106	107	108	109	110

29. DATE INITIAL ADMISSION (Y Y M M D D)

111	112	113	114	115	116

FOR LOCAL USE

① Tib/Fib Fx

ADMITTING OFFICER (Signature, as required)

(b)(6)-2

SIGNATURE OF ADMITTING CLERK

(b)(6)-2

DA FORM 2985, MAR 89 EDITION OF MAY 79 IS

ADMISSION AND CODING INFORMATION

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

30. AGE AT DISP			31. AUTOPSY Y / N	32. UNDERLYING CAUSE OF DEATH / SEP	33. RESIDUAL DISABILITY			34. DO NOT USE - DATA FILLER #1									35. CAUSE OF INJURY		
117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136
1	8	9	N																

36. FIRST DIAGNOSIS (Principal Diagnosis)								37. SECOND DIAGNOSIS								38. THIRD DIAGNOSIS							
137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160
		8	2	3		0	1																

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

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

44. FIRST PROCEDURE (Principal Diagnosis)								45. SECOND PROCEDURE								46. THIRD PROCEDURE							
201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224

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

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

52. NUMBER OF DIAGNOSTIC FIELDS CONTAINING CODES		53. NUMBER OF PROCEDURAL FIELDS CONTAINING CODES		54. PRIMARY PROVIDER SPECIALTY CODE			55. BLOOD USAGE Y/N
265	266	267	268	269	270	271	272
0	1						

MEDCOM - 3943

ENT TREATMENT RECORD COVER

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)		3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4	(b)(6)-4		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M		FRHAI				

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99	(b)(6)-4		ICU1

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
					INJ

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct	0600	ABAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	Home	04 MAY 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		11 APR 03	

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
86TH COMBAT SUPPORT HOSPITAL, LSA ADDER, IRAQ		

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

~~E991.9~~

Shrapnel L Flank S/P BKA

~~897.0~~

~~879.4~~

DX: B795
8971
E9654

PPX: 8622
843
8622
8622
843
8669
8669

Trauma
1

Injury
449

35. **Total Days This Facility**

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
23	29				23

36. **Total Days All Facilites**

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

(b)(6)-2

MAJ, MC, USA

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

(b)(6)-2

EDITION OF 1 AUG [illegible] OBSOLETE

USAPPC V1.10

...DICAL RECORD - NURSING DISCHARGE SU...ARY

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

1. Date/Time:

2. Discharge to: ☐ Home ☒ Other (specify) LOCAL HOSPITAL

3. Mode: ☐ Ambulatory ☒ Other (specify) AMBULANCE

4. Accompanied by: EMT

5. Activity: AD LIB ☒ Limitations (specify)
- NEED PHYSICAL THERAPY FOR (R) BKA AND PROSTHESIS FITTING
- LIMITED WALKING FOR NEXT 5 DAYS DUE TO SKIN GRAFT.

_____ Patient and/or Significant Other (S.O.) communicates knowledge and understanding of activity limitations.

6. Diet: ☒ No Dietary Restrictions If special, identify - NEEDS HIGH CALORIC / PROTEIN INTAKE FOR ↑ HEALING PROCESS.

_____ Patient/S.O. communicates understanding of dietary restrictions.

7. Medications: ☐ No Medication Required

Name of Medication	Dosage	Frequency of Medication	Special Instructions
ATARAX - ORAL	25mg	EVERY 6 HOURS	AS NEEDED FOR ITCHING
BACITRACIN OINTMENT		TWICE A DAY	1 INJECTION ON WOUNDS
MULTI - VITAMIN	1 PILL	ONCE A DAY	COMBAT MALNUTRITION
COLACE - ORAL	100mg	TWICE A DAY	STOOL SOFTNER
PERCOCET	1-2 TABS	EVERY 4 HOURS	AS NEEDED FOR PAIN CONTROL

_____ Patient and/or S.O. communicates knowledge and understanding of name, dosage, frequency and special instructions.

8. Treatments/Care:

Instructions Given:	Patient/S.O. observed Demonstrations (Date)	Patient/S.O. Returned Demonstration (Date)
CHANGE DRESSING (R) STUMP EVERYDAY	05/03/03	
APPLY BACITRACIN OINTMENT TO WOUND - SKIN GRAFT TWICE A DAY.		

Equipment/Supplies (Specify) PROVIDED 3 DAY SUPPLIES OF GAUZE/DRESSINGS AND 3 TUBES OF BACITRACIN

9. Follow-up: You should be seen in LOCAL HOSPITAL clinic in _____ (time period).

FOR DEFINITIVE AND FINAL CARE OF (R) BKA INCLUDING PROSTHESIS FITTING AND PHYSICAL THERAPY. ALSO NEEDS FOLLOW-UP ON SKIN GRAFT HEALING

_____ Patient/S.O. communicates understanding of follow-up instructions.

10. Patient's Condition (Health Status relative to Nursing Care Plan):
VSS, STABLE & MODERATE PAIN SOMETIMES WHEN DOING DRESSING CHANGES. NEEDS PT/OT IN LOCAL HOSPITAL AND DEFINITIVE CLOSURE ON (R) STUMP.

11. Signature (Registered Nurse)
1LT (b)(6)-2

13. Patient Identi...

12. Additional Information:
HELD & 3 DAY SUPPLIES OF
- GAUZE - 4x4
- TAPE - KERLEX
MEDICATIONS - 3 DAYS SUPPLIES AS LISTED ABOVE.

COPY 1 - INPATIENT RECORD COPY

MEDICAL RECORD - NURSING DISCHARGE SUMMARY

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

1. Date/Time:

2. Discharge to: ☐ Home Other *(specify)*

3. Mode: ☐ Ambulatory Other *(specify)*

4. Accompanied by:

5. Activity: ☐ Limitations *(specify)*

_____ Patient and/or Significant Other (S.O.) communicates knowledge and understanding of activity limitations.

6. Diet: ☐ No Dietary Restrictions If special, identify

_____ Patient/S.O. communicates understanding of dietary restrictions.

7. Medications: ☐ No Medication Required

(b)(6)-2,(b)(6)-4

_____ Patient and/or S.O. communicates knowledge and understanding of name, dosage, frequency and special instructions.

8. Treatments/Care:

Instructions Given:

Patient/S.O. observed Demonstrations (Date)

Patient/S.O. Returned Demonstration (Date)

(b)(6)-2,(b)(6)-4

Equipment/Supplies (Specify)

9. Follow-up: You should be seen (b)(6)-2,(b)(6)-4 clinic in _____ (time period).

(b)(6)-2,(b)(6)-4

(b)(6)-2,(b)(6)-4

_____ Patient/S.O. communicates understanding of follow-up ir

10. Patient's Condition (Health Status relative to Nursing Care Plan):

(b)(6)-2,(b)(6)-4

(b)(6)-2,(b)(6)-4

(b)(6)-2,(b)(6)-4

11. Signature (Registered Nurse)

12. Additional Information:

13. Patient Identification:

COPY 1 - INPATIENT RECORD COPY

DA FORM 3888-3 JUN 04 REPLACES DA FORM 3888-3 (TEST), AUG 85 WHICH IS OBSOLETE USAPPC V1.00

NSN 7540-01-075-3786

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

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

25 yo Iraqi seen & treated c the FST → (b)(3)-1 to us. c large macerated wound. Pt has undergone dressing Δ elsewhere. S/p R BKA

PE: OX3

1y CTA cm and soft c large punctate open area?

prev 12D (FST) c fibrinous exudate ? prev will take to OR for washout, dressing Δ & local explanation

Net 26.5%

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT ... AND STAMP

(b)(6)-2

PR... ...P

DIAGNOSIS

Soft tissue injury (L) flank S/p (R) BKA

CODES

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

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

(b)(6)-4

NSN 7540-01-075-3786

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

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

SEX | AGE

DUTY/LOCAL PHONE: AREA CODE | NUMBER

HOME PHONE: AREA CODE | NUMBER

ARRIVAL

DATE *(Day, Month, Year)* | TIME

TRANSPORTATION TO FACILITY

MILITARY STATUS

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

THIRD PARTY INSURANCE

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

CURRENT MEDICATIONS

ALLERGIES

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☐ NON-URGENT

TIME

(b)(6)-2

SPO2

VITAL SIGNS

TIME					
BP 131/90					
PULSE 116					
RESP 16					
TEMP 98.4					
97					

LAB ORDERS

☐	CBC/DIFF	☐	BHCG/URINE/BLOOD/QUANT
☐	URINE C&S	☐	CHEM:
☐	BLOOD C&S X		

X-RAY ORDERS

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

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE

DISPOSITION ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

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

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ | TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

PATIENT'S IDENTIFICATION

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

(b)(6)-4

DATE	NOTES
16Apr03 @0230	Pt voided 525cc clear amber urine via urinal. [redacted] CPT AW
16Apr03 @0400	VS: P 105, BP 91/48 map 63, RR 23, Pulse Ox 89% on room air, T 98.7 oral. Encouraged use of Oxygen mask, pt takes it off. Will continue to monitor. [redacted] CPT, AW
16 Apr 03 0600	End of Shift Note: Pt assessment done. Pt A&O, speaks Arabic - translator available. All dressing on flank (L) and shoulder are clean, dry & intact. No drainage or odor noted. Pt able to move around in bed without assistance. Lungs clear ↓ bases c̄ scattered rhonchi anteriorly. Abd slightly firm c̄ (+) bs x 4. Pt tolerating PO well. Discussed importance of oxygen with pt, but he refuses to keep it on. Without supplemental oxygen pt sats in ↑ 80s. Will continue to monitor. [redacted] CPT AW
16APR03 0745 (local time)	Nursing: pulse ox 88% RA - pt refuses O2, BP 106/68, T 99.2 P 65, RR 24; LR infusing to (R) AC @ 150cc/hr (R) BKA ace wrap intact, c/o pain - medicated c̄ 2mg MSO4 IVP; dressing to (L) bicep-CDI; +2 pulse bilateral upper extremities; dressing to (L) flank-dry, tape falling off - will change when pain is under control; lung sounds - (R) side rhonchi @ bases (L) side clear, (+) BS 9 4 quads [redacted] CPT/AW
0905	3Mg MSO4 & 1Mg versed given IVP as pre-med to dressing change; 7mg MSO4 & 4Mg versed IVP given during dressing change @ 0930 [redacted] CPT/AW

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	Nursing Note
15APR03	T100.8; BP112/57, R 20, Pulse Ox 82% on Room Air; Pt
1623	A transferred from ICU #1 [(b)(3)-1] fixed facility to
(local time)	ICU #1 8th CSH (temper); s/p (R) BKA, (L) flank
	soft tissue injury; pt placed on mask 6L O2 -
	pulse Ox 96%; no c/o pain @ this time; +2 pulses
	to bilateral upper extremities & (L) LE; dressing (L)
	flank CDI; (L) arm dressing CDI; (R) BKA ace wrap
	CDI; LR infusing via (R) arm [(b)(6)-2] PT/AN
1900	Pt has taken O2 mask off during shift. explained
	to pt to keep on; nasal cannula used, pt sat 90%
	on 3L NC but refuses to wear; sats on RA
	80-85% [(b)(6)-2] CPT/AN
15Apr03	Pt voided amber urine 650cc via urinal.
@2000	[(b)(6)-2] CPT AN
15Apr03	Pt voided 400cc light amber urine via urinal
@2200	Will continue to monitor. [(b)(6)-2] CPT AN
15Apr03	VS: T100.8 PO, HR 111, BP 106/63 map 79
@2201	and Pulse Ox 90% on RA. Attempted to place
	4L NC on pt and pt refused oxygen. Will
	continue to encourage O2 use [(b)(6)-2] CPT AN
15Apr03 @2200	Gave Tylenol 650mg PO x1 for temp 100.8 [(b)(6)-2]

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

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

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

DATE	NOTES
(cont)	1000cc dark urine output via foley this shift [redacted] CPT AN
1900	1 Vicodin given for c/o pain [redacted] CPT AN
16Apr0220 1930	Report received assessment done. VS: T 101.2 oral, HR 109, BP 100/52 map 70, RR 23. 650mg Tylenol given PO. Will continue to monitor closely. [redacted] CPT AN
16Apr0320 1930	Pulse Ox 89% on RA, encouraged use of O2. Will continue to monitor closely. [redacted] CPT AN
17Apr0300 1130hrs	VS: T 98.4, oral, Pulse Ox Sat 92% on RA, P 91, BP 107/60 map 77, RR 22. Will continue to monitor @ 0600 as ordered [redacted] CPT AN
17 Apr 03 0030hrs	Emptied 1100cc amber urine from foley. Had to lower foley to ground and assist with drainage Pt c/o abd pain - when bladder palpated found full. After foley drained Pt felt better. Will continue to monitor closely. [redacted] CPT AN
17 Apr 03 @ 0615	Pt continues to rest in bed. VSS. Afebrile. Oriented and follows commands. Pt remains non-compliant with supplement O2 use at times. Currently 91% Sat on RA. Pt flank dressing with some serosanguinous drainage noted - unchanged due to pt returning to DK this AM @ 0715hrs. Pt kept NPO since MN. Palpable pulses x 3 extremities. (R) BKA c drainage on dressing - palp femoral pulse. Lungs CTA c occasional fine scattered rhonchi anteriorly. Abd slightly distended c @ bs x 4. + BS + N + V. Foley to gravity. Will continue to monitor level of comfort and VS closely. [redacted] CPT AN CK

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
16APR03	Wet to dry dressing change done to ⓛ flank soft
1000	tissue wound; 2 large soft tissue wounds, c multiple smaller wound - some granulation tissue present, 90% slough tissue is in smaller wounds [redacted] [(b)(6)-2] CPT/AN
1130	Pt OOB to chair for 60 minutes, ate some lunch - tolerate well, pt insisted ne return to bed; dressing to ⓛ flank and ® [redacted] dry & intact [redacted] [(b)(6)-2] CPT/AN
1500	Pt c/o unable to void, q void this shift, urethra red, swollen, Dr. [redacted] into assess and cathe patient, over 800 cc out immediately; catheter left in; pt resting comfortably [redacted] [(b)(6)-2] CPT/AN
1815	T 100.9 P 119 RR 20 BP 106/62 pulse ox 96% on RA; Dressing to ® BKA - shadow drainage posterior; Dressing to ⓛ flank shadow drainage posterior; ⓛ arm dressing CDT; instructed & encourage deep breath and OOB to chair; pt sat at side of bed for dinner; thru translator instructed pt on importance of getting OOB; pt OOB x 1 today to chair & ↑ to side of bed x 1; urine output total

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. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
4/17/03 @0700	Emptied 450cc clear amber urine from foley; had to lower bag to ground before it emptied. Will continue to monitor. (b)(6)-2 [redacted] CPT AN
17apr03 0714	Nursing: BP 104/61, T 100.5, P 107, RR 22, pt scheduled for surgery this am, instructed he is NPO, 88% pulse ox on RA - pt refuses O2; dressing to (R) BKA & (L) flank c̄ shawdow drainage - will be changed this am in OR (b)(6)-2 [redacted] CPT/AN
4/17/03 0905	~~Ort~~ Op Note Preop Dx: (L) flank wounds (R) BKA Postop Dx: Same Proc: (R) revision BKA c̄ application of skin traction Surgeon: Nilsson Anesth: Gen EBL: Min Comp: ∅ Drains: Penrose Findings: small subQ fluid collection adjacent to ~~a~~ tibial stump. Nice granulation. Post comp. shortened.

(b)(6)-2 [redacted]

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

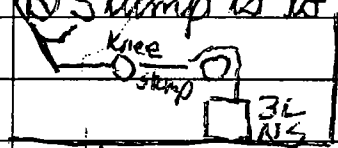
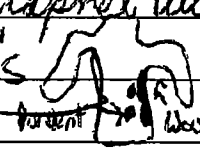
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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.

(b)(6)-4 [redacted]

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

DATE	NOTES
18APR03	0800 hrs Nurses Note: Patient lying in bed sleeping quietly. Easily arousable to verbal expression and tactile reception through motor kinetics. Pupils equal & reactive to penlight luminescense. Intravenous line to right antecubital is size 18 gauge flowing without inhibition c̄ a dial-a flow coupler for accurate accountability of intravenous fluid input. Foley catheter draining bronze colored urine. Foley Evacuated p̄ balloon stabilizer depressurized using a 10cc B-D syringe, purulent drainage observed on distal catheter epithelium. (R) stump is to 3L NS traction as diagramed below: Skin Traction
	 Blue chucks x 2 set under serosanguinous draining stump. (−) Pussy purulent drainage observed
	(L) Flank presents c̄ multiple confluent schrapnel ulcerations requiring sterile irrigations and wet & dry Δ's 
18APR03	Tolerating PO well. [redacted] ILT/AN
1600	Patient received 20 gauge IV & (L) FA. D/C (R) AC IV because of venous swelling & tenderness. Colace prescribed for difficulty c̄ evacuating feces. Monitoring VOP, (−) void in 6 hours. Will recath @ 1700 if no void [redacted]
18APR03 1730	Foley catheter started on patient. Dark golden glazed tinged urine evacuated & gravity. [redacted]
18APR 1800	Patient alert & oriented. Able to state name and repeat name of nurse. Fluid ↑ p̄ dark urine emptied and volume of urine borderline. [redacted] ILT/AN
18APR03 1918	Pt A+O x 1, VSS - sinus tach, c̄ shrapnel wounds to (L) side + BKA (R) LE. BKA Dressed + wrapped to 3L NS traction. Stump is bloody, draining moderate amounts of blood. Dressing to (L) side is C/D/I. draining small amounts of

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MEDCOM - 3954

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
17APR03	(0925) Patient groggy from anesthesia. Vitals stable. Sats 100% c̄ 4L O2 Stump wrapped & intact to traction [redacted] 3L bag. Lungs clear to auscultation. ⊖ vomiting. Urine to foley gravity clear straw colored quant. Sufficient. Heart rate WNL & skin color appropriate for ethnicity. Ⓛ Flank dressing CDI [redacted]
17APR03	1300 Δ flank dressing. Multiple deep ulcerations packed c̄ wet-dry. Beefy red appearance. Mild odor. ⊖ purulent drainage. Pre-medicated c̄ 10mg MSO4 & an additional 5mg MSO4 during the procedure. Tolerate PO well. IV to Ⓡ FA presents c̄ ⊖ Redness & swelling. [redacted]
17APR03 2011	Pt Alert, VSS, PAO2 fluctuates to low 90's / high 80's. Given O2 via simple mask @ 4L/min, ↑ PAO2 to 99%. Dressing to Ⓛ side is covered in gauze / foam tape. Saturating dressing / chux c̄ clear, serious fluid. Ⓡ BKA draining to dressing moderate amount of bloody drainage. Attached to 3L bag of fluid for traction. Slightly elevated. Foley draining clear yellow urine > 30 cc hr. Infusing LR to Ⓡ FA @ 125cc/hr. O2 on blowby. [redacted] 91C3H
2200	Pt c/o nausea / stomach pn. Given 25mg phenergan IV. [redacted]
0035	Pt removed dressing to Ⓛ side. Replaced dressing + given Vicodin for pain. [redacted] 91C3H

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

DEPART./SERVICE	[redacted]	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]

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

MEDCOM - 3955

509-114

DATE	NOTES
2130	Wound. Packed ⊂ gauze soaked ⊂ Dakin's solution. Ⓡ BKA Dressed + elevated ⊂ 3L NS to traction. Dressing oozing sero-sanguinous fluid. Premedicated ⊂ MSO4; tolerating dressing Δ well. IV of NS @ 200 cc/hr infusing to Ⓡ FA ⊼ infiltration. Foley draining clear yellow urines >30 cc/hr. Tolerating PO H_2O ⊼ N,V. [b)(6)-2] 91C3H
2300	Pt c/o Ⓡ thigh pain. Site is warm + dry, ⊖ deformities noted Given 3 mg MSO4. [b)(6)-2] 91C3H
0430	Pt c/o pain; offered 2 T3 PO. Pt refused; signed he wants morphine. Tried to explain to pt. MSO4 only for dressing Δ. Will continue to monitor. [b)(6)-2] 91C3H
0745	Patient sleeping quietly. Skin traction in place x ⊖ dyspnea, ⊖ Vomiting. Will perform dressing Δ ⊼ Doc early. Dressing Ⓡ leg Stump presents breakthrough serosanguinous fluid. [b)(6)-2] LCT/AN
1830	Patient sleeping quietly, Sats transiently dip into the 89% barrier. O_2 restores Sats >95% quickly <30 secs. Dressing ⊂ Ⓛ flank Δ'd and beefy red granulations. Appetite decreased, ensure utilized ⊂ make up calories [b)(6)-2]
1845	Tylenol 650 given for fever [b)(6)-2]
2000	Pt A+O x 1, VSS, temp 100.4° F. Premedicated ⊂ 10 mg MSO4 prior to dressing Δ. All wounds appear to be healing well ⊼ S/S of infection. Redressed and soaked in Dakins solution. Ⓡ BKA Was rewrapped in Coban by a.m. shift, appears dry + intact. Small amounts of sanguinous drainage to chux on bed. Lungs CTA Ⓑ, BS active x4, distal neuro-vascular intact x3. NS @ 200 infusing into Ⓡ hand, ⊼ S/S of infiltration or infection. [b)(6)-2] 91C3H

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
18 APR 03 1918	Serous fluid Foley catheter draining dark amber urine. Resting comfortably, tolerates PO ☆ N, V NS @ 200 cc/hr to (L) FA. [(b)(6)-2] 91C3H
2330	Dressing Δ to (L) side reveals 2 large + multiple small wounds all are healing well, ☆ S/S of infection. Tiny amount of eschar noted in one wound. Dakins solution used to change Dressings. [(b)(6)-2] 91C3H
0540	PT foley drained 1100 cc, extremely odiferous amber urine. Intake - 2400 cc NS, 200 Ancef.
0732	U/A - Glucose - NEG, Bilirubin - Small, Ketone - Large SG - 1.020, Blood - Neg, PH - 5.0, Protein - trace, Urobilinogen - 1, Nitrite - Neg. [(b)(6)-2] 91C3H
19 APR 03 0760	Patient alert, tolerates breakfast well. (R) leg ☆ 3 cms tracts. Plan: Penicillin ☆ MS04 Δ dressing to (L) flank. [(b)(6)-2]
0830	Dressings changed to (L) flank. Good granulation tissue ☆ small blood streaks showing uniformly. Packed ☆ 1/4 Dry Dakins solution. Flank
0930	Patient lying in bed. Repositioned for better traction effectiveness. [(b)(6)-2] LT. IAN
2180	A+O x 1, VSS, Lung sounds CTA (B), BS active x 4, Dressing to stage 4 wound on (L) side Δ'd. Granulating well, ☆ S/S of infection. Small amount of purulent drainage noted on one small

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.

[(b)(6)-4]

DATE	NOTES
22 APR03 2330	patient, and moved pt out of bed to chair for 30min. Attempting to get patient to drink Mag Citrate, tolerates small amounts at a time. (R) BKA redressed during am. shift, small amounts of sero-sanguinous drainage to dsg + dressing. Pt voiding clear urine via foley >30 cc/hr. NS infusing to (L) FA @ 200 @ [redacted]
22 APR03 0205	Recieved pt resting in bed. Pt easily arousible. Lungs CTA. S1 S2 sinustachy. Distent BS#4. +2 radial pulses. +2 (L) pedal pulse. Cap refil <3 sec. @ 0200 Dr. Petroski preformed dressing A on (L) flank. Pt premedicated c 10mg Morphine 5mg Versed by VO Dr [redacted] Pt tollerated well. After dressing A on flank (R) BKA dressing change done. Area was pink/red. Wet to dry using Jenkins solution. Pt tollerated procedure well. @ 1015 1 enema given. 5 minutes pt placed on bedside comode. With No results @ 1030 2nd enema given. Pt set on comode 15 minutes with no results. Dr [redacted] wrote an order for dulcolax supp q 6° until results. @ 1400 pt has small BM, diarrhea about 50cc. to bedside comode. @ 1630 Dulcolax 10mg Supp given. Pt tollerated well. 1700 pt had appx 300cc diarrhea c formed stool, at bedside comode. W/I continue to monitor. Pt did not eat breakfast or dinner, ate 2 pears & crackers for lunch. @ 1700 Dr [redacted] gave VO to dc ~~Foley~~ Foley. Foley DC. Pt has not voided prior to shift change. [redacted]

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
21APR03 0600	Pt Alert, VSS, T MAX 98.5°F. Foley output 750cc dark amber urine c̄ trace sediment over 12°. Stump to (R) BKA c̄ small drainage (sero-sanguinous). (b)(6)-2 [redacted], 91C3H.
21APR03 0600	Recieved pt sleeping in bed. Pt easily arousible Lungs CTA, sinus tachy. Distent BS x4. +2 radial pulses +2 (L) pedial pulses. Cap refill < 3 sec. Dressing change to (L) flank done by Dr (b)(6)-2 [redacted]. Tissue mostly pink. IV in (L) foram. 200cc/hr NS. Foley to gravity. (R) BKA dressing with clear bloody drainage. 3L bag of fluid used for traction. Will continue to monitor - (b)(6)-2 [redacted] 91W1
1130	Dr (b)(6)-2 [redacted] preformed the dressing change on pt (R) BKA. Pt was pre medicated c̄ 100mg Demoral + 2mg versed by verbal order of Dr (b)(6)-2 [redacted]. Pt tollerated procedure fairly well. Pt was cleaned up afterwards and ate ~~eat~~ half a cup of blueberry sause will continue to monitor (b)(6)-2 [redacted] 91WM
2330 21APR03	Pt Alert, VSS, NAD, presents c̄ shrapnel wounds to (L) side and (R) BKA. (L) side wounds are healing well, tissue is granulating, s̄ s/s of infection. Redressed c̄ sterile gauze soaked c̄ Dakins solution. Multiple small lacerations to (L) arm, back, leg. Performed AM care on

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

MEDCOM - 3959

509-114

DATE	NOTES
23APR03	0700 recieved pt resting in bed. Lungs C/T/A. S_1S_2 sinus tachy. BS active X4. +2 radial pulses. +2 (L) pedal pulse. Cap refil <3 sec. Dressing to (L) Flank C/D/I Dressing to (R) BKA has scant amount of clear brown secreations. (R) BKA to traction c 3L NS. @ 0900 Dr [b)(6)-2] preformed dressing chang on (L) Flank. Tissue pink/red. healthy looking. Pt was premedicated c 10mg morphin 5mg versed. After dressing Δ to flank, dressing change to BKA. Tissue pink, red, c white throughout. Old dressing has small amount of bloody drainage Yellowish, beige color drainage noted on old dressing. No foul oder noted Pt tollerated procedure well. @ 1400 PT came by at steer pt up with cruches. Pt tollerated well. Pt became dizzy after standing after about 2 minutes. Pt ate all of breakfast and an apple for lunch. Did not eat dinner. VS within normal limits. Pt has uneventful shift. Will continue to monitor- [b)(6)-2]
23APR03 2156	Pt A+O x3, VSS, NAD. Shrapnel wounds to (L) side are healing well, granulating c epithelial buds present. Ø S/S of infection seen. (R) BKA covered in dressing, which has a small amount of drainage. IVF of NS infusing to (L) FA @ 200cc @ H. Tolerating PO c Nausea / Vomiting. Pt voided, BM x 1 on BS commode approx. 600 cc clear yellow urine. BM was small yellow in color, soft, c formeed stool. Pt c/o ph to (R) BKA. [b)(6)-2] 91C3H
24APR03 2400	Assumed care of pt. Report via SSG [b)(6)-2]. Pt resting comfortably. [b)(6)-2] CPT, AN.

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
22APR03	1845 Pt penis has purlent discharge. Some reddness noted. Will continue to monitor — [redacted] 9LWM6
22APR03	Pt Alert + oriented x 3, VSS, NAD, c̄ (R) BKA + (L) sided
BP:	Shrapnel wounds. Δd dressing to (L) side, healing
T: 100.0°	Well c̄ epithelial buds, s̄ signs/symptoms of infection.
P: 90	Used 1/4 strength Dakins solution + packed c̄ gauze.
R: 22	Multiple small lesions also appear to be healing well, beefy red in color, (−) purulent drainage, (−) tenderness to palpation, surrounding area is warm + natural skin tones. (R) BKA is dressed in stockinette gauze + covered by Coban wrap, c̄ small amount of bloody drainage to anterior portion of dressing. Pt voided 850 then an additional 500 cc of clear, light yellow urine via urinal. Given Ducolox PR x1 s̄ results, although pt did verbalize the urge to deficate, and sat on B/S commode. Used incentive spirometer c̄ medium results achieved - approx. 1500 mls of inspiratory pressure. Taking PO fluids s̄ nausea, vomiting, BS active x4. Lungs sounds CTA (B) [redacted] 91C3H
23APR03	Gave Ducolax PR s̄ result. Pt voided approx 300 cc
0630	clear yellow urine. [redacted] 91C3H

RELATIONSHIP TO SPONSOR	SP[redacted]			SPONSOR'S ID NUMBER (SSN or Other)
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[redacted]

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PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

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509-114

DATE	NOTES
25APR03 0730	assumed care of pt. pt spont awaken with light touch. PT refused to eat breakfast. pt c/o pain : request MSO4. Last MSO4 IVP @ 0300hr. PT response to commands, PERRL, ABle to turn : reposition self on bed ē assistance. RR 20, unlabored. BS End EXP coarseness ē few wheez @ bil bases, RA O2SATs , HR 89, S.S2 (PPP X 3, @ BKA) SKIN W-D CAP Refill ≈ 3sec. Skin color WNL, ABD soft NON ~~de~~tented, B S x 4, has NOT Voided this shift. DSG L Chest Flank, Intact, @ BKA Intact (Plan BACK to OK on Monday) Sm scattered healed / healing (wounds) on L↑ ext DSG to be done this AM. IV in L FA, 20g, ϕ S·S infec/infl NS infusing @ 200cc hr. [redacted] mayn
25APR03 0745	pt request IV MSO4 vs Tylenol 3. for pain 5mg NQ given. Instructed by Surg team to inform pt if he continue to refuse to wear his brace for his strong he will be Discharged. [redacted] mayn
25APR03 0900	DSG Δ done to L Chest Flank. by DR [redacted] W-D done ē Dr Ken 25%. Two Lg wounds beefy red granulation of edges, Mult SM wounds also. wounds ē S·S infec, Surg PAP / 2x2, place on wet dsg. PT Tol ok versed / MSO4 given Before procedure. [redacted] mayn
25APR03 1400	PT sleeping off: on Throughout The Shift c/o pain chest / BKA 03' pt request MSO4 IVP doesn't want Tylenol #3, refused to eat breakfast lunch, voided 1000cc cl amber urine, VS stable —

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[redacted] mayn

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
0600	Pt c/o pain. Medicated c MS 10mg IV. Pt refused to place amputated leg on traction. after being off for a period of time. [(b)(6)-2]
24APR03	Recieved pt resting in bed at 0600. Lungs CTA. S1S2 sinustachy. BS Active. +2 radial pulses. +2 (L) pedial pulses. Cap refil <3 sec. (L) flank dressing c/d. Dressing to (R) BKA with scant amount of clear brown drainage. Pt premedicated with 10mg MSO4 & 5mg versed @ 0830. 0845 Dr [(b)(6)-2] changed dressing on (L) flank. Tissue looks healthy pink/red. After flank dressing wet→dry dressing done on BKA. BKA has some bridge yellowish secreasions on bandages. Wet→Dry c dakins solution. BKA pink/red. Pt refusing to have BKA in traction. [(b)(6)-2]
24APR03 2200	Pt A+O x3, VSS, presents c (R) BKA / (L) side multiple shrapnel wounds. Dressing A's reveal healthy granulating tissue. s signs/symptoms of infection. ∅ drainage noted to dressing. IV site d/c to (L) FA, infusing NS @200cc. Pt voiding well via urinal, qs, clear, light yellow urine. Pt refusing traction to (R) BKA. [(b)(6)-2], qICBH

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DATE	NOTES
26 APR 03 0800	pt awakened to start IV & am assessment.
	neuro: pt follow commands, move all ext.
	Resp: BS CTA, O2 SAT 92% on RA, IS X 10
	∅ cough, CV S. S2 Skin Warm & Dry CAP L3 sec
	PPP X 4 ∅ JVD ∅ (M). GI, ABD SOFT NT, BS X 4, LAST BM 2
	hypoactive. GI has not voided this am. Skin wounds
	Chest L Flank, Lg DSG intact ∅ DSG, ® BKA, DSG
	intact c̄ old DSG drainage. Plan of Care. DIC to
	CIV Hosp or Pt will remain @ mil Hosp pending
26 APR 03	skin grafting on Monday [redacted] (b)(6)-2 MAJ [illegible]
0810	IV placement pending this am, attempts
	unsuccessful by off going shift [redacted] (b)(6)-2 MAJ [illegible]
0830	20 g IV placed in L wrist, LR ↑ @ 125cc hr
26 APR 03	per D.O [redacted] (b)(6)-2 MAJ [illegible]
0900	DSG Δ done by pr [redacted] (b)(6)-2, ~~[illegible]~~ [redacted] b6-2 / Ugoy
	given by LT [redacted] (b)(6)-2, wound site cont
	to show signs of healing @ edges & S S S
26 APR 03	infection [redacted] (b)(6)-2 MAJ [illegible]
1315	Hygiene care done by pt c̄ min assistance.
	Interpreter @ BS. pt received information
	on the importance of WT on BKA, but
	he still refuse R/T pain control. also
	pt received information of diet & intake
	which is poor, one of the interpreter stated
	he will bring bread ea day for the pt
	and write a letter to his family.
	∅ Δ in assessment [redacted] (b)(6)-2 MAJ [illegible]

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
Cont 1400	pt reported relief from GI upset $\bar{p}$ 30cc Mylanta was given (b)(6)-2 [redacted] mark
25 APR 2200	Pt was A+0x3 able to feel sensation in all ext, able to move extremities independently. Lungs CTA. using IS during shift, O_2 sats 93% RA. +2 pulses in all ext. <2 sec cap refill ext. warm and dry. S_1 & S_2 heard. Patient tolerating regular diet ate 10% of meal this evening. +BS all 4 quadrants ∅ tend, ∅ dist. 1x BM, solid moderat amount. Patient voiding spontaneously in urinal. Clear yellow urine. Wound on (L) flank small amount of sanguanous drainage. healthy pink granulated tissue present. (L) BKA: small amount of drainage bloody medicated for pain x3 during shift. VSS. Will continue to monitor. (b)(6)-2 [redacted]
25 APR 03 2349	pt A+0x3, VSS - t-max 99.6°, Lungs CTA (B), Distal Neuro-vascular intact x3. (R) BKA is wrapped in a stockinette and Coban c̄ a small amount of drainage to the posterior aspect. (L) side is dressed in Gauze + tape; C, D, I. ∅ signs + symptoms of infection at either site. Tried to explain to pt that he is leaving tomorrow. c̄ some success. Pt tearful, but responds appropriately to interaction. (b)(6)-2 [redacted] 91C3H

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(b)(6)-4 [redacted]

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DATE	NOTES
27APR03 0745	Patient resting quietly. Bandage to (L) flank CDI. Stump to (R) Proximal Tib/Fib Secure c̄ minor breakthrough. ⊖ dyspnea ⊖ difficulty urinating. (b)(6)-2
1100	Dressing Δ'd to patients (L) flank. 2 large open wounds healing to secondary intention. Borders present c̄ beefy red interior, small 1cm areas cleaned out. ⊖ necrosis. IV started to (L) FA. Benadryl given for itching (b)(6)-2
27APR03	1600 recieved pt resting in bed. Easily arousible Lungs C/T/A. S_1S_2 NSR. BS. Dressing on (L) flank C/D/I. Dressing on (R) BKA, no drainage noted. VS within normal limits. Will continue to monitor. @2115 pt premedicated c̄ 10mg morphine & 5mg versac @2130 dressing change done on (L) flank wet→dry c̄ NS. Wounds were pink/red. no foul odor noticed. At 2200 dressing Δ done on (R) BKA, yellow biedge discharge noted on old dressing. Area irrigated c̄ NS. Tissue red/pink. Wet→Dry dressing done. Pt tollerated procedure well. Pt resting comfortable in bed. (b)(6)-2
28APR03 0600	PA A+O×3, VSS, NAD, NPO p̄ MN for skin graft this am., Lungs CTA (B), BS Active×4, Dressing to (L) flank C/D/I (R) BKA has no drainage. Distal Neuro-vascular intact×3. Voiding via urinal 775 cc clear/yellow. tolerated PO @2330 s̄ nausea, vomiting (b)(6)-2 -91C3H

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
26 APR 2130.	Pt is AtOx3 has sensation in all ext. pt ambulated with crutches x1. Lungs CTA bilaterally O_2 sats >95% Pt using incentive spirometry accurately. Ø evidence of labored breathing. has +2 pulses all ext. <2 sec cap refill ext are warm and dry ø edema present. Patient tolerating regular diet, last BM on 25 April ø dist ø tend. of abdomen, +BS all 4 quadrant. Voiding spontaneously in urinal. Clear yellow urine. Pt has (L) wrist PIV 20 gauge c̄ LR @ 125 cc/hr. Wound care done on patient (L) flank wound healthy c̄ pink tissue surrounded by granulated tissue on edges. Small amount of drainage present. (R) BKA has moderate amount of bloody drainage. Pt refuses skin traction at this time. medicated for pain x1 c̄ dsg Δ 10 mg MSO4 IVP c̄ relief. VSS Continue to monitor
	(b)(6)-2 [redacted] LT, AN
26 APR 03 2350 hrs	Pt Alert, VSS - T-MAX 99.0°F, PAO_2 - 92%. WNL for patient. Lung sounds CTA (B), BS active x4, Distal Neuro-vascular intact x3. IVF of LR @ 125/hr via 20G ~~R~~ (L) wrist. (L) Flank dressing C/D/I. (R) BKA has small amount of old bloody drainage. Medicated for pain. Tolerates PO c̄ nausea, vomiting. (b)(6)-2 [redacted] 91C3H

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

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

PROGRESS NOTES
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DATE	NOTES
29 Apr 03 0430	Pt alert and eating crackers / lemonade. Voided 600 cc clear urine. Stator Lt (b)(6)-2 ~~chart~~ dressing itchy. Administered Ambien for sleep. Chapstick applied to lower lip. DRSG Lt thigh Dry & Intact. Stump coban DRSC Dry vs stable. c/o pain. Adm morphine twice. Patient slept most of the night. IV LR patent Lt forearm IV site Ø redness or swelling (b)(6)-2 [redacted] [illegible]
29 APR 03 0730	Patient sleeping quietly, arousable on calling Skin color uniform and warm. Dressing to (L) flank White, clean, dry & intact. Dressing to (R) DE stump CDI. No dyspnea noted. Will further assess p̄ breakfast. (b)(6)-2 [redacted]
29 APR 03 1500	Pt resting in bed. Easily arousible. Lungs CTA. S_1S_2 NSR. +2 radial & (L) pedial pulse. Cap refil <3 sec. IV 18G in (L) forarm. BS active (R) upper & lower quad. Unable to acess do to dressing. Dressing to (L) flank C/D/I Dressing to (R) BKA C/T/I. Pt has no complaints at this time. Will continue to monitor. @1700 pt voided 500 cc clear yellow urine @1800 pt IV would not flush. 18G IV started in (R) forarm. TKO. @2100 pt voided 600 cc clear yellow urine. Pt resting in bed. Will continue to monitor — (b)(6)-2 [redacted] [illegible]
30 Apr 03 0545	Patient slept most of the night. Medicated for Lt flank pain twice (x2) with morphine. c/o itching Lt flank, adm. benedryl x2 (twice). Voided 1000 cc clear urine. Rt leg stump dressing came off. Abd, kerlix and ace wrap applied. Wound site Ø drainage Ø pus. IV Rt forearm patent. Drank 8 oz ensure @ 0550. Applied chapstick and lidocaine (topical) to lower lip. Lt (b)(6)-2 [redacted] dressing dry & intact. Old drainage spot marked. Otherwise dry and intact — (b)(6)-2 [redacted] [illegible]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
28APR03 1500	Pre-op pt. VSS, A+Ox3, abd soft, bs x4 quadrants. Pt urinates via urinal quantity sufficient clear yellow urine. ⊖ drainage from dressing. Ⓛ Flank dressing changed in OR. Post-op pt. VSS. Lung sounds CTA. Pt stating between 90-94% RA, P 123-111, R-20-30 bpm. Pt bite lower lip in OR. Litocain applied, chapstick at Pt bedside. IV LR running 125cc/hr in Ⓛ forearm 20G. IV running well no signs of infection. Pt is on strict bedrest skin graft on Ⓛ flank. Donor site Ⓛ thigh. No Dressing changes to be done. Diet advance as tolerating. [redacted]
28APR03 1500	Recieved pt on litter resting in bed. Pt is alert Lungs C/T/A. S.S. sinustachy. BS distant x4 +2 radial pulses. +2 pedal pulse. 18G IV in Ⓛ forearm. Dressing to Ⓛ Flank c/d/I. Dressing on Ⓛ thigh c/d/I. Dressing on ⓇBKA c/d/I. Pt has no complaints at this time will continue to monitor. @1830 pt voided 900cc clear yellow urine. @2000 pt voided 600cc clear yellow urine. Pt tollerating po. IV heplock. Pt ate a banana and drank about 75 cc of ensure. Pt had uneventful evening. Will continue to monitor [redacted]

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

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[redacted]

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DATE	NOTES
30APR03 1616	(B), BS active x4, pt voided 1100cc clear, yellow urine via urinal. IVF of LR @ TKO to (R) FA c̄ signs of infiltration/infection. [redacted] ,SSG, 91C3H
30APR03 (1800)	Pt. c/o itching. 25mg. Benadryl given IV. [redacted] 91WN SGT
~~1800~~ 1May03 0615	Pt slept majority of the night. Adm pain med 4 times. LT flank dressing dry & intact. Xerofoam remains on LT thigh. Right stump dressing intact & dry. IV left forearm patent. ∅ urine output during the shift. Continue to monitor for BM. Last BM 25 Apr 03 — [redacted]
0745	Patient sleeping quietly. (b) Flank dressing CDI. Voiding clear straw colored urine. IV Flowing to (L) FA c̄ (−) redness or swelling. Stump to (R) distal extremity CDI. [redacted] ILT/RN
1030	Patient itching, gave 50mg Benadryl IV.
1110	Dressing changed to patient's stump. Circumferential boundary well approximated c̄ pink boundary and red, beefy interior. Premedicated c̄ MSO4 and versed. c/o itching → benadryl IV utilized. [redacted]
1420	Got supplies for patient to do personal hygiene. Patient refused. State "pain" in Arabic. Pain medicine given @ 1110. Offered patient water also refused. Took MVI c̄ a small sip. [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
30 Apr 03 0640	pt states seeking motion from Rt hip stump - He did it once before my eyes. Adm pain medication for Lt flank pain. VS stable [redacted] (b)(6)-2 s/a
30 APR 03 0800	Patient alert & oriented. HEENT: No masses, ⊖ JVD, neck soft/supple. ⊖ lesions/drainage. Tongue pink. Pt c/o itching & graft site, benadryl IV administered. Dressing to left flank is dry, clean & dry. 3" tape intact, ⊖ redness or redness to taped area circumference. Ⓡ stump unwrapped d/t. Patient frequently asking for pain meds. Will monitor for D/C. Lungs clear to auscultation. Ⓣ voids shows odor urine. [redacted] (b)(6)-2
1155	Bulky dressing removed from donor site & Xeroform left in place to dry. Patient premedicated but still experiencing pain and itching. Translator utilized and patient verbalizes understanding of not to touch surgical sites for possibility of infection. [redacted] (b)(6)-2 CT/PN
1616	Pt Alert, Dressing to Ⓛ Flank C/D/I. Ⓛ leg skin graft covered by Petroleum Gauze bandage which has dry edges but portion covering graft donor site is still wet, ⊖ signs of infection. Ⓡ BKA dressing D'd by a.m. shift, still clean, dry, & intact, FAROM to stump, although pt expresses pain & full extention. Ⓣ Distal Neuro-Vascular x 3. [redacted] (b)(6)-2 CTA

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[redacted] (b)(6)-2		

PROGRESS NOTES
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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
2MAY03	Pt c/o itching, given 50mg Benedryl. Pt c/o dysuria, given urinal, able to micturate 900cc spontaneously. Bladder (-) distention. (b)(6)-2 91C3H
2 May 03 2300	Initial assessment: pt alert, Rt stump wound dry & intact, Lt flank wound dry. Xeroform on Lt thigh in place. Medicated for Lt flank itching (b)(6)-2
3 May 03 0410	Pt took part of Lt flank dressing off while scratching area. Dressing removed and 4x4s x 4 reapplied. Wound site healing. Still had old dressing with old drainage. Not removed. Foam tape applied. Pt told not to scratch area. Benedryl and morphine administered. IV Right forearm patent. (b)(6)-2
3MAY03 0745.	STABLE, PERRLA, A&Ox3, VSS - SEE FLOW SHEET, DRESSING CHANGE ON (R) STUMP DONE, OTHERWISE CLEAR TO D/C BY ORTHOPEDICS STILL FEELING ITCHY ON SKIN GRAFT (L) FLANK - DRESSING D/C BY GENERAL SURGERY LATER IN THE MORNING - 50mg OF BENADRYL IV GIVEN PRN. LUNGS CTA, (+) BS, GOOD PULSES AND CAPILLARY REFILL x 3 ((R) BKA)
1015.	GENERAL SURGERY ARRIVED FOR GRAFT SITE DRESSING D/C, WOUND TOOK 95% OF GRAFT, HEALING WELL & NO S/S OF INFECTION, PLAN TO D/C TO LOCAL HOSPITAL TOMORROW, CLEAR ACSD BY ORTHOPEDIC TEAM AFTER ROUNDS TODAY. GATHERED 3 DAY SUPPLIES OF DRESSINGS FOR

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