DATE	NOTES
1030.	(R) STUMP AND MEDICATIONS TO INCLUDE PERCOCETS FOR PAIN. WAITING TRANSLATOR IN ORDER TO INFORM PATIENT. 50 mg OF ATARAX AND MVI GIVEN P.O NOW [redacted] BACITRACIN APPLIED TO AREA.
1300	50 mg OF BENADRYL GIVEN IV PER ↑ ITCHING
1330	760 cc OF CLEAR / YELLOW URINE COLLECTED BY URINAL
1400.	STABLE, VSS, TRANSLATOR WILL INFORM PAD (CPT [redacted]) ABOUT D/C PLAN, SUPPLY OF MEDS / DRESSINGS ALREADY AVAILABLE AND READY. PT BRIEFED ABOUT PLAN OF CARE. VERBALIZED UNDERSTANDING THROUGH USE OF TRANSLATOR. [redacted]
1530	Pt AT0+3, VSS (TMAX 99.2°) Lungs CTA (B), BS active x4, (R) BKA site dressed, clean, dry, & intact, FROM, (L) Flank shrapnel wounds are open to air. Skin graft intact, healing well, sutures intact, (−) drainage. IVF of LR infusing into (R) FA @ 50 cc/hr. Graft donor site to (L) thigh is covered by petroleum gauze, which is drying, and peeling off on the edges. Pt c/o constipation, put on bedside commode, s̄ results. Pt washed + linen Δ'd. [redacted] 91C3H
1730	Pt c/o constipation, abdominal pain. Given enema c̄ small results + Bisacodyl suppository s̄ result. Pt c/o abdominal cramping. In bed, resting c̄ BS commode at bedside. [redacted] 91C
1800	Pt ate only local food, brought in. Refuses offered meal except cake and orange (approx 25%). [redacted] 91C3H

DATE	NOTES
2May03	0900 Patient alert & oriented lying quietly in bed. Legs elevated. (R) BKA is dressed c̄ self adhesive bandage & wet/dry which is clean & dry. (L) flank presents c̄ multiple bandages to graft site x3 days. Medication administered for pruritus. Patient ate one small waffle and drank water. Will reckon (R) stump & clean patient up. (b)(6)-2 [redacted]
1400	(R) stump dressing changed. Area is pink c̄ red boundary. Wet kerlex applied to raw area and wrapped c̄ dry kerlex then the whole area fit snuggly c̄ self adhering kolan. Patient ate a moderate amount of indiginous food c̄ approx 1 cup H_2O. No voids on the shift. IVF (L) foot presents c̄ redness & swelling and is positioned c̄ foot placement. Patient washed up c̄ cloths & water. Vitals stable. Flank dressing intact, benadryl given for pruritus. (b)(6)-2 [redacted]
2MAY03	Pt A to x3, VSS, IVF LR @ 50 cc/hr, infusing via 20G to (R)
1541	FA. (L) Flank dressing C/D/I, although dressing is loose, covering graft site. Skin graft donor site to (L) leg is covered by petroleum gauze, which is drying at the edges, center is still slightly damp, c̄ some old bloody drainage noted. (R) BKA dressing Δd during a.m. shift is C/D/I. FROM to BKA. Distal Neuro-vascular intact x 3, (b)(6)-2 [redacted], 91C3H
1645	Pt c/o urticaria, given 50mg Atarax PO. Performed p.m. care on pt. Pt also ate only cake from dinner, followed by a cup of peanuts. Tolerated well, s̄ nausea or vomiting. We continue to monitor. (b)(6)-2 [redacted], 91C3H

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
1MAY03 1758	Pt A+O x3, VSS, NAD, Lungs CTA, BS Active x4. (R) BKA dressed is clean, dry, & intact. End of stump is granulating well, healing. ∅ signs or symptoms of infection. (L) side shrapnel wounds b6-2 are [redacted] covered in gauze / tape which is C/D/I. Skin graft [redacted] donor site to (L) thigh is covered by petroleum gauze which has drying edges, but slightly wet on the actual donor site. Distal Neuro-vascular intact x3, New IV site established to (L) foot, infusing LR @ TKO. Pt voiding QS clear yellow urine via urinal. Reg diet, pt. does not eat provided meals from hospital, but will eat potatoe chips and local food when provided. Pt refused broth as well. [redacted], 91C3H
1817	Pt c/o itching, and 5/10 pain. Given 50mg Benedryl IV + 2 Percocet PO. Pt also used I.S. c̄ poor results (approx. 1500). Will continue to monitor, [redacted], 91C3H
2238	Pt c/o itching to skin graft site. Given 50mg Benadryl IV. [redacted] 91C3H
1 May 03 2340	Pt alert. States Lt flank graft site itching. Given Benadryl 50mg IV. Xeroform Lt thigh peeling slightly. ∅ drainage. Dressing Rt stump intact. Dressing Lt flank dry and intact. IV Lt foot patent. @ 0005 voided 480 cc clear urine. 0615 - Pt states pain Lt flank. Med for pain [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.
[redacted] [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
03May03 1025	Summary -Shrapnel to L flank; s/p BKA . s/p split thickness skin graft 5 days prior - Needs Follow-up wound care - Needs revision and prosthesis of AKA -Needs physical therapy
	(b)(6)-2
	MD OB/GYN

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
4MAY03 0700	P4 asleep. responds to verbal stimuli. Organizing pt for D/C to home / Red Crescent. Ratified PAD. Supplies for home at bedside. Nursing Discharge translated to Arabic. Will continue to monitor. (b)(6)-2 SSG/Swanc

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
3MAY03	Pt produced large, formed, brown BM. Pt c/o pain, given
1930	ii percocet for pain. (b)(6)-2 [redacted] 91C3H
2220	Pt c/o itching - given 50mg of Atarax. (b)(6)-2 [redacted] 91C3H
3 MAY 2350	assumed care of pt. pt awake & alert.
	lying on back pt is able to move all exts.
	BS CTA, O2 SAT 92% on RA. Ø evidence of distress
	HR 90'S S. S2 ⊖M ⊖ JUD. Cap refill L 3sec skin
	color WNL, skin W.D., ABD SOFT NT Hypoactive
	BS x 4, @ BKA Ace wrap / dsg intact in clean,
	psgcss removed from chest, graft on L flank
	in good condition, Donor site L leg drag & 5
	drainage. Pt ajenile c/o itching Ant / Lat
	Chest wall. (b)(6)-2 [redacted] mayor b6-2
3 MAY 03	2355 jv D'C pt pending D'C in Am [redacted] msn
4 may 03	0030 pt c/o itching L flank benachyl given
	50mg PO (b)(6)-2 [redacted] mayor
4 may 03	0230 pt awakened pass R/T noise level in ICU
	c/o itching a second dose of PO Benachyl
	given (b)(6)-2 [redacted] msn b6-2
4 MAY 03	0400 pt sleeping, Ø scathing noted [redacted] msn

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

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PROGRESS NOTES
Medical Record

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

MEDCOM - 3978
509-114

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
4-11	VS - 93% 2L NC, HR 90, BP 116/58, T 98.6
0630	from EMT - (R) BKA dressing (L) flank dressing, O2 2L NC sats 90%. foley to gravity.
	NPO. follow stump care, VSS, I & O,
	R AC, (+) BS - MSO4 given per [illegible]
4-11	Δ'ed (L) flank w/ 400 total 2 oz NSS gtt in ER
1330	per DR [illegible]. NPO 1300 order [(b)(6)-2]
1400	Foley Drn 1500 cc ACU. SPC [(b)(6)-2] 91WM6
1625	pt assessment complete he is A+O x 3 he offers no c/o pain @ this time. he c/o SOB, lungs CTA O_2 sats 98% on RA resp 20 pt not using accessory muscles, pt HR tachy @ 124 BPM, he has dressing loosely applied to (L) flank CDI, he has stump dressing on (R) stump below the knee compl deep breath encouraged [(b)(6)-2] 91WM6
2320	c/o pain given 4mg MSO4 @ this time [(b)(6)-2] 91WM6
0300	c/o pain given 4mg MSO4 [(b)(6)-2] 91WM6
0930.	PT AOx3. PERRL. NEURO INTACT. VSS. PT. PSO2 ≥ 95% ON 2L N/C. LUNGS CTA PRODUCTIVE COUGH C̄ THICK MUCUS SECRETIONS. CARDIAC RRR. ACTIVE BS IN ALL 4 QUADS. NON DISTENDED NON TENDER ABD. TOLERATING PO FLUIDS AND CLEAR FLUIDS DIET. FOLEY DRAINING CYU TO GRAVITY. PT HAS SCROTAL EDEMA THAT IS SENSITIVE TO TOUCH. ELEVATED C̄ TOWEL BUT PT REPOSITIONS HIMSELF. (R) BKA DRSNG C/D/I. Δ'd AND CLEANED (L) TRICEP WOUND AND (L) CHEST WOUNDS. IRRIGATED C̄ STERILE SALINE AND DRESSED SLOPPY WET TO DRY. PREMEDICATED PT FOR PAIN C̄ MSØ4. PT TOLERATED THE DRSNG Δ WELL. WILL CONT TO MONITOR PT AND ABX TX. PT NPO AFTER MIDNIGHT TONIGHT FOR SX ON 13 APRIL Ø3 FOR STUMP CARE AND I/D. [(b)(6)-2] LT/AN

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)*
	25 yo Iraqi c̄ Shrapnel to (L) flank and
OD2R	(R) leg. S/P Right BKA, (L) flank debridement
	4/9, repeat debridement 4/10. Brought to
	EMT from (b)(3)-1 for disposition. Pt
	Ambit & oriented x 3. CNII-XII grossly intact
	NC/AT PERRL, EOMI Neck supple
	Chest - BS ↓ on (L), (R) wide clear Heart RRR
	Drainage on (L) flank clear & dry.
	Abd soft. Foley in place
	S/P (R) BKA, drainage clear & dry
	A/P Stetch
	Admit to ICU for rehabilitation
	✓ CXR, pelvic film
	Q2, Crack, pain control.
	(b)(6)-2
	CXR - no DTX, shrapnel may overly
	peritoneal cavity. Marked gastric
	distention. W.O. place NG, observe for now
	(b)(6)-2

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

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

REGISTER NO.	WARD NO.

(b)(6)-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4/12/03 1630	PT Resting upright bed - O2 4L NC c̄ SAO2 90%, Drsg T2 (L) flank intact, (R) BKA Drsg intact, Foley @ BSD - PT c/o discomfort c̄ Foley - irrigated c̄ 120cc NS, c̄ difficulty secured cathetor noted - IVT @ (L) FA noted c̄ s/s infiltration or infection. PT encouraged to sit up straighter + C+DB to promote ↑ lung expansion - reinforced pt teaching through interpreter. pt verbal understanding - [redacted] 91WM6H
1940	Co pain given 4mg MSO4 [redacted] 91WM6
13 Apr 03	0416 Report received, care assumed [redacted] 91WM6
13 APR 03	Brief Op Note: Preop Dx: Scrotal (L) chest, (R) BKA Postop Dx: same Procedure: I/D of wounds, washout (R) BKA Surgeons: [redacted] b6-2 Anesthesia: [redacted] EBL: ~50 cc Fluids: Findings: ⊕ necrosis, ⊕ pus, developing granulation Drains: Foley Disposition: to ICW/stable
	[redacted] MD
	[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.

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CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

-turned from OR, S/P I/D of (L) flank wound and (R) BKA. Pt Alert, RLA, 2-3mm/Reactive. Lungs CTA, sating 795% c̄ 4L NRB. ST c̄ HR 110's, BP 130's/70's, capillary refill < 3 seconds. Foley to gravity c̄ 550ml of dark yellow urine post-op. Afebrile c̄ T-max of 98.6. Pt currently s̄ any c/o discomfort, will continue to monitor. (b)(6)-2 [redacted] 1LT, AD

.30 APR 03 Pt c̄ c/o pain to (R) BKA and (R) bottom tooth (loose) per translator. Administered 4mg MSO4 IV push. Will continue to monitor. (b)(6)-2 [redacted] LT, AD

1650 pt assessment completed @ this time he is A+O x 3 he c/o pain in (L) flank and abd. 4mg MSO4 given @ this time his lungs CTA c̄ good breath sounds HR reg @ 96 ⊖ edema; AM care completed @ this time, IV in (R) arm infusing area CDI, foley to gravity putting out 735cc urin (b)(6)-2 [redacted] 91WM:

STANDARD FORM 600 (REV. 6-97) BACK

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

MEDCOM - 3982

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
0930 14 APR 03	Pt had dressing Δ to (R) flank side (wet/dry). Received total of 8mg ~~Vers~~ PAM MSO4 and 5mg Versed prior to procedure for patient comfort. Pt alert, PERLA. Lung sounds clear c̄ sats 88-92%. Instructed patient to keep NC on to ↑ oxygen sats. NSR c̄ HR ~~900~~ PAM 90's-100 bpm, BP 114/59, afebrile. Hypoactive BS x 4 quads, no BM @ this time. Voiding large amounts of dark yellow urine via foley. Pt resting @ this time, will continue to monitor. (b)(6)-2 [redacted] ILT, AN
1700	pt c/o pain he was given 4mg MSO4 @ this time pt. A+O x3 AM care completed, he attempted a BM but no success, pt lungs CTA c̄ good breath sounds HR reg rate and no edema, pt stump dressing to (L) BKA CDT foley to gravity @ this time putting out >35cc/hr dressing to (L) flank CDT (b)(6)-2 [redacted] 9 [illegible]
1815	c/o pain given 4mg MSO4 9 [illegible]
2155	c/o pain given 4mg MSO4 (b)(6)-2 [redacted] 9 [illegible]
0300	c/o pain given 4mg MSO4 9 [illegible]
0700	Foley D'cd @ 0600 s̄ complications per physicians order. No void @ this time. Pt c/o pain to (R) BKA, administered 4mg MSO4 c̄ minimal effect. Administered 5mg Versed and total of 16mg MSO4 d/t pain c̄ dressing Δ this AM c̄ good effect. Pt afebrile, ST c̄ HR 100-105 bpm. 2+ pulses x 3 c̄ (+) capillary refill <3 seconds. Hypoactive BS x 4 quads. Pt still noncomplian

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.

(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)*
	with wearing NC, satting 86-88%. Patient resting at this time. Will continue to monitor. (b)(6)-2 1LT

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

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

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
4/9/03	OP NOTE
2100 (7)	Preop: 1/F (R) BKA & I&D (wide) shrapnel
	c FST
	Pt to Op Same
	OP: Re I&D (R) BKA & (L) flank shrapnel
	wounds
	Dr CHO / Dr [illegible]
	Fluid 1L Findings: large shrapnel wound
	Urine 200 x8 (largest 25x25 cm)
	Ø compr from FST debridement
	To ICU Ø obd [illegible] penetration
	(b)(6)-2 CHO MD
	CT SURG

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

(b)(6)-4

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

CHRONOLOGICAL RECORD OF MEDICAL CARE **STANDARD FORM 600** (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

MEDCOM - 3985

510-112

NSN 7540-00-634-4

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
10 Apr 03	2100	(2)	pt. arrived from OR see post anesthesia care Record for assessment — [redacted] CP
	2200		Urine - foley 400cc — [redacted] CP P
11 April 03	00	20	98.5°F. O_2 sat 94-95% on 5L SFM, (R) BS c̄ late insp. crackles, (L) BS diminished @ bases. BP 135/79, HR 88, RR - 40bpm. Dre [redacted] intact. Medicated for (R) LE (S/p BKA) pain. Will eat with chest PT. — [redacted] CP
			(L) thoracic dressing & (L) Flanks dressing stained with sero-sang drainage. [redacted] CP
	01:20		Medicated for pain c̄ good results [redacted]
	02:20		134/85, HR-90, O_2 sat 95%, 5L NP. Started Incentive spirometry. — [redacted]
			Medicated for pain. — [redacted]
	03	00	A/E for further treatment. — [redacted]

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

[redacted]

NURSING NOTES

Medical Record

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

MEDCOM - 3986

MEDICAL RECORD LRMC **INTRAOPER[illegible] DOCUMENT**

For use of this form, see AR 40-407, the pro[illegible]gency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY May (b)(6)-2

2. PATIENT IDENTIFIED, RE[illegible] VERIFIED BY May (b)(6)-2 [illegible] 66E

3. DATE 4-10-03 TIME PATIENT ARRIVED IN SUITE 1955hrs

4. PATIENT IN ROOM TIME 1955hrs NUMBER Emerg.

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: T discomfort due to open wounds. Anesth. Sedation given by anesth for comfort.

6. NURSING PERSONNEL

ASSIGNED SCRUB	556 (b)(6)-2 [redacted] 910	RELIEF SCRUB	
ASSIGNED CIRCULATOR	May (b)(6)-2 [redacted] 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* Warm sheets provided. At my Bean Bag.

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

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☐ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

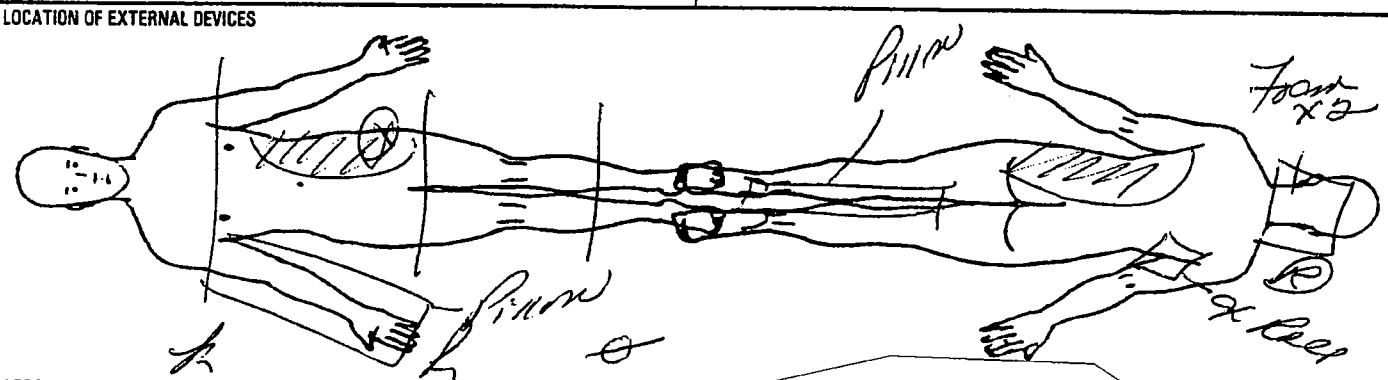
PREP SOLUTION *(Specify)*

SITE: BY WHOM:

SITE: BY WHOM:

COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect (b)(6)-2

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

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

(b)(6)-4 [redacted]

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

☑ ESU NO: Valley lab 082 (30-60)

GROUND PAD: BRAND Valley lab Rem II

LOT NO:

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA F

MEDCOM - 3987

MCEUL OP 358, 2 Mar 00
MRRC apprvl - 3 Feb 00

USAPA V1.00

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):

N/S

OTHER ORDERS	TIME	CARRIED OUT BY

(b)(6)-2

PHYSICIAN'S SIGNATURE

NA

15. X-RAY IN OPERATING ... IF YES, SITE

YES ☐ NO ☑

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

TYPE/SIZE	1. Puffs	2.	3.
SITE	(L) Lat Side Open Wounds		

18. DRESSING/IMMOBILIZATION *(Specify)*

Abds
Tape

19. ADDITIONAL INFORMATION

The medical record (SF 539), the progress note (SF 509), the operative consent (SF 522), and the patient agree that the correct operative site is the _____ side.

Verified by: _____ Patient/guardian _____ Surgeon _____ Anesthesia _____ Operating Room Nurse

Emergency

20. OPERATION(S) PERFORMED

(1) Debridement (R) BKA
(2) Debridement left Shoulder wounds.

21. PATIENT TRANSFERRED TO ICU 3 TIME 2100 METHOD Litter

22. REGISTERED NURSE SIGNAT... (b)(6)-2

REVERSE OF DA FORM 5179-1, ...

EUL OP 358, 2 Mar 00
...RC apprvl - 3 Feb 00

USAPA V1.00

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR 4 2003

DAY	11				12	13 Apr	13 Apr						14 Apr	
HOUR	630	1700	0300	0800	1715		0800	880	0835	0840	0900	0930	1000	0930

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	116/58	122/81	112/63	20	26	24							
SI	93%	90%	99%	85	93	139/73	133/75	136/73	134/74	128/73	121/66	116/71	
		P-111	P 99			97%	98%	93°	93°	98	89	98%	
						97%	98%	112	110	111	115	114	

HEIGHT: WEIGHT →

	240 H2O 13 Apr 2100	240 H2O 13 Apr 2200	1000 Lp 13 Apr 2100	
Out	11 Apr 93 900 vm 2000	12 Apr 93 1100 0200	13 Apr 1600 0300	14 Apr 1500 0300

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.GPO:1996-404-763/40069

(b)(6)-4

MEDCOM - 3989

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY														
POST-	DAY													
MONTH-YEAR	DAY	14APR		14APR		15								
19	HOUR	0800		1200		0300	0700							
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		114/59		114/58			113/62							
		P-121		P-120			105							
	02	87%		89%			88%							
HEIGHT:	WEIGHT →													
IN		4-14-03 more dizzy												
OUT		4-15-03 1750 out 0300												

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

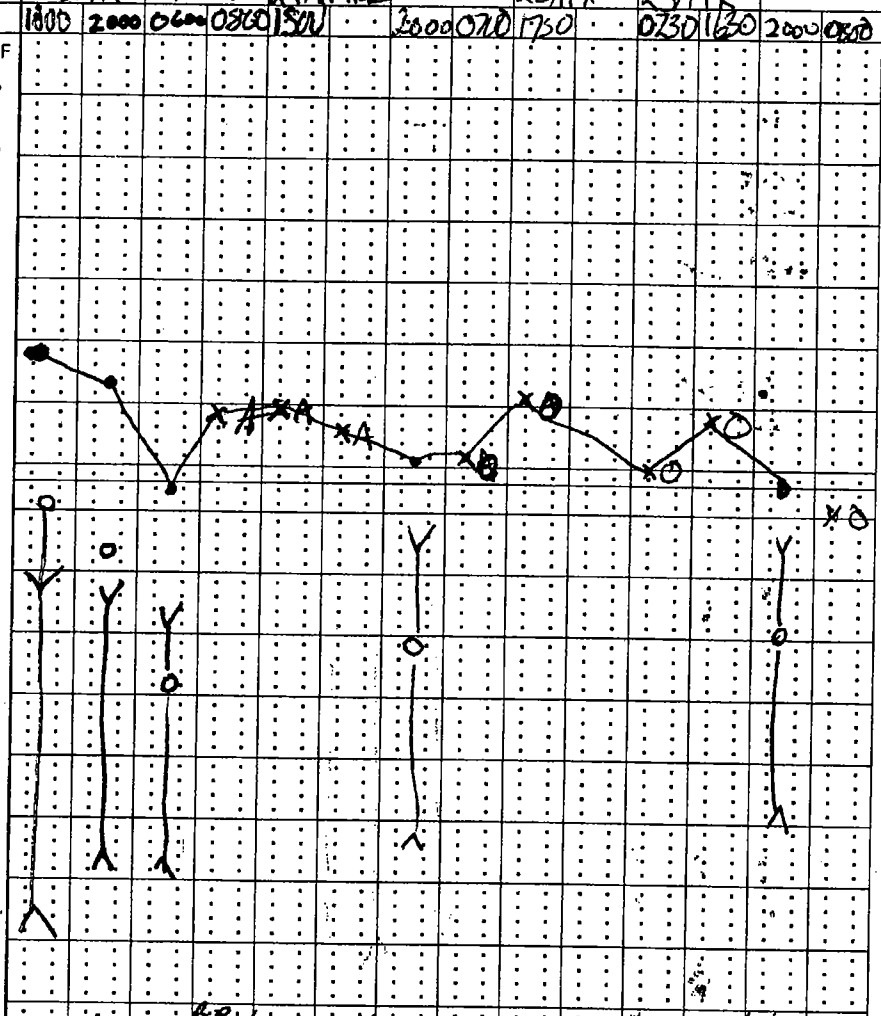
STANDARD FORM 511 (REV. 7-95) BACK

*U.S. Government Printing Office: 1995 - 609-626

MEDCOM - 3990

MEDICAL RECORD

VITAL SIGNS RECORD



HOSPITAL DAY																
POST- DAY																
MONTH-YEAR	DAY	20APR		21 APR		21APR03				22APR		23APR				
19	HOUR	1800	2000	0600	0800	1500		2000	0700	1750		0730	1630	2000	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																
RESPIRATION RECORD		19	18	20	BP 121/70		115/66	116	118/71	115/58		107/63	112/68	118	111/70	
BLOOD PRESSURE		107	106	112	105		105	115	103			94	101	115	101	
		55	65	63				67						72		
SaO_2					92	0	94		92	94		90	90		91	
HEIGHT:	WEIGHT →															
MAP		74			89		85		7	79			83			
UOP		1000		750				875			850		1850 800 total 1650		1200	
Input - IV LR NS		400		2400				0 800		urine 1450						
PO		200		75												

Record special data only when so ordered

(Centigrade Equivalents, for Reference only)

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

REGISTER NO.

WARD NO.

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

511-119

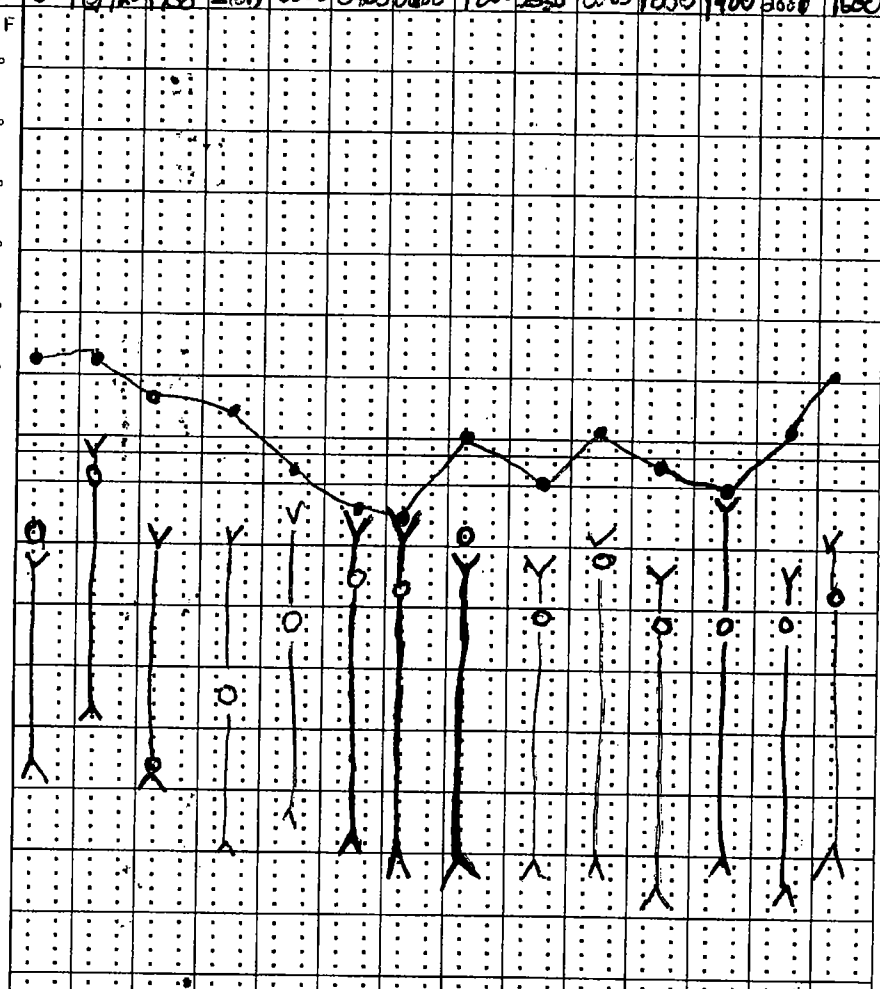
NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY		DOS													
POST- DAY				APR				APR							
MONTH-YEAR	DAY	17		17				18						18 APR	
2003	HOUR	09	0920	1700	2100	0000	0400	0800	1800	2030	0500	1000	1400	2000	1600

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	107/74	125/83	110/73	110	114	112	111	106	106	110	105	118	107	111
				61	68	63	61	59	59	59	57	60	56	62
HEIGHT: WEIGHT →		100%												
SPO2 FEO2	100%	100%	92%	90%		93	90%	92%	92%	90%	91%			
Foley Output			450			425	200	500	1100			700	1300	1700
IN LR							300						400	
IN NS								1000	2400				2000	
PO / Piggyback									200				300	

Record special data only when so ordered

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

(b)(6)-4

(b)(3)-1

(b)(6)-4

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 3992

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																
POST- DAY																
MONTH-YEAR	DAY	28 APR		28 Apr		29 Apr		29 Apr		30 Apr		30 Apr		1 May		
19	HOUR	1420	1425	1530		07	1400	1530		06	1430			07	1430	
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		128	126	108/	1	110/ 60	18	104/ 63	98/ 55	98/ 55	18	1 6		2	19
BLOOD PRESSURE	B/P	178	82	56			102				92 46	111		109/ 63	106/68
	P	128	123	111		87	62	97	96	96		58		80	89
	PAO2	95%	93	94			94	92		92				88	
HEIGHT:	WEIGHT →														
	R	29	29	25				22		20				12	
	Temp			98.0A		97.6				97.9	98.7			97(A)	97.8A
Intake -	IV			800			125				700				
	PO										200				
OUTPUT -	Urine			900cc		600cc	725	500 600 400		450 550	1100				1100

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

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

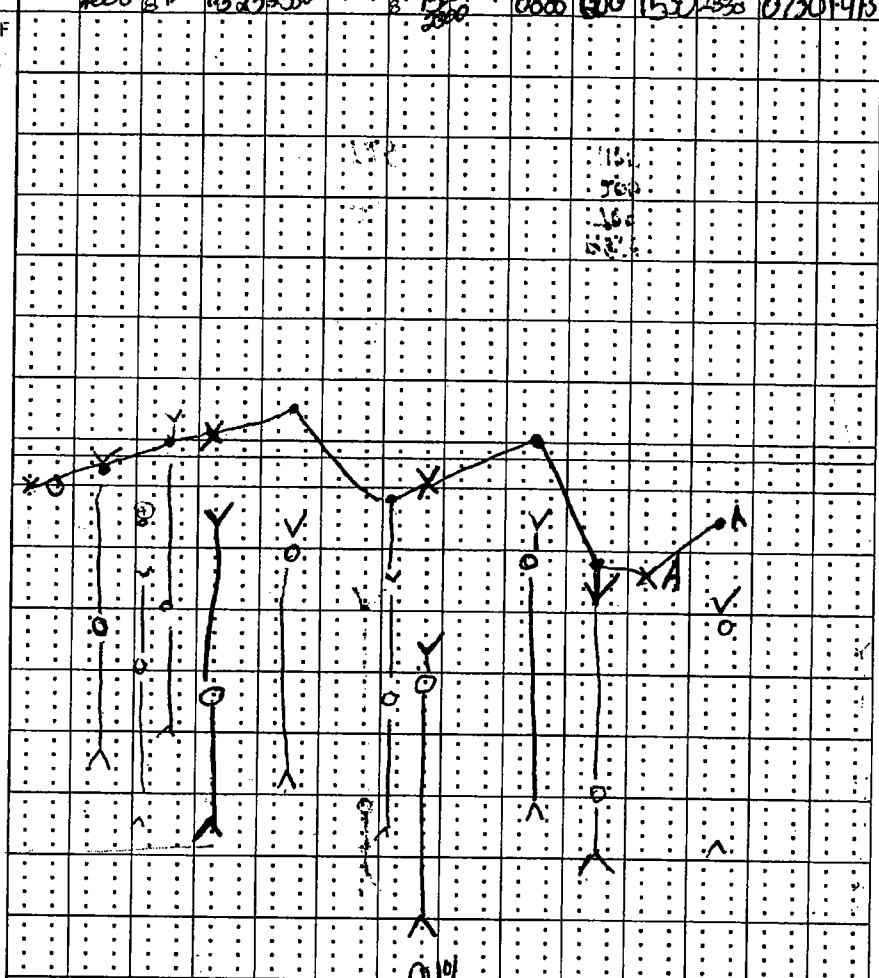
VITAL SIGNS RECORD

HOSPITAL DAY														
POST- DAY														
MONTH-YEAR	DAY	24 APR 03		25 APR 03				26 APR 03		27 APR 03		27 APR 03	28 APR	
19	HOUR		2000	0-12	08-23	2330		0-8 1500 2300		0000	1300	1530	2330	0730 1415

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		108/71	1 8	2 2 0 0	114/65	1 9		2 0	94%	2 0	16	102/60	1 9	107	123
BLOOD PRESSURE	Map	84	126	108 134	84	113		106/69		114	102/62	25	101	70	78
	HR	114	77	66 80	110	74				68	71	80	63	96	129
	RR	20			18			12				20			
HEIGHT:	WEIGHT →				93%	90%		92%		92%	91%	90	92%	92	95
													Temp	97.5	98.6
													Res		32
In Take								350							
Out put		850 550 575 500		Urine 700cc Urine 1000 Urine 880				Urine 800			575	650 675 500			

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

MEDCOM - 3994

511–119 NSN 7540–00–634–4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY															
POST- DAY															
MONTH-YEAR	DAY	01 may 03		02 may		02 may		03 may		03 may 03		03 MAY			
MAY ~~19~~ 2003	HOUR	1730	06	14	1530	0600	1100	1400		24					
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	RR	1 2		1 9	17	1 2			20	22	1 8				
BLOOD PRESSURE	B/P S	112		101	113	76		93	108	119	102	109/			
	D	62		57	65	59		51	60	57	62	65			
	Pulse			91	96			85	87	110					
HEIGHT:	WEIGHT →														
	O_2			90	92	91%		91	90%	92%		92%			
	Temp			97	97.5	98.2°		97.8(A)	98.9	99.5					
Urine O/P		675 750 650 2075				900				760					

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

MEDCOM - 3995

(THIS FORM IS SUBJECT TO THE PRIVACY ACT - AS A CLINICAL RECORD FORM, IT IS COVERED BY DD 2205)

ANESTHESIA RECORD

Page 1 of 1

START	IN OR	ANES. END	DATE
1945	1955		10 APR 05

OPERATION PERFORMED: R LE amp w/o /(1) Flank I&D w/o

SURGEON(S): OR Chs

TOTS	SURG START	DRESSING	OR NO
2015			1

PREOPERATIVE

- [x] IDENTIFIED [x] ID BAND [x] QUESTIONING
- [ ] CHART REVIEWED [ ] NPO SINCE
- [x] PRE-OP MEDICATION:

Drug	Dose	Route	Time
Versed	2 mg	IV	0915

Pre-Anesthetic State: [x] CALM [ ] APPREHENSIVE [x] AWAKE [ ] SEDATE [ ] UNRESPONSIVE

MONITORS AND EQUIPMENT

- [x] ANES. MACHINE # 1749 & EQUIP. CHECKED
- [x] NON-INV. B/P [ ] PNS
- [x] CONT. EKG [ ] V LEAD EKG
- [ ] ESOPH. STETH. [ ] PRECORD STETH.
- [x] PULSE OXIMETER [x] O2 ANALYZER
- [x] END TIDAL CO2 [ ] MASS SPEC.
- [ ] TEMPERATURE DX
- [ ] WARMING BLANKET [ ] FLUID WARMER
- [x] AIRWAY HUMIDIFIER
- [ ] N/G TUBE [x] O/G TUBE
- [x] IV(s) 1 g R
- [ ] ARTERIAL LINE
- [ ] CENTRAL LINE
- [ ] SWAN-GANZ
- [x] FOLEY INSERTED: [x] O.R. [ ] FLOOR
- [ ] EYE CARE Tape x 2
- [x] PRESSURE POINTS CHECKED / PADDED

ANESTHETIC TECHNIQUE

- [x] GENERAL [ ] LOCAL / MAC
- [ ] REGIONAL [ ] NERVE BLOCK

INDUCTION

- [x] PREOXYGENATION [ ] INHALATION
- [ ] RAPID SEQUENCE [ ] INTRAMUSCULAR
- [ ] INTRAVENOUS [ ] RECTAL

AIRWAY MANAGEMENT

- [x] INTUBATION [x] ORAL [ ] NASAL
- [x] DIRECT VISION [ ] BLIND [ ] AWAKE
- [ ] FIBER OPTIC [ ] STYLET USED
- [x] ATTEMPTS x 1 [ ] BLADE Mac 4
- [x] ETT SIZE 8.0 [ ] DOUBLE LUMEN
- [ ] STRAIGHT [ ] RAE [ ] ANODE
- [x] CUFFED 7 ML AIR INJECTED
- [ ] UNCUFFED, LEAKS AT ____ CM H2O
- [x] ETT SECURED AT 24 CM
- [ ] BREATH SOUNDS 2/5.1
- [ ] AIRWAY [ ] ORAL [ ] NASAL [ ] NATURAL
- [ ] MASK CASE [ ] VIA TRACHEOSTOMY
- [ ] NASAL CANNULA [ ] SIMPLE O2 MASK
- [ ] LMA SIZE

		(1)	(2)	(3)	(4)	(5)	TOTALS
AGENTS	Prop mg	200					200
	Succ mg	140					140
	Fent mcg	<150>	<100>				250
	Mid mg			<2>			2
	Vec mg		5				5
	1330 ETT						
	N2O L/min	X	1	1	1	X	
	O2 L/min	4	2	1	1	2	
FLUIDS	NS	500					
	LR	→	500	→	100	– X	1500
	Urine	→	200	→	300	– 400	400
	EBL	→	→	min	→	X	min
MONITORS	EKG	ST	ST	ST	ST	ST	
	% O2 Inspired	.21	.98	.98	.98	.98	
	O2 Saturation	100	100	100	100	100	
	End Tidal CO2	4	37	42	46	44	
	Temperature	36	36	36	36	36	
	PNS	→7/4	4/4	4/4	–	4/4	

VITAL SIGNS

PRE-OP VALUES	
B/P	112/62
P	96
R	14
SAT	94%
H/H	SEC bzw

TIME (200 / 180 / 160 / 140 / 120 / 100 / 80 / 60 / 40 / 20)

RESP	(1)	(2)	(3)	(4)	(5)
Tidal Volume	500	700	900	800	
Resp Rate		12	12	12	
Peak Pressure		28	26		

Symbols for Remarks

Position: Supine → Prone → Supine

SYMBOLS: X ANESTHESIA; ⊙ OPERATION; V ^ B/P CUFF PRESSURE; ⊥ T ARTERIAL LINE PRESSURE; ● PULSE; ○ SPONTANEOUS RESP; Φ ASSISTED RESP; ⊗ CONTROLLED RESP; T TOURNIQUET; F CRYSTALLOID FLUID; B BLOOD

RECOVERY

TIME IN PACU	CONDITION		
2057	VSS		
B/P 141/85	PULSE 112	RESP 24	O2 SAT 96
REMARKS			TEMP

REPORT TO: ICU staff PARRS: 7

REMARKS:
- [x] Patient reevaluated. No change from preop plan / evaluation.
- [ ] Significant changes from preop plan / evaluation.

2-17

1945 PT examined in PR.
1955 PT to O.R. – all monitors/alarms active
2000 PT induced / Rapid Seq – Cricoid Pressure – 6cm
2005 PT following commands – 4/4 & sust. tetany – extubated – O2 via mask
2057 PT to ICU. Report given to ICU staff

Tourniquet Time: N/A

FLUIDS TOTALS

IN		OUT	
Crystalloid	1500	EBL	min
		Urine	400
		Gastric	0
Blood	0		

(b)(6)-2 Maj. M.D. Anes

PHYSICIAN / CRNA (b)(3)-1

PATIENT'S IDENTIFICATION (b)(6)-4

NAME: (b)(6)-4 SURGEON: Dr Cho Planned Surgery Date:

ANESTHESIA PREOPERATIVE EVALUATION

AGE	M / F	HEIGHT	WEIGHT
25	(M)	(est) 72"	200 lb

PROPOSED OPERATION (L) LE Amp w/s

PREOPERATIVE VITAL SIGNS: B/P P R

PREVIOUS ANESTHESIA / OPERATIONS ☐ NEGATIVE
(R) BKA FST?

CURRENT MEDICATIONS ☐ NONE

FAMILY HISTORY OF ANESTHESIA COMPLICATIONS ☐ NEGATIVE

ALLERGIES ☐ NKDA

AIRWAY / TEETH / HEAD & NECK

SYSTEM	WN	COMMENTS	PERTINENT STUDY RESULTS
RESPIRATORY Asthma, Bronchitis, COPD, Dyspnea, Pneumonia, Productive Cough, Recent cold, SOB, Tuberculosis	☐	Tobacco Use: ☐ No ☐ Yes ____ Pack/Day for ____ Years	Chest X-ray, Pulmonary Studies
CARDIOVASCULAR Angina, Arrhythmia, CHF, Exercise Tolerance, Hypertension, MI, Murmur, MVP, Pacemaker, Rheumatic fever	☐		EKG
HEPATO/GASTROINTESTINAL Bowel obstruction, Cirrhosis, Hepatitis, Hiatal Hernia, Jaundice, N&V, Reflux/Heartburn, Ulcers	☐	Ethanol Use: ☐ No ☐ Yes Frequency ____	LFTs
NEURO/MUSCULOSKELETAL Arthritis, Back problems, CVA/Stroke, DJD, Headaches, Loss of consciousness, Neuromuscular disease, Paralysis, Paresthesia, Syncope, Seizures, TIAs, Weakness	☐	Unknown - EPW	
RENAL/ENDOCRINE Diabetes, Renal failure/Dialysis, Thyroid disease, Urinary retention, Urinary tract infection, Weight loss/gain	☐		Urinalysis, Thyroid, FBS
OTHER Anemia, Bleeding tendancies, Hemophilia, Pregnancy, Sickle cell trait, Transfusion history			Hgb / Hct / CBC, Lytes 12.7 / 8.2 / 26.5 / 2.35 PCT: 457

PROBLEM LIST / DIAGNOSES

ASA: 1, 2, 3, 4, 5, E

PREOPERATIVE MEDICATIONS ORDERED

COUNSELING STATEMENT

Anesthesia alternatives, benefits and risks from minor to death explained. All questions answered.
Patient / legal guardian voices understanding and gives consent for :
Local / MAC, SAB, Epidural, IVR, General Anes.
Other: ____
Appropriate alternative as backup.
NPO status explained.

PATIENT'S SIGNATURE ____ DATE ____

EVALUATOR(S) SIGNATURE

CRNA (b)(6)-2 [signature] DATE 15 Apr 03

PHYSICIAN ____ DATE ____

POST ANESTHESIA VISITS

ANESTHESIA RECOVERY COMPLICATED BY THE FOLLOWING PROBLEMS: (IF NONE, SO STATE)

DATE: ____

SIGNED: ____ TIME: ____

MEDCOM - 3997

(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
0d	1005		4/13/04
TOTS	SURG START	DRESSING	OR NO
1010	1020		

OPERATION PERFORMED: Debride of (L) Thumb, (L) arm, I+D (L) Stump

SURGEON(S): (b)(6)-2

PREOPERATIVE

☑ IDENTIFIED ☑ ID BAND ☐ QUESTIONING
☑ CHART REVIEWED ☑ NPO SINCE MW
☐ PRE-OP MEDICATION:
Drug Dose Route Time

Pre-Anesthetic State: ☐ AWAKE ☐ CALM ☐ SEDATE ☑ APPREHENSIVE ☐ UNRESPONSIVE

MONITORS AND EQUIPMENT

☑ ANES. MACHINE # 3 & 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)
☐ 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

INDUCTION

☐ PREOXYGENATION ☐ INHALATION
☐ RAPID SEQUENCE ☐ INTRAMUSCULAR
☐ INTRAVENOUS ☐ RECTAL

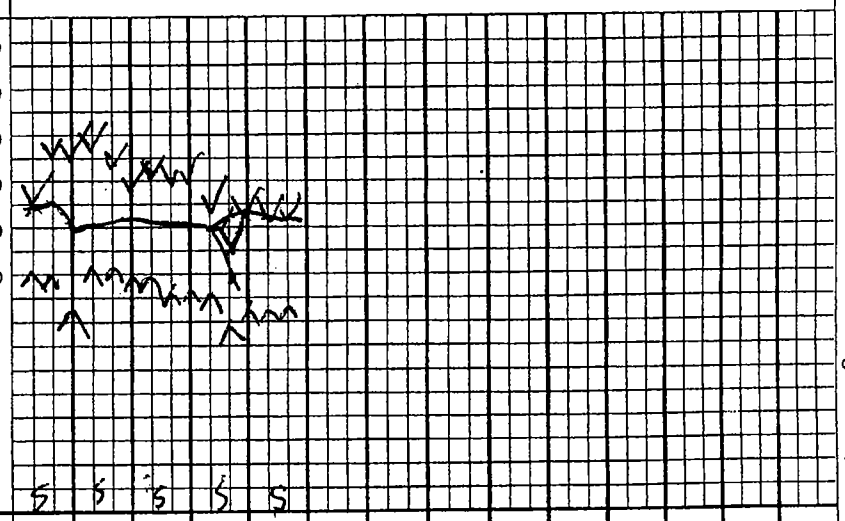
AIRWAY MANAGEMENT

☐ 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

	(10)		(11)		(12)										TOTAL
AGENTS: Ketamine	100	100	100	100	100										600
		30	20	50											
Valium	5														5
Midazolam			5												5
N2O L/min															
O2 L/min NC	3														
FLUIDS: NS 2000	→	→	→	→											700
Urine															
EBL															
MONITORS: EKG	ST	ST	ST	ST	ST										
% O2 Inspired	95														
O2 Saturation	94	95	95	96	96										
End Tidal CO2															
Temperature															
PNS															

TIME

VITAL SIGNS: PRE-OP VALUES; B / P; P; R; SAT; H / H



H / H	5	5	5	5	5
RESP: Tidal Volume					
Resp Rate	26	30	32	32	26
Peak Pressure					
Symbols for Remarks					
Position	(R)	Lateral			

SYMBOLS: X ANESTH; ⊙ OPERAT; V ^ B/P CU PRESSI; ⊥ T ARTER LINE PRESSI; ● PULS; ○ SPONT OUS RI; ¢ ASSIST RES; ⊗ CONTRO RES; T TOURNI; F CRYST LOID FI; B BLOC

REMARKS: ☐ Patient reevaluated. No change from preop plan / evaluation.
☐ Significant changes from preop plan / evaluation.

RECOVERY

TIME IN PACU	CONDITION		
1112	Sleeping		
B/P	PULSE 114	RESP 20	O2 SAT 99
REMARKS			TEMP

REPORT TO: PARRS:

Tourniquet Time:

FLUIDS TOTALS

IN	OUT
Crystalloid	EBL
	Urine
	Gastric
Blood	

(b)(6)-2

CRNA

SICIAN / CRNA

PATIENT'S IDENTIFICATION

(b)(6)-4

(THIS FORM IS SUBJECT TO THE PRIVACY ACT O ... S A CLINICAL RECORD FORM, IT IS COVERED BY DD 220

ANESTHESIA RECORD

Page 1 of

ANES. START	IN OR	ANES. END	DATE
0730	0740	0915	17 Apr 03
TOTS	SURG START	DRESSING	OR NO
0743	0755	0855	

OPERATION PERFORMED: I+D RKA + Skin Traction

SURGEON(S): (b)(6)-2

PREOPERATIVE

- [x] IDENTIFIED [ ] ID BAND [ ] QUESTIONING
- [ ] CHART REVIEWED [ ] NPO SINCE 24.00
- [ ] PRE-OP MEDICATION:

Drug	Dose	Route	Time

Pre-Anesthetic State: [ ] CALM [x] APPREHENSIVE [ ] AWAKE [ ] SEDATE [ ] UNRESPONSIVE

MONITORS AND EQUIPMENT

- [ ] ANES. MACHINE # ____ & EQUIP. CHECKED
- [x] NON-INV. B/P [ ] PNS
- [x] CONT. EKG [ ] V LEAD EKG
- [ ] ESOPH. STETH. [ ] PRECORD STETH.
- [x] PULSE OXIMETER [ ] O2 ANALYZER
- [ ] END TIDAL CO2 [ ] MASS SPEC.
- [ ] TEMPERATURE ____
- [ ] WARMING BLANKET [ ] FLUID WARMER
- [ ] AIRWAY HUMIDIFIER ____
- [ ] N / G TUBE [ ] O /G TUBE
- [ ] IV(s) (R) AC R
- [ ] ARTERIAL LINE ____
- [ ] CENTRAL LINE ____
- [ ] SWAN-GANZ
- [x] FOLEY INSERTED: [x] O.R. [ ] FLOOR
- [ ] EYE CARE ____
- [x] PRESSURE POINTS CHECKED / PADDED

ANESTHETIC TECHNIQUE

- [x] GENERAL [ ] LOCAL / MAC
- [ ] REGIONAL [ ] NERVE BLOCK

INDUCTION

- [ ] PREOXYGENATION [ ] INHALATION
- [ ] RAPID SEQUENCE [ ] INTRAMUSCULAR
- [x] 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 [x] SIMPLE O2 MASK
- [ ] LMA SIZE

		0730	0745					TOTAL
AGENTS	Diazepam	5						5
	Robinol	.3						.3
	Ketamine	100	100	100	100	100	100	750
	Propofol	30	30	50	—	450	—	620
	MSO4	5	5					10
	N2O L/min							
	O2 L/min							
FLUIDS	RL (R) AC	#1						
	Urine							
	EBL							
MONITORS	EKG	ST	ST	ST	ST	ST	ST	
	% O2 Inspired	>.21	>.21	>.21	>.21	>.21	>.21	
	O2 Saturation	97	98	99	99	100	100	
	End Tidal CO2	(+)	(+)	(+)	(+)	(+)	(+)	
	Temperature							
	PNS							

TIME: 45 15 45

PRE-OP VALUES: B/P 130/66; P 111; R 20; SAT 97%; H/H

VITAL SIGNS (200, 180, 160, 140, 120, 100, 80, 60, 40, 20)

RESP						
Tidal Volume	SV	SV	SV	SV	SV	SV
Resp Rate	20	20	26	26	28	26
Peak Pressure	—	—	—	—	—	

Symbols for Remarks

Position: O-S

SYMBOLS: X ANESTH; ⊙ OPERAT; V / ^ B/P CL PRESSI; ⊥ T ARTER LINE PRESSI; ● PULS; C SPONT. OUS R; ¢ ASSIS RES; ⊗ CONTR RES; T TOURN; F CRYS LOID; E BLO

REMARKS: [ ] Patient reevaluated. No change from preop plan / evaluation. [ ] Significant changes from preop plan / evaluation.

RECOVERY

TIME IN PACU	CONDITION		
0902	Sleepy		
B/P	PULSE	RESP	O2 SAT
107/74	111	24	99
REMARKS			TEMP

REPORT TO: LT (b)(6)-2 PARRS:

Tourniquet Time:

IN	FLUIDS TOTALS	OUT
Crystalloid 900	EBL 150	
	Urine Foley	
Blood 750	Gastric 0	

(b)(6)-2 CRNA

PHYSICIAN / CRNA

PATIENT'S IDENTIFICATION (b)(6)-4

MEDCOM - 3999

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF ... S A CLINICAL RECORD FORM, IT IS COVERED BY DD 220

ANESTHESIA RECORD

Page 1 of 1

ANES. START	IN OR	ANES. END	DATE
1200	1225	1410	28 APR 03
TOTS	SURG START	DRESSING	OR NO
1230	1254	1404	

OPERATION PERFORMED: Split thickness skin graft (L) Thigh → (L) Thorax

SURGEON(S): (b)(6)-2

PREOPERATIVE

- [x] IDENTIFIED [x] ID BAND [ ] QUESTIONING
- [x] CHART REVIEWED [ ] NPO SINCE ____
- [ ] PRE-OP MEDICATION:

Drug	Dose	Route	Time

Pre-Anesthetic State: [x] CALM [ ] APPREHENSIVE [ ] AWAKE [ ] SEDATE [ ] UNRESPONSIVE

MONITORS AND EQUIPMENT

- [x] ANES. MACHINE # ____ & EQUIP. CHECKED
- [x] NON-INV. B/P [ ] PNS
- [x] CONT. EKG [ ] V LEAD EKG
- [ ] ESOPH. STETH. [ ] PRECORD STETH.
- [x] PULSE OXIMETER [x] O2 ANALYZER
- [ ] END TIDAL CO2 [ ] MASS SPEC.
- [ ] TEMPERATURE ____
- [ ] WARMING BLANKET [ ] FLUID WARMER
- [ ] AIRWAY HUMIDIFIER ____
- [ ] N / G TUBE [ ] O / G TUBE
- [x] IV(s) 20g (L) forearm
- [ ] ARTERIAL LINE ____
- [ ] CENTRAL LINE ____
- [ ] SWAN-GANZ ____
- [ ] FOLEY INSERTED: [ ] O.R. [ ] FLOOR
- [ ] EYE CARE ____
- [ ] PRESSURE POINTS CHECKED / PADDED

ANESTHETIC TECHNIQUE

- [ ] GENERAL [x] LOCAL / MAC
- [ ] REGIONAL [ ] NERVE BLOCK

INDUCTION

- [ ] PREOXYGENATION [ ] INHALATION
- [ ] RAPID SEQUENCE [ ] INTRAMUSCULAR
- [ ] INTRAVENOUS [ ] RECTAL

AIRWAY MANAGEMENT

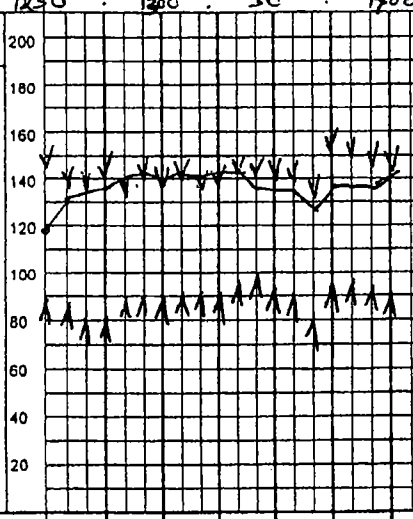
- [ ] INTUBATION [ ] ORAL [ ] NASAL
- [ ] DIRECT VISION [ ] BLIND [ ] AWAKE
- [ ] FIBER OPTIC [ ] STYLET USED
- [ ] ATTEMPTS x ____ [ ] BLADE ____
- [ ] ETT SIZE ____ [ ] DOUBLE LUMEN
- [ ] STRAIGHT [ ] RAE [ ] ANODE
- [ ] CUFFED ____ ML AIR INJECTED
- [ ] UNCUFFED, LEAKS AT ____ CM H2O
- [ ] ETT SECURED AT ____ CM
- [ ] BREATH SOUNDS
- [ ] AIRWAY [ ] ORAL [ ] NASAL [x] NATURAL
- [ ] MASK CASE [ ] VIA TRACHEOSTOMY
- [ ] NASAL CANNULA [x] SIMPLE O2 MASK
- [ ] LMA SIZE

								TOTAL
AGENTS	Diazepam mg	5						5 mg
	Robinul mg	3						3 mg
	Ketamine mg	100/50	50				300	200 mg
	MSO4 mg	5	5			5/5		20 mg
	Anc gtt	1	—					
	FORANE							
	N2O L/min							
	O2 L/min	5	5	5	5	4		
FLUIDS	NS				500	200		
	Urine							
	EBL				100			
MONITORS	EKG	ST	ST	ST	ST	ST	ST	
	% O2 Inspired	RA	>.21	>.21	>.21	RA	RA	
	O2 Saturation	99	98	98	98	94	94	
	End Tidal CO2							
	Temperature							
	PNS							

TIME: 1230 · 1300 · 30 · 1400 · 30 · 1500 · 30 · 1600

VITAL SIGNS

PRE-OP VALUES	
113/58	B/P
84	P
	R
98	SAT
	H/H



RESP							
Tidal Volume							
Resp Rate	14	18	14	14	16	14	
Peak Pressure							
	SV	SV	SV	SV	SV	SV	

Symbols for Remarks

Position: OL → RLD

SYMBOLS: X ANESTH; ⊙ OPERAT; V / ^ B/P CUFF PRESSU; ⊥ T ARTERIAL LINE PRESSU; ● PULS; ○ SPONTANEOUS RE; ◐ ASSIST RES; ⊗ CONTROL RES; T TOURNI; F CRYSTALLOID F; E BLO

REMARKS:
- [ ] Patient reevaluated. No change from preop plan / evaluation.
- [ ] Significant changes from preop plan / evaluation.

RECOVERY

TIME IN PACU	CONDITION		
1407	STABLE		
B/P 123/78	PULSE 136	RESP 14	O2 SAT 92

REMARKS

TEMP 98.6 (A)

REPORT TO: PARRS:

Tourniquet Time:

FLUIDS TOTALS

IN		OUT	
Crystalloid	100	EBL	100
		Urine	—
		Gastric	—
Blood	—		

(b)(6)-2

MAJ CRNA

PATIENT'S IDENTIFICATION

(b)(6)-4

MEDCOM - 4000

NKDA

Iraqi national, no interpreter present.

NAME: SURGEON:

Planned Surgery Date:

ANESTHESIA PREOPERATIVE EVALUATION

AGE	M / F	HEIGHT	WEIGHT	
PROPOSED OPERATION	PREOPERATIVE VITAL SIGNS:	B /P	P	R

PREVIOUS ANESTHESIA / OPERATIONS ☐ NEGATIVE

CURRENT MEDICATIONS ☐ NONE

FAMILY HISTORY OF ANESTHESIA COMPLICATIONS ☐ NEGATIVE

ALLERGIES ☒ NKDA

AIRWAY / TEETH / HEAD & NECK

SYSTEM			WN	COMMENTS	PERTINENT STUDY RESULTS		
RESPIRATORY Asthma Dyspnea Recent cold	Bronchitis Pneumonia SOB	COPD Productive Cough Tuberculosis	☐	Tobacco Use: ☐ No ☐ Yes____ Pack/Day for____ Years	Chest X-ray	Pulmonary Studies	
CARDIOVASCULAR Angina Exercise Tolerance Murmur Rheumatic fever	Arrhythmia Hypertension MVP	CHF MI Pacemaker	☐		EKG		
HEPATO/GASTROINTESTINAL Bowel obstruction Hiatal Hernia Reflux/Heartburn	Cirrhosis Jaundice Ulcers	Hepatitis N&V	☐	Ethanol Use : ☐ No ☐ Yes Frequency _____	LFTs		
NEURO/MUSCULOSKELETAL Arthritis DJD Neuromuscular disease Syncope Weakness	Back problems Headaches Paralysis Seizures	CVA/Stroke Loss of consciousness Paresthesia TIAs	☐				
RENAL/ENDOCRINE Diabetes Urinary retention	Renal failure/Dialysis Urinary tract infection	Thyroid disease Weight loss/gain	☐		Urinalysis	Thyroid	FBS
OTHER Anemia Pregnancy	Bleeding tendancies Sickle cell trait	Hemophilia Transfusion history			Hgb / Hct / CBC		Lytes

PROBLEM LIST / DIAGNOSES

ASA	PREOPERATIVE MEDICATIONS ORDERED
1	
2	
3	
4	
5	
E	

COUNSELING STATEMENT

Anesthesia alternatives, benefits and risks from minor to death explained. All questions answered.
Patient / legal guardian voices understanding and gives consent for :

Local / MAC, SAB, Epidural, IVR, General Anes.
Other: _____
Appropriate alternative as backup.

NPO status explained.

PATIENT'S SIGNATURE _____ DATE _____

EVALUATOR(S) SIGNATURE

CRNA (b)(6)-2 MJ CRNA DATE 28 APR 03

PHYSICIAN _____ DATE _____

POST ANESTHESIA VISITS

ANESTHESIA RECOVERY COMPLICATED BY THE FOLLOWING PROBLEMS: (IF NONE, SO STATE)

SIGNED: _____ DATE: _____ TIME: _____

MEDICAL RECORD SUPPLEMENTAL MEDICAL

For [illegible] form, see AR 40-66, the proponent agency is the Office of Th[illegible] General

REPORT TITLE

POST ANESTHESIA CARE RECORD

OTSG APPROVED (Date)

Time In: 2100 | Procedure: (b)(6)-2 | ASA Grade (I – V):

Physician: | Anesthesia Provider: | Pre-Op Vitals: T= P= R= BP= / SaO2=

ANESTHESIA: General Spinal Epidural Sedation Local Nerve Block:
Intrathecal w/ narcotic: time:
Other:

REVERSALS: Narcotic: No / Yes time:
Muscle Relaxant: No / Yes time:

Allergies:
Latex allergy: N / Y
Medical/Birth Hx:
Complications:
Tourniquet time:

INTAKE: OR / PACU
Crystalloids /
Blood Prod /
Colloids /
Irrigations /
Other /

OUTPUT: OR / PACU
Urine /
EBL /
Drains /
Emesis /
Other /

VITAL SIGNS							POST ANESTHESIA RECOVERY SCORE						PAIN ASSESSMENT					OTHER			
Time	BP	T	P	R	SaO2	O2	Act	Resp	Circ	LOC	Skin	Total	0-10	Qual/ Locat	Derm Level	N/V	Nurse action				Init
2105	114/83	98	98	30	93	15											↑HOB				
2115	152/80	—	86	26	93	NRB	2	2	2	1	2	9	sleeping								
2130	136/79	—	87	27	96	NRB							c/o pain					Med			
2200	130/76	—	70	24	98																

VITAL SIGNS
BP = blood pressure
P = pulse
R = respirations
T = temperature ax = axillary
SaO2 = oxygen saturation

Activity (Act)
2 = Moves 4 extremities
1 = Moves 2 extremities
0 = Moves 0 extremities

RESPIRATIONS (Resp)
2 = Cough/deep breath
1 = Dyspnea, airway
0 = Apnea

CIRCULATION (Circ)
2 = 20% +/- PRE-OP BP
1 = 20% - 50% +/-
0 = 50% +/-

LEVEL OF CONSCIOUSNESS (LOC)
2 = Fully awake
1 = Verbally aroused
0 = Unresponsive
No nystagmus w/ ketamine

SKIN
2 = Pink
1 = Pale, dusky
0 = Cyanotic

Axn = suction IS = incentive spirometry C/DB = cough/deep breath HOB = elevate head of bed EE = elevate extremity ICE = cold compress CDI = clean/dry/intact Init = initials PtT = patient teaching – see notes WB = warm blankets HL = heat lamps IC = ice chips H = hygiene care RA = room air BB = blow-by Other:
Quality Codes: AH = Aching BN = burning CO = complaints of pain CR = crushing DL = dull IR = irritable PE = painful expression PR = pressure RT = restless SH = sharp SL = sleeping SP = splinting ST = stabbing TH = throbbing UD = unable to describe Other:
Location Codes: H = head F = face Fd = fundus Tr = throat N = neck Sd = shoulder B = back Ch = chest ABD = abdomen U = umbilicus UE = upper extremity LE = lower extremity Hd = hand Ft = foot K = knee Vag = Vagina Other:

MEDICATIONS RECEIVED IN PACU

TIME	PROBLEM/COMPLAINT For analgesic include Quality, Intensity (0-10), and Location	MED DOSE/ROUTE	INIT	REASSESSMENT/RESPONSE For analgesic include Quality, Intensity (0 – 10), and Location	TIME	INIT
2130	c/o pain	6mg MSO4 IV	TR			

PREPARED BY (Signature & Title) | DEPARTMENT/SERVICE/CLINIC | DATE (Continue on reverse)

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

(b)(6)-4

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

DA FORM 4700, MAY 78

MEDCOM - 4002

MCEUL OP 45(Rev), 19 Sep 01
apprvl - 02 Aug 01

RN ASSESSMENT

	ADMISSION ASSESSMENT TIME: 2105	DISCHARGE ASSESSMENT TIME:
RESP	Airway: patent / unassisted / chin lift / jaw thrust / sniff position Artificial airway: N/A / nasal / oral / endotracheal / other: Respirations: clear / unlabored / spontaneous / other: enc CDB Oxygen by: simple mask / nasal canula / BB / RA / other: NRB	Airway: patent / unassisted / chin lift / jaw thrust / sniff position Artificial airway: N/A / nasal / oral / endotracheal / other: Respirations: clear / unlabored / spontaneous / other: Oxygen by: simple mask / nasal canula / BB / RA / other:
CV	Monitor: sinus rhythm / RRR by pleth / other: Peripheral pulses: palpable / other: (L) pp Capillary refill: < 3 seconds / other: Skin: warm / dry / pink nail beds / other:	Monitor: sinus rhythm / RRR by pleth / other: Peripheral pulses: palpable / other: Capillary refill: < 3 seconds / other: Skin: warm / dry / pink nail beds / other:
NEURO	LOC: A V P U Oriented x 3 / other: Movement: grasps & plantar-dorsiflexion strong and equal: Yes / No / N/A Sensation: denies numbness and tingling: Yes / No / N/A Other: Pt able to MAE except (R) ft d/t BKA	LOC: A V P U Oriented x 3 / other: Movement: grasps & plantar-dorsiflexion strong and equal: Yes No/ N/A Sensation: denies numbness and tingling: Yes / No / N/A Other:
GI/GU	Abdomen: soft / non-distended / other: round Foley catheter: Yes / No Urine clear yellow / other: amber Other:	Abdomen: soft / non-distended / other: Foley catheter: Yes / No Urine clear yellow / other: Other:
PSYCHO-SOCIAL	Affect: calm and appropriate / cooperative / other: Language: English / other: Interpreter present Y / N / NA "Special Needs": N/A / identified: Other:	Patient informed of present condition: Yes / No Family updated on patient condition: Yes / No Other:
IV	None: Gauge: 14G Location: (L) AC Condition: patent / no redness / no edema Other: Solution: LR Rate: 150 Amount remaining: 1000	None: Gauge: Location: Condition: patent / no redness / no edema Other: Solution: Rate: Amount remaining:
DSG	None: Type: #1 Gauze + ABD pads & tape Location: #1 (L) Neck #2 gauze & coban wrap Condition: clean / dry / intact Other: #2 - (R) - Stump BKA Drains: N/A / Hemovac / Jackson Pratt / Other: Drainage: none / serous / serosanguenous / bloody / Other:	None: Type: Location: Condition: clean / dry / intact Other: Drains: N/A / Hemovac / Jackson Pratt / Other: Drainage: none / serous / serosanguenous / bloody / Other:
SAFETY	Safety measures taken: side rails up / bed straps on / bed locked Pediatric: staff/parent at bedside at all times / crib sides padded x 4 Other:	Safety measures taken: side rails up / bed straps on / bed locked Pediatric: staff/parent at bedside at all times / crib sides padded x 4 Other:
PEDS	Parent at bedside to comfort child: Yes / No Humidified oxygen: Yes / No / N/A IV on armboard: Yes / No / N/A	Parent at bedside to comfort child: Yes / No Humidified oxygen: Yes / No / N/A IV on armboard: Yes / No / N/A
OTHER		
	RN Signature: (b)(6)-2 CPT	RN Signature:

PATIENT TEACHING IN PACU (circle all that apply)

Topic	Level of Involvement	D=demonstrated V=verbalized	INIT
Pulmonary Toileting: Importance of / Cough-deep breathing exercises / incentive spirometer / ABD splinting / Other:		D / V	
Wound care: ice compress / heat application / extremity elevation / signs of compartmental syndrome / Other:		D / V	
Pain management: Medications: type, dose, route, indications, side effects / positioning / activity restrictions / prn Rx requests on ward / Other:		D / V	
Surgeons and Anesthesia post-op orders		D / V	
Pediatric: safety: padded sides, IV armboard / monitoring equipment / staff-parent at BS at all times / pediatric post-op agitation vs pain / Other:		D / V	
Spinal anesthesia: use nursing assistance first time OOB, avoid pressure points while numb / Fundal massage / lochia and pad count / Other:		D / V	
Post cardiac cath: signs of bleeding / apply pressure over site when coughing, sneezing, or vomiting / lie flat with leg straight / use of sandbag / Other:		D / V	
MISC: Elevate HOB / avoid eye strain / wire cutter worn around neck / Oral intake restrictions Other:		D / V	

NURSING NOTES

DISCHARGE NOTE: This patient meets criteria for discharge from the PACU or has been cleared by the anesthesia provider indicated on MCEUL OP 501: Anesthesia Record.

Nursing Care Plans remain open: #

Report called to: Ward: Via: At: hours

(RN Signature) (Anesthesia Services)

STANDARD FORM 545 (rev. 10-75)
545-108

LABORATORY REPORT DISPLAY

TEST(S)			
SPECI	SPECIMEN TAKEN		
DATE 4/11	DATE	TIME	A.M. P.M.
RESULTS	RESULTS	REQUESTED	(X)
107	107	GLUCOSE	
7	5	UREA N.	
		CREATININE	
		URIC ACID	
138	138	SODIUM	
3.1	3.5	POTASSIUM	
100	103	CHLORIDE	
3.	26	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)	
31	22	HCT	
11			

CHEMISTRY I
STANDARD FORM 546 (Rev. 8-77)
PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45,505
546-107

STAND
PRESCI
FIRMR

REMARKS
Dr.

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

Enter in above space

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REPORTED
(b)(6)-2

MD DATE
TECH 19 APR 03

ICU # 3

(b)(6)-4

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

REMOVE PROTECTIVE STRIP—PLACE TOP OF 3D REPORT HERE AND SUCCEEDING ONES ON LINES TO THE RIGHT

PRESSURE MUST BE APPLIED TO ATTACH LABORATORY REPORTS

① ② ③ ④ ⑤ ⑥ ⑦

ALIGN ALL LABORATORY REPORTS ALONG THIS BASE LINE

INSTRUCTIONS: This form may be used to display laboratory reports as a flow sheet to be read as a progressive table. If so, a separate sheet should be used for each type of report form. When assorted report forms are mounted on the display sheet, both test names and results should always be visible.

ENTER IN SPACE BELOW: PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

FORMS DISPLAYED ON THIS SHEET ARE *(Check one)*

MOUNTED ON STRIPS 1 THROUGH 7	MOUNTED ON STRIPS 1, 3, 5, AND 7
☐ CHEMISTRY I (SF 546)	☐ PARASITOLOGY (SF 552)
☐ CHEMISTRY II (SF 547)	☐ IMMUNOHEMATOLOGY (SF 556)
☐ CHEMISTRY III (SF 548)	☐ ASSORTED FORMS
☐ HEMATOLOGY (SF 549)	☐ OTHER *(Specify)*
☐ URINALYSIS (SF 550)	**MOUNTED ON STRIPS 1, 4, AND 7**
☐ SEROLOGY (SF 551)	☐ MICROBIOLOGY I (SF 553)
☐ SPINAL FLUID (SF 555)	☐ MICROBIOLOGY II (SF 554)
	☐ MISCELLANEOUS (SF 557)
	☐ ASSORTED FORMS

PRESCRIBE BY GSA/ICMR
FIRMR (41-CFR) 201-45,505

LABORATORY REPORT DISPLAY

(b)(6)-4

(b)(3)-1

☆ U.S. GOVERNMENT PRINTING OFFICE PROG. 1752-2001/2002

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 4/10/03	TIME OF ORDER 2045 (Z) HOURS	LIST TIME ORDER NOTED AND SIGN
1	Admit Patient to ICU 3		
2	Diagnosis: (R) BKA, RE-DEBRIDEMENT		(L) FLANK WOUND
3	Condition: Stable/Serious/Critical		
4	Allergies: NKDA/		
5	Vital signs q hr/q2hr/q6hr/q8hr/q shift		
6	Cardiac respiratory monitoring		
7	Diet: NPO / regular/ soft/ clear liquid		

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)-4

	DATE OF ORDER	TIME OF ORDER WHEN AVAILE 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		

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

Noted CRT 10 Apr 03

(b)(6)-2

	DATE OF ORDER	TIME OF ORDER HOURS	
13	PCXRAY q AM/QOD		
14	IVF NS/ LR/ D5NS/ D51/2NS To run @ 150 cc/hr.		
15	Ancef 1 GM IV Q 8 hrs	D/C IVF WHEN TOL	
16	Gentamycin IV Q	po well	
17	Cefoxitin 2gm IV q8hrs.		
18	O2 titrate to keep SPO2 > 92%		
19	Versed gtt 1-10mg/hr IV titrate to		

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

	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 2-8 MG IV q 1-2 HR PRN Pain		
23	Phenergan 12.5-25mg IV q 4-6hrs PRN N/V		
24	MOM 30cc PRN Gastric upset		

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

DATE OF ORDER: 4/10/03 TIME OF ORDER: 2045(7) HOURS

LIST TI ORDE NOTED 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 DRESSING Δ q d W→D

STARTING AFTERNOON 4/11

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORD

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER

HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER

HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

747

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
(b)(6)-4 [redacted]					
			4/11/03	Cdit ICU	
				Dx: Shrapnel (2) flank, S/P BKA	
			06 00	Condition guarded	
				VS per nourtime	
				NKDA	
NURSING UNIT	ROOM NO.	BED NO.		Upper chair Qnlift	
				Clear liquid diet	

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER ____ HOURS	
				D5LR @ 140cc/hr	
				Fully ut gravity	
				Vetted dressing Δ at	
				flank Daily	
				Do not Δ BKA dressing	
NURSING UNIT	ROOM NO.	BED NO.		MSO4 4mg IVQ10 pm pain	
				Phenergan 12.5mg IVQ10 pm nausea	

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER ____ HOURS	
				Qrefl, IVQ8	
				O2 4L NC	
				H+H, chem 7 now	
				CxR, Pelvis films in EMT	
				(b)(6)-2 [redacted]	
NURSING UNIT	ROOM NO.	BED NO.			

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER ____ HOURS	
			4/12/03	Regular diet	
			07 30	NPO - MN	
				(b)(6)-2 [redacted]	
				Valium 2mg PRIOR TO DRSNG Δ Q Day	
NURSING UNIT	ROOM NO.	BED NO.			

(b)(6)-2 [redacted]

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY E

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CLINICAL RECORD - DOCTOR'S ORDERS

For use of [illegible] form, see AR 40-66, the proponent agency is [illegible]

THE DOCTOR SHALL RECORD DATE, TIM[illegible] SIGN EACH SET OF ORDERS. IF PROBL[illegible] [illegible]IENTED 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	13APR03	0800 HOURS	(b)(6)-2
	(1) Resume Preop orders	Noted	
	(2) Reg Diet	(b)(6)-2 4/13/03	
	(b)(6)-2	VD	
NURSING UNIT / ROOM NO. / BED NO.	(b)(6)-2	MAJ, VCO	

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER
		HOURS
	VIO per D Tyler 2345 4-13-03	
	Ambien 10mg PO NOW	
	(b)(6)-2	
NURSING UNIT / ROOM NO. / BED NO.		

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

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

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

PATIENT IDENTIFICATION: (b)(6)-4

NURSING UNIT: ICU #1 | ROOM NO.: | BED NO.: 7

DATE OF ORDER: 15 Apr 03 | TIME OF ORDER: 1615 HOURS | LIST TIME ORDER NOTED AND SIGN

1. Transfer to ICU 1-T
2. Dx: Shrapnel, s/p BKA
3. Condition: Stable
4. Vitals: Q 6° c̄ pulse ox
5. Allergies: NKDA
6. Activity: up in chair TID
7. Diet: Reg

PATIENT IDENTIFICATION: (b)(6)-4

NURSING UNIT: ICU #1 T | ROOM NO.: | BED NO.: 7

DATE OF ORDER ↓ | TIME OF ORDER ↓ | HOURS ↓

8. IVF: D5 LR @ 150cc/hr
9. Meds: Ancef 1.0 g IV Q8°
   MSO4 4mg IV Q 2° PRN pain
   Phenergan 12.5mg IV Q 2° PRN nausea
10. Nursing: foley to gravity
    wet → dry dressing ⊗ flank Q day
    do not Δ BKA dressing

PATIENT IDENTIFICATION: (b)(6)-4

NURSING UNIT: ICU #1 T | ROOM NO.: | BED NO.: 7

DATE OF ORDER ↓ | TIME OF ORDER ↓ | HOURS ↓

11. O2: 2L PRN O2 sats < 92%
    titrate to keep O2 > 92%

(b)(6)-2

MAJ, MC
Internal Medicine

PATIENT IDENTIFICATION: (b)(6)-4

NURSING UNIT: ICU #1 T | ROOM NO.: | BED NO.: 7

DATE OF ORDER: 16 Apr 03 | TIME OF ORDER: 0815 HOURS

1. Versed 2-4 mg IV PRN dressing Δ
2. MSO4 5mg IV PRN dressing Δ
3. Vicodin I - II PO Q4-6° PRN
4. D/c IVF, maintain heplock
5. NPO p̄ MN tonight

16 Apr 0900

(b)(6)-2

MAJ, MC
Internal Medicine

NURSING UNIT: ICU #1 T | ROOM NO.: | BED NO.: 7

DA FORM 1 APR 79 4256 REPLA CH MAY BE USED.

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CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: (b)(6)-4

NURSING UNIT: ICU #1 T | ROOM NO.: | BED NO.: 7

DATE OF ORDER: 16 Apr 03 | TIME OF ORDER: 2100 HOURS | LIST TIME ORDER NOTED AND SIGN

Restoril 15-30mg QHS PRN for sleep.

V.O. Dr. (b)(6)-2 CPT (b)(6)-2 T.

) noted (b)(6)-2 @ 2100 hrs — CPT AN

PATIENT IDENTIFICATION: (b)(6)-4

NURSING UNIT: ICU #1 T | ROOM NO.: | BED NO.: 7

DATE OF ORDER: 4/17/03 | TIME OF ORDER: 0655 HOURS

Admit to ICU

Dx: (L) flank wounds

(R) BKA

Cond: Stable

VS Q4°

~~Activity: up on crutches BID~~

Nursing: 3L NS bag off end of bed for stump skin traction.

PATIENT IDENTIFICATION: (b)(6)-4

NURSING UNIT: ICU #1 T | ROOM NO.: | BED NO.: 7

DATE OF ORDER: | TIME OF ORDER: HOURS

Diet: Reg

IV LR @ 125cc/hr; Hep lock IV when tolg PO

Daily wet to dry dressing changes to left flank.

Meds: Ancef 1g IVPB q 8°

Vicodin 1-2 PO Q4-6° prn for pain.

Phenergan 12.5-25mg IV Q6° prn for nausea

PATIENT IDENTIFICATION: (b)(6)-4

NURSING UNIT: ICU #1 T | ROOM NO.: | BED NO.: 7

DATE OF ORDER: | TIME OF ORDER: HOURS

Restoril 15-30mg PO QHS prn for sleep.

Foley to gravity for 24° then D/C.

(b)(6)-2 MD

Noted (b)(6)-2 17 Apr 03 1000

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CLINICAL RECORD - DOCTOR'S ORDERS

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

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
18 Apr 03	0830 HOURS	
(1) Dakins - 1/4 strength		✓
dressing Δ BID		✓
(2) Morphine sulfate 1-10 mg		✓
IVP prn dressing Δ		✓
(3) Levoflox 500mg PO QDay		
(4) Δ Foley off	(b)(6)-2	✓
1st dose Levoflox		✓

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2 18APR

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
18APR03	(b)(6)-2	
1600hrs		OB/Gin
1) Colace + gelcap PO BID		
VO: Dr. (b)(6)-2 / LT (b)(6)-2		
(b)(6)-2 (X) (b)(6)-2		

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
18APR03 1730	HOURS	
1) Restart Foley		
VO: Dr (b)(6)-2 / LT (b)(6)-2		Noted (b)(6)-2
(b)(6)-2 (X) (b)(6)-2		18 APR

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
18APR 03	1830 HOURS	
1) I Stat 8 and UA in AM		Noted
2) NS @ 200 cc/hr		LT (b)(6)-2
VO: DR (b)(6)-2 / LT (b)(6)-2		18APR03
(b)(6)-2		

NURSING UNIT | ROOM NO. | BED NO.

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CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION			↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4				19APR 03	1500 HOURS	(b)(6)-2
				Versed 3mg x 1 Now		1515
				(b)(6)-2		
NURSING UNIT	ROOM NO.	BED NO.				

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
(b)(6)-4					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
(b)(6)-4					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
(b)(6)-4					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

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PATIENT IDENTIFICATION (b)(6)-4

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

4/20/03 (1) Tylenol 650mg T po q 4-6° prn temp (b)(6)-2
(2) Incentive Spirometry (b)(6)-2 [redacted] 7/20

NURSING UNIT: ICU 3 | ROOM NO. | BED NO.

PATIENT IDENTIFICATION (b)(6)-4

DATE OF ORDER: 21 Apr 03 | TIME OF ORDER: 1100 HOURS

1) 1-5mg MSO4 PRN Severe Pain IV q 4-6° Dr. (b)(6)-2 [redacted] (b)(6)-2 [redacted]
VO: Dr (b)(6)-2 [redacted] CT
(b)(6)-2 [redacted] MD (b)(6)-2 [redacted]
(b)(6)-2 [redacted]

NURSING UNIT: ICU 3 | ROOM NO. | BED NO.

21 APR 03 0730
2mg Versed prior to dressing change - done (b)(6)-2 [redacted]
Now. VO Dr (b)(6)-2 [redacted]

PATIENT IDENTIFICATION (b)(6)-4

DATE OF ORDER | ORDER _____ HOURS

21 APR 03 1130 done
100mg Demoral & 2mg Versed (b)(6)-2 [redacted]
now for dressing change VO
VO Dr (b)(6)-2 [redacted]

4/21/03 (1) Tylenol #3 T-TT po q 4-6 prn in place of Vicoden (b)(6)-2 [redacted]

NURSING UNIT: ICU 3 | ROOM NO. | BED NO.

PATIENT IDENTIFICATION (b)(6)-4

DATE OF ORDER | TIME OF OR[redacted]

4/21/03 (1) 60cc MOM now (b)(6)-2 [redacted]

4/21/03 (1) Mag Citrate 10oz bottle ~~with~~ follow with 8oz water (b)(6)-2 [redacted]

NURSING UNIT: ICU 3 | ROOM NO. | BED NO.

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CLINICAL RECORD - DOCTOR'S ORDERS

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

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER: 22 April 03 TIME OF ORDER: ~~22~~ 0850 HOURS

LIST TIME ORDER NOTED AND SIGN

1) ~~Colace~~ error MVI + tab PO QD.

2) Dicolax Supp + PR Q6° until BM.

(b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

22 April 2003

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER: D/C Foley TIME OF ORDER: _____ HOURS

done

(b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

22 April 03 09:00

Versed 1-5mg IVP PPN prior to dressing Δ VO

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER: 25 April 03 TIME OF ORDER: 0900 HOURS

1) NPO after midnight 27 April 03

2) start LR TV at 125cc/H at that time.

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

noted (b)(6)-2 0910 25 APR 03

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER: 25 APR 03 TIME OF ORDER: 1300 HOURS

1) Give Mylanta PO X 1 Now

(b)(6)-2 V.O [redacted] MAYRE

66-2

NURSING UNIT | ROOM NO. | BED NO.

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

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CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
28APRL03	1410 HOURS	
1) D/C all prev. orders		
2) admit to ICC-3		
3) Dx: SKIN GRAFT		
4) Vitals: per routine, call HO for F7/101		
5) activity: STRICT BEDREST		
6) NURSING: DO NOT		

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
	HOURS	
CHANGE DRESSINGS		
7) Diet: Regular + I can ensure TID		
8) IVF: LR IV at 125cc/H until taking PO then Heplock.		
9) Meds: Vicodom I tab PO Q4° pm		
• Colace I cap PO BID		

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
error	HOURS	
~~Meds~~ MSO4 1-10mg IV Q30min PRN		
VERSED 1-5mg IV QID PRN		
• MVI I tab PO QD		
Ambien 5mg PO QHS PRN		
• Ancef I gm IV Q8°		

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF
28Apr03 0730	
1) Δ Ambien from 5mg PO to 10mg PO QHS PRN insomnia	
2) Benadrol 25-50mg IV/PO PRN itching	
VO: (b)(6)-2 / LT (b)(6)-2	

Noted (b)(6)-2 28APR03

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

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CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER: 30 APR 03 TIME OF ORDER: 0830 HOURS

LIST TIME ORDER NOTED AND SIGN

1) D/C: Kerlex on (L) leg & leave Xeroform in place

2) Allow Xeroform to dry

(b)(6)-2 30 Apr

NURSING UNIT | ROOM NO. | BED NO.

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

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER: TIME OF ORDER: 30 HOURS

1) Clarification Benadryl frequency q 2-3° PRN.

VO: Dr (b)(6)-2 /LT (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

double Chart ✓ 1 MAY 03 @ 2330 (b)(6)-2 MAJ

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER: TIME OF ORDER: 2 May 2003 HOURS

atrium 50 pm 94 pm (b)(6)-2

(b)(6)-2 (b)(6)-2 2 May 03

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER: 2 May 03 TIME OF ORDER: 0737 HOURS

1) D/C Versed

2) Continue Morphine and percocet as previously ordered

VO: Dr. (b)(6)-2 /LT (b)(6)-2

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

NURSING UNIT | ROOM NO. | BED NO.

double Chart ✓ 4 May 03 0110 (b)(6)-2 Noted 2 May 03

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MEDCOM - 4016

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

1) Δ order from Vicodin to percocet 1-2 PO q 4-6° PRN Pain
2) D/C Vicodin 25 #
3) Amitriptyline 50 mg PO q HS

VO: Dr. (b)(6)-2 / LLT (b)(6)-2

Noted by 7A 30 APR 03

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 30 APR 03 | TIME OF ORDER 1400 HOURS

1) Daily dressing Δ to stump

VO: Dr. (b)(6)-2 / (b)(6)-2 / (b)(6)-2 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

double check / / may 03 (b)(6)-2 mysm @ 2330

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER _____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER _____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4				3 MAY 03	1000 HOURS	
			1)	Bacitracin to skin graft		
				sites BID		
			2)	D/C ANCEF		
			3)	(b)(6)-2		
NURSING UNIT	ROOM NO.	BED NO.				

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
				03 May 03	1005 HOURS	
			1)	Discharge to Red Crescent		
				on 04 May		
			2)	Rx on chart		
				(b)(6)-2		
NURSING UNIT	ROOM NO.	BED NO.				

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

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

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CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER: 5/3/03 TIME OF ORDER: 0705 HOURS

LIST TIME ORDER NOTED AND SIGN

Will sign off. Medically clear for D/C from Ortho perspective.

NURSING UNIT | ROOM NO. | BED NO.

noted

(b)(6)-2

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER TIME OF ORDER _____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER TIME OF ORDER _____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)-4

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.

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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: 3 litres via Mask /Prongs to maintain O2 Sats greater than 94%;		
	Wean to room air.		
2	IVF: NS @ 75 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 _____ or greater		
9	Call Anesthesia for any questions or concerns		
10	Phenergan 25 mg IV PRN N/V may repeat once.		
	SIGNE (b)(6)-2 [redacted] MD [illegible].		

PATIENT IDENTIFICATION

(b)(6)-4 [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.

MEDCOM FORM 688-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE MC V1.00

MEDCOM - 4020

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		(b)(6)-2
1	OXYGEN: 2 litres via Mask /Prongs to maintain O2 Sats greater than 94%;		
	Wean to room air.		
2	IVF: NS @ 125 cc/hr, bolus 250 cc x 1		
3	MORPHINE: 3 mg IV q 5-10 minutes PRN pain. MAX dose of 20 mg		
4	DEMEROL: 12.5 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 _____ or greater		
9	Call Anesthesia for any questions or concerns		
	(b)(6)-2		
	SIGNE		

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	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. 04 Yr. 3

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 10	11
10 Apr 03	(b)(6)-2	Vital signs q hr / q 2hr / q6h4 / q8hr /	07	/	(b)(6)-2
		q shift	19	(b)(6)-2	
10 Apr 03		Cardiac Respiratory Monitoring	07	/	
			19	(b)(6)-2	
10 Apr 03		Diet: NPO / Regular / Soft / Clear	07	/	
		Liquid When awake	19	(b)(6)-2	
10 Apr 03		Activity: Ad Lib / Strict BR / BR with	07	/	
		BSC / NWB R or L LE	19	(b)(6)-2	
10 Apr 03		HOB up 30 Degrees	07	/	
			19	(b)(6)-2	
10 Apr		Nursing I/O, CDB / NG to LIS / LCS	07	/	
			19	(b)(6)-2	
		Labs: Chem 7 / H&H / PT/PTT /	04		
		CBC q AM / 4 hrs / 8 hrs / BID	08		
			12		
			16		
			20		
			24		
		EKG q AM / QOD	06		
		PCXRAY q AM / QOD	06		
		Neuro checks q 1hr / 2 hr / 4 hr / 6 hr /	07		
		q shift	19		
		Vascular checks nq 1hr / 2 hr / 4 hr /	07		
		6 hr / q shift	19		
10 Apr 03	(b)(6)-2	Dressing Δ qd W→D	16	/	
		Starting 11 Apr in			
		afternoon			

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

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

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 PLAN *(NON-MEDICATION)*				Mo _____ Yr _____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
	.....	Admit Patient to ICU				
10 Apr		Diagnosis: (R) BKA - redebridement, (L) flank wound			(b)(6)-2	
	.....	Condition: Stable / Serious / Critical				
	.....	Allergies: NKDA				
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					

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

USAPA V1.00

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (~~MEDICATIONS~~) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 4 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 28	29	30	1	2	3	4	5	6	7	8	9	10	11
28 APR 03	(b)(6)-2	VS per routine call HO	07 15	(b)(6)-2													
	-----	for temp > 101	15 23														
	-----		23 07														
28 APR 03	(b)(6)-2	act: Strict Bedrest	07 15														
	-----		15 23														
	-----		23 07														
28 APR 03	(b)(6)-2	DO NOT CHANGE DRESSING	07 15														
	-----	to (L) Flank	15 23														
	-----		23 07														
28 APR 03	(b)(6)-2	Diet: Regular + 1 can	07 15	(b)(6)-2													
	-----	ensure TID	15 23		Δ'd see below												
	-----		23 07														
28 APR 03	(b)(6)-2	Diet: Regular + 1 can	08	(b)(6)-2													
	-----	ensure TID	13														
	-----		16														
30 APR	(b)(6)-2	Allow xeroform to dry	07 19														
	-----	on (L) leg	19 07														
	(b)(6)-2																
30 APR	(b)(6)-2	Daily chessing Δ	10														
	-----	to stump															

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Skin graft

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.

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 04 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
28APR 03	(b)(6)-2	admit to ICU 3	28APR 03	1410	1410	(b)(6)-2
30APR 03		DIC Kerlex on (L) leg & leave perform				
		in place	30APR 03	1000	1000	
3MAY 3		Will sign off. Medically Clear	3 MAY	NOW	0730	
		for D/C from ortho Perspective				

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. APR Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 17	18	19	20	21	22	23	24	25	26	27	28
17APR	(b)(6)-2	Vital Signs Q8 ~~X~~ Stat	07 19	(b)(6)-2											
			19 07												
17APR		Activity: UP on Crutches	08												
		BID	18												
17APR		3L NS bag off end of bed	07 19												
		for stump skin tx	19 07												
17APR		Diet Regular	07 19												
		BID	19 07												
17APR		~~Daily~~ Wet to dry dsg Δ to	07 19	19 (b)(6)-2					Order Δ DICT Order						
		(L) thigh ĉ Dakins 1/4 strength	19 07						See below						
17APR		Foley to gravity for 24°	07 19	(b)(6)-2					Restarted See below						
		then D/C	19 07						18 APRIL 03						
18APR		Dressing Δ BID ĉ	08	(b)(6)-2											
		Dakins 1/4 strength	20												
18APR03		Foley to gravity	07 19												
			19 07												
20APR		Incentive Spirometry	07 19												
			19 07												

ALLERGIES: ☐ YES ☑ NO

PRIMARY DIAGNOSIS: (L) FIANK Wounds (R) BKA

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION: (b)(6)-4 (b)(3)-1 (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.

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
17 APR	(b)(6)-2	Admit to ICU Dx ⓛ flank wounds, ⓡ BXA	17APR	0945	0945	(b)(6)-2
		Condition Stable				
18 APR		Δ foley ā 1ST dose Levoflox	18APR	09	[redacted] 1730	
18APR		I Stat 8 & UA in AM	19APR	06	18APR [redacted] 2100	
22APR		DC Foley	22APR	1700	1700	
25 APR		NPO after MN 27 APR @ 3	27 APN	MIN	0000	
25 APR		Mylanta PO 30cc X1 NOW	25 APN	NOW	1300	

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

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

MEDS:

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. 4 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 28	29	30	31	~~32~~	~~33~~	~~34~~	5	6	7	8	9	10	11
28APR03	(b)(6)-2	IV Fluids - LR @ 125cc/hr	07 15	(b)(6)-2													
		Heplock c̄ good PO	15 23														
			23 07														
28APR03		Ancef ÷ 6m IV Q8°	06														
			14														
			22														
28APR03		MVI ÷ tab PO QD	10														
28APR03		Colace ÷ cap PO BID	06														
			18														
30APR		Amitetryline 25mg	21														
		PO Qhs Amitriptyline															

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Skin graft

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

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo _____ Yr _____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
	.....					
	.....					
	.....					
	.....					
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	.....					

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
28 APR 03	(b)(6)-2	Vicodin 1 tab PO Q4° Prn	28Apr 2000	29Apr 0745	29APR 1445	29Apr 2015	D/C	30 APR	03	EW						
28APR 03		MSO4 1-10mg IV Q30min Prn	28Apr 1800	28Apr 1850	28Apr 2115	28Apr 2245	28Apr 2345	29Apr 0120	29Apr 0630	29Apr 1700	29Apr 2045	29Apr 0145	29Apr 0300	30Apr 0020	30Apr 0225	30Apr 0510
28APR 03		versed 1-5mg IV QID prn	30APR 1100	1MAY 1111			D/C	2 May 03	EW							
28APR 03		Ambien 5mg PO QHS prn	28Apr 1155				A	28 Apr 03	EW							
28APR 03		Benadryl 25-50mg IV/PO	25mg 29APR	25mg 29APR		29Apr 2100	29Apr 2300	30Apr 0120 25mg IV	30Apr 0350 50mg IV	30Apr 0630 50mg IV	30Apr 0900	30Apr 1320 50mg		30APR 1800 25mg	30APR 2130 50mg	30Apr 2355 50mg
.....		PRN itching q2-3°	2003 0740	1MAY 1445	1May 0300 50mg	1MAY 0930 50mg	1MAY 1200	1May 1440 50mg	1MAY 1715 50mg	1MAY 2035 50mg	1MAY 2230 50mg	2May 0030 50mg	2MAY 0215 50mg			
28APR		Ambien 10mg PO qhs PRN	30Apr 0120 10mg	1May 0001 10mg	2May 0001 10mg											
28Apr 03		MSO4 1-10mg IV q 30min PRN	30Apr 0610 5mg	30APR 2135			See below									
30APR		Percocet 1-11 PO q4-6° PRN Pain	30Apr 0[illegible]	30APR 1245	30APR 2[illegible]	30APR 1830	30Apr 2340	1MAY 1440								
28APR		MSO4 1-10mg Q30min PRN	10mg 1110	1May 0150 10mg	1May 0410 10mg	1MAY 10mg 1111	2May 10mg 0320	2May 10mg 0630	Transcribed to new sheet							

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. May Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 2	3	4	5	6	7
28APR03	(b)(6)-2	LR@125cc/hr (HL	07						
		when tol Po well)	15						
			23						
			07						
28APR03		Ancef 1gm IV q8°	06						
			14						
			22						
28APR03		MVI ONE tab PO	Po						
		Qd	/						
28APR03		Colace 1 cap PO BID	06						
			18						
			/						
30APR03		Amitriptyline 25mg	21						
		po qhs							

D/C

D/C

D/C

ALLERGIES: ☐ YES ☑ NO

NKDA

PRIMARY DIAGNOSIS:

Ⓡ BKA / Ⓛ Flank GSW

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 - 4030

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
2May 7May	(b)(6)-2	MS04 1-10mg IV	2May 1330 10mg	2May 1310 10mg	3May 0150 IV 10mg	3May 0420 IV 10mg										
		q 30min prN														
28APR		Benadryl 25-50mg	2May 0910 50mg	2May 1410 50mg	2MAY 2030 50mg	2May 2315 50m (b)(6)-2	2May 8410 50mg	3MAY 0730 50mg	3MAY 1300 50mg	3MAY 0030 50mg PO	4 MAY 0230 50mg PO					
		IV/PO q2-3° PRN														
		- or -														
2May03	(b)(6)-2	Atarax 50mg po	2May 0845 (b)(6)-2	2MAY 1630 50mg	2MAY 50mg 1030	3MAY 50mg 0220										
		q 4° prn itching														
28APR	(b)(6)-2	Ambien 10mg PO q HS PRN	See below													
2May 7May		Percocet 1-2 PO q 4-6°	2May 0845 (2) (b)(6)-2	2May 1410 (2)	3MAY 1907 2											
		PRN Pain														
28May	(b)(6)-2	Ambien 10mg PO qhs	3May 0001 (b)(6)-2													
		PRN														

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

Meds

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. 4 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 11	12	13	14	15	16	17	18	19	20
4-11	(b)(6)-2	Ancef 1gm IV q8	08	4	(b)(6)-2								
	-----		16	12									
	-----		24	20	(b)(6)-2								
4-11	-----	O2 4L NC	08	4									
	-----		20	16	(b)(6)-2								
15APR03	(b)(6)-2	Ancef 1GM IV q8°	08	02				(b)(6)-2					
			16	14									
	-----		24										
15APR03	(b)(6)-2	O2 2L NC PRN	07										
	-----	sats > 92%	19					(b)(6)-2					
15APR03	(b)(6)-2	Heplock IV	07										
	-----		19										

DC'd on changed to local time

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

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.

Verify by Initialing		...ERAPEUTIC 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
4-11	(b)(6)-2	H & H, Chem 7 now	4/11	Now		(b)(6)-2
4/13		Resume pre op orders	4/13	Now		
4/13		Ambien 10mg PO Now	4/13	2345	234	
4/14		5mg Versed x 1 Now for Dress Δ	(b)(6)-2	0845	0845	
15 Apr 03		Versed 5mg IVP, MS04 8mg IVP		0930	0930	
16 Apr 03		NPO p̄ MN	4/16/03	2400	4/17/03 0001	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
4/11	(b)(6)-2	MS04 4mg IV g1° pain	4/11 [redacted] 4/14 [illegible]	4 Apr 2320 [illegible] 0050 [illegible]	2mg [redacted]	4mg [redacted]	4mg [redacted]	4mg 12 Apr 1600 NJS	[illegible]	13 Apr 3mg KDS 447	[illegible]	[illegible]	4/14 4mg [illegible]	4/14 4mg [illegible]	4/14 2mg [illegible]	4/14 4mg [redacted]
4/11		Phenergan 12.5 IV g2° pen nausea														
4/15	(b)(6)-2	MS04 4mg IV g2° pain	4mg 4/15 0545	6mg 0230 pam 4/15	10mg 0200 pam 4/15	4mg 2050 4/15 [illegible]	4mg 2200 4/15 [illegible]	2mg 2345 4/15 [illegible]	4mg 0230 4/16 [illegible]	4mg 0530 4/16 [illegible]	16 Apr 0730 2mg JF	16 Apr 1030 [illegible] JF	17 Apr 0030 4mg [illegible]			
16 Apr		Vicodin I or II 4 abs Q4-6 hr prn	16 Apr 1100 JF	16 Apr 1900 JF												
16 Apr 2003	(b)(6)-2	Restoril 15-30mg QHS PRN for sleep														
16 Apr 2003	(b)(6)-2	MS04 5mg IV PRN for dressing Δ														
16 Apr 2003	(b)(6)-2	Versed 2-4mg IV PRN for dressing Δ														

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

Verify by Initialing		ERAPEUTIC DOCUMENTATION CARE . AN (MEDICATIONS)				Mo. _____ Yr. _____
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
21Apr	(b)(6)-2	Tylenol #3 I-II PO	21Apr 1800 II [redacted]	22Apr 0920 II [redacted]	22Apr 1430 II [redacted]	23Apr 1430 II [redacted]	24 APR 2200 2 tabs [redacted]	25 APR 0230 2 tabs [redacted]	25APR 2300 II [redacted]	26 Apr 0300 [redacted]	0600 26 APR 2 tabs [redacted]					
		9 4-6° prn in place of vicoden														
23APR		Versed 1-5mg IVP PRN	23 APR 0900 5mg [redacted]	24Apr 0830 5mg [redacted]	27Apr 2100 5mg [redacted]											
		prior to dressing Δ														
18APR		MSO4 1-10mg IV	23APR 2000 10mg [redacted]	24Apr 0600 10mg mw	24Apr 0830 10mg [redacted]	24Apr 2100 10mg [redacted]	25APR 0300 mw 7mg	25APR 2130 KKBAR	26APR 1900 10mg [redacted]	27Apr 2100 10mg [redacted]						
		PRN Dressing Δ														

Medication

*U.S. GPO: 1996-454-110/95216

M. I

MEDCOM - 4034

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. 4 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 11	12	13	14	15	16	17	18	19
4/11	(b)(6)-2	Admit ICU NKDA	D	(b)(6)-2								
		Dx: SHRAPNEL @ FLANK, S/P	N									
		BKA, Condition: Guarded										
4/11	(b)(6)-2	VS per Routine, Q6° c P.O.	D	(b)(6)-2								
			N									
4/11		Up in chair @ shift	D									
			N									
4/11		CL Diet	D	(b)(6)-2								
			N									
4/11		D5LR @ 140/HR	D	(b)(6)-2								
			N									
4/11		foley to gravity	D	(b)(6)-2								
			N									
4/11		Wet to dry dressing	D									
		Δ's to flank qs daily	N									
4/11		Do not Δ BKA	D									
		dressing	N									
4/13		Regular Diet	D									
			N									
15 Apr 03	(b)(6)-2	Foley to gravity	07	/	/	/						
			19	/	/	/						

DC'D 4/13/03

D/ced

D/C 4/15/03

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

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.

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. APR Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 17	18	19	20	21	22	23	24	25	26	27	28	29	30
17APR	---	LR @125cc/hr (heplock	07 19	(b)(6)-2													
	-----	when tol PO well)	13 03	(b)(6)-2													
17APR	---	Ancef + Gm IVPB q8°	06	(b)(6)-2													
	-----		14	(b)(6)-2													
	-----		22	(b)(6)-2													
18APR	---	Levofloxacin 500mg PO															
	-----	Q day															
18APR	---	Colace + Lactulose PO BID	06	(b)(6)-2													
	-----		18														
18APR03	---	Normal Saline @ 200cc/hr	07 19	(b)(6)-2									D/C	25APR03			
	-----		19 07	(b)(6)-2										0915			
22APR03	---	MVI + tab PO QD	10						(b)(6)-2								
22APR03	---	Dulcolax Supp + PR	04						(b)(6)-2								
	-----	Q 6° int.l BM	10														
	-----		16						(b)(6)-2								
	-----		22														
25APR03	---	Start LR IV @	07									(b)(6)-2					
	-----	125cc/hr @ this time	15														
	-----		23														

ALLERGIES: ☐ YES ☑ NO

PRIMARY DIAGNOSIS:
(L) FLANK Wounds
(R) BKA

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

PATIENT IDENTIFICATION (b)(3)-1 (b)(6)-4 (b)(6)-2 (b)(3)-1

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 - 4036

(b)(3)-1 (b)(6)-4 (b)(3)-1 (b)(6)-2

ATION CARE PLAN (NS)

Mo. APR Yr. 03

Order Date	Clerk/ Nurse	Medication, Dose, Frequency	Date to be Given	Time to be Given	Time Given	Initials
19 Apr		3mg XT Now	19 Apr	1515	1515	
21 Apr		2mg Versed prior to dressing change	21 Apr	0730	0730	
21 Apr		100mg Demerol & 2mg Versed now for dressing change	21 Apr	1130	1130	
21 Apr		10 cc MOM now	21 Apr	1900		
21 Apr		Mag Citrate 10oz Bottle follow w 8oz of water	21 Apr	1900	22 APR 0430	
25 APR		Versed 5mg Now	25 APR	0845	0845	

Order/ Expir Date	Clerk/ Nurse	PRN Medication, Dose, Frequency	Initial proper column following administration — Time/Date dispensed												
17 APR	(b)(6)-2	Vicodin 1-II PO q 4-6°	17 APR 1 PO	17 APR 2	17 APR 2 tabs 2100	18 APR 2 tabs 0085	18 APR 2 tabs 0330	18 APR 2 tabs 0830	18 APR 1400	18 APR 1 tab 2140	19 APR 2 tabs 0830	19 APR 1 tab 1000	19 APR 2 tabs 2300	20 APR 2 tabs 0430	21 APR 2 tabs 0130	22 APR 2 tabs 0100
		PRN Pain	1055 22 APR 2 tabs 0900	1600 22 APR 2 tabs 2300	1630	37 APR 2 tabs 0320	1610	2300								
17 APR		Phenergan 12.5-25mg	25 MG 0830	25 MG 0830	25 MG 1915	25 MG 0030										
		IV q 6° PRN N/V	17 APR	19 APR	19 APR											
17 APR	(b)(6)-2	Restoril 15-30mg PO	30 MG 2330	18 APR 2350 30 MG	19 APR 2300 30 MG	21 APR 0030 30 MG	22 APR 0000 30 MG	22 APR 2200 30 MG	23 APR 0930	26 APR 2330 30 MG	27 APR 2330 30 MG					
		QHS PRN Sleep	17 APR													
17 APR		MSO4 1-10mg IVP	17 APR 0800	18 APR 2030 6 MG	18 APR 2350 2 MG	19 APR 0340 2 MG	19 APR 0945 10 MG	19 APR 2000 10 MG	19 APR 2300 2 MG	20 APR 0530	20 APR 1015	20 APR 1515	20 APR 10 MG 2000		21 APR 5 MG 2100	21 APR 0750 10mg
		PRN Dressing Δ	6 MG													
20 APR		Tylenol 650mg + PO q 4-6° PRN Δ	20 APR 1840													
21 APR		MSO4 1-5mg q 4-6°	21 APR 1800 5mg	21 APR 2300 5 MG	22 APR 0000 2 MG	22 APR 1730	23 APR 0000 10 MG	24 APR 1720	25 APR 0740 5 MG IVP	25 APR 0830 5mg	25 APR 1330 3 MG IVP	25 APR 1630 3 MG	25 APR 0930 3 MG			
		PRN Severe Pain IV														
21 APR		MSO4 1-10 MG	21 APR 1530		22 APR 0300											
		IVP PRN Dressing Δ					10 MG									

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

CLINICAL RECORD	TH. EUTIC DOCUMENTATION CARE PLA .ON-MEDICATION) 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 COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 10	11
10 Apr	- - - - - -	IVF NS / LR / D5NS D5 1/2NS To run	07	/	(b)(6)-2
	- - - - - -	@ 150 cc/hr D/c when tolerating PO well	19	(b)(6)-2	
10 Apr	- - - - - -	Ancef 1 GM IV q 8 HRs	06	/	
	- - - - - -		14	/	
	- - - - - -		22	(b)(6)-2	
	- - - - - -	Gentamycin IV Q			
	- - - - - -				
	- - - - - -	Cefoxitin 2 gm IV q 8hrs			
	- - - - - -				
	- - - - - -				
10 Apr 03	- - - - - -	02 titrate to keep SPO2 > 92%	07	/	(b)(6)-2
	- - - - - -		19	(b)(6)-2	
	- - - - - -	Versed gtt 1-10mg/hr titrate to Ramsey	07		
	- - - - - -	scale of	19		
	- - - - - -	Fentanyl gtt start at 50mcg/hr titrate for	07		
	- - - - - -	adequate pain control MAX Dose of	19		
	- - - - - -	Vecuronium 1mcg/kg/min	07		
	- - - - - -		19		
	- - - - - -				
	- - - - - -				
	- - - - - -				
	- - - - - -				
	- - - - - -				
	- - - - - -				
	- - - - - -				
	- - - - - -				
	- - - - - -				

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: soft tissue injury (L) Flap, s/p (R) BKA

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

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		THE[illegible]UTIC DOCUMENTATION CARE PLA[illegible] *(NON-MEDICATION)*				Mo 4 Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
	- - - - -					
	- - - - -					
	- - - - -					
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	- - - - -					
	- - - - -					
	- - - - -					

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
10 Apr	(b)(6)-2	Morphine Sulfate 2-8mg IV q1-2 hr PRN pain	2315 10 Apr 03	11Apr 6mg	11Apr 6mg	11Apr 4mg										
- - - - -		~~Phenergan 12.5-25mg IV q 4-6 hrs~~ prn N/V	1amc	00:20	1:20	2:20										
10 Apr		MOM 30cc PRN Gastric Upset														
- - - - -		NS / LR bolus X ____liters														
- - - - -																
10 Apr		Phenergan 12.5-25mg														
- - - - -	- - - - -	IV q 4-6 PRN N/V														
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															

(b)(6)-2

USAPA V1.00

(b)(6)-4

1. [redacted]		3a. STATUS	3b. SERVIC	4. PRECEDENCE	5. GRADE
		EPW		U P R	

6. AGE	7. SEX	8.WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F)--	11.ACCEPTING MD	12.CITE/AUTH #
21	X MALE / FEMALE			AMBUL / X LITTER		

13.APPT/SURG DATE	14a. ORIGINATING FACILITY (b)(3)-1	15a. DESTINATION F (b)(3)-1	16. # OF ATTENDANTS 16a. MED	16b.NON-MED
	14b.ORIGINATING FACILITY PHONE NUMBER 558-(b)(3)-1	15B. DESTINATION FACILITY PHONE NUMBER		

17. DIAGNOSIS

(1) SOFT TISSUE INJURY (L) CHEST & FLANK

18. | BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

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

	YES	NO	ISSUE		YES	NO	
a.			Hypertension	i.			Bowel Problem
b.			Cardiac Hx	j.			Self-care
c.			Diabetes	k.			Ambulatory
d.			Respiratory	l.			Ambulatory Aid
e.			Ears/Sinus	m.			Self-meds
f.			Motion Sick	n.			Adequate Supply of Meds
g.			Vision Impaired	o.			Other:
h.			Voiding Prob.				

20. PHYSICIANS ORDERS

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

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

RENAL ___ Gm Prot ___ Gm Na ___ MagK ___ 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

				FOLEY CATH
	SUCTION		TRACTION	ORTHO BRACES
	NG TUBE		IV PUMP	CHEST/HEIMLICH
	STRYKER		TRACH	RESTRAINTS
	INCUBATOR		MONITOR	OTHER (*USE 23*)

OXYGEN: ___ PERCENT or ___ LITERS | ROUTE: ___

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No ___ feet

20h. RECORDS TO ACCOMPANY PATIENT

	OUTPATIENT RECORDS		XRAYS	OTHER:
	INPATIENT RECORDS		OB	
	NARRATIVE SUMMARY		DENTAL	
	FINANCIAL			

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE

21 yo SEEN @ FST UNDERWENT WIDE DEBRIDEMENT (L) FLANK & (R) BKA.

23. MEDICATIONS / TREATMENTS

FST (I & D)

21 2TH (RE I & D)

(R) S/P BKA (FST)

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

24. STAMP AND SIGNATURE OF ATTENDING PHYSICIAN

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF Form 3899 (433 AES Excel version)

M CAL RECORD - SUPLEMENTAL MEDI DATA [redacted]

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

OTSG APROVED (Date)

EPORT TITLE

TRAUMA FLOWSHEET

INITIAL ASSESSMENT ☐ IMMEDIATE ☐ DELAYED ☐ MINIMAL

ate: A Apr 03 Arrival Time: 0545 Sex: M F Age: _____ Wt: _____

llergies: _____ Tetanus Status: UTD Unknown

MP: Last Meal:

hief Complaint: (R) BKA, (L) Chest Wound

MH: Medications:

reatments PTA:

ITAL SIGNS: BP: 143/76 P: 96 RR: 24 TEMP: SAO2: 84

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: 15

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 1 ☒ LT X 2
MOVES EXTREMETIES X 4
NO EDEMA
NO DEFORMITIES

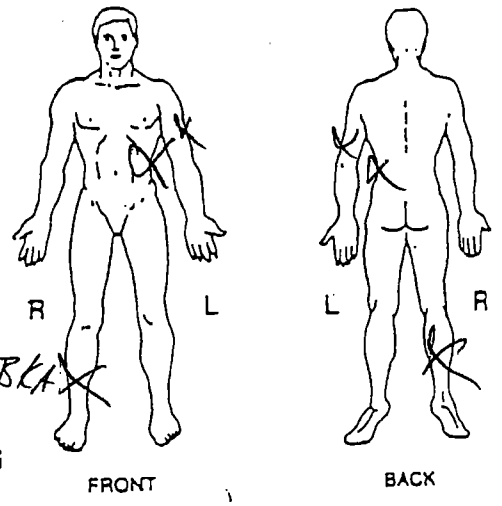
XCEPTIONS TO BOVE ARAMETERS:

SPLINTS:

REATMENTS: BKA
2: LPM NC MASK
~~TT~~ # MM
~~IONITOR~~ ☐ Y ☐ N EKG ☐ Y
~~IG TUBE~~ #
OLEY: # 16 Fr
~~HEST TUBE~~ ☐ R ☐ L

ORAL AIRWAY
NASAL AIRWAY
☐ N
DPL ☐ POS ☐ NEG
CM H20

R L L R
BKA
FRONT BACK



A = Abrasion
AP = Amputa
AV = Avulsion
B = Burn
C = Contusion
D = Deformity
E = Evisceratio
OF = Open Fr
CF = Closed
G = GSW (
L = Laceratio
PW = Puncture
S = Stab Wou
O = Other

(Continue on

REPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC 399th CSH

DATE

ATIENT'S IDENTIFICATION (For typed or written ntries give: Name - last; first; middle; grade; date; ospital or medical facility)

(b)(6)-4

(b)(3)-1

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

MEDCOM - 4041

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
1 2 3 4 5 6	7 8	9 10 11 12 13 14 15		16 17	18
(b)(3)-1		(b)(6)-4	(b)(6)-4		M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC	RELIGION
19 20 21 22 23 24 25 26	27 28 29	30	31 BACK-GROUND	
1 9 7 8 0 1 0 1	2 5 Y	I		MUSLIM

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
		~~9~~ 9 20	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	0600	

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

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
62 63	64 65 66 67 68 69 70	71	YEAR ☐ NO
1 2		INJ	

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
1 Direct	ICU 1	
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
(b)(3)-1		

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y Y Y M M D D)
73 74 D/C: Home	75 76 77 78 79 80	81 82 83 84 85 86 87 88
		2 0 0 3 0 5 0 4

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y Y Y M M D D)
89 90 91 92	93 94 95 96 97 98	99 100 101 102 103 104 105 106
A B A A		2 0 0 3 0 ~~4~~ ~~0 5~~

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y Y Y M M D D)
107 108	109 110 111 112 113 114	115 116 117 118 119 120 121 122
1 2		

FOR LOCAL USE

Shrapel L flank S/P BKA
E9654

DX: 8795
8971

Dx: 8622
843 8669
8622 8669
8622
843

Trauma
1

Injury
449

ADMITTING OFFICER (Signature as required)	SIGNATURE OF ADMITTING CLERK
(b)(6)-2	(b)(6)-2

EDITION OF MAR 89 IS OBSOLETE

USAPA V1.00

MEDCOM - 4042

...ENT TREATMENT RECORD COV...

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

1. REGISTER NUMBER (b)(6)-2		(b)(6)-2			3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE	6. RACE Black	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
11. FMP 99		12. SSN (b)(6)-2	13. ORGANIZATION			14. WARD 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 Trans				22. HOURS OF ADMISSION 2100	23. CLINIC SERVICE HBAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION Trans		26. DATE OF DISPOSITION 26 apr 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)			27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION 10 apr 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 L Thigh, L Back

DX: 8761
8901
86804
82032
56400
E9659

Trauma
1

PPX: 5491
8622
7965

Injury
450

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
					21

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

SI (b)(6)-2 SIGNATUR (b)(6)-2

DA... EDITION OF 1 AUG 76 IS OBSOLETE

MEDCOM - 4043

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	9 Apr 03 SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
#1 BP 102/80	S- EPW PT #[redacted] presents c̄ 2 small caliber entry
#2 BP 15:53 96/64	wounds. 1 upper, outer (L) hip. 1 Lumbar
T: 96.4	spine (L) side. 36 y/o ♂ in NAD, Lungs - CTA, Abd Soft, NT
P 84	O- 1 small, circular entry wound upper, outer (L)
R ☐	hip. Spontaneous blood oozing c̄ manipulation, not
73 B/P 103/50	bright red. NVI distal
92/70 1640	1 small, circular entry wound, near midline (L)
98/76 1650	Side lumbar spine, dark oozing/draining blood
	upon dressing manipulation
Came in field	XRays of hip show no metallic FB noted AP/lat
c̄ 500ml NS	XRay Abd show (AP) show metallic FB Lumbar level
orders:	lateral unable to decerne level, DRE - (-) Frank blood
- 1L NS drip 1600	A - Multiple GSW
- 1L NS Bolus	P - 1) Consult surgery
Per surgeon	2) will have exploratory lap to r/o internal bleed
1700	3) Post op protocols [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;* [redacted] | 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)*
9Apr 03	EPW c̄ GSW (L) low back and (L) lat thigh (entry) Fragments in pelvis area on AP (lat unobtainable) pelvis. Projectile also seen (L) of spine c/o low back, thigh pain originally then developed worsening abd pain. Pressures had been 120's systolic on arrival then down to 70's - 80's c̄ ↑ confusion. Responded to ↑ WF.
	HEENT - NP/OP clear PERRLA
	cephalohematoma (R) occ.
	neck NT/nl ROM
	Chest CTA (B) S, S_2 ng AT (Apry scan)
	Abd - S/obese/tender low abd / + BS
	Bil fem PT/DP pulses palp Dectal
	(L) back c̄ GSW c̄ mild bleeding nl tone (Φ blood)
	o/w midline NT
	(B) LE c̄ intact sensation 5/5 EHL/DF/PF
↓UB as above	(L) lat thigh c̄ hematoma + GSW laterally
	Φ ext bleeding
	Imp - hemodynamic lability + potential for intraabdominal injury
	Plan - Will explore in OR

(b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK

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

MEDCOM - 4045

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9 April 03	EPW #3/C was brought in from OR to ICU
19:02	at 1902 vitals are B/P 123/59
NKDA	P. 83
WT 100 Kg	R 23
	SPO2 97
	T 98
1902	IV Fluids LR in (L) AC x 2 Liters PT disoriented, lethargic, UA output 1050 ml
	IV Fluids SC (R) AC x 1 Liter. O2 6% via Concentrator. [redacted] Lt 9/CW/16/LPN
1910	Given Demerol 25mg IVP/MAJ [redacted] Lt 9/CW/16/LPN
1920	BP 102/52 HR 83 R 22 Temp 98°F SPO2 [redacted] Lt 9/CW/16/LPN
1935	BP 96/57 HR 82 R 22 Temp 98 SPO2 100% 6% O2 via Concentrator [redacted] Lt 9/CW/16
1950	BP 102/52 HR 83 R 22 T SPO2 100% [redacted] 9/CW/20 2005 BP 123/59 HR 83 98°F SPO2 88% Lt 9/CW
9 April 05	To RR → Lobby — [redacted]
	s/p chest wound debridement
	Stable VS q2° I's/O's Foley to gravity
	NPO
	IVF LR @ 125 cc/hr
	MSO4 - 1-2 mg MSO4 IV q 1°
	Call for HR >110 BP <90 sys, UOP <30 cc/hr
	[redacted]
	[redacted]
	[redacted]

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

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

[redacted]

REGISTER NO. | **WARD NO.**

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)*
7 Apr 2005	Op note
	Prepp – GSW back / L thigh possible intraabdominal injury
	Postop – GSW back / L thigh & intraabdominal injury
	Surgeon – (b)(6)-2 [redacted] Procedure – ex lap debridement of back + (L) thigh wounds.
	Asst – (b)(6)-2 [redacted]
	Anest – General
	Indications – hemodynamic lability, worsening abdominal exam
	Findings (L) retroperitoneal hematoma, soft, nonexpanding w/ SB / colon, & intraabdominal (peritoneal) injury
	EBL – min
	Compl – 8
	Details – Under Gen anesthesia, prepped + draped sterilely. Opened abd through midline incision. Exploration c̄ findings as above. Irrigated + closed midline fascia c̄ #1 looped PDS. Wound divided c̄ staples + packed.
	– explored (L) lat thigh wound minimal debridement required as min nonviable tissue identified packed
	– back wound similarly explored + back minimal debridement required.
	Disp – recover + Tx. Would still want to procto and consider IVP though wine is clear

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9 Apr 03	
2055	Given MSO 2mg IVP / [redacted] (b)(6)-2 [redacted] SGT 91W20
2055	BP 96/61 HR 92 R 29 Temp 98°F SPO2 95% (b)(6)-2 [redacted] SGT 91W20
2100	Urine 200cc Empty [redacted] SGT 91W20
2110	Given MSO 3mg IVP / DC IV (R) arm (b)(6)-2 [redacted] SGT 91W20
2205 Z	B/P: 110/76 T: 96 R: 20 SpO2: 95 P: 87. Pt on O2 15LPM
	pt resting quietly. (b)(6)-2 [redacted] 91W20/SGT
2342	Morphine Sulphate 2mg IV slow push for pain. - LTC (b)(6)-2 [redacted] RN
0055:	Vitals: P: 78 T: 98 R: 22 BP: 110/68 SPO2: 99% (b)(6)-2 [redacted]
0148	Patient awakens periodically, but then readily returns to sleep.
	Abd dressing - dry & intact. Oxygen Concentration c̄ humidifier continues
	at 4lpm, SpO2 = 99%. — LTC (b)(6)-2 [redacted]
02:36	B/P 116/72, pulse 84mg, SpO2 97 (4lpm O2), resp 16.
	— LTC (b)(6)-2 [redacted] RN
0324 Z	Pt. IV clogged. New tubing & stopcock added.
	IV flowed as normal. 650 ML clean yellow
	urine drained from foley. - SPC (b)(6)-2 [redacted] 91W10
11 Apr 2003	Surgery
	Doing well & c/o. Pain controlled
	VSS overnight UOP good
	Abd - sl ND appropriate tendered ABS dressing intact
	Back/thigh wounds stable (B) LE (F) DP/PT pulses good
	A/P (1) Still needs proctor p tx movement (b)(6)-2 [redacted]
	(2) Wound changes today or tomorrow

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE
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.

(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

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
10 APR 03			T-99.4 BP 118/71 P-82 R-18 SAO2 96% on R/A.
0800			Pt admitted to ICU #3 from EMT S/P ex lap, +
			GSW (L) thigh + (L) BACK. Pt drowsy but wakes
			easily + follows commands. Dressings to ABD and
			(L) thigh clean, dry + intact. Dressing to back
			intact c̄ small cut serousanguinous drainage.
			Pt in ∅ distress and moves all extremities. [redacted]
F/C →		600cc	
1460			Foley 1200 cc ACU. SPC [redacted] 91WMG

(Continue on reverse side)

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

[redacted]

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

MEDCOM - 4049

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
	Gen Surg Admit:
10APR03	~35 yrs Iraqi ♀ S/P GSW to (L) back & (L) thigh
	undergoing Ex lap @ FST → non-expanding retroperitoneal
	hematoma & debridement of (L) thigh wound
	on 9 APR. Transferred from (b)(3)-1 for
	further post-op care. H/D stable. Foley clear /
	intact. Requiring O_2 for 84% sats.
	PTS: HR 101 BP 117/64 RR 32
	A&O GCS 15, nonfocal
	HEENT - WNL
	Lungs - CTA (B)
	CV - tachy, reg rhythm
	Abdom - soft, dressing intact, appropriate TTP
	(L) flank dressing intact
	GU - Testes ↓ ∅ mass
	Rectal - deferr to procto
	Ext - Pulses 2+/=, (L) lat thigh wound dressing
	clean
	A/P S/P GSW to back / (L) thigh S/P Ex lap c̄ debridement
	- (L) thigh film
	- Plan proctoscopy
	- Admit to ward

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

(b)(6)-2

MD

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

REGISTE

WARD NO.

(b)(6)-4

(b)(3)-1

PROGRESS NOTES
Medical Record

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

MEDCOM - 4050

509-114

DATE	NOTES
4/10/03	Ortho
1930	S/P GSW (L) prox thigh
	intact to LTT gross motor 2+ DP
	Xray - subtrach femur fx
	Skin traction
	Evac
	(b)(6)-2 [redacted] MAJ MC
13 APR 03	Brief op note:
	Preop Dx: (L) subtroch femur fx S/P GSW
	Postop Dx: same
	Procedure: I & D, washout
	Surgeon: (b)(6)-2 [redacted]
	Anesthesia: MAC
	EBL: min
	Fluids: 200
	Findings: ϕ pus, good granulation
	Drains: ϕ complications: ϕ
	Disposition: To ICW stable
	(b)(6)-2 [redacted] -MD
	MAJ, MC

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10 Apr 1900	Pt VSS c/o minimal pain pt scheduled for proctology exam Dx: E Ch. lap and (L) femur accident. Traction to (L) leg. 2 bags of NS for weight. Will contact to monitor t [redacted] 7/Dr
	0330 VSS O2 sat 96% on 10L FM. (L) LE remains in Traction. Abd dsg D+I. [redacted] Sig Woman
4/1/00	118/80, 94%, 95 HR, RR 22, T 99.9, Tylenol given po 650 [redacted]
11 Apr 05 1700	Ambulant ambulated — IV infiltrated (L) arm — d/c'd — several attempts to start IV — requests Cons to stick pt. — Pt c/o Cons no pliers passed out — Abd dsg c/d/i — (L) thigh (lateral) intact — Sca to (L) Lower ext. — DP x 4 ext. — [redacted] 4g Mday IVP @ 1630 for Tpain [redacted]
2100	Pt c/o Cons O pliers [redacted]
	Pt attempting to pull out foley — attempted to reason w/ pt — pt calmed down [redacted]
4/12 0200	Drained 2000cc c/g/m off foley — ↑ 1000cc CR [redacted]
0300	Total output 2400cc INTAKE — IV — 1500cc [redacted]
0400	1g Ang ↑ UI — BP 113/61 P 97 R 20 T 99.6 Po 97% 10L [redacted]
0345	Adm 4g Mday IVP for ↑ pain [redacted]
0405	Pt resting in bed no c/o pain. Lung sound clear b/lat. Dressing on leg CDI. Reinforced dsg on upper thigh. [redacted] Sig Wm

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)*
12 APR	0450 changed ABD DRSG - wet/Dry - pt C/O pain 2mg MSO4 given. Pt repositioned in bed [redacted] 9/WM6
	0845 PT ate few crackers and 3-4 spoonfuls of lentil stew. C/O N/V. Output of 950cc dark yellow fluid urine. Pt c/o pain 2 mg MSO4 given 1230 Pt c/o pain in leg gave 2mg MSO4 given 1400 Pt ate only few bites of diner. No c/o N/V. c/o pain in abdomen. 750cc dark yellow urine out.
12 Apr. 1700	Report received, initial assessment complete pt. has no c/o of Pain SOB. drsg to Abd and (L) femur c/pt. pt is NPO for possible procedure tomorrow VSS (L) extremity cooler than (R) will continue to monitor. I.V. L/R 125cc/hr c̄ antibiotic therapy [redacted]
	2230 - 1500cc CLEAR URINE OUTPUT FROM FOLEY SGT [redacted]
13 APR	0645 PT back from OR. via liter. S/P I+D of (L) leg. P: 96 BP 126/73 Pox 100 T. 99.2 [redacted]
	0830 Pt c/o pain in leg. 2mg MSO4 given. [redacted] 9/WM6
	1230 Pt had temp 100.5. Gave 650° Tylenol [redacted] 9/WM6
	1300 Δ ABD DRSG. Wound clean no s/s of injection. Pt had c/o pain. 2mg MSO4 given. [redacted]
	1330 Pt didn't eat but a few bites of dinner. No c/o pain. [redacted]
13 APR 03	Assessment completed IV (L) Hand patient - Dry (L) Leg - Acc c/d/i,
1700	(L) thigh Dry intact. Host 30' Foley patient. Ad Dr c/d/i. [redacted]
1830 -	4g MSO4 for 4 pain gathered pt [redacted]
2325 -	IV out - 1g Anaf W [redacted]
0300 14 Apr	- Pt c/o need to urinate - o/c'd foley - pt pulling out [redacted]

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)*
4/14/03 0300	PT c/o 9 pain Adm 4g [redacted] - IV out
14APR03	c/o constipation & N/V tol. regular diet @ BS abd NT/ND anesthesia unable to obtain peripheral IV access → po abx [redacted] MAJ, MC)
14APR03	1145 PT unable to void. Placed foley. 650cc Clear amber urine PT c/o pain 2 vicodin given. [redacted]
14Apr	Pt. has foley replaced initial assessment complete adequate output No c/os of pain or SOB. Will continue to monitor Vicodin for pain pu [redacted]
15APR03	Pt resting in bed c/o pain in leg. Breath sounds clr bilaterally. Abdominal sounds active x 4 quad. Pedal pulses equal. Pt able to move toes & feel/sensation. 0500 Δ DRSG on abdomen. PT tolerated well. Encouraged pt to drink H2O [redacted]
Local time -	1619 Pt to be transfered 450 dark urine w/ blood noted in urine [redacted]
15APR03	1655 RECEIVED PT FROM ICU2, PT STABLE ON ARRIVAL VSS, (L) LEG C̄ TRACTION, (L) LEG DRESSING C̄ SMALL AMOUNT OF SERO SAN GUINOUS DNL NOTED, NV STATUS INTACT FOLEY C̄ SMALL AMOUNT OF AMBER URINE [redacted]

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

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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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
15APR03	2010 Pt on BR c̄ HOB @ 30°. A+O x3. PERRLA. USS. HR RRR. Breathe sounds clear Bi-lat. Hyperactive Bowel Sounds x4. Pt (L) leg in external traction. Pulses +3 bounding Bilat on lower extremities. Pt able to move feet/toes bilat. Dressing to Midline C/D/I. Dressing to UE small amount of serous sang. fluid noted. Foley to gravity draining amber fluid. Pt c/o Flatulence in abdomen. Malox given @ 1940. Pt ↓. c/o pain @ this time. Will Cont to Monitor. (b)(6)-2 SGT LPN. 2310 Pt given ⊤ Vicoden for Pain KU 0350 Pt given ⊤ Vicoden for pain 0410 Pt given 50mg Benydiol for insomnia (b)(6)-2
16Apr03	0730 - Assumed care. Pt resting in bed c̄ HOB 30°. A+O x3. PERRL. HR 90's +S1S2 Lungs. Clear bilat & bases. Shallow breaths. Mmembranes pink + moist. Sats 98% RA. (+) BSH. Foley to BSD c̄ amber urine. Midline abd. dressing COI. Skin tactive to (L) Leg. (+) PPx4 able to move ext x3. Able to move toes (L) foot. Edema to (L) foot. Pt refused breakfast interpreter @ bedside. Pt frustrated + expressed desire to go home if no further surgery planned. Will discuss with surgeons & will continue to monitor. Pain @ this time (b)(6)-2 NTS
	1000 Medicated for pain per orders. Dressing Δ wet to dry. Ø S/S of infection (+) granulation Staples to middle of incision site. Will continue to monitor. (b)(6)-2 NTS

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.

Pt (b)(6)-4 (b)(3)-1

OD# (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
16 Apr 03	(1545) Pt C/O of pain. Given medication per orders. Pt repositioned. Pt expressed relief. Will continue to monitor [redacted] (b)(6)-2
	(1700) VSS. Pt resting in bed. Ate approx 25% of dinner. Encourage ↑ of PO. Will cont. to monitor [redacted] (b)(6)-2
16 Apr 03	[2030] Assumed care of pt. Pt currently resting c̄ HOB ↑ 30° AtOx3 Lung sound CTA bilat c̄ diminished bases, HR RR PERRL. Cap refill < 2 sec. Sats @ 96% on RA VSS. (+) BS x4 Abd Soft round non-distended c̄ mid line incisition Δ c/d/i (+) PP x4. ROM x3. LLE in traction. Pt able to move foot. 18g IV started in (R) forearm hep loc. 2mg MSO4 given @ [2100] for pain. Pt consulted c̄ interpreter over future status. Verbalize understanding of Tx Will Continue to Monitor. [2200] Pt given 30mg of Restoril for sleepaids. [2245] Pt given π vicodin P.O. for pain [redacted] b(6)2 [0200] Pt given 2mg MSO4 IVP for pain. Taken off traction for 20 min. [redacted] (b)(6)-2 [0400] Pt given 2mg MSO4 for pain. [0500] Pt given Vicodin π PO for pain [illegible]
17 APR 03.	(0800) Assumed care. Pt resting in bed HOB 30° traction in place to (+) log (+) pond. Cap refill < 3 sec. Able to move toes. Sk to (R) forearm flushes c̄ [illegible] Lungs CTA bilat c̄ ↓ bases. Sats 94% RA. Abd round soft. Midline pressing c/d. Pt refused breakfast but requested tea. Will cont. to monitor [redacted] b6-2
	(1100) Pt medicated for dressing Δ c̄ vicodin + MSO4. Tol well. Pt resting VSS. (1000) Pt washed self + translator @ bedside to explain evac plan. Pt verbalized understanding [redacted] (b)(6)-2 [redacted] (b)(6)-2 [redacted] (b)(6)-2 [redacted] (b)(6)-2

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MEDCOM - 4056

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
17 Apr 03	2030 Assumed Care of pt. Resting HOB↑30°. A+O×3. Lung sounds CTA Bilat c̄ diminished bases. HR RRR S_1 S_2 Cap refill <3sec. PERRL. Vats @ 94% on RA. (+) BS×4 hyperactive. Abd soft non-distended c̄ mid-line incision c̄ ↓ c/d/i. (+) PP×4 ROM×3. LLE in traction. pt able to move foot. Pt had ∅ c/o pain or discomfort @ this time. PIV to (R) forearm hep lor. Will cont. to monitor. (b)(6)-2 LPN SGT. Pt void clear yellow urine via foley to gravity. 2200 Pt given Restril for sleepaid 2300 Pt give vicodin PO ⅡⅡ for pain Dark 0545 Pt had uneventful night. VSS Did not eat or have BM. 875cc U/O dark amber color. Pt taken off traction @ 0315 for remainder of night (b)(6)-2
18 APR 03	0800 PT SLEEPING INTERMITTENTLY, REQUESTING TEA TO DRINK WHEN OFFERED FLUIDS, CONTINUES TO HAVE LOW PO INTAKE, A=O, C/O PAIN IN (L) LEG RELIEVED BY APPLYING TRACTION DISTAL PULSES +2 IN (L) LE, MIDLINE ABDOMINAL INCISION TO BE Δ THIS AM, CLEAN DRY AND INTACT (b)(6)-2 CTA

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

(b)(6)-4 (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
18 Apr 03	Pt seems to be A & O; VSS; afebrile; dressing to abd area CDI; ace wrap to LLE intact c̄ good cap refill; c/o pain to W site; Δ W site to (B) AC; given restoril & vicodin for c/o pain; enema administered by RA; had 1 mm BM; foley care given; ∅ s/s of irritation to Area; NVI; Cap refill < 3 sec; Do ADL c̄ ASSIST; HOB ↑; dressing (L) hip area intact; stable, continue monitor (b)(6)-2 [redacted] 9 LWM6
19 APR 03	(0800) assumed care. Pt awake. c/o pain. given MSO4 2mg. VSS. Pt refused breakfast lungs CTA. (+) P.Px4. Midline abd. dressing Δ'd. Pt med. c̄ Tylenol III for dressing Δ. Pt tol well. Will continue to monitor (b)(6)-2 [redacted] (1330) Pt awake. c/o pain given MSO4 per orders. Pt asking when he'll leave. Informed that evac pending. Encourage ↑PO. Pt ate 2 small pears + 2 cups of H_2O. Will cont. to monitor (b)(6)-2 [redacted] (1630) Pt eating dinner. approx 50%. ↑PO intake noted. UOP ↑ less dark. 950cc UOP. Pt c/o of leg pain. Given Tylenol III per orders. Pt talking c̄ other pt's (b)(6)-2 [redacted]
19 Apr 03 1900 B/P 122/20 P-91 R-18 T: 98.7 O_2 Sat - 93%	Assume pt care; pt Alert; 10 in (L) AC intact c̄ s/s of complications; dressing to abd CDI; dressing to (L) hip CDI; Ace wrap to LLE intact c̄ traction; pulse (+) c̄ cap refill < 3 sec; pt able to wiggle toes; NVI; slight edema to LLE; foley to gravity draining quantity sufficient; HOB ↑; tolerating po well; stable; continue monitor. (b)(6)-2 [redacted] 9 LWM6

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)(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
20 APR 03	0830 ASSUMED CARE OF PATIENT AT 0700 PT RESTING ⊙ HOB @ 30°, C/O PAIN IN ⊙ CE RELIEVED ⊙ REPOSITIONING ~~DUE TO~~, PATIENT ⊙ POOR PO INTAKE, DUE TO EVAC. TODAY PER ORTHO, PATIENT IS ANXIOUS TO DEPART (b)(6)-2 [redacted]
	(1000) Dressings Δ'd. Pt tol well. Repositioned ⊙ assistance. Medicated for pain (b)(6)-2 [redacted]
	(1400) Pt c/o of pain/discomfort to groin area. Foley Δ'd. Pt cleaned. (b)(6)-2 [redacted]
	(1445) Pt c/o of pain to leg. Medicated per orders. ⊕PPx4. Will cont to monitor (b)(6)-2 [redacted]
	(1800) Pt attempting to void. unable to @ this time. Encouraged ↑ PO intake. Pt c/o of pressure in abd area. Dulcolax supp given. Will continue to monitor. (b)(6)-2 [redacted]
20 Apr	
1945	received report, assumed care pt lying in bed, VSS, pt c/o abd pain, pt attempted to pass stool, unable to at this time, pain meds given as ordered pt currently resting in bed, will continue to monitor (b)(6)-2 [redacted]
2045	pt tried to move stool, pt was unsuccessful, enema was given, pt able to pass stool after enema, stool was formed, pt no longer has urge to have a movement will continue to monitor (b)(6)-2 [redacted] (b)(6)-2 [redacted]
0645	pt was awake throughout night, had cliff passing stool enema was given as noted before, he had 2 BM during the night, VSS, pt did void at separate occasion, has no c/o pain, currently resting at bed side will continue to monitor (b)(6)-2 [redacted]
21 APR 03	0700. Assumed care. Pt sleeping. VSS. Pt c/o of leg pain. Medicated per orders. ⊕PPx4. Requested traction. AM care complete. ⊕void 250 amber urine. Pt awaiting evac. Will continue to monitor (b)(6)-2 [redacted]
	(1130) Wound care completed. Pt tol well. Pt request bedpan. ⊕ BM small + liquid. ⊕void. 450cc amber urine. Incourage pt to ↑ PO intake. Pt resting. Will cont to monitor (b)(6)-2 [redacted] (1300) Void 400 cc amber urine. Request bedpan. ∅BM ⊕gas. Drinking H2O
	(1600). Void, 700cc light amber urine. Pt resting. Still awaiting evac (b)(6)-2 [redacted]

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
21Apr03 2000	Pt voids 600cc of yellow urine. —SPC (b)(6)-2 91WM6
	VS—BP 109/57 ITR84 RR16 temp 98.2 SaO2 94% on RA
2120	Pt med with 30 mg Restoril for sleep —— SPC (b)(6)-2 91WM6
2130	Pt voids 400 cc of dark yellow urine —SPC (b)(6)-2 91WM6
2200	Pt given 100 mg Colace —— SPC (b)(6)-2 91WM6. Lorenox given @2200 —SPC 91WM6
22Apr03 0230	Pt voided 400 cc of urine. —SPC (b)(6)-2 91WM6
0430	Pt currently in bed. LLE slightly swollen. traction in place. Pt c/o pain when traction applied. pt can wiggle toes. pulse ox 95% on RA. cap refill <3sec in LLE. (+) pulses present in all extremities. Pt given 100 mg of Demerol IM @0100 per doctors order for pain. IV site at this time. will continue to monitor —SPC (b)(6)-2 91WM6
0545	Pt currently in bed with traction off. Attempted to explain the need for traction as long as possible. Pt verbalized understanding. Completed self AM Care —SPC (b)(6)-2 91WM6
0645	Pt performed am care this am. Pt refused breakfast at this time. c/o stomach pain at this time. No further changes noted —SPC (b)(6)-2 91WM6
0930	Pt is in bed with c/o pain c̄ traction applied. Pt has VS
BP 118/68	in normal range. Pt has complaints of flatulence & was
P 89	given Maulox, & T3 for pain. Pt voided with 700 ml of urine
IR 16	Pt given Colace for bowel movement. Pt ate 2 pieces & has now
SpO2 91	awaken. Pain meal seems to be effective & pt is calm. SPC (b)(6)-2
Temp 97.9	
22 Apr 1428	Pt is A&O x3, c̄ no apparent signs of distress. Pt has been eating & drinking water all day. Pt is hydrated @ this time.

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 (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
	at beginning of shift urine was dark amberish color, & now it is clear/slight yellowish tin. Pt has had flatulence & has voided 1500 ml of urine today. Pt has had dressing change to abdomen, & ⓛ side of ⓛ hip. Pt has been sitting up & moving/turning in bed. Pt given T3 after dressing change & pt is relaxing. Pt is still waiting to take a steel. (b)(6)-2
22 Apr 03	
1930	Received report from Day Shift assumed pt care, VS: 96% 8 AO2 18 R 84 P 115/64 BP T 98.2 will continue to monitor (b)(6)-2
1945	pt resting in bed, no c/o pain at this time, ⓛ leg in line with traction ⊕ pulses x 4, hob @ 30° as ordered will continue to monitor pt (b)(6)-2
2200	meds given as ordered, colace 100 mg and Lovenox 30 mg (b)(6)-2
2210	pt c/o pain and restlessness, meds given as ordered 1/1 T3 ~~[illegible]~~ for pain, and 1/1 Restoril for restlessness, will continue to monitor pt (b)(6)-2 [illegible]
23 Apr 03 0200	Pt c/o pain given 2 T3 tabs. left leg traction applied at this time. pt uses bar above bed to move freely around bed w/o complaint. Pt has no other complaints at this time — SPC (b)(6)-2, 91 WM6
0300	emptied 600 cc of dark yellow urine. pt requested traction to be off for a while. explained that it had to be put back on soon. Pt understood. No further complaints at this time. — SPC (b)(6)-2 91 WM6
0530	Pt c/o abdominal pain. Combine dvsg pad to wound wet. changed with a new combine dvsg. pt satisfied. self AM care done. — SPC (b)(6)-2 91 WM6
0610	Pt currently in bed with traction applied to left leg. No further complaints or changes at this time — SPC (b)(6)-2 91 WM6
0800	BP 118/62/HR 66/Resp 16/SpO2 91% on RA/Temp 96.9°F. Initial assessment performed. S1, S2 audible. Pulses x 4 ext ⊕ 3. Lungs CTA Ⓑ. Sating 91% on RA. BS active. Taking

FPI LEX Printed on Recycled Paper STANDARD FORM 509 (REV. 5/99) BACK

MEDCOM - 4061

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
23APR03 0800 cont.	Colace BID po. Dsg Δ to abd wound Δ'd. Small amt green drainage from bottom abd wound. Wet to dry dsg performed. Trapeze hanging above bed. Pt able to Δ position prn. (L) leg traction on as tolerated by pt. Tol reg diet well c̄ no c/o n/v. — (b)(6)-2 [redacted] LT/an
0840	2 tylenol #3 given po for pain. Dsg to (L) thigh packed & Δ'd wet to dry. Upon removal of old dsg gauze c̄ green & red drainage noted, ∅ oozing. — (b)(6)-2 [redacted] LT/an
1615	2 tylenol #3 given for pain. 400cc amber urine emptied - kd
1930	pt c/o stomach pain / requests dose of Colace at this time. pt given 100 mg of Colace at this time. — SPC (b)(6)-2 [redacted] 91WM6
2015	pt voided 700cc dark yellow urine in a urinal — SPC (b)(6)-2 [redacted] 91WM6
	VS → BP 140/63 HR81 RR12 temp 97° SaO2 97% on RA
~~2115~~ 2115	
T2115	pt given 1 restoril tab for sleep and 2 T3 tabs for pain — SPC (b)(6)-2 [redacted] 91WM6
2230	pt awake at this time. Using trapeze bar to readjust self in bed. Left leg traction applied at this time with no further pt complaints noted. will continue to monitor — SPC (b)(6)-2 [redacted] 91WM6
0130	pt c/o pain to (L) leg, meds given as ordered, ∥ T3 given for pain, pt awake and lying in bed, no further c/o pain, will continue to monitor pt — (b)(6)-2 [redacted] 91C

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)(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
24 Apr 03 @0310	- Pt c/o of pain in (L) leg. Discussed with ER physician and gave pt 50 mg Demerol IV, using Z-Track method as ordered. If pain remains will repeat in an hour. — (b)(6)-2 [redacted] CPT, Ar
0615	pt slept through night mostly, he was medicated 3x pain, pt had no further c/o pain. pt currently laying in bed with traction applied. will continue to monitor pt — (b)(6)-2 [redacted] ok
0830	BP 117/62/HR 83/Resp 18/SpO2 92% on RA / Temp 98.7°F. Initial assessment performed. S_1, S_2 audible. +3 pulses x 4 ext. Lungs CTA (B). Sats >91% on RA. BS active x 4 quads. (+) flatus. Pt has sensation to (L) leg. Traction on as tolerated by pt. Pt able to move (L) toes ~~& sen~~ Dsg to midline abd Δ c̄ wet to dry. Small amt of pus on old dsg upon removal. Dsg to (L) thigh repacked c̄ wet to dry dsg. Small dsg to back removed. Site cleaned c̄ hydrogen peroxide, packed c̄ iodoform & covered c̄ sterile gauze. Wound to back has red edges, oozing small amt of pus & warm to touch c̄ foul odor. Pt has been on Levoquin 500 mg po qd since 16 APR 03 & remains afebrile. Tolerating reg. diet well. Able to make slight mvmt Δ's c̄ trapeze assistance which hangs above pt's bed. No c/o pain currently. — (b)(6)-2 [redacted] UTCan
1845	650 cc UO emptied. Fleets enema given @ 1100 c̄ Ø results. Pt continues to have lg amt of flatus. Fluid intake encouraged. Denies need for pain meds — (b)(6)-2 [redacted] UTCan

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
24 Apr 03	
1930	received report from day shift assumed pt care, VS BP 117/67 P 84 R 18
	SaO2 90% T 99.1, abd dsg CDI, (5) leg in traction, pt has no c/o pain
	at this time will continue to monitor (b)(6)-2 (b)(6)-2
2130	pt c/o pain & restlessness, meds given as ordered, T3 # for pain, retrial
	for restlessness, pt has no further c/o pain or restlessness at this time
	will continue to monitor (b)(6)-2 (b)(6)-2
2200	Colace 100 mg and Lovenox 30 mg given as ordered (b)(6)-2
25 Apr 03 0000	pt c/o pain, pt given Demerol 50 mg IV as IX order, pt has no further c/o pain
	will continue to monitor (b)(6)-2 (b)(6)-2
0110	emptied 600 cc of dark yellow urinal from pt urinal — SPC (b)(6)-2 91WM6
0230	reapplied traction to left leg at this time — SPC (b)(6)-2 91WM6
0300	Pt c/o pain, given 2 T3 tabs at this time — SPC (b)(6)-2 91WM6

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

MTF (b)(3)-1

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
25APR03 0700	assumed care of pt, pt is resting comfortably in bed, VSS, ∅ signs of distress, ∅ c/o pain pt had >50% of breakfast, will continue to monitor pt. (b)(6)-2 [redacted]
0915	pt c/o pain to (L) leg, medicated c̄ 2 tabs Tylenol c̄ codeine as ordered, will continue to reassess pt's pain level. (b)(6)-2 [redacted]
1200	I'd pt's Hd dressing wet to dry as ordered ∅ smell, ∅ necrotic tissue noted will continue to monitor site (b)(6)-2 [redacted]
1330	Dsg to (L) thigh I'd wet to dry. Old dsg had blood & small amt green drainage on it. Back dsg I'd c̄ iodoform. Back wound has reddened edges & pus from site. Pt currently has traction on (L) leg, +3 pulses to (L) foot. Pt moving self in bed well c̄ assistance from overhead trapeze. Denies need for pain meds currently. (b)(6)-2 [redacted]
1500	600cc amber UO (b)(6)-2 [redacted]
1830	2 tylenol #3 for pain (b)(6)-2 [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

(b)(6)-4 [redacted]

(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
25 Apr	
1945	received report from night shift, assumed pt care, vs BP 115/62 p 72
	R 18 SAO2 % 90 T 8.8°, pt (L) leg in traction, pt has c/o c/o pain
	at this time, will continue to monitor (b)(6)-2 (b)(6)-2 91C
2200	meds given as ordered, 100 mg of [illegible], 30 mg of [illegible] (b)(6)-2
2230	pt c/o pain + restlessness, meds given as ordered, ∇3 [illegible] for pain
	and [illegible] for restlessness, will continue to monitor (b)(6)-2
0400	Pt c/o pain. 2 tabs T3 given @ this time — SN (b)(6)-2 91 [illegible]
0600	emptied - 100 cc of dark yellow urine from pt urinal — SN (b)(6)-2 91 [illegible]
26 Apr 03 0800	BP 122/40 / HR 72 / Resp 18 / SpO2 92% on RA / 96.6°F.
	Pt VSS. Given 2 tylenol #3 for pain. Am. care
	conducted. Pt did not want to eat breakfast. Initial
	assessment performed. S1, S2 audible. +2 pulses x 4
	ext. lungs CTA (B). BS active x 4 quads. Dsgs to
	ABD, (L) thigh & back changed. All wound sites have
	green drainage. wet to dry dsgs performed on all 3
	wounds. Traction on (L) leg as tolerated by pt. Pt
	moving himself in bed c̄ assistance of overhead
	trapeze. Sensation to (L) foot (+). — (b)(6)-2 [illegible]

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR 19

DAY	10 Apr		11 Apr		11 Apr			12 Apr			13 Apr		14 Apr	
HOUR	1800		0300		0800	1700	2100	0300	1200	1800	0300	2100	0400	2200

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE	120/67				118/70	22		20		22	22	20	22	20
Spo2 RR					02	12		NC	NC			124/67	111/70	114/62
					94%	92%		10L	4L			94	99	
								93%	92	91	91%	90% RR		
												0L 02 = Mask		
												02 Sat 94%		

HEIGHT: WEIGHT →

Intake 125 1500 12 Apr

Output/Foley 900 Intake-IV-1500

Foley-2400

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

(b)(6)-4

(b)(3)-1

OD # (b)(6)-4

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

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY															
POST- DAY		15 Apr		16 APR		16 APR		17 APR		18 APR		19 APR		20 APR	
MONTH-YEAR	DAY	N													
19	HOUR	0400		0800	1700	2100		1000	2030	0800		0800	1900	0830	1945
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															
70															
60															
50															
40															
RESPIRATION RECORD	B/P	116/64	116/78	121/78	102/62	111/68	126/71	117/68	123/66	117/70	119/64	122/70	104/72	114/80	
BLOOD PRESSURE	HR	103	94	91	91	82	91	85	85	86	92	91	84	86	
	O_2	92	93	93%	94	95 RA	93%	94%	94%	96	98%	98%	94%	96%	
	TEMP	100.8	98.2	99.2	98.2	98.4	98.5	98.8	99.0	99.7	97.9			98.8	
HEIGHT:	WEIGHT →														
	Ocw	675	375	400		925		815	1070		1050/600				
											450				
											T-1050				

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

(Centigrade Equivalents, for Reference only)

Record special data only when so ordered

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

(b)(6)-4

(b)(6)-4

REGISTER NO.

WARD NO.

400
270
400

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 21APP

19 | HOUR

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE 122/73

91

HEIGHT: | WEIGHT → 97.5

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**

(THIS FORM IS SUBJECT TO THE PRIVA ... 74 - AS A CLINICAL RECORD FORM, IT IS COVERED BY DD 220

ANESTHESIA RECORD

Page 1 of

ANES. START	IN OR	ANES. END	DATE
0910	0915	0940	13 APR 03
TOTS	SURG START	DRESSING	OR NO
0926	0928	0941	

OPERATION PERFORMED: I&D (L) DOWN POWER PP

SURGEON(S): HARRIS

PREOPERATIVE

- [x] IDENTIFIED [x] ID BAND [ ] QUESTIONING
- [x] CHART REVIEWED [ ] NPO SINCE
- [ ] PRE-OP MEDICATION:

Drug	Dose	Route	Time

Pre-Anesthetic State: [x] CALM [ ] APPREHENSIVE [x] AWAKE [ ] SEDATE [ ] UNRESPONSIVE

MONITORS AND EQUIPMENT

- [x] ANES. MACHINE # 1 & EQUIP. CHECKED
- [x] NON-INV. B/P
- [x] CONT. EKG
- [ ] ESOPH. STETH.
- [x] PULSE OXIMETER
- [ ] END TIDAL CO2
- [ ] TEMPERATURE
- [ ] WARMING BLANKET
- [ ] AIRWAY HUMIDIFIER
- [ ] N / G TUBE
- [x] IV(s)
- [ ] ARTERIAL LINE
- [ ] CENTRAL LINE
- [ ] SWAN-GANZ
- [ ] FOLEY INSERTED: [ ] O.R. [ ] FLOOR
- [ ] EYE CARE
- [ ] PRESSURE POINTS CHECKED / PADDED

[ ] PNS
[ ] V LEAD EKG
[ ] PRECORD STETH.
[x] O2 ANALYZER
[ ] MASS SPEC.
[ ] FLUID WARMER
[ ] O /G TUBE

ANESTHETIC TECHNIQUE

- [ ] GENERAL
- [ ] REGIONAL
- [x] LOCAL / MAC
- [ ] NERVE BLOCK

INDUCTION

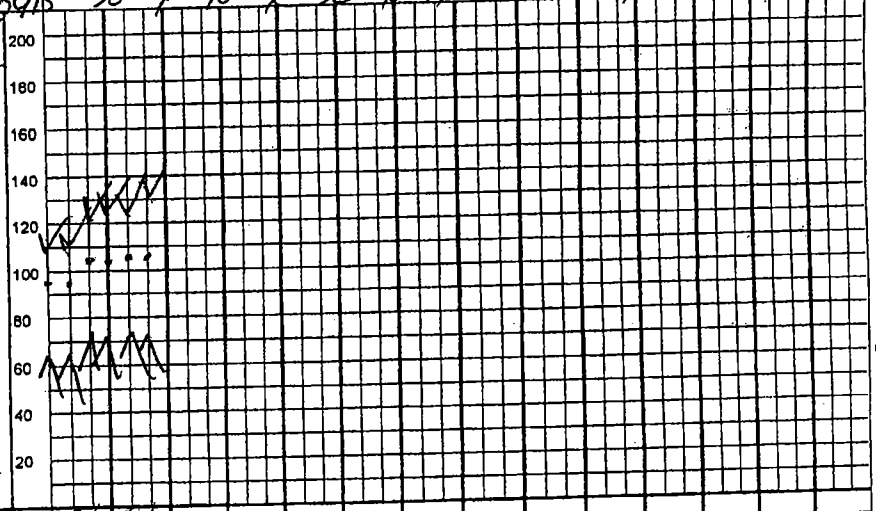
- [ ] PREOXYGENATION
- [ ] RAPID SEQUENCE
- [ ] INTRAVENOUS
- [ ] INHALATION
- [ ] INTRAMUSCULAR
- [ ] RECTAL

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 [x] SIMPLE O2 MASK
- [ ] LMA SIZE

	0915	30	10	30	11	30	12	30	TOTAL
AGENTS: Valium	5								
Robinul	.3								
Ketamine	80	20							
Propofol	80	20							
N2O L/min									
O2 L/min	3								
FLUIDS: LR	1000								
Urine									
EBL									
MONITORS: EKG	SR	SR							
% O2 Inspired	10	10							
O2 Saturation	95	97							
End Tidal CO2	–	–							
Temperature	–	–							
PNS	–								
RESP: Tidal Volume	500	500							
Resp Rate	14	12							
Peak Pressure	–	–							
Symbols for Remarks	X								
Position									

VITAL SIGNS (PRE-OP VALUES: 108/64 B/P; 95 P; 12 R; 95 SAT; — H/H)



SYMBOLS: X ANESTH; ⊙ OPERAT; V ^ B/P CL PRESSI; ⊥ T ARTER LINE PRESSI; ● PULS; C SPONT OUS R; ◊ ASSIS RES; ⊠ CONTRO RES; T TOURNI; F CRYS LOID F; B BLO

REMARKS: [x] Patient reevaluated. No change from preop plan / evaluation. [ ] Significant changes from preop plan / evaluation.

RECOVERY

TIME IN PACU	CONDITION
0945	STABLE

B/P	PULSE	RESP	O2 SAT
124/78	103	16	96-98

TEMP —

REMARKS

REPORT TO: PARRS:

Tourniquet Time:

IN	FLUIDS TOTALS	OUT
Crystalloid 1000	EBL min	
2000	Urine —	
Blood	Gastric —	

MAJ (b)(6)-2 CRNA, ISAR, RNA

PHYSICIAN / CRNA

PATIENT'S IDENTIFICATION

OD # (b)(6)-4

(b)(6)-4

NAME: SURGEON: Planned Surgery Date:

ANESTHESIA PREOPERATIVE EVALUATION

AGE 40s | (M) F | HEIGHT ~5' 7" | WEIGHT 230#

PROPOSED OPERATION I & D (L) OPEN FEMUR FX

PREOPERATIVE VITAL SIGNS: B/P P R

PREVIOUS ANESTHESIA / OPERATIONS ☒ NEGATIVE

CURRENT MEDICATIONS ☒ NONE

FAMILY HISTORY OF ANESTHESIA COMPLICATIONS ☒ NEGATIVE

ALLERGIES ☒ NKDA

AIRWAY / TEETH / HEAD & NECK MPI OPENS WIDE TEETH INTACT

SYSTEM	WN	COMMENTS	PERTINENT STUDY RESULTS
RESPIRATORY Asthma, Dyspnea, Recent cold, Bronchitis, Pneumonia, SOB, COPD, Productive Cough, Tuberculosis	☒	Tobacco Use: ☒ No ☐ Yes ____ Pack/Day for ____ Years	Chest X-ray, Pulmonary Studies
CARDIOVASCULAR Angina, Exercise Tolerance, Murmur, Rheumatic fever, Arrhythmia, Hypertension, MVP, CHF, MI, Pacemaker	☒		EKG
HEPATO/GASTROINTESTINAL Bowel obstruction, Hiatal Hernia, Reflux/Heartburn, Cirrhosis, Jaundice, Ulcers, Hepatitis, N&V	☒	Ethanol Use: ☒ No ☐ Yes Frequency ____	LFTs
NEURO/MUSCULOSKELETAL Arthritis, DJD, Neuromuscular disease, Syncope, Weakness, Back problems, Headaches, Paralysis, Seizures, CVA/Stroke, Loss of consciousness, Paresthesia, TIAs	☒		
RENAL/ENDOCRINE Diabetes, Urinary retention, Renal failure/Dialysis, Urinary tract infection, Thyroid disease, Weight loss/gain	☒		Urinalysis, Thyroid, FBS
OTHER Anemia, Pregnancy, Bleeding tendancies, Sickle cell trait, Hemophilia, Transfusion history			Hgb / Hct / CBC, Lytes

PROBLEM LIST / DIAGNOSES

MOBILITY, DECREASED 2° FEMUR FX
SKIN INTEGRITY. ALT. OF
INFECTION, POS. FOR

ASA: 1, (2), 3, 4, 5, E

PREOPERATIVE MEDICATIONS ORDERED

Anesthesia IV 98°

COUNSELING STATEMENT

Anesthesia alternatives, benefits and risks from minor to death explained. All questions answered.
Patient / legal guardian voices understanding and gives consent for :
Local / MAC, SAB, Epidural, IVR, General Anes.
Other: ____
Appropriate alternative as backup.
NPO status explained.

PATIENT'S SIGNATURE ____ DATE ____

EVALUATOR(S) SIGNATURE

CRNA ____ DATE ____

PHYSICIAN ____ DATE ____

POST ANESTHESIA VISITS

ANESTHESIA RECOVERY COMPLICATED BY THE FOLLOWING PROBLEMS: (IF NONE, SO STATE)

DATE: ____

SIGNED: ____ TIME: ____

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		(b)(6)-2 0920
1	OXYGEN: 3 litres via Mask /Prongs to maintain O2 Sats greater than 94%;		
	Wean to room air.		
2	IVF: LR @ 126 cc/hr, bolus 250 cc x 1		
3	MORPHINE: 2-4 mg IV q 5-10 minutes PRN pain. MAX dose of 10 mg		
4	DEMEROL: 12.6 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		
	(b)(6)-2		
	Cave, ANC		

PATIENT IDENTIFICATION (b)(6)-4

OD # (b)(6)-4

Complete the following information on page 1 only. Note any changes on subsequent pages.

Diagnosis: S/P [illegible] FX

Height: 57" Weight: 200# Diet:

Allergies: NKDA

Nursing Unit	Room No.	Bed No.	Page No.
ICU/ICW 2			

MEDCOM FORM 688-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE MC V1.00

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER 10 Apr 03 TIME OF ORDER 0654 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit Patient to ICU 3
2. Diagnosis: s/p GSW the (R) thigh, (L) back; s/p ex lap
3. Condition: Stable/Serious/Critical
4. Allergies: NKDA
5. Vital signs q hr/q2hr/q6hr/q8hr/q shift x 4 hrs, then q4°
6. Cardiac respiratory monitoring
7. Diet: NPO / regular/ soft/ clear liquid → advance to regular diet as tolerated

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

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~~ Foley to gravity

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

(b)(6)-2

13. PCXRAY q AM/QOD
14. IVF NS/ LR/ D5NS/ D51/2NS To run @ 125 cc/hr → HLIV to KVO
15. Ancef 1 GM IV Q 8 hrs * Ancef ↓ Avail CDC
16. Gentamycin IV Q
17. Cefoxitin 2gm IV q8hrs. Cef as replacement CDC
18. O2 titrate to keep SPO2 > 93%
19. Versed gtt 1-10mg/hr IV titrate to Ramsey Scale of

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)-4

(b)(3)-1

OD # (b)(6)-4

DATE OF ORDER TIME OF ORDER HOURS

20. Fentanyl gtt start at 50mcg/hr titrate for adequate pain control. MAX DOSE of
21. Vecuronium 1mcg/kg/min
22. MSO4 2-6 MG IV q ? HR PRN Pain
23. Phenergan 12.5-25mg IV q 4-6hrs PRN N/V
24. MOM 30cc PRN Gastric upset

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION				DATE OF ORDER (Cont)	TIME OF ORDER _____ HOURS	LIST TI ORDE NOTED 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	Percocet ♀ - ♂ PO q4-6° PRN pain		
			29	Motrin 800mg ♀ PO q8° PRN pain		
NURSING UNIT	ROOM NO.	BED NO.	30	Dressing Δs to Abd, back, + (L) thigh BID (wet - dry on abd only). Just Δd in EMT.		
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER (b)(6)-2	
			31	Toradol 30 mg IV X ♀ now	(b)(6)-2 MAJ, USA, MC DEPT OF OB/GYN	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER _____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION (b)(6)-4 (b)(3)-1 OD (b)(6)-4				DATE OF ORDER	TIME OF ORDER _____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

... 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.	BED NO.

DATE OF ORDER: 10 APR 03 — TIME OF ORDER: 1425 HOURS — LIST TIME ORDER NOTED AND SIGN

1. Admit ICW - Dr (b)(6)-2 / Gen Surg
2. S/P Enlap / Debridement
3. Stable
4. VS per routine
5. NPO
6. NR @ 125 cc/hr
7. Foley → gravity

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER — TIME OF ORDER — HOURS

8. ① Thigh film in EMP
9. WKDA
10. Bedrest ā HOB 30°
11. O_2 per FM/NC - titrate to keep sats ≥ 95%
12. MSO4 1-2 mg IV ē 1-5° PRN pain
13. Anecf ī gm IVPB ē 8° ~~[illegible]~~ [illegible]
14. Notify MD for T>101.5

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER — TIME OF ORDER — HOURS

P>120<60 SBP>180<110

NOP<350 cc/shift

(b)(6)-2 MD

MAJ, MC

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 4/10/03 — TIME OF ORDER: 1930 HOURS

traction by skin 2x3l bagging

(b)(6)-2 MAJ, MC

1. Regular Diet
2. NPO ā hs
3. Wet/Dry dressing Δ(abd) qd

12 APR 03 / 0450

(b)(6)-2

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

MEDCOM - 4075

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	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
13 APR 03	0640 Z HOURS	
(1) Resume previous orders		
(2) S/P I & D		
(3) Reg Diet		
	(b)(6)-2 MD	
	MAS, MC	

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
13 APR 03	1230 HOURS
Tylenol 650 g po q 4° prn	
	(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
14 APR 03	0445 Z HOURS
(1) Heparin 5000 u SQ BID	
	(b)(6)-2 MD
14 APR 03/0950	
Dulcolax Supp ÷ pt qd prn	
constipation	
	(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)-4

OD # (b)(6)-4

(b)(3)-1

DATE OF ORDER	TIME OF ORDER
14 APR 03	1000 HOURS
(1) Levaquin 500 g ÷ po qd	
(2) D/C Anal	
(3) D/C IV access	(b)(6)-2
(4) Vicodin ÷ - ÷ po q6° prn pain	

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

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

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MEDCOM - 4076

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.

PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4				15 Apr 03	1625 HOURS	

1. Transfer to ICU 1-T
2. Dx: (L) femur fx / ex lap
3. Condition: Stable
4. Activity: Bedrest ; HOB @ 30°
5. Diet: Regular
6. Allergies: NKDA
7. Vitals: Q shift ; pulse ox / neurovasc VS

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

8. Meds: Vicodin I-II PO Q4-6° PRN pain
   Levaquin 500mg PO QD
   Dulcolax supp I PR QD PRN constipation
   Heparin 5000u SQ Q12°
   Tylenol 650mg PO Q6° PRN
   MSO4 2mg IV Q2° PRN
9. IV: Ø

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

10. Nursing: wet → dry abd dressing Δ QD
    foley to gravity

(b)(6)-2

(b)(6)-2

PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	
(b)(6)-4 # (b)(6)-4 (b)(3)-1				16 Apr 03	Ø855. HOURS	

1. Traction to LLE as tolerated

(b)(6)-2

(b)(6)-2

(b)(6)-2

MAJ, MC
Internal Medicine

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 FORM NUMBER IN COLUMN INDICATED BY ↓ BELOW.

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
# (b)(6)-4		16Apr03 2100 HOURS Restoril 30mg QHS PRN for sleep V.O. Dr. (b)(6)-2 CPT (b)(6)-2 (b)(6)-2	(b)(6)-2
NURSING UNIT: ICU #1 ROOM NO.: T BED NO.: 3			

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
# (b)(6)-4		18 Apr 03 1830 HOURS 1) Colace 100 mg Po BID 2) Fleets enema x 1 tonight (b)(6)-2 MAJ, MC	(b)(6)-2 18 Apr 03 1830
NURSING UNIT: ICU #1 ROOM NO.: T BED NO.: 3			

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
# (b)(6)-4		19APR03 0840 HOURS 1) Tylenol c̄ Codeine (T3) 1-2 Q4-6° PRN pain. V/O Dr Mays / (b)(6)-2 (b)(6)-2 2) 30mg Lovenox SQ BID. V/O Dr (b)(6)-2 / (b)(6)-2 (b)(6)-2.	Noted 19APR03 0845 (b)(6)-2
NURSING UNIT: ICU #1 ROOM NO.: T BED NO.: 3			

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4 OD # (b)(6)-4 (b)(3)-1		20APR03 1800 HOURS 1) Dulcolax Supp 1 PR 2) Fleets enema x1 tonight if no results VO. Dr (b)(6)-2 / (b)(6)-2	
NURSING UNIT: ICU #1 ROOM NO.: T BED NO.: 3			

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

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the pr gency is OTSG

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

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT: ICU-1T | ROOM NO. | BED NO. 3

DATE OF ORDER: 22 Apr 03 | TIME OF ORDER: 0100 HOURS | LIST TIME ORDER NOTED A SIGN

Demerol 50-100mg IM x1 for severe pain.

V.O. Dr. (b)(6)-2 / CPT (b)(6)-2

noted (b)(6)-2 CPT, AN

4/22/03 @0103hrs

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 24 Apr 03 | TIME OF ORDER: 0300 HOURS

Demerol 50-100mg IM x1 for severe pain.

V.O. Dr. (b)(6)-2 CPT (b)(6)-2

noted (b)(6)-2 CPT AN

4/24/03 @ 0305 hrs

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 25 APR 03 | TIME OF ORDER: 0030 HOURS

(1) Demerol 50mg IM x1 for breakthrough pain

V.O. Dr (b)(6)-2 (b)(6)-2 CPT AN

Noted (b)(6)-2 CPT AN

4/25/03 @ 0038hrs

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

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

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

CLINICAL RECORD

...ERAPEUTIC 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. 4 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 10	11	12
	(b)(6)-2					
10Apr03		Vital signs q hr (q 2hr) q6h4 / q8hr /	07	(b)(6)-2		
		q shift then Q4°	19			
10Apr03		Cardiac Respiratory Monitoring	07			
			19			
10Apr03		Diet: NPO / Regular / Soft (Clear	07			
		Liquid) advance to Regular via TDL.	19			
10Apr03		Activity: Ad Lib / (Strict BR) BR with	07			
		BSC / NWB R or L LE (Adv. ad lib)	19			
10Apr03		HOB up 30 Degrees	07			
			19			
10Apr03		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~~			
10Apr03		O2 titrate SpO2 >93%	16	(b)(6)-2		
	.....		20			
	.....		24			
	.....	EKG q AM / QOD	06			
	.....	PCXRAY q AM / QOD	06			
10Apr	(b)(6)-2	Neuro checks q 1hr / 2 hr / 4 hr / 6 hr /	07	(b)(6)-2		
	.....	q shift	19			
	.....	Vascular checks nq 1hr / 2 hr / 4 hr /	07			
	.....	6 hr / q shift	19			
10Apr03	(b)(6)-2	Foley to Gravity	07/19	(b)(6)-2		
	.....		19/07			
	.....					

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: s/p GSW (L) thigh, (L) Back; s/p Exploratory Laparotomy.

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

PATIENT IDENTIFICATION:
(b)(6)-4 (b)(6)-4

ICU #3

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

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													
			Z	10													
10Apr03	(b)(6)-2	Dressings Δ to Abd, Back	04	SL													
	-----	and (R) thigh BID ~	12														
	-----	(wet → dry on Abd only!)	/														
	-----		/														

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
s/p GSW: (R) thigh, (L) Back; s/p Exploratory Lap.

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

PATIENT IDENTIFICATION:
#(b)(6)-4 (b)(6)-4

ICU #3

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 1 OCT 78 4677 EDITION OF 1 DEC 77 MAY BE USED.

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 10	11	12	13	14	15	16	17	18	19	20	21	22
10APR	(b)(6)-2	VS per Routine	D	/		(b)(6)-2										
~~10APR~~		c̄ pulsepox / neuro vasc ✓	N	(b)(6)-2												
10APR		NPO	D	/	(b)(6)-2											
			N	(b)(6)-2												
10APR		Foley to Gravity	D	/	(b)(6)-2											
			N	(b)(6)-2												
10APR		BR c̄ HOB 30°	D	/	(b)(6)-2											
			N	(b)(6)-2												
10APR		Notify MD for T>101.5	D	/	(b)(6)-2											
		P >120 <60 SBP>180	N	(b)(6)-2												
		<110 UOP < 250/shift														
10APR		Traction to	D	/	(b)(6)-2											
		Ⓛ Leg c̄ 2 x 3l	N	(b)(6)-2												
		saline bags														
12APR		Reg Diet	D	/	/	(b)(6)-2										
			N	/	/	(b)(6)-2										
12APR		Wet/Dry DSG Δ (ABD) QD	D	/	/	(b)(6)-2									(b)(6)-2	
15 APR		FOLEY TO GRAVITY	D	/	/	/	/	/	(b)(6)-2							
			N	/	/	/	/	/	(b)(6)-2							
16APR		Traction to ⓁLE as	07	/	/	/	/	/	/	(b)(6)-2						
		tolerated	19	/	/	/	/	/	/	(b)(6)-2						

DC'd 12 APR

DC'd 14 APR

D/C'd 4/12

D/C

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS:

GSW Ⓛ Back / Thigh Femur Fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

1/2 hop Cap 2 dependent

(b)(6)-4

DD# (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. — USAPA V1.00

MEDCOM - 4082

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo _____ Yr _____

Verify by Initialing: Order Date	Verify by Initialing: Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
10APR	(b)(6)-2	O thigh film in EMT	10APR	DONE		
15APR	(b)(6)-2	TRANSFER TO ICU 1-T	15APR	DONE		

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
4/14	(b)(6)-2	Vicodin T-II po prn pain	1750 (b)(6)-2	22a	0320 (b)(6)-2	640 (b)(6)-2										

USAPA V1.00

CLINICAL RECORD

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

Mo. Apr Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED /	22	23	24	25	26	27	28	29	30					
10 Apr 03	(b)(6)-2	VS QS c̄ Pulse Ox and	07	(b)(6)-2														
		neuro vascular ✓	19															
10 Apr 03		Bedrest c̄ HOB 30°	07															
			19															
10 Apr 03		Notify MD for T >101.5;	07															
		P >120, <60; SBP >180,	19															
		<110; UOP <250cc/shift																
12 Apr 03		Regular Diet	07															
			19															
12 Apr 03		Wet to Dry Dsg Δ (abd) QD	10															
16 Apr 03		Traction to LLE as	07															
		tolerated	19															

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: (D) femur fx: GSW (D) back/thigh

ADDITIONAL PAGES IN USE: ☐ YES ☒ NO

PAGE NO: 1

PATIENT IDENTIFICATION:

(b)(6)-4

(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

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.* 4 *Yr.* 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED													
				10	11												
10Apr03	(b)(6)-2 -----	IVF: LR @125ml/°	07/19	(b)(6)-2													
	-----		19/07														
	-----		/														
10Apr03	(b)(6)-2	Ancef 1gm IV Q8°	07	/													
	-----		15	(b)(6)-2													
	-----		23														

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
S/P GSW (L) thigh, (L) back
S/P exploratory lap

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

PATIENT IDENTIFICATION:
(b)(6)-4
(b)(6)-4

ICU #3

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. 4 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
10Apr03	(b)(6)-2	Toradol 30mg IV X 1 pain	10Apr03	ASAP	Z 0836	(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
10Apr03	(b)(6)-2	MSO4 2-6mg IV q 1hr														
		prn pain														
10Apr03	(b)(6)-2	Phenergan 12.5-25mg IV														
		q 4-6 hrs Per ~~Pain~~ cc N/V														
10Apr03	(b)(6)-2	MOM 30cc Per Gastric														
		Upset														
10Apr03	(b)(6)-2	Percocet 1-2 PO Q4-6°														
		prn Pain														
10Apr03	(b)(6)-2	Motrin 800mg 1 po q														
		8° prn pain														

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 10	11	12	13	14	15	16	17	18	19	20	21	22	23
10APR	(b)(6)-2	IVF LR @ 125cc/hr	D														
			N														
10APR		O_2 per Fm titrate	D														
		to Keep Sats ≥ 85%	N														
10APR		Ancef 1gm IVPB	06														
		q 8°	14														
			20														
14APR		Heparin 5000 u SQ BID	07														
			19														
14APR		Levaquin 500 po QD	07														
15APR		HEPARIN 5000 u SQ BID	10														
			22														
15APR		LEVAQUIN 500 mg PO QD	10														
18APR		COLACE 100mg PO BID	06														
			18														
19APR		Lovenox 30mg SQ BID	10														
~~18 Apr~~		~~Colace 100mg BID~~	22														
18 Apr		Colace 100mg BID	10														
			22														

D/Ced 4/14

D/C 4/16

D/C'd 14APR

RETURNED

RETURNED

D/C'd 18APR

Recopied 4/22/03 @ 0010hrs

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION: (b)(6)-4

OD (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.

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
18	(b)(6)-2	FLEETS ENEMA x T TONIGHT	18	2100	2100	(b)(6)-2
20		Fleets Enema x i tonight if no results.	20APR	2030	2030	

Order/Expir Date	Clerk/Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
10 APR	(b)(6)-2	MSO4 1-2 mg IV q 1-2° PRN pain	2mg 4/10; 4/10 2mg; 4/10; 4/10; 4/10; 4/10; 0500; 0610; 07; 08; 1200 2mg; 1300 2mg; 1610 4mg; 0345; 0455; 2mg 12APR; (b)(6)-2
	(b)(6)-2	MSO4 1-2 mg IV q 1-2° PRN pain	2mg 12APR 0900; 2mg 12APR 1230; 2mg 12APR 1415; 2mg 1730; 2mg 1950; 2mg 2310; 2mg 0114; 2mg 0214; 2mg 13APR 0830; 2mg 13APR 1300; 2mg 13APR 1645; 4mg 4/13 1655; 4mg 4/13 2295; 4mg 4/14 0330; (b)(6)-2
		MSO4 1-2 mg IV q 1-2° PRN Pain	2mg 0530 14APR; 2mg 0715 14APR; 2mg 0900 14APR; 2mg; 2mg 0720 16APR; 0620 2mg; 17 APR 1203 2mg; 17 APR 2mg; 4/18 2mg 0330; 18 Apr 1600 2mg; 18 Apr 2345 2mg; 19 APR 0815 2mg; 19 APR 1330 2mg; (b)(6)-2
14APR	(b)(6)-2	Dulcolax Sup i PR PRN QD constipation	14APR 1035; 20 APR 0830; (b)(6)-2
14 APR	(b)(6)-2	Vicodin i-ii po q4 prn pain	15Apr ii 2310; 16Apr ii 1400; 16APR ii 1500; 16APR ii 2110; 17APR ii 0500; 17Apr ii 1115; 17Apr ii 1600; 17APR ii 2200; 4/18 ii 0330; 18APR ii 0430; 18APR i 0235; (b)(6)-2
15APR	(b)(6)-2	Tylenol 650mg PO Q6° PRN	
16 Apr		Restoril 30mg Q hs prn for Sleep	16Apr 30mg 2130; 17Apr i 2130; 18Apr i 2110; 20Apr 0215; 21Apr 2115; (b)(6)-2
		Tylenol c codeine i-ii Q4-6hr PRN	19 apr03 0840; 19 apr03 1130; 19 Apr 2215 ii; 20 Apr 0215 ii; 20APR 1045 i; 20APR 2245; 20APR 1945 ii; 21Apr03 0230; 21APR 0745 ii; 21APR 1715 ii

CLINICAL RECORD

APEUTIC DOCUMENTATION E PL EDICATIONS)
For use of this form, see AR 40-40; the proponent agency is the Office of The Surgeon General.

Mo. Apr Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED													
			/	22	23	24	25	26	27	28	29	30					
15 Apr 03	(b)(6)-2	Levaquin 500mg PO QD	10	(b)(6)-2													
18 Apr 03		Colace 100mg PO BID	10														
			22														
19 Apr 03		Lovenox 30mg SQ BID	10														
	-----		22														

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: (L) femur fx., GSW (L) back/thigh

ADDITIONAL PAGES IN USE: ☐ YES ☒ NO

PAGE NO. 1

PATIENT IDENTIFICATION:

(b)(6)-4

#(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 - 4089

CLINICAL RECORD

APEUTIC DOCUMENTATION E PL. EDICATIONS)

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

Mo. Apr Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED													
			/	22	23	24	25	26	27	28	29	30					
15 Apr 03	(b)(6)-2	Levaquin 500mg PO QD	10	(b)(6)-2													
18 Apr 03		Colace 100mg PO BID	10														
			22														
19 Apr 03		Lovenox 30mg SQ BID	10														
	-----		22														

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: (L) femur fx, GSW (L) back 1st Hitz

ADDITIONAL PAGES IN USE: ☐ YES ☒ NO

PAGE NO. 1

PATIENT IDENTIFICATION:

(b)(6)-4

(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 MEDCOM - 4090 XHAUSTED.

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. Apr Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
22 Apr 03	(b)(6)-2	Demerol 50mg - 100mg IM x 1	22Apr03	0100	100mg given 0105	(b)(6)-2
		Demerol 50mg - 100mg IM x 1	24Apr03	0300	50mg given 0310	
24Apr	(b)(6)-2	Demerol 50 mg IM x 1	24Apr	0030	0030	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
10 Apr 03	(b)(6)-2	MS04 1-2mg IV Q1-2°														
		PRN for pain														
14 Apr 03		Dulcolax Suppository	24Apr 0945 1PR													
		T PR PRN QD for constipation	(b)(6)-2													
15 Apr 03		Tylenol 650mg PO Q6 PRN														
16 Apr 03		Restoril 15-30mg QHS	23Apr 2210 30mg	23Apr 2115 30mg	24Apr 2135 30mg	[illegible]										
		PRN for Sleep	(b)(6)-2													
16 Apr 03		Tylenol c̄ Codeine T-T̈	22Apr 0010 T-T̈	22Apr 0800	22Apr 1420	22Apr 2145 T-T̈	23Apr 0200 2tab	23Apr 0335 2tab	23Apr 1615 2tab	23Apr 2115 2tab	23Apr 0130 2tab	24Apr 2135	25Apr 0300 2tab	25Apr 0415 2tab	25Apr 1830	25Apr 2230
		tabs PO Q4-6° PRN					(b)(6)-2									
16 Apr		Tylenol c̄ Codeine T-T̈	24Apr 0400 2tab	26Apr 0800 2m												
		tabs PO Q4-6° PRN	(b)(6)-2	(b)(6)-2												

U.S. [illegible]NMENT PRINTING OFFICE: 1993 342-027/70450

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

(b)(6)-4

RECORD-SUPPLEMENTAL MI ATA

For use of ... AR 40-66; the proponent agency is the Office of the Surgeon General.

REPORT TITLE: ANESTHETIC RECORD — Preanesthesia Assessment, Time — Date — OTSG APPROVED (Date)

Drug Sensitivity: NKDA | Premed: Drug/Dose/Time, Effect: | Wt. 100 Kg. | Chart Reviewed | Pt ID'd | Plan Reviewed | Pt. Exam

Pre-induction Vital Signs, BP P RR O2 SAT: Procedure EXPLAP C (D) hip / Open wound exploration

24 HR. TIME: 1530 1700 1730 1800 TOTAL

Oxygen	L/MIN	3	3	3	3	3	3	3				
N. O/Air/He	L/MIN											
Sevoflurane/desflurane/forane	%	1.5	2.0	2.5	2.5	0.5	1.0	.75	0			
Midazolam	mg											
Sufentanil/Alfenanil/Fentanyl	ugm	50										
Propofol/Propofol	KETAMINE mg	100										
Succinylcholine	mg	100										
Vecuronium/Rocuronium/Mivacurium	mg	6	2	2	2							
ANCEF 2gm IVPB		1										
CEFOTIN 1gm												
NEOSYNEPHRINE												

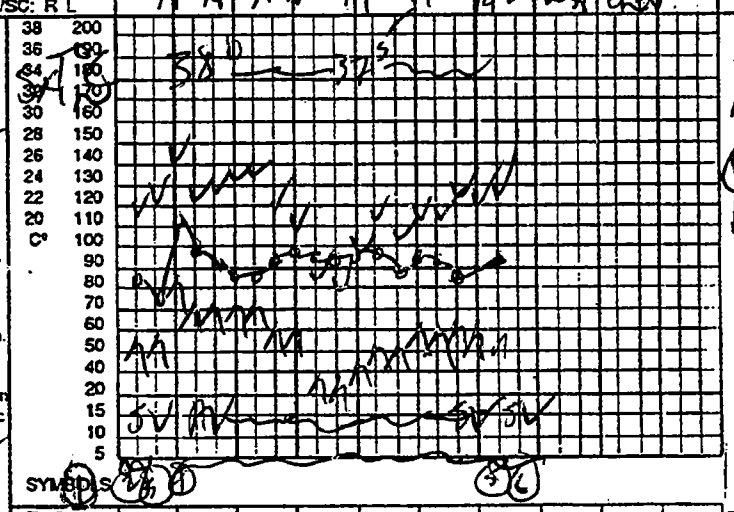
IV	Gage	Vga	Site
1	18		Hand/Arm: R L
2			IJ/EJ/SC: R L

Remarks:

Phys. Status: 1 2 3 4 5 6

(1) (E) EPW S/P GSW (2) TO OR. BRIEF HIP THUM INTERPRETER & AIRWAY EXAM.
(2) PLACE MONITORS / PREO2
(3) RSI C CCP GIVEN
(4) OCT ⇒ DECOMPENSATE
(5) SUCTION & EXTUBATE C DEPRESSIVE AIRWAY REFLEXES INTACT
(6) TO ICU/RECOVERY C NSBME P/N (L) NAVIS. REPORT GIVEN VSS.

1 MONITORS: ☐ ECG ☑ ETCO2 ☐ Precord. ☐ N. Stim. ☐ Esoph. ☑ Pulse Ox Loc: (L) ☐ BP Auto Loc: (R) ☐ Temp Loc.
2 INDUCTION: ☑ IV ☐ MASK ☐ IM ☐ Other ☐ Pre O2 ☐ Cric. Pres.
3 AIRWAY: ☐ Oral ☐ Nasal
4 INTUBATION: ☑ Oral ☐ Nasal ☐ Trach. ☐ Awake ☐ Fiberoptic ☐ Easy ☑ Difficult
Tube Size: 8.0 mm Depth 23 cm ☐ Cuff 10 cc ☑ CO2 ☐ Stylet BS ☑ R ☑ L
5 MAINTENANCE: ☐ Semi Clos. ☐ TIVA ☑ Semi Open ☐ IM ☐ Regional ☐ MAC ☐ Insufflation
6 MISCELLANEOUS: ☐ Bl Warmer ☐ Humidf. ☐ OG Tube ☐ Blanket ☐ NG Tube ☑ R ☑ L Eye Oint./Taped ☐ Egg Crate Mat. ☐ Fx Table ☐ Arms:Padded/Armboard
Procedure location
Machine/Circuit Check



TV/Pres							
ECG	SR	SR	SR	SR	SR	SR	SR
FiO2	2.0	1.0	1.0	.65	.50	.50	.50
SaO2/SvO2	95	100	100	98	95	99	99
ETCO2		35	35	35	35	35	
PAP							
Blood Loss							
Urine							
Tourniquet							

Total EBL: 100
Total Urine: 1250
Fluids Summary
Crystalloid 2000
Colloid
Blood

SYMBOLS: Supine, Prone, Lithotomy, Sitting, Jackknife, (R)(L) Lat Decubitus; BP Cuff, Intra-art, Mean, Pulse, Temp; Start Anesthesia, Intubation, Start Op, Extubation, End Anesth., RESPIR Spon, Asst, Cont

REVERSAL: 1810 Time
Naloxone ugm
Edrophonium/Neostigmine 0.5 mg
Atropine/Glycopyrrolate 0.8 mg
N. Stim. Response % TOF
☐ Sust .TET.

PACU/CCU/ICU Time In:
☐ Guarded ☑ Satisfactory
☐ Unresp. ☑ Awake
☐ ETT ☐ NC/AFM/T.Piece
☐ Ventilator: ☐ @ L/m O2
Mode: TV: R: FiO2 PEEP
BP: P: R: % SAT:

Anes Start 1715
In Room 1715
Out Room 1715
Anes End 1903
TOTS 1725
Surg Start 1735
Surg End 1945

(b)(6)-4

(b)(6)-2 (Title) CPT, CRNA STAFF — DEP (b)(6)-2 — CLINIC — DATE 9 APR 03

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

EPW (b)(6)-4 C (b)(6)-4

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

DA FORM 4700, MAY 78 — MED FC OP 562 (Rev)1 MAR 2002 — USAPPC

MEDCOM - 4092

MEDICAL RECORD - SUPLEMENTAL MEDICAL DATA [redacted]

r use of this form, see AR 40-66; nt agency is the Office of the Surgeon G

EPORT TITLE: TRAUMA FLOWSHEET

OTSG APROVED (Date)

INITIAL ASSESSMENT ☐ IMMEDIATE ☐ DELAYED ☐ MINIMAL

Date: 10APR03 Arrival Time: 1400 Sex: (M) F Age: _____ Wt: _____

Allergies: _____ Tetanus Status: UTD (Unknown)

LMP: Last Meal:

Chief Complaint:

PMH: Medications:

Treatments PTA:

VITAL SIGNS: BP: 112 P: 101 RR: 32 TEMP: SAO2: 94

CHEST
TRAUMA ☐ YES ☐ NO
PAIN ☐ YES ☐ NO
SOB ☐ YES ☐ NO
LUNG 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

GLASGOW COMA SCALE

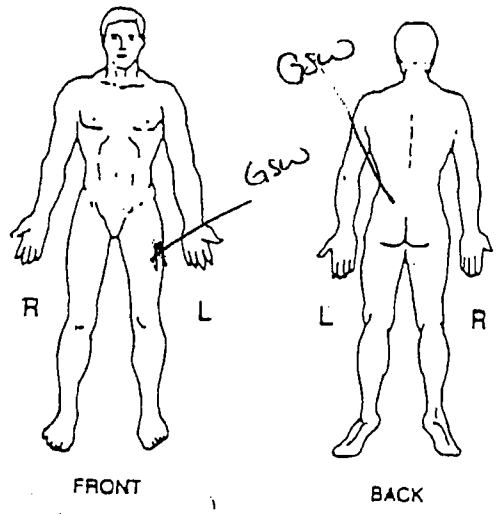
1. EYE OPENING		2. VERBAL RESPONSE		3. MOTOR RESPONSE	
Spontaneous	4	Oriented	5	Obedient	6
To Voice	3	Confused	4	Purposeful	5
To Pain	2	Inappropriate	3	Withdrawal	4
None	1	Incomprehensible	2	Flexion	3
		None	1	Extension	2
				None	1

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

EXCEPTIONS TO ABOVE PARAMETERS:

SPLINTS:

TREATMENTS:
2: LPM NC MASK ORAL AIRWAY
ETT # MM NASAL AIRWAY
MONITOR ☐ Y ☐ N EKG ☐ Y ☐ N
NG TUBE #
FOLEY: # DPL ☐ POS ☐ NEG
CHEST TUBE ☐ R ☐ L CM H20



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

(Continue on reverse)

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

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

(b)(6)-4

(b)(6)-4

OD

(b)(3)-1

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

DA FORM 4700, MAY 78

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 #(b)(6)-4

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
GSW back/thigh. +intraabd. injury SP ex lap (L) suprarenal fem fx

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)*
Levaquin 500 PO DD
Lovenox 80mg SQ BID ~~heparin~~ 5000u.
Traction to LLE
Foley
Reg diet

SIGNATURE OF MEDICAL OFFICER SIGNATURE DU MÉDECIN	DATE DATE

REGULAR DIET RÉGIME NORMAL	SPECIAL DIET *(Describe)* 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

EMBARKATION TAB – FICHE D'EMBARQUEMENT

1. NAME (Last, First, Middle Initial) (b)(6)-4	# (b)(6)-4 N	3a. STATUS EPW	3b. SER...	4. PRECEDENCE U P R X	5. GRADE
6. AGE	7. SEX X MALE / FEMALE	8. WEIGHT 100kg	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F)-- AMBUL / LITTER	11. ACCEPTING MD
12. CITE/AUTH # 2001968					
13. APPT/SURG DATE	14a. ORIGINATING FACILITY (b)(3)-1	15a. DESTINATION FACILITY		16. # OF ATTENDANTS 16a. MED	16b. NON-MED
	14b. ORIGINATING FACILITY PHONE NUMBER 558-4987	15B. DESTINATION FACILITY PHONE NUMBER		(b)(6)-2	(b)(6)-2

17. DIAGNOSIS

S/P GSW to (L) thigh, (L) back S/P EX lap
C retroperitoneal hematoma

18. X BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

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

	YES	NO	ISSUE		YES	NO	
a.		X	Hypertension	i.		X	Bowel Problem
b.			Cardiac Hx	j.			Self-care
c.			Diabetes	k.			Ambulatory
d.			Respiratory	l.			Ambulatory Aid
e.			Ears/Sinus	m.		✓	Self-meds
f.			Motion Sick	n.	X		Adequate Supply of Meds
g.			Vision Impaired	o.			Other:
h.		✓	Voiding Prob.				

20. PHYSICIANS ORDERS

20a. DATE	20b. TIME	20c. ALLERGIES
10 April 03	0710 (Z)	NKDA

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

RENAL ___ Gm Prot ___ Gm Na ___ MagK ___ 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 → Heplock

20f. SPECIAL EQUIPMENT

	SUCTION		TRACTION	FOLEY CATH
	NG TUBE		IV PUMP	ORTHO BRACES
	STRYKER		TRACH	CHEST/HEIMLICH
	INCUBATOR		MONITOR	RESTRAINTS
				OTHER (*USE 23*)

OXYGEN: ___ PERCENT or ___ LITERS | ROUTE: ___
VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No ___ feet

20h. RECORDS TO ACCOMPANY PATIENT

✓	OUTPATIENT RECORDS		XRAYS	OTHER:
✓	INPATIENT RECORDS		OB	
	NARRATIVE SUMMARY		DENTAL	
	FINANCIAL			

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE

20i. MEDICATIONS / TREATMENTS

Ancef ÷ gm IV 48°
Percocet ÷ PO q4-6 PRN pain
Nap Motrin 800mg ÷ PO q8° PRN pain

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

24. STAMP AND SIGNA... (b)(6)-2 (b)(6)-2 MD
MAJ, USA, MC
DEPT OF OB/GYN

AF Form 3899 (433 AES...

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

OD ZA (b)(6)-4

(b)(6)-4

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF: 1 2 3 4 5 6 (b)(3)-1
... LOCATION: 7 8 IG (State or Country Code.)

3. REGISTER NUMBER: 9 10 11 12 13 14 15 (b)(6)-4

NAME (Last, First, Middle Initial): OD# (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 — 1 9 7 1 0 1 0 1

7. AGE AT ADMISSION: 27 28 29 — 3 2 7

8. RACE: 30

9. ETHNIC BACK-GROUND: 31

RELIGION

10. LENGTH OF SERVICE: 32 33 34

ETS

11. FMP: 35 36 — ~~9 9~~ 20

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: 2100

BRANCH / CORPS

14. FLYING STATUS: 47 48 49

15. BENEFICIARY CATEGORY: 50 51 52 — K 7 8

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 INJ

PREV. ADMISSION: YEAR ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 72 D

WARD: ICU1

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: 86TH CSH LSA ADDER, IRAQ

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION: 73 74 — D/C: Trans

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

23. DATE OF DISPOSITION (Y Y Y Y M M D D): 81 82 83 84 85 86 87 88 — 2 0 0 3 0 4 2 6

24. CLINIC SVC - ADMITTING: 89 90 91 92 — A B A A

25. MTF TRANSFERRED FROM: 93 94 95 96 97 98

26. DATE THIS ADMISSION (Y Y Y Y M M D D): 99 100 101 102 103 104 105 106 — 2 0 0 3 0 4 ~~0 5~~ 10

27. LOCATION OF OCCURRENCE (Battle Casualty Only): 107 108

28. MTF OF INITIAL ADMISSION: 109 110 111 112 113 114

29. DATE INITIAL ADMISSION (Y Y Y Y M M D D): 115 116 117 118 119 120 121 122

FOR LOCAL USE

GSW L Thigh, L Back
~~890.0~~ ~~876.0~~

DX: 8761
8901
86804
82032
56400
E9659
Px: 5411
8622

Trauma
1

Injury
450

ADMITTING OFFICER (Signature, as required): (b)(6)-2 M. D.

SIGNATURE OF ADMITTING CLERK: (b)(6)-2

DA FORM 2985, MAR 2000 — EDITION OF MAR 89 IS OBSOLETE — USAPA V1.00

MEDCOM - 4096

PATIENT TREATMENT RECORD CO SHEET

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

(b)(6)-4

1. REGISTER NUMBER (b)(6)-4					3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE	6. RACE Black	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
11. FMP 99	(b)(6)-4		13. ORGANIZATION			14. WARD 8
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE IN

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct	22. HOURS OF ADMISSION: 1245	23. CLINIC SERVICE: ABAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION: Home	26. DATE OF DISPOSITION: 16 apr 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION: 7 apr 03	ADMITTING OFFICER
29. NA (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

R BKA

897

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
	9			9	9

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

(b)(6)-2

EDITION OF

USAPPC V1.10

INPATIENT TREATMENT RECORD CONTINUATION SHEET

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

1. REGISTER NUMBER (b)(6)-4			(b)(6)-4			3. GRADE CIV	ADMISSION REMARKS
4. SEX M	5. AGE	6. RACE Hispanic	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION	
11. FMP		12. SSN (b)(6)-4		13. ORGANIZATION		14. WARD 8	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN		18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE Ins	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct				22. HOURS OF ADMISSION 1245	23. CLINIC SERVICE ABAA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE				25. TYPE DISPOSITION Home	26. DATE OF DISPOSITION 16 apr 03		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)				27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION 7 apr 03		ADMITTING OFFICER
29. (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

R BKA

~~897~~

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
				9	9

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

(b)(6)-2

EDITION OF 1

USAPPC V1.10

NSN 7540-00-634-4178 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
9 Apr 03	S/O - Iraqi EPW evacuated in s/p (R) BKA
BP: 115/53	Dress in place
P: 130	Airway patent
T: —	Lungs CTA (B)
R: 24	Distal pulses nml, cap re-fill < 2 sec.
O_2 Sat - 99%	Imp: s/p BKA - stable
ALLERGIES:	Plan: (1) Admit: pt hold
	(2) Dx: (R) BKA
	(3) Cond: stable
MEDS:	(4) V/S: Q shift
	(5) All: unknown.
	(6) IV NS @ 200 cc/hr
MHx:	(7) Ancef 1gm Q 12 hrs.
	(8) Tornadol 30mg IV Q 4-6 hr pm pain
	(9) Foley Catheter
SHx:	(10) Rg diet
	(12) Activity BR
	(b)(6)-2
	CPT, RMPA-C
TOB:	
LMP:	

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

(b)(6)-4

RECORDS MAINTAINED AT:

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

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

MEDCOM - 4099

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11 APR 05	Ortho Op Note OR.
2056 Z	Dx: infected (R) BKA stump
[redacted]	procedure (R) BKA stump I&D,
	surgeon: Dr. [redacted], ortho
	anesthesia: MAJ [redacted], CRNA ([redacted])
	findings: purulence (R) BKA stump, tight
	sutures in layers - removed.
	necrotic fascia, fat and muscle removal.
	stump cleaned open c̄ moist flyers and
	retention sutures (proline).
	post-op plan: - IV antibx
	- repeat debridement in 48hrs
	- keep stump open 2° infection
	[redacted] M.D.
	TC, MC, USA ORTHOPAEDIC SURGERY
13 APRIL 05	Op Note
1205 (Z)	Pre-op: infected (R) BKA stump
	procedure: repeat I&D (R) BKA stump
	surgeon: Dr. [redacted], ortho
	anesthesia: MAJ [redacted], (General)
	finding: less purulence and necrotic burden.
	small pocket that tracked proximally on ant. tib.
	surface.
	post-op: IV antibx - ancef p Gent.
	- repeat debridement in 48hrs. [redacted]
	- ask-ever to use for further care M.D.
	TC, MC, USA ORTHOPAEDIC SURGERY

*U.S. Government Printing Office: 1995 - 404-763/20

STANDARD FORM 600 BACK (REV. 5-84)

MEDCOM - 4100

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
11 APR 03	1200z		T: 97.2 BP: 147/77 HR: 130 RR: 27 SAT O2: 95
			PT A+O X3 AND COOPERTIVE HEART SOUNDS STRONG
			LUNGS CLEAR IV IN (R) AC PATENT FOLEY IN
			NO SIGNS OF IRRITATION DRAINING AUBURN CLEAR
			URINE, BKA SLIGHT DRAINAGE. (b)(6)-2
11 APR 03	1220z		5 mg MSO4 GIVEN FOR PAIN (b)(6)-2
11 APR 03	1220z		2 gm CEFOXITIN IV GIVEN AS ORDERED (b)(6)-2
11 APR 03	1240z		0.5 ml TETANUS GIVEN IM (L) ARM AS ORDERED (b)(6)-2
11 APR 03	1240z		5000 u HEPARIN GIVEN SC RL QUAD (b)(6)-2
11 APR 03	1350z		PT OUTPUT 825 cc URINE CLEAR AND AUBURN
11 Apr 03	1500z		3 mg MSO4 for stump pain - IV. (b)(6)-2
11 APR 03	1730z		5 mg MSO4 FOR stump pain - IV (b)(6)-2
11 APR 03	2100z		PT. RETURNED FROM OR @ 2100z
	2100z		VS/ BP: 143/74 P: 125 R: 36 T: 102.7°F
			HEART SOUND STRONG, S1+S2 PRESENT LUNG SOUNDS
			CLEAR AND RISE AND FALL IS BILATERAL BS (+) X4
			LARGE BULKY DRESSING DRY + INTACT ON BKA
	2115z		VS/ BP: 148/75 P: 136 R: 36 SAO2: 94 (b)(6)-2
	2130z		VS/ BP 149/75 P/136 R: 35 SAO2: 98 (b)(6)-2
	2145z		VS/ BP 157/77 P: 130 R: 30 SAT O2: 94 (b)(6)-2
			5 mg MSO4 GIVEN @ 2150z FOR PAIN (b)(6)-2
	2200z		VS/ BP: 134/79 P: 135 R: 34 SAT O2: 99
	2230		VS/ BP: 132/79 P: 133 R: 32 SAT O2: 96

(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.

(b)(6)-4

NURSING NOTES

Medical Record

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

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
12APR 0215			Pt awake, alert + oriented in Ø acute distress and
			Responds appropriately and follows commands.
			Upper breath sounds clear + ↓ (B) in bases. Bowel
			sounds present x4. Dressing to (R) BKA clean, dry
			+ intact. Medicated ≈ MSO4 for c/o pain. T-102
			BP-136/83 P-124 R-28 SAO2 90% on R/A. Placed
			on 2l O2/NC and medicated ≈ tylenol for fever.
			[redacted]
1130	IN 500IV 600PO 1100 in 750 out		T-101.4 R-28 BP-132/68 P-120 SAO2 96% on R/A
1230			3mg MSO4 IV GIVEN FOR STUMP PAIN [redacted]
12APR03			PT. A+Ox3 HEART SOUNDS S1 + S2 PRESENT
			BS(R)x4 BULKY DRESSING (R) BKA CLEAN + INTACT.
			IV IN (L) AC CLEAR + PATENT
1400			GAVE 2 TAB PERCOCETS FOR PAIN [redacted]
1600	IN 1000 cc OUT 1900cc		VS/ BP: 130/60 P: 124 R: 26 T: 101 SAO2: 97% RA
			Clear yellow URINE [redacted]
11APR03			GAVE 5mg MSO4 FOR PAIN @ 1900
1950			GIVEN TWO TABS PERCOCET FOR PAIN [redacted]
2230			GIVEN 5 mg MSO4 FOR STUMP PAIN [redacted]
0200			BP-117/65 P-111 R-26 T-99.0 Medicated ≈ Percocet II
			for c/o pain. Pt awake, alert + oriented & responds appropriately.
			Medicated ≈ percocet II for c/o pain. Lungs clear but
			↓ in bases. Dressing to (R) BKA intact ≈ moderate
0830 1850 cc OUT			cut serous drainage. In Ø acute distress. [redacted]
14APR03	1000		RESP 24, Pulse 123, SpO2 92%, TEMP 101.0 B/P 135/81 [redacted]

*U.S. Government Printing Office: 1995 - 404-763/20065

STANDARD FORM 510 (REV. 7-91) BACK

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
13 Apr 03	1745		5mg MSO4 IV for c/o pain — [redacted] CPT
	2010		c/o pain ¼ po percocet given [redacted] CPT
14 APR 03	0400		BP - 146/60 P-124 R-24 T-100.2 Pt awake, alert, +
			oriented. c/o moderate to severe pain @ (R) BKA.
			Pt. stable in ∅ acute distress. Dressing to (R)
			stump clean, dry + intact. — [redacted] 45 ✓

*U.S. Government Printing Office: 1995 - 404-763/20065

[redacted]

STANDARD FORM 510 (REV. 7-91) BACK

MEDCOM - 4103

MEDICAL RECORD	PROGRESS NOTES
14 Apr 0930Z	pt received via stretcher - assessment completed - dressing CDI - pt given Tylenol 1000mg for pain [redacted]
1800/1400Z	Vicodin ½ tab given [redacted]
1400	1500cc urine output [redacted]
14 Apr 03 1519Z	T99°. Will Monitor [redacted]
14 APR 03 1930/1530Z	New IV start 16 guage in (R) Forearm Normal Saline hung KVO. Ancef 1 gram given IVP [redacted]
1720Z 14 Apr 03	BP 120/64 T 98.9 P 120 R 22 [redacted] SGT 91W 20mb
14 Apr 03 1750Z/2100	Pt has IV to RFA @ 60cc/hr Pt stump has foulodor drsg CDI. Pt unable to lift stump (R) leg is edematous. Foley to gravity c̄ dark yellow urine. [redacted] 2 LT A
14 Apr 03 2100/1700Z	350 mg Gentimicin IV [redacted] 5,000 u heparin SQ to abd [redacted] 2 LT A
14 Apr 03 1900Z/2200	~~87~~ 575 urine out [redacted] 2 LT A
14 APR 03 1900Z	ANCEF 1gm given [redacted] 91W
15 Apr 03 0555/1025Z	1gm Ancef IVP [redacted] 2 LT A
15 Apr 03 0300Z/0600	380cc out dark yellow urine [redacted] 2 LT A
0855/0455	BP 130/60 - HR 100 - 28 - T 99.6°
15 APR 03 0630Z	¶ T3 given for c/o pain. [redacted] 102 AM
15 Apr 1350	Tylenol 1000mg given [redacted]
15 APR 03 1734	¶ T3 for c/o pain. [redacted] AM

(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.

(b)(6)-4 [redacted]

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR(41CFR)201-45.505
509-111

PROGRESS NOTES

DATE	
15Apr 1845	Vicodin & [illegible] [redacted]
15Apr03 ~~17:17~~ 2000 hrs	140T78 P 104 R 16 T 98.7 Pt laying in bed c̄ eyes closed Drsg to (R) stump CDI pt leg is swollen Pt 3 c/o pain [redacted] 2 CTAN
15Apr03 2112 hrs	¶ MOTRIN 800 mg PO for pain [redacted] 2 CTAN
15Apr03 0001	pt c/o pain given 800 mg motrin — Spc [redacted] 9W
16Apr03 0211	¶ Vicodin PO for pain [redacted] 2 CTAN
16Apr03 0241	50 mg Demerol, 12.5 mg Phenergan IM to (R) Bertox [redacted] 2 CTAN
16Apr03 0600	¶ Vicodin PO for pain [redacted] 2 CTAN
0715	BP 132/68 - HR 88 - RR 16 T - 97.3
	pt assessment completed - dressing CDI [redacted]
	pt wants to leave AMA - complication identified and explained through an interpreter - MD notified [redacted]
4/16/03 0930	Patient requests to be released AMA, Patient counseled c̄ assistance of Arabic-speaking interpreter that failure to receive proper medical care could result in life-threatening infection that could cause death OR, at the very least, loss of function of the limb causing failure to fit for prosthesis. Patient voiced understanding of the risks at requests to be released. Transportation arranged through civil affairs for movement to a local hospital. [redacted]

[redacted]

☆U.S. GPO: 1995-397-405

STANDARD FORM 509 BACK (Rev. 11-77)

[redacted]

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Patient)*	LOG NUMBER	TREATMENT FACILITY (b)(3)-1
		RECORDS MAINTAINED AT	

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

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

TRANSPORTATION TO FACILITY: (b)(3)-1

SEX	DUTY/LOCAL PHONE	
M	AREA CODE	NUMBER
AGE	HOME PHONE	
27	AREA CODE	NUMBER

MILITARY STATUS

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

THIRD PARTY INSURANCE

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

CURRENT MEDICATIONS: Ø O/W Healthy

ALLERGIES: NKDA

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: S/P (R) BKA

CATEGORY OF TREATMENT

☐ EMERGENT
☒ URGENT
☐ NON-URGENT

TIME

INITIALS

VITAL SIGNS

TIME	10:15				
BP	147/90				
PULSE	127				
RESP	18				
TEMP	100.4				
WT	95% mAA				

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
	Dnc 1gm IV non	DNW	10:30		
	CBC	DNW			

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 ☐ DETERIORATED ☒ UNCHANGED

ADMIT TO UNIT/SERVICE: ICU #3

TIME OF RELEASE: 10:24

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

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

NSN 7540-01-075-3796

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

TEST RESULTS

CBC	WBC	SMAC		ABG/PULSE OX			RADIOLOGY — Check if read by radiologist ☐
	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

17 y o suffered traumatic amputation of (L) thigh

(b)(6)-2

PMHx
No previous hospitalization
NKDA
No med

PE
SHEENT
Heart RRR
Lung clear
Abd soft

(L) Lower extremity traumatic amputation

A/P LLE traumatic amputation
To OR for exp

CONSULT WITH	TIME	ACTION

RESIDENT/M (b)(6)-2

PROVIDER SIGNATURE AND STAMP

DIAGNOSIS

CODES

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

(b)(6)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA litter BY anesthesia

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

3. DATE 11 Apr 03 TIME PATIENT ARRIVED IN SUITE 1912

4. PATIENT IN ROOM TIME 1912 NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

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:

8. SKIN PREPARATION

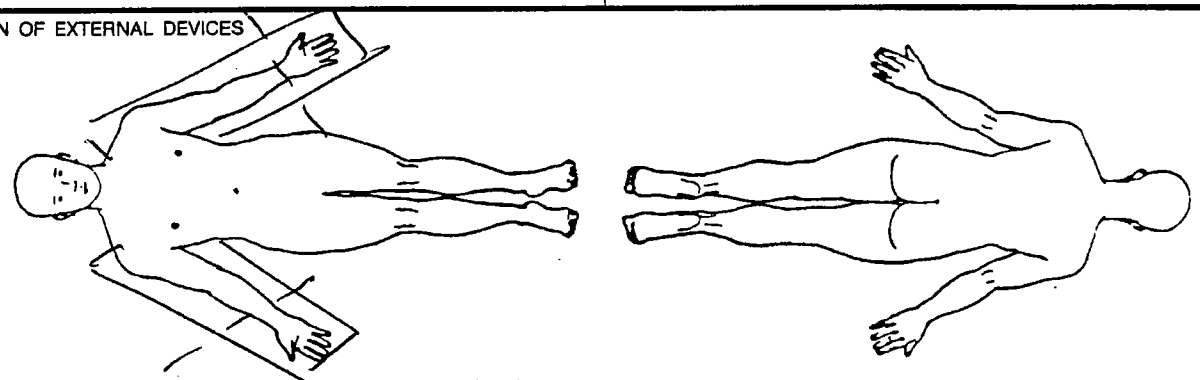
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* betadine betadine
SITE: right BKA BY WHOM: Cpt (b)(6)-2
SITE: BY WHOM:

COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes ☒ No					
Needle Sharp	☐ Yes ☒ No					
Instrument	☐ Yes ☒ No					
Other	☐ Yes ☒ No					

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

(b)(6)-4

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

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

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

☐ BIPOLAR NO: _____

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

NACL

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM IF YES, SITE

YES ☐ NO ☒

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*

Kerlix ABD
Fluffs
Ace

19. ADDITIONAL INFORMATION

20. OPERATION(S) PERFORMED

I & D Right BKA

21. PATIENT TRANSFERRED TO: ICU 3 TIME: 2050 METHOD: litter

22. REGISTERED NURSE SIGNATURE

(b)(6)-2

REVERSE OF [illegible]

*U.S. Government Printing Office: 1995 — 388-733/23952

MEDICAL RECORD | LRMC INTR[illegible]ATIV[illegible] DOCUMENT

For use of this form, see AR 40-4[illegible] [illegible]roponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Letter BY MAJ [redacted] (b)(6)-2	2. PATIEN[illegible] VERIFIED B[illegible] [redacted] (b)(6)-2 PROCEDURE CPT AN
3. DATE 13 Apr 03 TIME PATIENT ARRIVED IN SUITE 1050 Z	4. PATIEN[illegible] TIME 1050 Z NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL [ ] YES [X] NO

DONE BY: [ ] OR [ ] NURSING UNIT

METHOD: [ ] DEPILATORY [ ] RAZOR [ ] CLIP

COMMENTS:

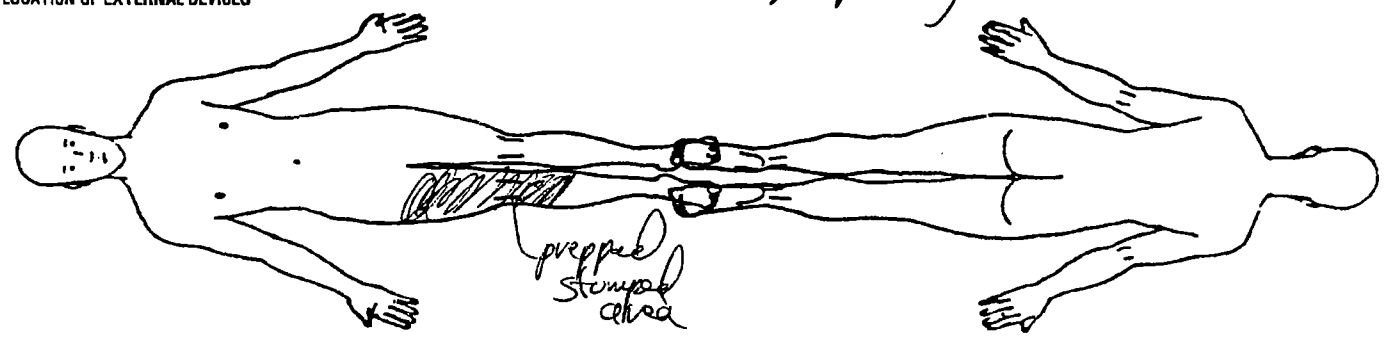
PREP SOLUTION *(Specify)* Beta/Beta

SITE: Right leg Stump BY WHOM: CPT [redacted] (b)(6)-2

SITE: BY WHOM:

COMMENTS: Ø pooling noted

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

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

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

[redacted] (b)(6)-4

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

[ ] ESU NO:

GROUND PAD: BRAND

LOT NO:

[ ] ESU NO:

GROUND PAD: BRAND

LOT NO:

[ ] BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES D MEDCOM - 4110 TE. MCEUL OP 358, 2 Mar 00 MRRC apprvl - 3 Feb 00 USAPA V1.00

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S): .9 NACL

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

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

19. ADDITIONAL INFORMATION
The medical record (SF 539), the progress note (SF 509), the operative consent (SF 522), and the patient agree that the correct operative site is the _____ side.

Verified by: N/A
Patient/guardian _____ Surgeon _____ Anesthesia _____ Operating Room Nurse _____

20. OPERATION(S) PERFORMED
I&D Left leg stump

21. PATIENT TRANSFERRED TO ICU3 TIME see ones record METHOD Litter

(b)(6)-2 CPTA

REVERSE OF DA FORM 5273-1, OCT 87

M[illegible]L OP 358, 2 Mar 00
M[illegible] apprvl - 3 Feb 00

USAPA V1.00

MEDCOM - 4111

TEST(S)

SPECIMEN TAKEN

DATE	TIME	A.M. / P.M.
13APR03	0200	

RESULTS	REQUESTED	(X)
3.06↓	RBC COUNT	
7.6↓	HEMOGLOBIN	
25.6↓	HEMATOCRIT	
83.4	MCV	
24.7↓	MCH	
29.6↓	MCHC	
27.0↑	WBC COUNT	
	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
	NEUTRO-BANDS	
	NEUTROSEGS	
26.0%	LYMPHS	
	EOSINOPHILS	
	BASOPHILS	
	MONOCYTES	
	PLATELETS	
	RBC	
	SED. RATE	
610↑	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PTT: CONTROL	
	PTT: PATIENT	
	PROTIME: CONTROL	
	PROTIME: PATIENT	
	PROTIME: % ACTIVITY	
	PROTIME: RATIO	
	SICKLING TEST	
	LE PREP	
7.0	Lymph #	

CBC

REMARKS

(b)(6)-2

Enter in above space

REQUESTING PHYSICIAN'S SIGNATURE

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

(b)(6)-4

ICU #3

REPORTED BY

(b)(6)-2

MD

TECH

DATE

13APR03

LAB. ID. NO.

HEMATOLOGY

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

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

SPECIMEN SOURCE: ☐ VEIN ☐ CAP ☐ OTHER (Specify)

PATIENTS MED. RECORD

HEMATOLOGY

STANDARD FORM 549 (Rev. 7-78)

Prescribed by GSA/ICMR

FIRMR (41-CFR) 201-45.505

549-107

TEST(S)

SPECIMEN TAKEN

DATE	TIME	A.M. / P.M.

REQUESTED

CBC

RESULTS

WBC 19.8

RBC 3.35

Hgb 8.2

HCT 27.5

MCV 82.3

MCH 24.6

MCHC 29.8

PLt 691.

% Lym

REMARKS

Dr.

(b)(6)-2

Enter in above space

REQUESTING PHYSICIAN'S SIGNATURE

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

(b)(6)-4

(b)(6)-2

DATE

LAB ID NO.

MISC

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

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

SPECIMEN SOURCE (Specify)

SPECIMEN/LAB RPT. NO.

PATIENT'S MED. RECORD

MISCELLANEOUS

STANDARD FORM 557 (Rev 3-77)

General Services Administration and Interagency Committee on Medical Records FPMR 101-11 806-8

557-106

(b)(6)-4

NAME: (b)(6)-4 SURGEON: Planned Surgery Date: 11 APR 03

ANESTHESIA PREOPERATIVE EVALUATION

AGE 27 (M) HEIGHT WEIGHT 80 kg

PROPOSED OPERATION: Washout (R) stump

PREOPERATIVE VITAL SIGNS: B /P P R

PREVIOUS ANESTHESIA / OPERATIONS: ☐ NEGATIVE
amputation (R) leg

CURRENT MEDICATIONS: ☒ NONE

FAMILY HISTORY OF ANESTHESIA COMPLICATIONS: ☒ NEGATIVE

ALLERGIES: ☒ NKDA

AIRWAY / TEETH / HEAD & NECK
class 2 FROM 3FB

SYSTEM	WN	COMMENTS	PERTINENT STUDY RESULTS
RESPIRATORY Asthma, Bronchitis, COPD Dyspnea, Pneumonia, Productive Cough Recent cold, SOB, Tuberculosis	☒	Tobacco Use: ☐ No ☐ Yes ____ Pack/Day for ____ Years	Chest X-ray, Pulmonary Studies
CARDIOVASCULAR Angina, Arrhythmia, CHF Exercise Tolerance, Hypertension, MI Murmur, MVP, Pacemaker Rheumatic fever	☒		EKG
HEPATO/GASTROINTESTINAL Bowel obstruction, Cirrhosis, Hepatitis Hiatal Hernia, Jaundice, N&V Reflux/Heartburn, Ulcers	☒	Ethanol Use : ☐ No ☐ Yes Frequency _____	LFTs
NEURO/MUSCULOSKELETAL Arthritis, Back problems, CVA/Stroke DJD, Headaches, Loss of consciousness Neuromuscular disease, Paralysis, Paresthesia Syncope, Seizures, TIAs Weakness	☒		
RENAL/ENDOCRINE Diabetes, Renal failure/Dialysis, Thyroid disease Urinary retention, Urinary tract infection, Weight loss/gain	☒		Urinalysis, Thyroid, FBS
OTHER Anemia, Bleeding tendancies, Hemophilia Pregnancy, Sickle cell trait, Transfusion history			Hgb / Hct / CBC, Lytes

PROBLEM LIST / DIAGNOSES
Healthy 27 yo ♂

ASA: (1) 2 3 4 5 (E)

PREOPERATIVE MEDICATIONS ORDERED

COUNSELING STATEMENT

Anesthesia alternatives, benefits and risks from minor to death explained. All questions answered.
Patient / legal guardian voices understanding and gives consent for :
Local / MAC, SAB, Epidural, IVR, (General Anes.)
Other: _____
Appropriate alternative as backup.
NPO status explained.

PATIENT'S SIGNATURE _____ DATE _____

EVALUATOR(S) SIGNATURE

CRNA (b)(6)-2 CRNA DATE 11 APR 03

PHYSICIAN _____ DATE _____

POST ANESTHESIA VISITS

ANESTHESIA RECOVERY COMPLICATED BY THE FOLLOWING PROBLEMS: (IF NONE, SO STATE)

DATE: _____

SIGNED: _____ TIME: _____

MEDCOM - 4113

(THIS FORM IS SUBJECT TO THE PRIVA F) AS A CLINICAL RECORD FORM, IT IS COVERED BY DD 2205)

ANESTHESIA RECORD

Page 1 of

ANES. START	IN OR	ANES. END	DATE
1030Z	1050	1205Z	13 APR 03
TOTS	SURG START	DRESSING	OR NO
1056	1108	1150	

OPERATION PERFORMED: Washout (R) BKA

SURGEON(S [redacted] 6612)

PREOPERATIVE

- [x] IDENTIFIED [x] ID BAND [x] QUESTIONING
- [ ] CHART REVIEWED [ ] NPO SINCE 0700
- [x] PRE-OP MEDICATION:

Drug	Dose	Route	Time
Versed	2 mg	IV	1045
Fentanyl	100	IV	1045

Pre-Anesthetic State: [ ] AWAKE [x] CALM [x] SEDATE [ ] APPREHENSIVE [ ] UNRESPONSIVE

MONITORS AND EQUIPMENT

- [x] ANES. MACHINE # ____ & EQUIP. CHECKED
- [x] NON-INV. B/P [ ] PNS
- [x] CONT. EKG [ ] V LEAD EKG
- [ ] ESOPH. STETH. [ ] PRECORD STETH.
- [x] PULSE OXIMETER [x] O2 ANALYZER
- [x] END TIDAL CO2 [ ] MASS SPEC.
- [ ] TEMPERATURE ____
- [ ] WARMING BLANKET [ ] FLUID WARMER
- [x] AIRWAY HUMIDIFIER
- [ ] N / G TUBE [ ] O /G TUBE
- [ ] IV(s) 18G (L) arm
- [ ] ARTERIAL LINE ____
- [ ] CENTRAL LINE ____
- [ ] SWAN-GANZ ____
- [ ] FOLEY INSERTED: [ ] O.R. [ ] FLOOR
- [x] EYE CARE eyes taped
- [ ] PRESSURE POINTS CHECKED / PADDED
- [x] Arms on arm boards

ANESTHETIC TECHNIQUE

- [x] GENERAL [ ] LOCAL / MAC
- [ ] REGIONAL [ ] NERVE BLOCK

INDUCTION

- [x] PREOXYGENATION [ ] INHALATION
- [x] RAPID SEQUENCE [ ] INTRAMUSCULAR
- [x] INTRAVENOUS [ ] RECTAL

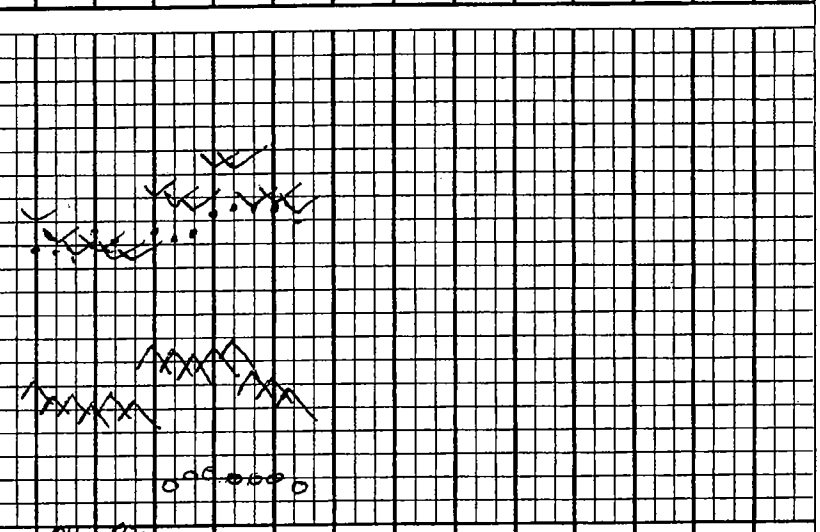
AIRWAY MANAGEMENT

- [x] INTUBATION [x] ORAL [ ] NASAL
- [x] DIRECT VISION [ ] BLIND [ ] AWAKE
- [ ] FIBER OPTIC [x] STYLET USED
- [x] ATTEMPTS x 1 [ ] BLADE 4 MAC
- [x] ETT SIZE 8 [ ] DOUBLE LUMEN
- [x] STRAIGHT [ ] RAE [ ] ANODE
- [x] CUFFED 10 ML AIR INJECTED
- [ ] UNCUFFED, LEAKS AT ____ CM H2O
- [x] ETT SECURED AT 23 CM
- [ ] BREATH SOUNDS ____
- [ ] AIRWAY [ ] ORAL [ ] NASAL [ ] NATURAL
- [ ] MASK CASE [ ] VIA TRACHEOSTOMY
- [ ] NASAL CANNULA [ ] SIMPLE O2 MASK
- [ ] LMA SIZE

		1045	1100	15	30	45	1200	TOTALS
AGENTS	Ketamine	50						
	Propofol	170						
	Cuk	120						
	Fentanyl		1	1	1			
	Fiso % E	1.5	1.6	1.5	1.1	X		
	~~N2O L/min~~ Air	1	1	1	1	1		
	O2 L/min	3 0.8	0.6	1	1	3		
FLUIDS	LR			100				
	Urine							
	EBL			100				
MONITORS	EKG	ST	ST	ST	ST	ST		
	% O2 Inspired	.44	.37	.67	.51	.9		
	O2 Saturation	99	99	98	100	100		
	End Tidal CO2	37	31	55	46	42		
	Temperature	Available		"	"	"		
	PNS							
RESP	Tidal Volume	840	830					
	Resp Rate	10	10					
	Peak Pressure	30	29					
		SV	MV	MV	SV	SV	SV	
Symbols for Remarks								
Position	supine							

TIME

VITAL SIGNS — PRE-OP VALUES: B/P 121/75; P 101; R 16; SAT 98%; H/H



SYMBOLS: X ANESTHESIA; ⊙ OPERATION; ∨ ∧ B/P CUFF PRESSURE; ⊥ T ARTERIAL LINE PRESSURE; ● PULSE; ○ SPONTANEOUS RESP; Ø ASSISTED RESP; ⊠ CONTROLLED RESP; T TOURNIQUET; F CRYSTALLOID FLUID; B BLOOD

RECOVERY

TIME IN PACU	CONDITION		
1155	stable		
B/P	PULSE 142	RESP 20	O2 SAT 92
REMARKS RA			TEMP

REPORT TO: PARRS:

REMARKS: [ ] Patient reevaluated. No change from preop plan / evaluation. [x] Significant changes from preop plan / evaluation.

1157 opens eyes lifts head oropharynx suctioned extubated c (+) pressure.

Tourniquet Time:

IN	FLUIDS TOTALS	OUT
Crystalloid LR 100	EBL 100	
	Urine	
Blood	Gastric	

(b)(6)-2

MAJ / CRNA
PHYSICIAN / CRNA

PATIENT'S IDENTIFICATION

(b)(6)-4

NAME: (b)(6)-4 (b)(6)-2 SURGEON: Planned Surgery Date:

ANESTHESIA PREOPERATIVE EVALUATION

AGE	M / F	HEIGHT	WEIGHT
27			80 1/3

PROPOSED OPERATION: Rt BKA washout

PREOPERATIVE VITAL SIGNS: B/P 134/83 P 124 R 28

PREVIOUS ANESTHESIA / OPERATIONS ☐ NEGATIVE

CURRENT MEDICATIONS ☐ NONE

FAMILY HISTORY OF ANESTHESIA COMPLICATIONS ☐ NEGATIVE

ALLERGIES ☐ NKDA

AIRWAY / TEETH / HEAD & NECK

SYSTEM	WN	COMMENTS	PERTINENT STUDY RESULTS
RESPIRATORY Asthma, Bronchitis, COPD, Dyspnea, Pneumonia, Productive Cough, Recent cold, SOB, Tuberculosis	☑	Tobacco Use: ☐ No ☐ Yes____ Pack/Day for____ Years BBS =	Chest X-ray, Pulmonary Studies
CARDIOVASCULAR Angina, Arrhythmia, CHF, Exercise Tolerance, Hypertension, MI, Murmur, MVP, Pacemaker, Rheumatic fever	☑	RRR	EKG
HEPATO/GASTROINTESTINAL Bowel obstruction, Cirrhosis, Hepatitis, Hiatal Hernia, Jaundice, N&V, Reflux/Heartburn, Ulcers	☑	Ethanol Use: ☐ No ☐ Yes Frequency _____	LFTs
NEURO/MUSCULOSKELETAL Arthritis, Back problems, CVA/Stroke, DJD, Headaches, Loss of consciousness, Neuromuscular disease, Paralysis, Paresthesia, Syncope, Seizures, TIAs, Weakness	☑		
RENAL/ENDOCRINE Diabetes, Renal failure/Dialysis, Thyroid disease, Urinary retention, Urinary tract infection, Weight loss/gain	☑		Urinalysis, Thyroid, FBS
OTHER Anemia, Bleeding tendancies, Hemophilia, Pregnancy, Sickle cell trait, Transfusion history			Hgb / Hct / CBC: HCT ↓ 22.5, Lytes

PROBLEM LIST / DIAGNOSES

ASA: 1, 2, 3, 4, 5, E

PREOPERATIVE MEDICATIONS ORDERED

COUNSELING STATEMENT

Anesthesia alternatives, benefits and risks from minor to death explained. All questions answered.
Patient / legal guardian voices understanding and gives consent for :
Local / MAC, SAB, Epidural, IVR, General Anes.
Other: _____
Appropriate alternative as backup.
NPO status explained.

PATIENT'S SIGNATURE _____ DATE _____

EVALUATOR(S) SIGNATURE

CRNA (b)(6)-2 DATE 12/17/05

PHYSICIAN _____ DATE _____

POST ANESTHESIA VISITS

ANESTHESIA RECOVERY COMPLICATED BY THE FOLLOWING PROBLEMS: (IF NONE, SO STATE)

DATE: _____

SIGNED: _____ TIME: _____

MEDCOM - 4115

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 TI ORDE NOTED 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

(b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 11 APR 03 | TIME OF ORDER 1245 HOURS

(1) tetanus D-Sml Im x i

(2) Heparin 5000u SQ BIM

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 11 APR 03 | TIME OF ORDER 2055 Z HOURS

Resume previous pre-op orders.

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

LTC, MC, USA

ORTHOPAEDIC SURGERY

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 12 Aug 03. | TIME OF ORDER 0900 Z HOURS

Cert. 35°mg IV q Day.

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

LTC, MC, USA

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JU

(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

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 11 April 03 TIME OF ORDER: 10:40 HOURS

LIST TIME ORDER NOTED AND SIGN

1 Admit Patient to ICU #3

2 Diagnosis: S/P (R) BKA & revision @ 2 [illegible]

3 Condition: Stable/Serious/Critical

4 Allergies: NKDA

5 Vital signs q hr/q2hr/q6hr/q8hr/q shift 94

6 Cardiac respiratory monitoring

7 Diet: NPO / regular/ soft/ clear liquid

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

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

(b)(6)-2

11 APR 03 1145

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER _____ HOURS

13 PCXRAY q AM/QOD

14 IVF NS/ LR/ D5NS/ D51/2NS To run @ 125 cc/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

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

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 2.5 MG IV q 1-2 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 40-66, 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

(b)(3)-1

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 12 Apr 03 — TIME OF ORDER: 1400 HOURS — LIST TIME ORDER NOTED AND SIGN

VO Dr (b)(6)-2 / (b)(6)-2 — CPT

Percocet tabs ⅟ or ⅟ po q 4-6° PRN

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER — TIME OF ORDER — HOURS

1 Resume previous orders

2 No dressing Δ x 48° then w/ d Δ i2 (STARTING 4/15) q d

(3) ANCEF ⅟ gm IVPB q 8° x 48° then 16 g/lex 200 Q 10 d

(b)(6)-2

13APR02

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 9/14 ANCEF 13 APR 03. — TIME OF ORDER: 1217 (2) — HOURS — CHO

P/C dressing Δ order

Gent. 350 mg IV q day.

(b)(6)-2

13APR02

4/14/03 @ 1555z

(1) ADMIT TO MCW 3

(2) Dx: Infected (R) BKA stump

(3) Condition: Stable

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER — TIME OF ORDER — HOURS

(4) Vitals BID

(5) Diet: NPO PMN tonight

(6) IV LR @ 60cc/°

(7) Ancef ⅟ gm IV Q 8°

(8) GENT 350mg IV Q 24°

(9) Heparin 5000 units SC Q 12°

(10) Foley to gravity

(b)(6)-2

(b)(6)-2

ORTHOPAEDIC SURG

NOTE: STATUS OF CASE

DA FORM 1 APR 79 4256 REPLA MEDCOM - 4118 CH MAY BE USED.

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)					Mo 4 Yr 3
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
	- - - - -						
	- - - - -						
	- - - - -						
	- - - - -						
	- - - - -						
	- - - - -						
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	- - - - -						
	- - - - -						
	- - - - -						

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
11 APR	(b)(6)-2	Morphine Sulfate 2-5 mg IV q 1-2hr PRN pain	12 5mg 1220	3mg 1500 (b)(6)-	12 5mg 1730	(b)(6)- 5mg 2158	4/12 0215	12 Apr 9:50	12 APR 1115	12 APR 1230	12 APR 1850	12 APR 2230 5mg	13 APR 0700	13 APR 1245 5mg	13 APR 1505 5mg	13 APR 1745 5mg
- - - - -	- - - - -	Phenergan 12.5-25mg IV q 4-6 hrs prn N/V	~~5mg~~				SL 12 APR	5mg IV	3 or IV (b)(6)-	3 mg (b)(6)-2	5 mg (b)(6)-2	(b)(6)-2	4 APR (b)(6)-2	IV (b)(6)-2	IV	IV
- - - - -	- - - - -	MOM 30cc PRN Gastric Upset														
- - - - -	- - - - -	NS / LR bolus X ____liters														
- - - - -	- - - - -															
- - - - -	- - - - -	Tylenol 650g PO	0230 12APR													
- - - - -	- - - - -	for T > 101.5	SL (b)(6)-2													
- - - - -	- - - - -	PERCOLET 1-2 TAB 4-6 4P 4P (b)(6)-2								12 APR 1400 (b)(6)- 2 tab	12 APR 1950 2 tab (b)(6)-2			13 APR 1340 1 TAB (b)(6)-	14 APR (2) 1700 SL 0045	
- - - - -	- - - - -															

USAPA V1.00

CLINICAL RECORD

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

Mo. 4 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 11	12
11 APR	(b)(6)-2	Vital signs q ~~hr / q 2hr / q6h4 / q8hr~~ /	07	(b)(6)-2	
		~~q shift~~ Q 4°	19		
11 APR		Cardiac Respiratory Monitoring	07		
			19		
11 APR		Diet: NPO / Regular / Soft / Clear	07		
		Liquid	19		
11 APR		Activity: Ad Lib / Strict BR / BR with	07		
		BSC / NWB R or L LE	19		
		HOB up 30 Degrees	07		
			19		
11 APR	(b)(6)-2	Nursing I/O, CDB / NG to LIS / LCS	07		
			19		
11 APR		Labs: Chem 7 / H&H / PT/PTT /	04		
		CBC q AM / 4 hrs / 8 hrs / BID	08		
			12		
			16		
			20		
			24		
		EKG q AM / QOD	06		
		PCXRAY q AM / QOD	06		
		Neuro checks q 1hr / 2 hr / 4 hr / 6 hr /	07		
		q shift	19		
		Vascular checks nq 1hr / 2 hr / 4 hr /	07		
		6 hr / q shift	19		

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: S/P BKA c̄ revision @ 212th 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

Treatment Facility: (b)(3)-1

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

ICU #3

MEDCOM - 4120

DICAL RECORD SUPPLEMENTAL MED
form, see AR 40-66; the proponent agency is the Offi General

REPORT TITLE **POST ANESTHESIA CARE RECORD** OTSG APPROVED (Date)

Time in: 1202 Z | Procedure: Washout (R) BKA | ASA Grade (I – V):

Physician: | Anesthesia Provider: | Pre-Op Vitals: T= P=101 R=16 BP=121/95 SaO2=

ANESTHESIA: General Spinal Epidural
Sedation Local Nerve Block:
Intrathecal w/ narcotic: time:
Other:

REVERSALS: Narcotic: No / Yes time:
Muscle Relaxant: No / Yes time:

Allergies: NKDA
Latex allergy: N / Y
Medical/Birth Hx:
Complications:
Tourniquet time:

INTAKE: OR / PACU
Crystalloids 700cc IV
Blood Prod /
Colloids /
Irrigations /
Other /

OUTPUT: OR / PACU
Urine /
EBL 100cc /
Drains /
Emesis /
Other /

VITAL SIGNS							POST ANESTHESIA RECOVERY SCORE						PAIN ASSESSMENT			OTHER					Init
Time	BP	T	P	R	SaO2	O2	Act	Resp	Circ	LOC	Skin	Total	0-10	Qual/ Locat	Derm Level	N/V	Nurse action				
1205z	141/85	101.1	140	16	90	—	2	2	2	1	2	9	10	(R) leg		Ø	HOB	RA			(b)(6)-2
1220z	130/80	99.4	136	16	89	—	2	2	2	1	2	9	10	"		Ø	"	"			
1235z	141/85	99.4	130	16	97	—	2	2	2	1	2	9	10	"		Ø	"	"			
1250z	147/81	98.7	130	16	98	—	2	2	2	1	2	9		"			"	"			
305	145/86	98.7	116	16	98	—	2	2	2	2	2	10	10	(R) Leg		Ø	"	"			
1335	140/79	98.3	119	16	95	—	2	2	2	2	2	10	10	(R) Leg		Ø	"	"			
1405	98/33	98.3	119	16	96	—	2	2	2	1	2	9	10	(R) Leg		Ø	"	"			
1505	142/84	98.6	110	16	98	—	2	2	2	1	2	9									
1605																					

VITAL SIGNS	Activity (Act)	RESPIRATIONS (Resp)	CIRCULATION (Circ)	LEVEL OF CONSCIOUSNESS (LOC)	SKIN
BP = blood pressure P = pulse R = respirations T = temperature ax = axillary SaO2 = oxygen saturation	2 = Moves 4 extremities 1 = Moves 2 extremities 0 = Moves 0 extremities	2 = Cough/deep breath 1 = Dyspnea, airway 0 = Apnea	2 = 20% +/- PRE-OP BP 1 = 20% - 50% +/- 0 = 50% +/-	2 = Fully awake 1 = Verbally aroused 0 = Unresponsive No nystagmus w/ ketamine	2 = Pink 1 = Pale, dusky 0 = Cyanotic

sxn = suction IS = incentive spirometry C/DB = cough/deep breath HOB = elevate head of bed EE = elevate extremity ICE = cold compress CDI = clean/dry/intact Init = initials PtT = patient teaching – see notes WB = warm blankets HL = heat lamps IC = ice chips H = hygiene care RA = room air BB = blow-by Other:
Quality Codes: AH = Aching BN = burning CO = complaints of pain CR = crushing DL = dull IR = irritable PE = painful expression PR = pressure RT = restless SH = sharp SL = sleeping SP = splinting ST = stabbing TH = throbbing UD = unable to describe Other:
Location Codes: H = head F = face Fd = fundus Tr = throat N = neck Sd = shoulder B = back Ch = chest ABD = abdomen U = umbilicus UE = upper extremity LE = lower extremity Hd = hand Ft = foot K = knee Vag = Vagina Other:

MEDICATIONS RECEIVED IN PACU

TIME	PROBLEM/COMPLAINT For analgesic include Quality, Intensity (0-10), and Location	MED DOSE/ROUTE	INIT	REASSESSMENT/RESPONSE For analgesic include Quality, Intensity (0 – 10), and Location	TIME	INIT
1250z	5mg Morphine					

(Continue on reverse)

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

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

DA FORM 4700, MAY 78

MCEUL OP 45(Rev), 19 Sep 01
MRRC apprvl - 02 Aug 01

MEDCOM - 4121

RN ASSESSMENT

	ADMISSION ASSESSMENT TIME:	DISCHARGE ASSESSMENT TIME:
RESP	Airway: patent / unassisted / chin lift / jaw thrust / sniff position Artificial airway: N/A / nasal / oral / endotracheal / other: Respirations: clear / unlabored / spontaneous / other: Oxygen by: simple mask / nasal canula / BB / RA / other:	Airway: patent / unassisted / chin lift / jaw thrust / sniff position Artificial airway: N/A / nasal / oral / endotracheal / other: Respirations: clear / unlabored / spontaneous / other: Oxygen by: simple mask / nasal canula / BB / RA / other:
CV	Monitor: sinus rhythm / RRR by pleth / other: Peripheral pulses: palpable / other: Capillary refill: < 3 seconds / other: Skin: warm / dry / pink nail beds / other:	Monitor: sinus rhythm / RRR by pleth / other: Peripheral pulses: palpable / other: Capillary refill: < 3 seconds / other: Skin: warm / dry / pink nail beds / other:
NEURO	LOC: A V P U Oriented x 3 / other: Movement: grasps & plantar-dorsiflexion strong and equal: Yes / No / N/A Sensation: denies numbness and tingling: Yes / No / N/A Other:	LOC: A V P U Oriented x 3 / other: Movement: grasps & plantar-dorsiflexion strong and equal: Yes No/ N/A Sensation: denies numbness and tingling: Yes / No / N/A Other:
GI/GU	Abdomen: soft / non-distended / other: Foley catheter: Yes / No Urine clear yellow / other: Other:	Abdomen: soft / non-distended / other: Foley catheter: Yes / No Urine clear yellow / other: Other:
PSYCHO-SOCIAL	Affect: calm and appropriate / cooperative / other: Language: English / other: Interpreter present: Y / N / NA "Special Needs": N/A / identified: Other:	Patient informed of present condition: Yes / No Family updated on patient condition: Yes / No Other:
IV	None: Gauge: 18 Location: (L) Arm Condition: patent / no redness / no edema Other: Solution: LR Rate: 25 cc/hr Amount remaining: 100 ml	None: Gauge: Location: Condition: patent / no redness / no edema Other: Solution: Rate: Amount remaining:
DSG	None: Type: Coban Location: (R) leg Condition: clean / dry / intact Other: Drains: N/A / Hemovac / Jackson Pratt / Other: Drainage: none / serous / serosanguenous / bloody / Other:	None: Type: Location: Condition: clean / dry / intact Other: Drains: N/A / Hemovac / Jackson Pratt / Other: Drainage: none / serous / serosanguenous / bloody / Other:
SAFETY	Safety measures taken: side rails up / bed straps on / bed locked Pediatric: staff/parent at bedside at all times / crib sides padded x 4 Other:	Safety measures taken: side rails up / bed straps on / bed locked Pediatric: staff/parent at bedside at all times / crib sides padded x 4 Other:
PEDS	Parent at bedside to comfort child: Yes / No Humidified oxygen: Yes / No / N/A IV on armboard: Yes / No / N/A	Parent at bedside to comfort child: Yes / No Humidified oxygen: Yes / No / N/A IV on armboard: Yes / No / N/A
OTHER		
	RN Signature:	RN Signature:

PATIENT TEACHING IN PACU (circle all that apply)

Topic	Level of Involvement	D=demonstrated V=verbalized	INIT
Pulmonary Toileting: Importance of / Cough-deep breathing exercises / incentive spirometer / ABD splinting / Other:		D / V	
Wound care: ice compress / heat application / extremity elevation / signs of compartmental syndrome / Other:		D / V	
Pain management: Medications: type, dose, route, indications, side effects / positioning / activity restrictions / prn Rx requests on ward / Other:		D / V	
Surgeons and Anesthesia post-op orders		D / V	
Pediatric: safety: padded sides, IV armboard / monitoring equipment / staff-parent at BS at all times / pediatric post-op agitation vs pain / Other:		D / V	
Spinal anesthesia: use nursing assistance first time OOB, avoid pressure points while numb / Fundal massage / lochia and pad count / Other:		D / V	
Post cardiac cath: signs of bleeding / apply pressure over site when coughing, sneezing, or vomiting / lie flat with leg straight / use of sandbag / Other:		D / V	
MISC: Elevate HOB / avoid eye strain / wire cutter worn around neck / Oral intake restrictions Other:		D / V	

NURSING NOTES

DISCHARGE NOTE: This patient meets criteria for discharge from the PACU or has been cleared by the anesthesia provider indicated on MCEUL OP 501: Anesthesia Record.

Nursing Care Plans remain open: #_____

Report called to:_____ Ward:_____ Via:_____ At:_____ hours.

_____ _____ for _____ _____

(RN Signature) (Chief. Anesthesia Services)

1. DATE AND TIME OF CAPTURE 08APR03	SERIAL NO 0205524 A
3. NAME (b)(6)-4	4. DATE OF BIRTH 1044HLTRA
5. RANK N/A	6. SERVICE NO.
7 UNIT OF EPW	8. CAPTURING UNIT (b)(3)-1
9. LOCATION OF CAPTURE (Grid coordinates) MB 421870	
10. CIRCUMSTANCES OF CAPTURE CHARGED U.S. VEHICLE WITH OWN VEHICLE	11 PHYSICAL CONDITION OF EPW SEVERE GUNSHOT WOUND (2) LEG	12. WEAPONS, EQUIPMENT, DOCUMENTS NONE

DD FORM 2745, MAY 96

REPLACES DA FORM 5976, JAN 91, USABLE UNTIL EXHAUSTED.

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF (1–6): (b)(3)-1
MTF LOCATION (7–8) (State or Country Code.)

3. REGISTER NUMBER (9–15): (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 (YYYYMMDD) (19–26): 19790101
7. AGE AT ADMISSION (27–29): 24
8. RACE (30): X
9. ETHNIC BACKGROUND (31): 9
RELIGION

10. LENGTH OF SERVICE (32–34): —
ETS
11. FMP (35–36): 99 20
12. SOCIAL SECURITY NUMBER (37–45): (b)(6)-4

ORGANIZATION (Active Duty Only)
13. MARITAL STATUS (46): Z
HOUR OF ADMISSION: 1345
BRANCH / CORPS

14. FLYING STATUS (47–49): —
15. BENEFICIARY CATEGORY (50–52): K91 K78
16. ZIP CODE OF RESIDENCE (53–61): 093 3000

17. UNIT LOCATION (State or Country Code) (62–63): —
18. MOS (64–70): —
19. TRAUMA (71):
PREV. ADMISSION YEAR: NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72): 1
WARD
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 (73–74): 05
22. MTF TRANSFERRED TO (75–80):
23. DATE OF DISPOSITION (YYYYMMDD) (81–88): 20030410

24. CLINIC SVC - ADMITTING (89–92): ABAA
25. MTF TRANSFERRED FROM (93–98):
26. DATE THIS ADMISSION (YYYYMMDD) (99–106): 20030407

27. LOCATION OF OCCURRENCE (Battle Casualty Only) (107–108): IZ
28. MTF OF INITIAL ADMISSION (109–114):
29. DATE INITIAL ADMISSION (YYYYMMDD) (115–122):

FOR LOCAL USE

R BKA

DX: 5971
E9912

Px: 843

Trauma
1
Injury
450

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

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF: 1 2 3 4 5 6 7 8 (b)(3)-1

2. MTF LOCATION (State or Country Code.)

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 CWM

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 Iraqi

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: 1345

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 Inj

PREV. ADMISSION: YEAR ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 72 D

WARD: ICU

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: 73 74

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

23. DATE OF DISPOSITION (Y Y Y Y M M D D): 81 82 83 84 85 86 87 88 — 2 0 0 3 0 4 1 6

24. CLINIC SVC - ADMITTING: 89 90 91 92

25. MTF TRANSFERRED FROM: 93 94 95 96 97 98

26. DATE THIS ADMISSION (Y Y Y Y M M D D): 99 100 101 102 103 104 105 106 — 2 0 0 3 0 4 0 7

27. LOCATION OF OCCURRENCE (Battle Casualty Only): 107 108

28. MTF OF INITIAL ADMISSION: 109 110 111 112 113 114

29. DATE INITIAL ADMISSION (Y Y Y Y M M D D): 115 116 117 118 119 120 121 122

FOR LOCAL USE

R BKA ~~887~~

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

ADMISSION AND CODING INFORMATION

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
123 124 125	126	127	128 129 130	131 132 133 134 135 136 137 138 139	140 141 142

36. FIRST DIAGNOSIS *(Principal Diagnosis)*

143	144	145	146	147	148	149	150
8	9	7				0	

37. SECOND DIAGNOSIS

151	152	153	154	155	156	157	158

38. THIRD DIAGNOSIS

159	160	161	162	163	164	165	166

39. FOURTH DIAGNOSIS

167	168	169	170	171	172	173	174

40. FIFTH DIAGNOSIS

175	176	177	178	179	180	181	182

41. SIXTH DIAGNOSIS

183	184	185	186	187	188	189	190

42. SEVENTH DIAGNOSIS

191	192	193	194	195	196	197	198

43. EIGHTH DIAGNOSIS

199	200	201	202	203	204	205	206

44. FIRST PROCEDURE *(Principal Diagnosis)*

207	208	209	210	211	212	213	214

45. SECOND PROCEDURE

215	216	217	218	219	220	221	222

46. THIRD PROCEDURE

223	224	225	226	227	228	229	230

47. FOURTH PROCEDURE

231	232	233	234	235	236	237	238

48. FIFTH PROCEDURE

239	240	241	242	243	244	245	246

49. SIXTH PROCEDURE

247	248	249	250	251	252	253	254

50. SEVENTH PROCEDURE

255	256	257	258	259	260	261	262

51. EIGHTH PROCEDURE

263	264	265	266	267	268	269	270

52. NUMBER OF DIAGNOSTIC FIELDS CONTAINING CODES	53. NUMBER OF PROCEDURAL FIELDS CONTAINING CODES	54. PRIMARY PROVIDER SPECIALTY CODE	55. BLOOD USAGE Y / N
271 272	273 274	275 276 277	278
0 0	0 0		

USAPA V1.00

MEDCOM - 4126

PATIENT 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) (b)(6)-4				3. GRADE	ADMISSION REMARKS
4. SEX: M	5. AGE	6. RACE: Black	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
11. SMP: 99	12. SSN (b)(6)-4		13. ORGANIZATION			14. WARD: ICW 3
15. FLYING STATUS	16. RATING/DSG	17. DEPT./BEN	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE: IN
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct				22. HOURS OF ADMISSION	23. CLINIC SERVICE: ABAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION: Trans		26. DATE OF DISPOSITION: 27 Apr 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)			27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION: 7 Apr 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

R Femur Fx ; L Heel wound

~~$21.00~~ ~~$92.0~~

I&D / EXT FIX ~~29.95~~ ~~29.94~~

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
	20			20	20

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 (b)(6)-2

(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. REGISTER NUMBER (b)(6)-4			(b)(6)-4					ADMISSION REMARKS
4. SEX M	5. AGE	6. RACE Black	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION		
11. FMP 99	12. SSN (b)(6)-4		13. ORGANIZATION			14. WARD ICW 3		
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	23. CLINIC SERVICE ABAA			
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION Trans		26. DATE OF DISPOSITION 27 Apr 03			
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)			27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION 7 Apr 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

R Femur Fx ; L Heel wound
~~821.00~~ ~~892.0~~

I&D / EXT FIX ~~79.95~~
~~79.99~~

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
					20

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

SIGN (b)(6)-2 SIGNATUR (b)(6)-2

DA FORM 3647, MAY 79 EDITION OF 1 AUG 76 IS OBSOLETE USAPPC V1.10

MEDCOM - 4128

NSN 7540-00-634-4176 600-108

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
4/4/13	OP NOTE
1320(7)	Preop Dx: (R) femur fx, open &
	(L) foot soft tissue injury
	OP: (R) femur I&D & ex. fixation
	(L) foot I&D
	Dr CHO / Dr ALARCON
	Fluid: 1L LR
	GETA
	Ø comp
	To IW → 86

(b)(6)-2

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

(b)(6)-4

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

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
11 April 03	Admitted to ICU 3 from FST. Temp 99.3°F, HR - 91 bpm BP 122/64, O_2 sat 99% Awake. MAE. No neuro-vascular deficits. BBS CTA, Abd-soft. (+)BS. (R) LE c̄ traction. dressings changed. (L) ankle & heel wound needs debredement. C/O pain Medicated with MSO4. Abx. given. Awaiting OR. (b)(6)-2
11 April 03 1345	Pt Received from OR via gurney 5 O_2 BP 140/86 pulse 106 Temp 97 (A) SPO_2 100% Resp 20 c̄ +3 DP + Pt to Rt Leg drsg to (Rt) Femur c̄ x Fix to Limb. Will continue to monitor — (b)(6)-2
1400 11 Apr 03	BP 148/89 Resp 20 HR 95 SPO_2 100% Temp 97.2 (A) —
1415 11 Apr 03	BP 138/87 Resp 20 HR 90 SPO_2 100% Temp 97.4 A —
1430 11 Apr 03	BP 152/72 Resp 20 HR SPO_2 Temp —
11 APR 03 1900	PT RECEIVED RESTING IN BED. REPORT RECEIVED FROM CPT (b)(6)-2 RESP CTA CV S_1S_2 +3 pulse u/L Extremities. CI: BS (+) x4. No complaints of pain. Will continue to monitor (b)(6)-2
12 APR 03 0100	BP 137/75 HR-103 RR16, SPO2 100% RA T-98' oral. (b)(6)-2
Voided 400cc	
Z 1330/12 Apr 03 -	BP 105/66 HR 104 RR16 PO x 98% RA temp 36°C. pt given T3 ⁊ PO for pain @ 1330. pt alert & dealing c̄ pain. Lungs CTA & DB well, HS normal S_1S_2 & BS present x4 quads. moves extremeties well +3 pulses to all extremeties. UOP >600cc clear yellow urine, ate some meal & did well — (b)(6)-2 CPT AN

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

(b)(6)-4

RECORDS MAINTAINED AT: (b)(6)-2

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1815Z/12Apr03	- pt resting well. pain controlled c̄ MSO4 +
	Tylenol #3. able to take PO well & tolerate.
	UOP >800cc clear yellow urine. [redacted] CPT AN.
1950	800 motrin PO for pain - [redacted] CPT AN —
13Apr03	Nsg: Pt easily aroused c̄ verbal stimuli to perform a.m.
0360	washing. Currently denies pain or discomforts, (speaks english
BP 147/64 P78	a little) VSS. Refused a.m. meal. P.E. unremarkable. RLE has a
Sp O2 99% RA	very pugnant odor, dsg is soiled c̄ blood (area marked c̄ blk pen)
R:18	(+) distal pulse (+) Tactile sens - BLE's. GU: voiding adeq clear yellow
	urine. Tol po fl. well 18g, (LA) T (L) wrist flushes well ∅ edema
	[redacted] . SSG [redacted]
4/13/03	OP NOTE
0670(Z)	Prep: S/P (R) femur ex fix & 1&D (L) foot
	OP: Washout (R) femur, open & (L) foot
	Q CHO
	Fluids: 400 LR
	MAC
	∅ Compr [redacted]
13April03	Post-op Nsg Note: Pt returned lying supine asleep ∅ suppl. O2 SpO2 96%,
126/86 80	transferred from Gurney to bed c̄ drawsheet s̄ incident. VSS, Pt easily
49.4 20	aroused c̄ verbal stimuli. Dsg Post-op marked by Nsg ~ C.D.I. Pt s̄ (C/O)
	pain. (+) Distal pulses (+) WD skin (+) Tactile sensations. WCTM [redacted]
1200Z/13Apr03	- pt doing well p̄ surgery. Alert and O x3
	follows commands, pain controled well. lungs
	CTA, HS normal S1 S2, BS X4 quads.
	V.S. 122/62 P103, RR16 PO x 98% on RA temp 98.8
+3	pulses to all extremities - (R) ext fix to femur & draining c
	Serious fluid [redacted] CPT AN

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
2210/13Apr03	O - 800cc yellow ime > pt doing well, I - 600c H_2O [redacted] Pt Am
~~13~~ 14 APR03	VS/BP: 120/67 P: 105 R: 18 T: 98.1° O_2 SAT: 98% / R/A
	PT A+OX3 FOLLOW COMMANDS. PT HEART SOUNDS STRONG S1 + S2
	PRESENT. LUNG SOUNDS CLEAR ALL FIELDS BS (+) X4 ABDOMEN
	SOFT TO TOUCH (R) LEG BULKY DRESSING C̄ DRAINAGE Δ X 48 HRS. LAST
	CHANGED 13APR @ 1300HR. ALSO BULKY DRESSING (L) ANKLE
	NO DRAINAGE. PT CAN WIGGLE TOES ON BOTH FEET.
	PULSES STRONG + BILATERAL [redacted]
14 APR 03	VSS Pt S C/O pain/discomfort. Pt informed through interpret of $\bar{x}$ to
BP 110/74 D100	different facility. Has tolerated P.O. well ∅ dsg Δ per MD's order.
R: 16 T 99.°	[redacted]
0620	GIVE ⅊ T35 FOR PAIN [redacted]

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

[redacted]

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

CHRONOLOGICAL RECORD OF MEDICAL CARE
MEDCOM - 4132
STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES	MASH
	Admit Note	
14 Apr 03	ID 23 y/o Iraqi o/m. Transfer from FST	
0955 Z	CC s/p (R) Femur fx., (L) soft tissue wound left foot.	
	HPI See Medical record — Stapled together	
	PE Lungs - CTA. CV - RRR. Abd - BS x 4 Quadrants	
	LUQ + RUQ - tender to light palpation (Murphy's) -	
	(? constipation). Skin - w/D. LE - (R) femur c external	
	fixator - dry drng on dressing. (L) foot - dry drng on	
	dressing. X-ray = ϕ fx or shrapnel in (L)	
	foot (R) Femur fx - since operated on.	
	A (R) Femur I+D and ext fixation	
	(L) foot I+D	
	P Admit to MCW2	
	Condition: Stable	
	Diet as tolerated.	
	VS BID	
	Meds - MSO4 5mg IM/IV Q 4-6° prn pain.	
	Tylenol #3 PO +-II Q 4-6° prn pain	
	Motrin 800mg PO TID	
	Heparin 5000 u SQ BID	

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
26 APR 03	VS 132/76, 88, 18, 98.7 CBX Neurovascular ✓'s To (R) LE c̄ Ext Fix-
1943	ator, WNL Drsg A+I, Neurovascular ✓'s To (L) Foot + Drsg WNL
	Pt Has (L) FA PCV - good flush. [redacted] MAJ AW
2000	C/O Pain MSO4 10mg - (R) Ext Fixation. [redacted] MAJ AW
2350	Pt Cas lm gradly. [redacted] MAJ AW
27APR03	R12 SpO2 99% P82 T98.0 BP 98/50 LS-CTA BS present X4 ~~Atitol~~ Abd soft ~~Ti~~ without tenderness A+O X3 capillary refill < 3 sec skin
	is warm dry + intact has 18G IV to (C) forearm patent gave 10mg MSO4
	IV and flushed heplock gave Percocet ÷ PO @ 0715. Drsng to (R) thigh
	S'dpin care done pt received 0800 colace was transported
	to local hospital in Al Nasiriyah Drsng to (L) heal still dry and
	intact, [redacted] 91W10 SPC

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STANDARD FORM 509 (REV. 5-99) BACK

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
14 Apr 03	Vitals = 99.4 temp, Spo2 = 97, pulse 120, B/p 120/70 RR 22
9:32 (2)	(b)(6)-2 [redacted] 91W
0932Z	Pt to MCW #2 via A/E. External fixator to (R) femur in place. (+) pedal pulse (B) LE. Drsg to (L) heel/ankle ± dried drainage. Pt states he has pain to (R) femur. Pt given water per request [redacted] CPT 2 66-2
14 Apr 03 1000Z	Pt given MSO4 5mg IV for pain in (R) extremity. (b)(6)-2 [redacted]
14 Apr 03 1057	PT recieved 1g Ancef VIA IV Spe (b)(6)-2 [redacted]
14 Apr 03 1410	PT recieved Tylenol #3 x II VIA PO Spe (b)(6)-2 [redacted]
2051	BP - 132/74 T - 98.9
	P-100 RR-20 (b)(6)-2 [redacted] 91W20
2120	Pt w/injury to (R) femur (+) ext fixator in place. Copius amts of serosang drainage noted. Chux placed under leg. Pt w/injury to (L) ankle. Dressing intact w/old drainage noted. Pt able to wiggle toes bilat. Both ↓ ext warm to touch cap refill <3sec. All other assessments WNL. Pt w/ IV access to (L) wrist + is patent. Pt c/o pain to (R) ↓ ext. Given 5mg MSO4 for pain. Will continue to monitor (b)(6)-2 [redacted] 2 [illegible]
15 Apr 03	Pt c/o pain given 5mg MSO4 IV (b)(6)-2 [redacted] 2 [illegible]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			
	LAST	FIRST	MI	[illegible]

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
0200	Pt awake & moaning c/o pain. Pt given 2 tylenol #3 & 25mg phenergan IV [redacted] 24/AN
0230	Pt given 2mg MSO4 IV for breakthrough pain [redacted] 24/AN
15 Apr 03 0500	Temp - 99.1, Pulse - 100, Resp - 18, B/P 118/58 - Spc [redacted]
0600 ②	Pt dressing removed from R ankle. Presents c̄ wounds x 3 ①: Fx R Femur. Pt c̄ ext Fixator in place. Dressing intact c̄ large amt of serosanguinous drainage noted. Dressing reinforced, Wound awaiting x-ray. ②+③: L Ankle wounds x 2 - Entrance wound 5x2 cm and 3.9cm deep. Wound is vascularized c̄ little drainage noted. Wound is ⊕ for fibrinous tissue, Ø necrotic noted Ø eryth. Wound is located center of Heel. - Exit wound is 8x6cm 3cm deep located on Lateral ankle. Wound is vascularized with moderate ~~amount~~ amount of fibrinous exudate noted. Wound has possible necrotic tissue present, Ø eryth noted. no s/s of infection. — [redacted] 24/AN
2040 (4)	Pt w/above wounds. All dressings C/D/I. Pt w/IV access to R wrist & is patent. Pt c/o pain MSO4 5mg IV given. Pt has ⊕ feeling, movement, & cap refill <3 sec. Pt will be NPO p MN & oncall to OR in AM [redacted] 24/AN
2152	BP 127/76 T - 99.2 P - 84 RR - 18 [redacted] 24/AN
2182	

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STANDARD FORM 509 (REV. 5-99) BACK

MEDICAL RECORD | **PROGRESS NOTES** | AUTHORIZED FOR LOCAL REPRODUCT

DATE	NOTES
	MD ORDERS
	4/16/03 @ 1550
	① NPOP MV (4/16/03)
	② OCTOR (4/17/03)
	(b)(6)-2
17 APR 03 1155	T 96.5 BP 147/90 P 90 R 16 POX 100 6l
1200	T 96.0 BP 140/84 P 94 R 16 POX 99 RA
1205	T 96.1 BP 141/88 P 88 R 16 POX 98 RA
1220	T 96.0 BP 143/81 P 88 R 16 POX 99 RA
1235	T 96.5 BP 134/79 P 84 R 18 POX 99 RA
1250	T 96.5 BP 139/86 P 85 R 18 POX 100 RA
1305	T 96.5 BP 134/80 P 81 R 16 POX 99 RA
1320	Pt stable. VS WNL. Pt returning to Tent 2

SPC (b)(6)-2 91 WM

4/17/03

① (R) femur X-ray 2-view

(b)(6)-2

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

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; 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
4/23/03 1220	Op Note Preop Dx: (R) open femur fx (L) heel wound Postop Dx: same Proc: (1) DHI (R) thigh & (L) heel (2) Partial closure (R) thigh wounds Surg: Nibbon Anes: IV sed EBL: Min Comp: ∅ Drains ∅ Plan: Wet to dry dressing Δs to (L) heel and (R) thigh. D/C when bed adequate and can self care. (b)(6)-2

DATE	NOTES
4/17/03	Post Op Note
1100	Pre/post op dx ① Segmental Gr III Aopen (R) for fx - extends to 1cm below lesser track
	② GSW (L) heel med foot
	Procedure I+D, (R) ex fix revision
	Findings - mod amt necrotic tissue from thigh wound - debrided
	~~dx~~ ∃ distal prox pin loose - replaced ∈ more prox pin through greater track → lesser - hopefully
	through + through GSW to med (L) ankle ∈ tract through heel 9 X 8cm med wound, 3 X 4cm heel pad wound.
	~~—~~ tibial artery prev tied off
	Plan ~~P~~ Return 72°
	(b)(6)-2
4/20/03	Post Procedure Note
0930	Pt to be evac'd today, was scheduled for I+D but did dressing Δ ∈ sedation to allow transport
	wounds ∈ good granulation tissue ∅ gross purulence
	c/o difficulty ∈ urination so UA sent - pending
	rec FLU ∈ urination issues
	also rec repeat I+D 48°
	will need definitive treatment of fx, possible coverage of ankle/heel
	(b)(6)-2
20APR03	VS 0945 B/P 122/75, 103P, 15R, T97, SaO_2 98%
Post-Op	0950 B/P 119/72, 99P, R-14, SaO_2 99%
	0955 B/P 112/69, 103P - SaO_2 100%, R-20 1000 B/P 119/71 P-91, SaO_2 99% R-18 91P
	(b)(6)-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
16Apr03 8:30	Vitals = 98.7 temp, 18 rr, 120/75 BP, 78 pulse [redacted] 9LW
16 Apr 03 0910	Pt received 2 Tylenol #3 PO By Spec [redacted]
16Apr03 11:20	pt received 5,000 units of heparin [redacted] 9LW
13:43	gave pt 2 #3 for pain [redacted] 9LW
1415	Pt given 4mg MSO4 for pain [redacted] 2LTAW
18:30	Pt. given 2 T3 for c/o allergy [redacted] 2LTAW
1945	T98.6 P80 R16 BP 120/85
2030	Pt c/o pain to (R) thigh given 5mg MSO4 + 25 mg phenergan IV [redacted] 2LTAW
0655	Pt has been NPO since MN. Pt has IV access in (R) FA w/ LR ↑ @ TKO. Pt w/ (R) LE fixator + dressing is soiled + foul smelling. Pt on call to OR [redacted] 2LTAW
17Apr03 7:50	Vitals = 98.0 temp, 18 R/R, 84 pulse, 120/70 BP [redacted] 9LW

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

[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)

DATE	NOTES
18 Apr 03 1200 hr	Pt tried to walk but didn't get very far out of bed. Need to find out when pt is able to so. we can let him know. Pt did not complain of any pn when he got up. SPC [redacted] 91W
18 Apr 03 2025	PT C/o not being able to sleep ∴ 10mg of Ambien given.
19 Apr 03 0025	PT C/o of pain in (R) Leg repositioned Leg and gave ∴ t-3. [redacted] SGT 91WB200
0130	Pt sleeping [redacted] SGT 91WB20
0600	Pt woke C/o pain in (R) leg gave 2 tabs tylenol #3 VS. BP 102/50 T-98.7 R 16 P 83
0815	Pt tolerates reg diet, restarted IV (R) AC. pt received ancef at 0830. Pt c/o pn, gave pt 800mg motrin to help relieve. pt vs. 110/62 R 16 T 98.2 P 74. SPC [redacted]
1830	Pt had BM, feels better. Pt also cleaned self up. SPC [redacted]
19 Apr 03 2030	Vs. BP 110/52 T-98.6 R 16 P 81. PT resting comfortably + talking with other pts. [redacted] SGT 91WB20
19 Apr 03 2205	Pt C/o pain and not being able to sleep. gave Pt ∴ t-3 and ∴ ambien. Pt resting now. [redacted] SGT 91WB20
20 Apr 03	0755 Pt resting good VSS @ BP 114/60 P 60 R 16 T 98.5 SPC [redacted] 91W
20 Apr 03 0815	received pt sleeping @ 1600. Gave Ancef 1gm @ ~~1445~~ Error 1445 pt went outside to commode via litter, had BM and slept till 1800. ate dinner and had ~~2~~ Error percocet ∴ PO tolerated well no c/o N/V or alam The ~~rest~~ Error rest of the shift. percocet was given at 1600 also pt had morphine 4mg at 1500 and 1145. [redacted] SPC USA 91W pt heploc'd 1830 [redacted] 91W10 SPC USA

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
4/17/03 - 1300	Pt returns from OR - Pt stable, (R) LE Drsg CDI, no complaints of pain. Pt recieves Ancef & gen IV — SPC [redacted] 91WME
1715	Pt recieved from MCW about 1630 hrs. Pt recieved Ancef at 1400 hrs, gent at 1700 hrs. Pt was given morphine 4mg for pn at 1710 hrs. Pt has external fixation to (R) femur, dressing looks good no soaking. Pt has GSW to (R) heal dressing looks good. Vital signs are BP 126/82, P 60, R16, T 98.2. Pt will let you know when in pn. SPC [redacted] 91W
4/17/03 1930	Pt Complain of pain IN (R) leg gave 3mg MSO4 SGT [redacted] 9W
2030 17 Apr 03	BP 122/60 T 99.3 P 100 R16 Dressing C/D/I pt. is c/o pain or discomfort at this time will continue to monitor [redacted] SGT
2200 17 Apr 03	PT given Lovenox. [redacted] SGT. 91W
2250 17 Apr 03	PT C/O Pain and not being able to sleep given 4mg of MSO4 & 2 Tylenol #3. PT Sleeping. SGT. [redacted] 91W
18 Apr 03 0115	4mg of MSO4 given for pain. [redacted] SGT 91W
18 Apr 03 0400	4mg of MSO4 given for pain. [redacted] SGT 91W
0740	Pt had problem sleeping last night. Vital signs stable at BP 108/48 P84 R 16 T 98.8. SPC [redacted] 91W

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	PROGRESS NOTES

DATE	NOTES
20 Apr 03 2030	Pt C/O Pain IN (R) Leg + Not being able to Sleep. Pt given ⅡⅡ Percocet PO + 25mg of Phenergan. Pt Now resting. [redacted] SGT 91W20
21 Apr 03 0130	Pt C/O Pain in (R) Leg, PT given 2mg MSO4. [redacted] SGT 91W20
21 Apr 03 0200	VS. Bp 112/60 R-16 T 98.8 P 78 [redacted] SGT 91W20
21 Apr 03	VS Bp 110/52 R 14 T 98.8 P 86 pt c/o pain tolerated percocet ⅡⅡ po @0840 stated they don't help he needs injections because the pain makes him not be able to sleep. Dr. [redacted] ordered restoril 15-30g po qHS had no other complaints pt is now sleeping. received his Gent 300 mg IV @ 1000 and Lovenox 30 mg SQ @1000. [redacted] 91W10
1845	pt asking for sleep meds gave 30mg tab of Restoril [redacted] 91W10
21 Apr 03 2000	Pt Sleeping. CKNG added benadryl 25-50mg IV. to RRN Meds. [redacted] 91W20
2300	Pt c/o of upset stomach gave pt 25 mg Phenergan. [redacted] SGT 91W20
22 Apr 03	V.S. Bp 105/58 R 15 T. 98.8 P87: [redacted] 91W20
0500	Pt awoke c/o Pain in (R) Leg. 4mg MSO4 given. Pt now Resting. [redacted] 91W20

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
22Apr0945 ~~094~~	VS 85/40 T 98.5 P85 R32 92% pt c/o of pain has been given 2mg MsO_4 IV and T-3 ii po since shift Δ. ate all of breakfast received. 06⁰⁰ ancef flushed IV and stabilized it with cover sponge (b)(6)-2 (R) external fixator to (R) femur clean, dry, intact no drainage noted. Drsng to (L) ankle clean, dry, intact ϕ drainage. (b)(6)-2 SPC 91W10
22Apr03 1850	pt ambulated via crutches 10 steps voided 500cc. ate all of meals hasn't had any complaints received 06⁰⁰ ancef. D/C'd old IV replaced with 18g to (L) forearm is patent & intact. (b)(6)-2 91W10 SPC
2050 ~~22~~Apr	Pt returned from outside c/o Pain (R) Leg. Pt given i Restoril & ii Percocet. Pt Now resting (b)(6)-2 SGT 91W20
	VS. BP 95/41 T 98.1° P101 R14 (b)(6)-2 SGT 91W20
0300	Pt c/o Not being able to sleep, Pt given 50mg Benadryl I.V. (b)(6)-2 SGT 91W20
23Apr03 0700	BP ~~110/50~~ 110/50 SpO_2 98 T 98.2 P76 R16 ~~pt consumed all of first~~ Error pt waiting to go to OR Did AM care ambulated via litter and crutches to bathroom gave Gentamycin 300mg IV @ 1000 and Lovenox 30mg SQ @ 1000 IV is patent & intact a little positional Drsng to (R) thigh & (L) heel clean dry & intact no drainage. (b)(6)-2 91W10
(b)(6)-2 ~~1315~~ 1415	received pt from post-op still sleep ~~easily aroused~~ Error not easily aroused T 95.4 P83 SpO_2 98% R16 BP 124/84 drsng to (R) thigh & (L) heel clean dry intact, no drainage. IV CR @ 125cc/hr in (L) forearm. gave ancef 1gm @ 1400 (b)(6)-2 91W10 SPC
1430	pt awake & oriented c/o dizziness ϕ N/V can wiggle toes all of them has good pedal pulse in (R) leg and popliteal. (b)(6)-2 91W10 SPC

98.7

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
1930 23APR03	Pt is alert and oreintated x3. Pt c/o pain in (R) leg recieved 3mg MSO4 prn pain. Lung sounds CTA. RR 20, SPO2 98%, HR 92 RRR, BP 100/58, BS active in all 4 quadrants, Pulses +2 in all extremities, Pt has urinal at bedside. Ø output since 1900, Pt has (R) femur ext. fixator c̄ bandage C/D/I. (L) foot dressing C/D/I. Pt resting comfortably in bed will continue to monitor. SPC [redacted] 9W
24APR 1030	R 18 SPO2 99 P 87 T 98.6 BP 116/56 pt c/o pain gave 4mg MSO4 IV and percocet ÷ PO @ 0850 received his 1000 Gentamycin IV is patent & intact. pt A* Error + O x 3 drsng to (R) thigh is intact wrapped with ace bandage Drsng to (L) heel has bloody + serosanguineous ~~fluid~~ Error drainage just reinforced doctor's want to start Δ Tomonow 4/25 Also received colace 100 mg @ 0840. [redacted] SPC 91W10
1240	pt given 10mg MSO4 ambulated to latrine c/o dizziness when he sits up. Ambulated via crutches to chair also Had BM no c/o pain. [redacted] SPC 91W10
1250	pt c/o pain gave percocet ÷ PO. [redacted] 91W10 SPC
4APR03@1639	Pt given ÷ tabs ~~pc~~ Percocet for c/o leg pain. Resting in bed. [redacted] 1LE RN

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

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PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
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DATE	NOTES
24 Apr 03 2000	Pt after returning from outside complained of pain in (R) Leg Pt was given 4mg MSO4. [redacted] SGT 91W
24 Apr 03 2100	Pt C/O Not being able to sleep. He was given 30mg Restoril PO. [redacted] SGT 91W
24 Apr 2130	VS. BP 109/54 T 99.1 P 94 R 14. PT resting in bed [redacted] 91W
25 Apr 0233	PT C/O Pain given 6mg MSO4 [redacted] SGT 91W
25 APR 03 0945	SpO2 99% P 96 T 98.5 BP 106/60 IV leaked restarted 18g in (L) forearm Drsng to (R) thigh Δ'd pin care done Drsng to (L) heel Δ'd. LS clear pt c/o tightness in chest started to hyperventilate then quickly recovered. SpO2 was 100% HR 133 R 30. HOB↑ gave water and a cool
1400	towel then let him rest and was fine afterwards. Received his Gentamycin @1000 + Ancef @1400. pt ambulated via crutches to bathroom. Is a smoker. c/o pain received percocet ii po @1300 has good pedal pulse in (R) ~~leg~~ Error foot can wiggle toes. is warm + dry. Abdomen soft ∅ distention bs present X4 received colace 30mg @0800. is NPO after midnight. [redacted] spc 91W
1830	R 18 SpO2 98 P 96 T 99.2 BP 112/42 pt has not c/o pain ambulated to bathroom by self with crutches [redacted] 91W spc
2000	VS 98.6, 88, 18 100/58 CBX: (R) Femoral Low External Fixator Drsg D+I good Nerve vascular ✓'s. (L) Heel Drsg D+I Nerve vascular ✓'s wnl. (L) FA IV good Flash/Flush. PT resting, p̄ c/o pain Txed c̄ 6mg MSO4 IOP [redacted] MAT AN
5APR03 @0740	VSS @ 118/68, HR 85, RR 18, T 98.1°F. Pt sitting up to eat. HRR, RRR, CTA, + Circ, + CMS. Pt c/o feeling cold from AC. Pulled up wool blanket. [redacted] 1CIRN
6APR03 @0955	Pt given 5mg IV MSO4 for c/o pain to a dressing Δ. [redacted] 1CIRN

FPI LEX Printed on Recycled Paper STANDARD FORM 509 (REV. 5-99) BACK

MEDCOM - 4146

NSN 7540-01-075-3786

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

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

EPW s/p. GSW (R) thigh and (L) foot. Treated by FST. sustained (R) open femur fx with considerable soft tissue loss and large open (L) heel wound. Wounds debrided by FST and traction splint placed (R) leg.
Chest - BS clear
Abd - Soft, ND/NT
Ext - open fx (R) lateral thigh (large defect), debrided
open medial (L) heal wound
A/P - GSW to (R) thigh, (L) heel.
(1) Admit ICU
(2) Possible OR for ex-fix.

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

(b)(6)-2

DIAGNOSIS

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

BT1 BL 2

MEDICAL RECORD

LRMC INTRA[illegible]TIVE DOCUMENT
For use of this form, see AR 40-46; the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA LITTER BY (b)(6)-2

2. PATIENT IDENTIFIED (Name, Room, Bed, Procedure) VERIFIED BY (b)(6)-2 MAJ AN

3. DATE 11 APR03 TIME PATIENT ARRIVED IN SUITE 1200 Z

4. PATIENT IN ROOM TIME 1200 Z NUMBER 81

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

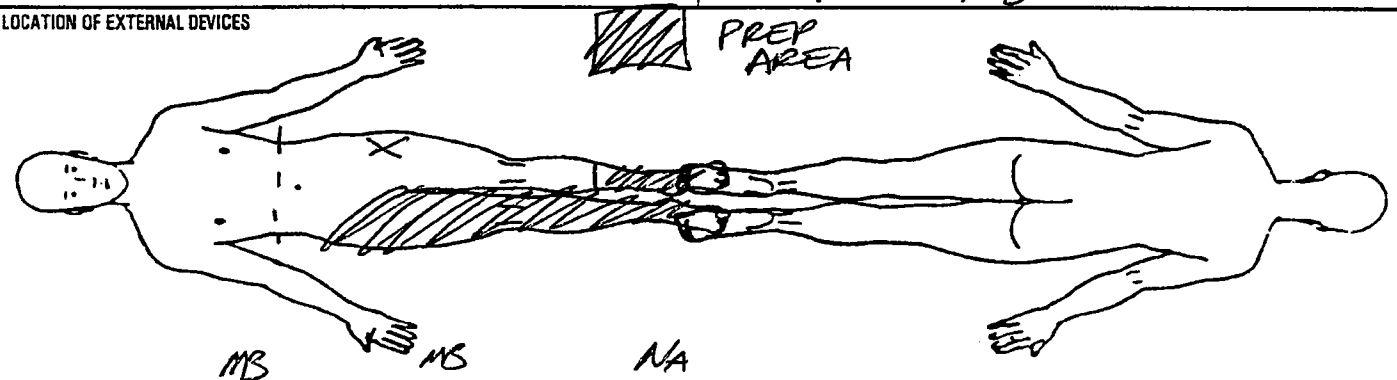
COMMENTS: (R) LEG IN TRACTION C COBAN WRAPS X 2

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* BETA/BETA
SITE: (R) LEG BY WHOM: BORO
SITE: (L) FOOT BY WHOM: BORO
COMMENTS: NO POOLING

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C - Correct I - Incorrect

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

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

(b)(6)-4

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

☒ ESU NO: OR 082 @ 30/30
GROUND PAD: BRAND VALLEYLAB
LOT NO:

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

HONMEDICA ULTRA-X EX FIX
5129-9-135 LOT# 8929869

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

(b)(6)-2

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
XEROFORM
FLUFFS
KERLIX
ACEWRAP

19. ADDITIONAL INFORMATION
The medical record (SF 539), the progress note (SF 509), the operative consent (SF 522), and the patient agree that the correct operative site is the NA side.

Verified by: Patient/guardian Surgeon Anesthesia Operating Room Nurse

20. OPERATION(S) PERFORMED
EX FIX (R) FEMUR
D & I (L) FOOT

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU 3	1330	LITTER

22. REGISTERED NURSE SIGNATURE (b)(6)-2 MAJ/AN

REVERSE OF DA FORM 5179-1, OCT 87

MEDCOM - 4149

M TL OP 358, 2 Mar 00
M , apprvl - 3 Feb 00

USAPA V1.00

MEDICAL RECORD | **INTRAO[illegible]TIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Cart BY LTC (b)(6)-2

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

3. DATE 13 Apr 03 TIME PATIENT ARRIVED IN SUITE 0550Z

4. PATIENT IN[illegible] TIME 0550Z NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC (b)(6)-2 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT (b)(6)-2 AN	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

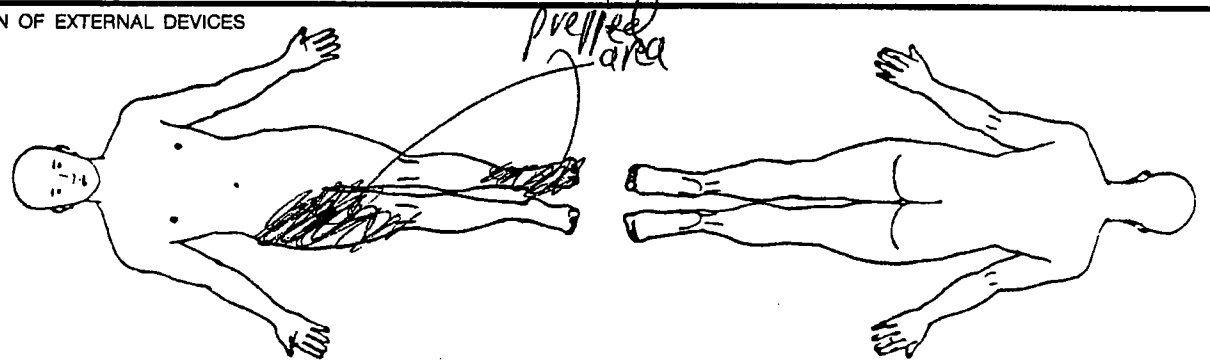
COMMENTS:

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine/Betadine
SITE: BY WHOM:
SITE: BY WHOM:
COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap ▬▬ Tourniquet

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes ☒ No				(b)(6)-2 91D	(b)(6)-2 CPT
Needle Sharp	☒ Yes ☐ No		C	C		
Instrument	☐ Yes ☒ No				SPC	
Other	☐ Yes ☒ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*
(b)(6)-4

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

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

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

☐ BIPOLAR NO: _____

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S): .9NACL

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
Xeroform
fluffs
Kerlix

19. ADDITIONAL INFORMATION

20. OPERATION(S) PERFORMED
Dt I Right thigh, Left foot

21. PATIENT TRANSFERRED TO
ICU 3

TIME Sep
ages recd

METHOD
Letter

(b)(6)-2

ATURE
CPT

REVERSE OF DA FORM 5179-1, 87

*U.S. Government Printing Office: 1995 — 386-733/23952

MEDCOM - 4151

TEST(S)		
SPECIMEN TAKEN		
DATE 20 Apr 03	TIME 0930 A.M. / P.M.	
RESULTS	REQUESTED	(X)
	ROUTINE	
	COLOR	
1.010	SPECIFIC GRAVITY	
norm	UROBILINOGEN	
neg	OCCULT BLOOD	
neg	BILE	
neg	KETONES	
neg	GLUCOSE	
neg	PROTEIN	
8	pH	
	MICROSCOPIC	
	WBC	
	RBC	
	EPITH CELLS	
	WBC (CASTS)	
	RBC (CASTS)	
	HYALINE (CASTS)	
	GRANULAR (CASTS)	
	BACTERIA	
	CRYSTALS	
	MUCUS	
	NITRITE	
	BENCE-JONES PROTEIN	
	HEMOSIDERIN	
	HCG	
neg	Leuk	
neg	Nit	

UA

REMARKS

(b)(6)-2

REQUESTING PHYSICIAN'S SIGNATURE

Enter in above space

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

(b)(6)-4

(b)(6)-4

REPORTED BY

(b)(6)-2

TECH

MD

DATE 20 Apr 03

URINALYSIS

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

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

SPECIMEN SOURCE: ☒ ROUTINE ☐ OTHER (Specify)

LAB. ID NO.

SPECIMEN/LAB RPT NO

PATIENTS MED. RECORD

URINALYSIS 550-107

Standard Form 550 (Rev. 4-77)
General Services Administration and Interagency
Committee on Medical Records FIRMR (41 CFR) 201-45.505

(b)(6)-4

NAME: (b)(6)-4 RGEON: (b)(6)-2 Planned Surgery Date: 11 APR 03

ANESTHESIA PREOPERATIVE EVALUATION

A 3 M F HEIGHT WEIGHT 70 Kg

PROPOSED OPERATION (R) femur ext fixation

PREOPERATIVE VITAL SIGNS: B /P P R

PREVIOUS ANESTHESIA / OPERATIONS ☒ NEGATIVE

CURRENT MEDICATIONS ☒ NONE

FAMILY HISTORY OF ANESTHESIA COMPLICATIONS ☐ NEGATIVE

ALLERGIES ☒ NKDA

AIRWAY / TEETH / HEAD & NECK class I

SYSTEM	WN	COMMENTS	PERTINENT STUDY RESULTS
RESPIRATORY Asthma, Bronchitis, COPD Dyspnea, Pneumonia, Productive Cough Recent cold, SOB, Tuberculosis	☒	Tobacco Use: ☐ No ☐ Yes ____ Pack/Day for ____ Years	Chest X-ray, Pulmonary Studies
CARDIOVASCULAR Angina, Arrhythmia, CHF Exercise Tolerance, Hypertension, MI Murmur, MVP, Pacemaker Rheumatic fever	☒		EKG
HEPATO/GASTROINTESTINAL Bowel obstruction, Cirrhosis, Hepatitis Hiatal Hernia, Jaundice, N&V Reflux/Heartburn, Ulcers	☒	Ethanol Use : ☐ No ☐ Yes Frequency _____	LFTs
NEURO/MUSCULOSKELETAL Arthritis, Back problems, CVA/Stroke DJD, Headaches, Loss of consciousness Neuromuscular disease, Paralysis, Paresthesia Syncope, Seizures, TIAs Weakness	☒		
RENAL/ENDOCRINE Diabetes, Renal failure/Dialysis, Thyroid disease Urinary retention, Urinary tract infection, Weight loss/gain	☒		Urinalysis, Thyroid, FBS
OTHER Anemia, Bleeding tendancies, Hemophilia Pregnancy, Sickle cell trait, Transfusion history		WNL	Hgb / Hct / CBC, Lytes

PROBLEM LIST / DIAGNOSES

Healthy 23 yo ♂

ASA: 1, 2, 3, 4, 5, E

PREOPERATIVE MEDICATIONS ORDERED

COUNSELING STATEMENT

Anesthesia alternatives, benefits and risks from minor to death explained. All questions answered.
Patient / legal guardian voices understanding and gives consent for :
Local / MAC, SAB, Epidural, IVR, General Anes.
Other: _____
Appropriate alternative as backup.
NPO status explained.

PATIENT'S SIGNATURE _____ DATE _____

POST ANESTHESIA VISITS

ANESTHESIA RECOVERY COMPLICATED BY THE FOLLOWING PROBLEMS: (IF NONE, SO STATE)

DATE: _____

SIGNED: _____ TIME: _____

EVALUATOR(S) SIGNATURE

CRNA (b)(6)-2 MAJ / CRNA DATE 11 APR 03

PHYSICIAN _____ DATE _____

MEDCOM - 4153

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974 - AS A CLINICAL RECORD FORM, IT IS COVERED BY DD 2205)

ANESTHESIA RECORD

Page 1 of

ANES. START	IN OR	ANES. END	DATE
1136Z	1200Z	1340	11 APR 03

OPERATION PERFORMED: (R) femur (L) heel Washout ext fixator

SURGEON(S): (b)(6)-2

TOTS	SURG START	DRESSING	OR NO
1205	1240	1325	

PREOPERATIVE

- [x] IDENTIFIED [x] ID BAND [ ] QUESTIONING
- [ ] CHART REVIEWED [x] NPO SINCE 24
- [x] PRE-OP MEDICATION:

Drug	Dose	Route	Time
Versed	2mg	IV	1155

Pre-Anesthetic State:
- [x] CALM [x] SEDATE
- [ ] APPREHENSIVE [ ] UNRESPONSIVE

MONITORS AND EQUIPMENT

- [x] ANES. MACHINE # ____ & EQUIP. CHECKED
- [x] NON-INV. B/P [ ] PNS
- [x] CONT. EKG [ ] V LEAD EKG
- [ ] ESOPH. STETH. [ ] PRECORD STETH.
- [x] PULSE OXIMETER [x] O2 ANALYZER
- [x] END TIDAL CO2 [ ] MASS SPEC.
- [ ] TEMPERATURE ____
- [x] WARMING BLANKET [ ] FLUID WARMER
- [x] AIRWAY HUMIDIFIER ____
- [ ] N / G TUBE [ ] O /G TUBE
- [x] IV(s) 18G (L) arm
- [ ] ARTERIAL LINE ____
- [ ] CENTRAL LINE ____
- [ ] SWAN-GANZ ____
- [ ] FOLEY INSERTED: [ ] O.R. [ ] FLOOR
- [x] EYE CARE OU taped
- [ ] PRESSURE POINTS CHECKED / PADDED

ANESTHETIC TECHNIQUE

- [x] GENERAL [ ] LOCAL / MAC
- [ ] REGIONAL [ ] NERVE BLOCK

INDUCTION

- [x] PREOXYGENATION [ ] INHALATION
- [ ] RAPID SEQUENCE [ ] INTRAMUSCULAR
- [x] INTRAVENOUS [ ] RECTAL

AIRWAY MANAGEMENT

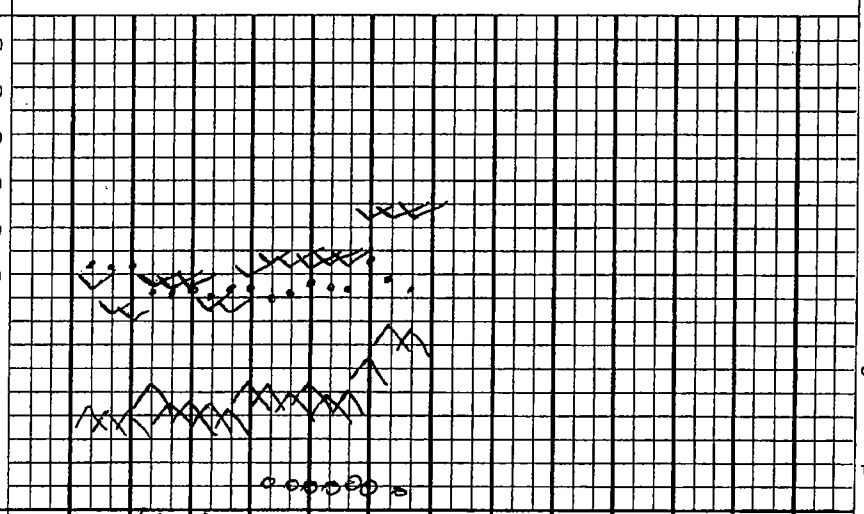
- [x] INTUBATION [x] ORAL [ ] NASAL
- [x] DIRECT VISION [ ] BLIND [ ] AWAKE
- [ ] FIBER OPTIC [x] STYLET USED
- [x] ATTEMPTS x 1 [ ] BLADE 4 MAC
- [x] ETT SIZE 8 [ ] DOUBLE LUMEN
- [x] STRAIGHT [ ] RAE [ ] ANODE
- [x] CUFFED 10 ML AIR INJECTED
- [ ] UNCUFFED, LEAKS AT ____ CM H2O
- [x] ETT SECURED AT 21 CM
- [x] BREATH SOUNDS BSSX 4
- [x] AIRWAY [ ] ORAL [ ] NASAL [ ] NATURAL
- [ ] MASK CASE [ ] VIA TRACHEOSTOMY
- [ ] NASAL CANNULA [ ] SIMPLE O2 MASK
- [ ] LMA SIZE

		1200	15	30	45	1300	15	30	45	1400					TOTALS
AGENTS	Fentanyl ec	2				0.5	0.5								
	SUX	120													
	Propofol	100													
	Fiso %	0.8	1.3	1.4	1.3	1.2	X								
	~~N2O L/min~~ Air	2	1	1	1	1	7								
	O2 L/min	1	6.8	0.8	0.6	0.6	3								
FLUIDS	RL	1000	LR 2	1400											
	Urine														
	EBL														
MONITORS	EKG	SR	SR	SR	SR	SR									
	% O2 Inspired	.9	.9	.9	.50	.43									
	O2 Saturation	100	100	100	100	100									
	End Tidal CO2	48	40	31	53	53									
	Temperature	Available		"	"	"									
	PNS														
RESP	Tidal Volume	700	650	600											
	Resp Rate	12	12	12											
	Peak Pressure	25	22	24											
		Supine	MU	MU	SU	SU	SU								
Symbols for Remarks															
Position	Supine														

TIME

VITAL SIGNS

PRE-OP VALUES	
110/60	B/P
102	P
16	R
98%	SAT
	H/H



SYMBOLS
- X ANESTHESIA
- ⊙ OPERATION
- V ^ B/P CUFF PRESSURE
- ⊥ T ARTERIAL LINE PRESSURE
- ● PULSE
- ○ SPONTANEOUS RESP
- Φ ASSISTED RESP
- ⊠ CONTROLLED RESP
- T TOURNIQUET
- F CRYSTALLOID FLUID
- B BLOOD

RECOVERY

TIME IN PACU	CONDITION
1335	stable

B/P	PULSE	RESP	O2 SAT
140/86	100	16	100

REMARKS RA TEMP 98

REPORT TO: PARRS:

REMARKS:
- [ ] Patient reevaluated. No change from preop plan / evaluation.
- [x] Significant changes from preop plan / evaluation.

1330 opens eyes lifts head oropharynx suctioned ext c (+) pressure

Tourniquet Time:

IN	FLUIDS TOTALS	OUT
Crystalloid 1500 LR	EBL	
	Urine	
Blood minimal	Gastric	

(b)(6)-2

MAJ / CRNA
PHYSICIAN / CRNA

PATIENT'S IDENTIFICATION
(b)(6)-4

NAME (b)(6)-4 RGEON: (b)(6)-2 Planned Surgery Date: 13 APR 03

ANESTHESIA PREO[illegible]ATIVE EVALUATION

A	M / F	HEIGHT	WEIGHT 70 kg

PROPOSED OPERATION

PREOPERATIVE VITAL SIGNS: B/P 147/64 P 78 R 18 99%

PREVIOUS ANESTHESIA / OPERATIONS ☐ NEGATIVE
(R) femur ex-fix 11 APR 03 } GA → ØAL
(L) heel washout

CURRENT MEDICATIONS ☐ NONE
Ancef
Heparin 5000U SQ BII
motrin PRN
T3 PRN
MSO4 PRN

FAMILY HISTORY OF ANESTHESIA COMPLICATIONS ☐ NEGATIVE

ALLERGIES ☒ NKDA

AIRWAY / TEETH / HEAD & NECK
MP 2, THD 4 FB Ord App 3 FB FROM

SYSTEM	WN	COMMENTS	PERTINENT STUDY RESULTS
RESPIRATORY Asthma, Bronchitis, COPD, Dyspnea, Pneumonia, Productive Cough, Recent cold, SOB, Tuberculosis	☒	Tobacco Use: ☐ No ☐ Yes ____ Pack/Day for ____ Years	Chest X-ray / Pulmonary Studies (B) CTA Ø R/R/W
CARDIOVASCULAR Angina, Arrhythmia, CHF, Exercise Tolerance, Hypertension, MI, Murmur, MVP, Pacemaker, Rheumatic fever	☒		EKG RR SIESZ, ØA
HEPATO/GASTROINTESTINAL Bowel obstruction, Cirrhosis, Hepatitis, Hiatal Hernia, Jaundice, N&V, Reflux/Heartburn, Ulcers	☒	Ethanol Use: ☐ No ☐ Yes Frequency ____	LFTs NPO since M.N.
NEURO/MUSCULOSKELETAL Arthritis, Back problems, CVA/Stroke, DJD, Headaches, Loss of consciousness, Neuromuscular disease, Paralysis, Paresthesia, Syncope, Seizures, TIAs, Weakness	☒	(R) femur fx (L) heel wound	
RENAL/ENDOCRINE Diabetes, Renal failure/Dialysis, Thyroid disease, Urinary retention, Urinary tract infection, Weight loss/gain	☒		Urinalysis / Thyroid / FBS
OTHER Anemia, Bleeding tendancies, Hemophilia, Pregnancy, Sickle cell trait, Transfusion history			Hgb / Hct / CBC / Lytes

PROBLEM LIST / DIAGNOSES

ASA: (1) 2 3 4 5 E

PREOPERATIVE MEDICATIONS ORDERED

COUNSELING STATEMENT

Anesthesia alternatives, benefits and risks from minor to death explained. All questions answered.
Patient / legal guardian voices understanding and gives consent for:
(Local / MAC,) SAB, Epidural, IVR, General Anes.
Other: ____
Appropriate alternative as backup.
NPO status explained.

PATIENT'S SIGNATURE ____ DATE ____

EVALUATOR(S) SIGNATURE

CRNA ____ DATE ____

PHYSICIAN (b)(6)-2 DATE 13 APR 03

POST ANESTHESIA VISITS

ANESTHESIA RECOVERY COMPLICATED BY THE FOLLOWING PROBLEMS: (IF NONE, SO STATE)

DATE: ____

SIGNED: ____ TIME: ____

MEDCOM - 4155

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974 - AS A CLINICAL RECORD FORM, IT IS COVERED BY DD 2205)

ANESTHESIA RECORD

Page 1 of 1 | ANES. START 0530 | IN OR 0547 | ANES. END | DATE 13 APR 03

OPERATION PERFORMED: WASHOUT LT Foot Rt Thigh | SURGEON(S) | TOTS 0555 | SURG START 0600 | DRESSING 0620 | OR NO 2

PREOPERATIVE

- [x] IDENTIFIED [ ] ID BAND [ ] QUESTIONING
- [ ] CHART REVIEWED [x] NPO SINCE
- [ ] PRE-OP MEDICATION:

Drug	Dose	Route	Time
versed	2 mg	IVP	530
Reglan	10 mg	IVP	530
Zantac	50 mg	IVP	541

Pre-Anesthetic State: [ ] AWAKE [ ] CALM [ ] SEDATE [ ] APPREHENSIVE [ ] UNRESPONSIVE

MONITORS AND EQUIPMENT

- [x] ANES. MACHINE # 1 & EQUIP. CHECKED
- [ ] NON-INV. B/P [ ] PNS
- [x] CONT. EKG [ ] V LEAD EKG
- [ ] ESOPH. STETH. [ ] PRECORD STETH.
- [ ] PULSE OXIMETER [ ] O2 ANALYZER
- [ ] END TIDAL CO2 [ ] MASS SPEC.
- [ ] TEMPERATURE RVM
- [ ] WARMING BLANKET [ ] FLUID WARMER
- [ ] AIRWAY HUMIDIFIER
- [ ] N / G TUBE [ ] O /G TUBE
- [ ] IV(s)
- [ ] ARTERIAL LINE
- [ ] CENTRAL LINE
- [ ] SWAN-GANZ
- [ ] FOLEY INSERTED: [ ] O.R. [ ] FLOOR
- [ ] EYE CARE
- [ ] PRESSURE POINTS CHECKED / PADDED

ANESTHETIC TECHNIQUE

- [ ] GENERAL [x] LOCAL / MAC
- [ ] REGIONAL [ ] NERVE BLOCK

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 [x] NATURAL
- [ ] MASK CASE [ ] VIA TRACHEOSTOMY
- [ ] NASAL CANNULA [ ] SIMPLE O2 MASK
- [ ] LMA SIZE - NR FM.

																		TOTALS
			4	100	15	30	4	200										
AGENTS	Fentanyl			50	50													
	Propofol			30	30	30												
	Bupivacaine																	
	Versed				1													
	Ketamine	25			25													
	N2O L/min																	
	O2 L/min	VR	FM	5	5													
FLUIDS																		
	LR	1000		—														
	Urine																	
	EBL																	
MONITORS	EKG			ST	ST	ST												
	% O2 Inspired			FM	—	FM												
	O2 Saturation			100	100	100												
	End Tidal CO2			+	+	+												
	Temperature																	
	PNS																	

VITAL SIGNS — TIME — PRE-OP VALUES — B/P, P, R, SAT, H/H — 200, 180, 160, 140, 120, 100, 80, 60, 40, 20

RESP				
Tidal Volume	FV	FV	FV	FV
Resp Rate				
Peak Pressure				

Symbols for Remarks

Position

SYMBOLS: X ANESTHESIA; ⊙ OPERATION; V ^ B/P CUFF PRESSURE; ⊥ T ARTERIAL LINE PRESSURE; ● PULSE; ○ SPONTANEOUS RESP; Ø ASSISTED RESP; ⊗ CONTROLLED RESP; T TOURNIQUET; F CRYSTALLOID FLUID; B BLOOD

RECOVERY

TIME IN PACU	CONDITION		
0624	oriented		
B/P 171/84	PULSE 99	RESP	O2 SAT 99
REMARKS			TEMP 97

REPORT TO: PARRS:

REMARKS: [x] Patient reevaluated. No change from preop plan / evaluation. [ ] Significant changes from preop plan / evaluation.

~~Induced intubated~~ ~~EYES bilateral taped shut~~ ~~O2 mask nasal cannula~~ at 0547 in Room 0624 00 OR

Tourniquet Time:

FLUIDS TOTALS

IN		OUT	
Crystalloid	1200	EBL	100
		Urine	
		Gastric	0
Blood			

(b)(6)-2 LTC

SICIAN / CRNA

PATIENT'S IDENTIFICATION (b)(6)-4

(THIS FORM IS SUBJECT TO THE PRIVA... ...F 15 ...S A CLINICAL RECORD FORM, IT IS COVERED BY DD 220

ANESTHESIA RECORD

Page 1

ANES. START	IN OR	ANES. END	DATE
0955	1000	1143	17APR03
TOTS	SURG START	DRESSING	OR NO
1005	1021	1135	

OPERATION PERFORMED: I+D, Revise Ex Fix Comm

SU (b)(6)-2

PREOPERATIVE

- [x] IDENTIFIED [x] ID BAND [ ] QUESTIONING
- [ ] CHART REVIEWED [ ] NPO SINCE
- [ ] PRE-OP MEDICATION: Drug Dose Route Time

Pre-Anesthetic State: [x] CALM [ ] APPREHENSIVE [x] AWAKE [ ] SEDATE [ ] UNRESPONSIVE

MONITORS AND EQUIPMENT

- [x] ANES. MACHINE # ___ & EQUIP. CHECKED
- [x] NON-INV. B/P [ ] PNS
- [x] CONT. EKG [ ] V LEAD EKG
- [ ] ESOPH. STETH. [ ] PRECORD STETH.
- [x] PULSE OXIMETER [x] O2 ANALYZER
- [ ] END TIDAL CO2 [ ] MASS SPEC.
- [ ] TEMPERATURE
- [ ] WARMING BLANKET [ ] FLUID WARMER
- [ ] AIRWAY HUMIDIFIER
- [ ] N/G TUBE [ ] O/G TUBE
- [x] IV(s) PIV (L) AC
- [ ] 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 [x] NATURAL
- [ ] MASK CASE [ ] VIA TRACHEOSTOMY
- [ ] NASAL CANNULA [x] SIMPLE O2 MASK
- [ ] LMA SIZE

RECOVERY

TIME IN PACU	CONDITION		
1142	Stable		
B/P 144/72	PULSE 110	RESP 16	O2 SAT 100
REMARKS			TEMP

REPORT TO (b)(6)-2 PARRS:

IN	FLUIDS TOTALS	OUT
Crystalloid 800	EBL min	
	Urine NM	
Blood 0	Gastric	

AGENTS

	1000	x 30	x 1100	x 30	TOTAL
Ketamine	100	50	50	100	
Midaz	25				
Fentanil	100				
MSO4		5			
N2O L/min					
O2 L/min					

FLUIDS

LR					800		
Urine							
EBL							

MONITORS

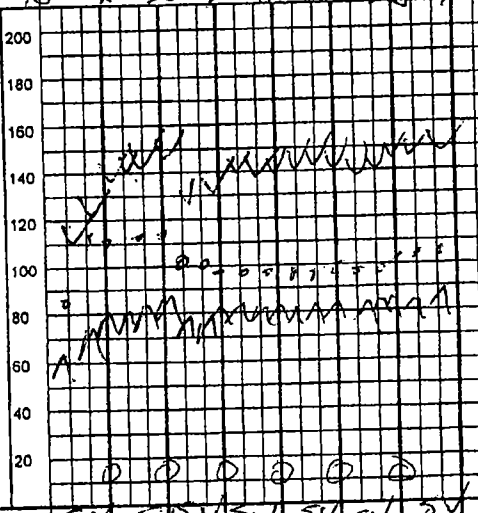
EKG	SR	ST	ST	SR	SR	SR	SR
% O2 Inspired	RA	RA	RA	RA	RA	RA	RA
O2 Saturation	98	99	99	99	99	100	100
End Tidal CO2							
Temperature							
PNS							

TIME

1000 x 30 x 1100 x 30 x 1200

VITAL SIGNS

PRE-OP VALUES: B/P ___ P ___ R ___ SAT ___ H/H ___



RESP

Tidal Volume	SV	SV	SV	SV	SV	SV	SV
Resp Rate	12	14	12	14	12	16	16
Peak Pressure							

Symbols for Remarks

Position: on

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

SYMBO... X ANESTH... OPERAT... B/P CL... PRESSI... ARTER... LINE PRESSI... PULS... SPONT... OUS R... ASSIS... RES... CONTRO... RES... T TOURNI... F CRYS... LOID F... E BLO...

MEDCOM - 4157

MSEHU OP 100, APR 00(Rev) (MRRC APPROVED: ...

(THIS FORM IS SUBJECT TO THE PRIVAC ... 1974 - AS A CLINICAL RECORD FORM, IT IS COVERED BY DD 220

ANESTHESIA RECORD

Dressing Δ

Page 1 of 1

ANES. START	IN OR	ANES. END	DATE
0905	0910	0945	20 APR 02
TOTS	SURG START	DRESSING	OR NO
0915	0917	0932	1 L

OPERATION PERFORMED: I&D; I+D Lute

SURGEON(S) (b)(6)-2

PREOPERATIVE

- [x] IDENTIFIED
- [ ] ID BAND
- [ ] QUESTIONING
- [ ] CHART REVIEWED
- [ ] NPO SINCE
- [ ] PRE-OP MEDICATION:

Drug	Dose	Route	Time
NA			

Pre-Anesthetic State:
- [x] CALM
- [ ] APPREHENSIVE
- [ ] AWAKE
- [ ] SEDATE
- [ ] UNRESPONSIVE

MONITORS AND EQUIPMENT

- [x] ANES. MACHINE # ___ & EQUIP. CHECKED
- [x] NON-INV. B/P
- [x] CONT. EKG
- [ ] ESOPH. STETH.
- [x] PULSE OXIMETER
- [ ] END TIDAL CO2
- [ ] TEMPERATURE NA
- [ ] WARMING BLANKET
- [ ] AIRWAY HUMIDIFIER
- [ ] N / G TUBE
- [ ] IV(s) LR
- [ ] ARTERIAL LINE
- [ ] CENTRAL LINE
- [ ] SWAN-GANZ
- [ ] FOLEY INSERTED: [ ] O.R. [ ] FLOOR
- [ ] EYE CARE
- [x] PRESSURE POINTS CHECKED / PADDED
- [ ] PNS
- [ ] V LEAD EKG
- [ ] PRECORD STETH.
- [ ] O2 ANALYZER
- [ ] MASS SPEC.
- [ ] FLUID WARMER
- [ ] O/G TUBE

ANESTHETIC TECHNIQUE

- [ ] GENERAL
- [ ] REGIONAL
- [x] LOCAL / MAC
- [ ] NERVE BLOCK

INDUCTION

- [ ] PREOXYGENATION
- [ ] RAPID SEQUENCE
- [x] INTRAVENOUS
- [ ] INHALATION
- [ ] INTRAMUSCULAR
- [ ] RECTAL

AIRWAY MANAGEMENT

- [ ] INTUBATION
- [ ] DIRECT VISION
- [ ] FIBER OPTIC
- [ ] ATTEMPTS x ___
- [ ] ETT SIZE ___
- [ ] STRAIGHT
- [ ] CUFFED ___ ML AIR INJECTED
- [ ] UNCUFFED, LEAKS AT ___ CM H2O
- [ ] ETT SECURED AT ___ CM
- [ ] BREATH SOUNDS
- [ ] AIRWAY [ ] ORAL [ ] NASAL [x] NATURAL
- [ ] MASK CASE
- [ ] NASAL CANNULA
- [ ] LMA SIZE
- [ ] ORAL [ ] BLIND [ ] NASAL [ ] AWAKE
- [ ] STYLET USED
- [ ] BLADE ___
- [ ] DOUBLE LUMEN
- [ ] RAE [ ] ANODE
- [ ] VIA TRACHEOSTOMY
- [ ] SIMPLE O2 MASK

RECOVERY

TIME IN PACU	CONDITION		
0935	Awake/Stable		
B/P	PULSE	RESP	O2 SAT
122/75	102	18	98

REMARKS

TEMP

REPORT TO: MAJ SLACK PARRS:

IN FLUIDS TOTALS OUT

Crystalloid:	EBL: ~~I+D~~
	Urine: ∅ I+D
	Gastric:
Blood: ∅	

AGENTS

			TOTAL
Robinul	mg	.3	.3mg
Valium	mg	5	5mg
Ketamine	mg	100	100mg
Fentanyl	mg	050	5+
Versed		2	2mg
N2O L/min			
O2 L/min			

FLUIDS

LR		
Urine	NOT meant	
EBL		

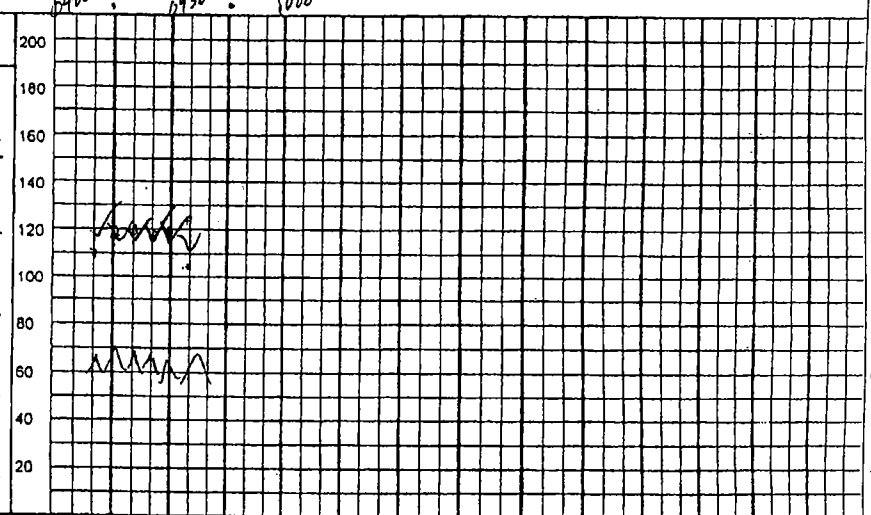
MONITORS

EKG	SR	SR
% O2 Inspired	RA	RA
O2 Saturation	96	98
End Tidal CO2		
Temperature	AVAIL	
PNS		

VITAL SIGNS

TIME: 0900 · 0930 · 1000

PRE-OP VALUES	
136/62	B/P
90	P
14	R
RA 97	SAT
	H/H



RESP

Tidal Volume			
Resp Rate	12	14	15
Peak Pressure			
Symbols for Remarks	SV	SV	SV
Position	Supine		

REMARKS:
- [ ] Patient reevaluated. No change from preop plan / evaluation.
- [ ] Significant changes from preop plan / evaluation.

SYMBO
X ANESTH
OPERA
B/P CL PRESS
ARTER LINE PRESS
PULS
SPONT OUS R
ASSIS RES
CONTRO RES
T TOURNI
F CRYS LOID F
E BLO

(b)(6)-2

Tourniquet Time:

PATIENT'S IDENTIFICATION

(b)(6)-4

PHYSICIAN / CRNA

MEDCOM - 4158

(THIS FORM IS SUBJECT TO THE PRIVAC... 1974 - AS A CLINICAL RECORD FORM, IT IS COVERED BY DD 220

ANESTHESIA RECORD

Part closure of (L) femur wound

Page 1 of

ANES. START	IN OR	ANES. END	DATE
1030	1045	1230	23 Apr 03
TOTS	SURG START	DRESSING	OR NO
1050	1055	1213	

OPERATION PERFORMED: I & D of (R) femur + (L) heel

SURGEON(S): N

PREOPERATIVE

- [x] IDENTIFIED [ ] ID BAND [ ] QUESTIONING
- [x] CHART REVIEWED [ ] NPO SINCE MN
- [ ] PRE-OP MEDICATION:

Drug	Dose	Route	Time

Pre-Anesthetic State: [x] AWAKE [ ] SEDATE [x] CALM [ ] APPREHENSIVE [ ] UNRESPONSIVE

MONITORS AND EQUIPMENT

- [ ] ANES. MACHINE # ____ & EQUIP. CHECKED
- [x] NON-INV. B/P [ ] PNS
- [x] CONT. EKG [ ] V LEAD EKG
- [ ] ESOPH. STETH. [ ] PRECORD STETH.
- [x] PULSE OXIMETER [x] O2 ANALYZER
- [x] END TIDAL CO2 [ ] MASS SPEC.
- [x] TEMPERATURE ____
- [ ] WARMING BLANKET [ ] FLUID WARMER
- [ ] AIRWAY HUMIDIFIER ____
- [ ] N / G TUBE [ ] O / G TUBE
- [x] IV(s) ____
- [ ] ARTERIAL LINE ____
- [ ] CENTRAL LINE ____
- [ ] SWAN-GANZ ____
- [ ] FOLEY INSERTED: [ ] O.R. [ ] FLOOR
- [ ] EYE CARE ____
- [ ] PRESSURE POINTS CHECKED / PADDED

ANESTHETIC TECHNIQUE

- [x] GENERAL [x] LOCAL / MAC
- [ ] REGIONAL [ ] NERVE BLOCK
- [ ] ____

Ketamine simple mask

INDUCTION SV

- [x] PREOXYGENATION [ ] INHALATION
- [ ] RAPID SEQUENCE [ ] INTRAMUSCULAR
- [ ] INTRAVENOUS [ ] RECTAL
- [ ] ____

AIRWAY MANAGEMENT

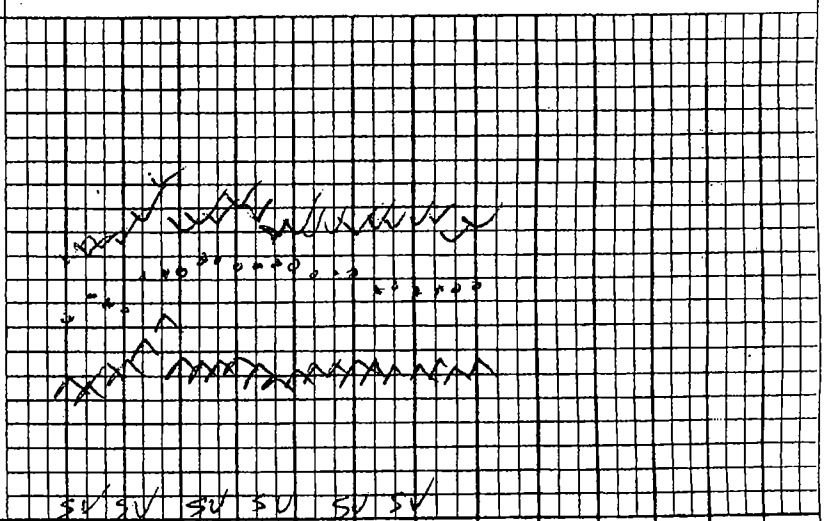
- [ ] INTUBATION [ ] ORAL [ ] NASAL
- [ ] DIRECT VISION [ ] BLIND [ ] AWAKE
- [ ] FIBER OPTIC [ ] STYLET USED
- [ ] ATTEMPTS x ____ [ ] BLADE ____
- [ ] ETT SIZE ____ [ ] DOUBLE LUMEN
- [ ] STRAIGHT [ ] RAE [ ] ANODE
- [ ] CUFFED ____ ML AIR INJECTED
- [ ] UNCUFFED, LEAKS AT ____ CM H2O
- [ ] ETT SECURED AT ____ CM
- [ ] BREATH SOUNDS ____
- [ ] AIRWAY [ ] ORAL [ ] NASAL [ ] NATURAL
- [ ] MASK CASE [ ] VIA TRACHEOSTOMY
- [ ] NASAL CANNULA [x] SIMPLE O2 MASK
- [ ] LMA SIZE
- [ ] ____

		1045	1100	30	1200	30	1300	TOTAL
AGENTS	Ketamine	<100>	140	<200>	<100>			
	Versed	(2)	<2>					
	MSO4	(2-3)	<5>					
	Propofol	20	30	40-60	K(100)			
	Toradol					30		
	Zofran				8			
	N2O L/min							
	O2 L/min FM	4	4	4	4	4	3 RA	
FLUIDS	LR							
	Urine							
	EBL							
MONITORS	EKG	SR	ST	ST	ST	ST	SR	SR
	% O2 Inspired	.9	.9	.9	.9	.9	.9	.9
	O2 Saturation	100	100	100	100	100	100	100
	End Tidal CO2							
	Temperature							
	PNS							

TIME

PRE-OP VALUES: B/P 108/69; P 80

VITAL SIGNS: B/P, P, R, SAT, H/H



		1045	1100	30	1200	30	1300
RESP	Tidal Volume						
	Resp Rate	16	16	16	16	16	16	16
	Peak Pressure						
	SAT	SV	SV	SV	SV	SV	SV
Symbols for Remarks							
Position							

SYMBOLS: X ANESTH; ⊙ OPERAT; V ^ B/P CL PRESS; ⊥ T ARTER LINE PRESS; ● PULS; C SPONTANEOUS R; ◐ ASSIS RES; ⊗ CONTRO RES; T TOURNI; F CRYS LOID F; E BLO

RECOVERY

TIME IN PACU	CONDITION
1230	

B/P	PULSE	RESP	O2 SAT
103/65	94		99%

TEMP 98 RA

REMARKS

REPORT TO: PARRS:

REMARKS: [ ] Patient reevaluated. No change from preop plan / evaluation. [ ] Significant changes from preop plan / evaluation.

In RM @ 1045

To ICU #3 for recovery

Tourniquet Time:

FLUIDS TOTALS

IN		OUT	
Crystalloid: LR 1000		EBL	Mini
		Urine	
		Gastric	
Blood			

(b)(6)-2

Maj, CRNA

PATIENT'S IDENTIFICATION

(b)(6)-4

NAME: SURGEON: Planned Surgery Date:

ANESTHESIA PREOPERATIVE EVALUATION

AGE	M / F	HEIGHT	WEIGHT

PROPOSED OPERATION

PREOPERATIVE VITAL SIGNS: B/P P R

PREVIOUS ANESTHESIA / OPERATIONS ☐ NEGATIVE

CURRENT MEDICATIONS ☐ NONE

FAMILY HISTORY OF ANESTHESIA COMPLICATIONS ☐ NEGATIVE

ALLERGIES ☐ NKDA

AIRWAY / TEETH / HEAD & NECK

SYSTEM				WN	COMMENTS	PERTINENT STUDY RESULTS	
RESPIRATORY				☐	Tobacco Use: ☐ No ☐ Yes____ Pack/Day for____ Years	Chest X-ray	Pulmonary Studies
Asthma	Bronchitis	COPD					
Dyspnea	Pneumonia	Productive Cough					
Recent cold	SOB	Tuberculosis					
CARDIOVASCULAR				☐		EKG	
Angina	Arrhythmia	CHF					
Exercise Tolerance	Hypertension	MI					
Murmur	MVP	Pacemaker					
Rheumatic fever							
HEPATO/GASTROINTESTINAL				☐	Ethanol Use: ☐ No ☐ Yes Frequency _____	LFTs	
Bowel obstruction	Cirrhosis	Hepatitis					
Hiatal Hernia	Jaundice	N&V					
Reflux/Heartburn	Ulcers						
NEURO/MUSCULOSKELETAL				☐			
Arthritis	Back problems	CVA/Stroke					
DJD	Headaches	Loss of consciousness					
Neuromuscular disease	Paralysis	Paresthesia					
Syncope	Seizures	TIAs					
Weakness							
RENAL/ENDOCRINE				☐		Urinalysis	Thyroid FBS
Diabetes	Renal failure/Dialysis	Thyroid disease					
Urinary retention	Urinary tract infection	Weight loss/gain					
OTHER						Hgb / Hct / CBC	Lytes
Anemia	Bleeding tendencies	Hemophilia					
Pregnancy	Sickle cell trait	Transfusion history					

PROBLEM LIST / DIAGNOSES

ASA
1
2
3
4
5
E

PREOPERATIVE MEDICATIONS ORDERED

COUNSELING STATEMENT

Anesthesia alternatives, benefits and risks from minor to death explained. All questions answered.

Patient / legal guardian voices understanding and gives consent for :

Local / MAC, SAB, Epidural, IVR, General Anes.

Other: _____

Appropriate alternative as backup.

NPO status explained.

PATIENT'S SIGNATURE _____ DATE _____

EVALUATOR(S) SIGNATURE

CRNA _____ DATE _____

PHYSICIAN _____ DATE _____

POST ANESTHESIA VISITS

ANESTHESIA RECOVERY COMPLICATED BY THE FOLLOWING PROBLEMS: (IF NONE, SO STATE)

Stable. B/P - 103/65, P-87, RR 22 SaO2 100%, RA lungs CTA, VBS bowel capacity, alert x4 (b)(6)-2

SIGNED: (b)(6)-2 HCT/AN DATE: 04/23/03 TIME: 1245

MEDCOM - 4160

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. | BED NO.

DATE OF ORDER 11 April 03 TIME OF ORDER 1000Z HOURS

LIST TIME ORDER NOTED AND SIGN

1 Admit Patient to ICU

2 Diagnosis: (R) fever fx, (L) heel wound

3 Condition: Stable/Serious/Critical

4 Allergies: NKDA/

5 Vital signs q hr/q2hr/q6hr/q8hr/q shift

6 Cardiac respiratory monitoring

7 Diet: NPO/ regular/ soft/ clear liquid

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER WHEN AWAKE 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

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER _____ HOURS

13 PCXRAY q AM/QOD

14 IVF NS/ LR/ D5NS/ D51/2NS To run @ 150 cc/hr.

15 Ancef 1 GM IV Q 8 hrs first dose now

16 Gentamycin IV Q

17 Cefoxitin 2gm IV q8hrs. O/C IVF WHEN AWAKE

18 O2 titrate to keep SPO2 > 98%.

19 Versed gtt 1-10mg/hr IV titrate to

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

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 1-2

22 MSO4 2-8 MG IV q 4 HR PRN Pain

23 Phenergan 12.5-25mg IV q 4-6hrs PRN N/V

24 MOM 30cc PRN Gastric upset

NURSING UNIT | ROOM NO. | BED NO.

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

(b)(6)-2

CLINICAL RECORD - 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	TIME OF ORDER	LIST TI ORDE NOTED SIGN
	11APR03	HOURS	
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	tetanus 0.5 ml SQ IM		
29	Heparin 5000 units SQ BID		
	Jeffe 5431		

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

PATIENT IDENTIFICATION

	DATE OF ORDER	TIME OF ORDER	
	4/11/03	1330 (Z) HOURS	
1	NO DRESSING Δ UNTIL 13 APRIL 2003		1400

(b)(6)-2

NURSING UNIT | ROOM NO.

(b)(6)-2

PATIENT IDENTIFICATION

	DATE OF ORDER	TIME OF O	
	11APR03	1530 HOURS	
1	Heplock IV		
2	T#3		
	T-TI p.o.		
	Q6 PRN pain		

NOTED 11APR03 1900

(b)(6)-2

1535

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)-4

	DATE OF ORDER	TIME OF ORDER	
	4/13/03	0820 HOURS	
1	✓Resume previous order		
	✓Reg diet		
	✓Q6 IVF when tol. pr well		
	✓IVF: LR @ 100 cc/hr		
	~~Keflex 250mg pr Q6~~		
	Anvil ± gm IVF @ 8° x 48°		
	Chem 16 Keflex 250 Q6		

13 Apr CC

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

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

NO DRESSING Δ FOR 48°

(b)(6)-2

MEDCOM - 4162

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. | BED NO.

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

14 Apr 03 0955Z HOURS

Admit to MCW 2

Condition Stable

Diet as tolerated

VS BID

Meds: MSO4 5mg/IV Q4-6° prn pain

Tylenol #3 PO I-II Q4-6° prn pain

Motrin 800mg PO TID

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

Heparin 5000U HOURS SQ BID

Maintain Heplock

(b)(6)-2

14 Apr 03 1050 LTC, AN FNP

Ancef 1gm Q8° IV x 72°

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE O

LTC, AN FNP HOURS

4/14/03

Q GenT 300mg IV Q 24°

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

15 Apr 03 0555Z HOURS

1. X-ray (R) femur

2. NPO tonight @ midnight - OR tomorrow

3. X-ray (L) foot/ankle (3 views)

(b)(6)-2

LTC, AN FNP

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

MEDICAL RECORD - DOCTOR'S ORDERS

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

DIRECTIONS: The provider will DATE, TIME, and SIGN each order or set of orders recorded. Only one order is allowed per line. Nursing will list the time the new order(s) are noted and initial in the column provided. Orders completed during the shift in which they were written do not require recopying. They may be signed off, as completed, in the far right column.

ORDER NUMBER	17APR03 1145 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 20 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		
	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

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. | BED NO.

DATE OF ORDER 4/17/03 TIME OF ORDER 1100 HOURS

Adit to ward
S/P I+D ex fix (R) for fx
I+D (L) heel ward
stable
Vitals routine
Act bed rest
Diet reg

LIST TIME ORDER NOTED AND SIGN

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

D52R @ 70cc/hr heplock c̄ good po
Meds ancef ¢ g IVq 8°
Vicodin ¢ ¢ po q 4° pm
MSO4 2-4g IVq 2° pm
Phenergan 12.5-25mg IMq 6°
Lovenox 30g SQ bid

[illegible] SEARLE

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 18 Apr 03 TIME OF ORDER 08:10 HOURS

Ambien 10mg PO q HS PRN

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 4/18/03 TIME OF ORDER HOURS

1) May substitute Tylenol #3 for Vicodin since pharmacy out of Vicodin

(b)(6)-2

(b)(6)-2 9 Apr 03 (b)(6)-2 CAT AN

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77 WHICH MAY BE (b)(6)-2 20 APR 03 (b)(6)-2 MAJ AN

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994-363-710

MEDCOM - 4165

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. | BED NO.

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

Admit to ward 4/20/03 0930 HOURS

(R) segmental fem fx, (L) heel wound

Stable

Vitals routine

Act - ad lib

Diet reg

IV D5 2K @ 80 ml/hr beplock c̄ good

Meds T#3 ÷ - ÷ po q 4° pm

(b)(6)-2

20 Apr 03 / 1030

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

Percocet ÷ - ÷ po q 4° pm HOURS

MSO4 2-4 mg IV q 2° pm

Cancef ÷ g IV q 8°

Phenergan 12.5-25 mg IM q 6° pm

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2 MAT AN [illegible]

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

4/21/03 HOURS

Percocet ÷ - ÷ po q 4° pm

Restoril 15-30 mg po qhs prn

Dilaudid 2-4 mg po q 4° pm

Demerol 50-100 mg po q 4° pm

(b)(6)-2

24° chart check done

(b)(6)-2 @ 1100 mg / 22 Apr 03

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

21 Apr 03 HOURS

(1) Benadryl 25-50 mg IV qhs prn sleep

(b)(6)-2

CPT AN CRNA

- noted 0100/22 April 03 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 73 WHICH MAY BE USED.

MEDCOM - 4166

CLINICAL RECORD - DO

For use of this form, see AR 40-66, t OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ... BLEM ORIEN ... RD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATE ... W.

PATIENT IDENTIFICATION			DATE OF ORD	E OF ORD	T TIME RDER ED AND IGN
(b)(6)-4			22Apr03		
			Percocet 1/1 - 4/11 PO Q4° PRN PAIN		
			NO Q8°		
				NO Given by to Spc (b)(6)-2	(b)(6)-2 9W10
				Noted 23Apr03	
NURSING UNIT	ROOM NO.	BED NO.		(b)(6)-2	

PATIENT IDENTIFICATION			DATE OF ORD	E OF ORD
NURSING UNIT	ROOM NO.	BED NO.		

PATIENT IDENTIFICATION			DATE OF ORD	E OF ORD
NURSING UNIT	ROOM NO.	BED NO.		

PATIENT IDENTIFICATION			DATE OF ORD	E OF ORD
NURSING UNIT	ROOM NO.	BED NO.		

DA FORM 1 APR 79 **4256** REPLACES EDITION OF 1 JUL 77, ... USED.

☆ U.S. GOVERNMENT PRINTING O...

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			23 APR 03	1930 HOURS	
			(1) Colace 100mg Cap PO BID		
			(b)(6)-2		(b)(6)-2
NURSING UNIT	ROOM NO.	BED NO.		M	23 APR 03 2050

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER
			4/25/03	HOURS
			NPO 7mn	
NURSING UNIT	ROOM NO.	BED NO.	(b)(6)-2	

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: 1994-363-710

CLINICAL RECORD - DOC S
For use of this form, see AR 40-66, the is OT G

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF C BLEM OR RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED W.

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF OR | E OF OR | TIME DER ED AND GN

① Heplock IV
② NPO after midnight
Verbal Dr (b)(6)-2

(b)(6)-2 MAT (b)(6)-2 F. AN

noted 19 APR 03 @ 1612hr

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF OR | E OF O

4/27/03
Contin Gentamicin 400mg IV QD
Lovenox 30mg Im BID
~~Pin drainage A (L) foot~~
NPO > MN.
MSO4 2-10mg IV Q 3-6° PRN.

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF OR | E OF OR

4/23/03 1215
Admit to ward
Dx: (R) open femur fx
Cond: stable
VS Q4°
Activity: up Ad Lib on crutches
Wt bearing as tol'd on (L) LE
Nursing: Up on crutches BID
Wet to dry dressing changes to (R) thigh and (L) heel BID
Pin care BID

(b)(6)-2

Noted 23 Apr 03 1245

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF OR | E OF OR

Diet: Reg.
IV LR @ 125; hep lock when tol'g PO
Meds: Ancef Tg IVPB Q8°
Gentamicin 400 mg IV QD
MSO4 2-10mg IV Q3-6° prn pain
Restoril 15-30mg PO QHS prn sleep
Phenergan 12.5-25mg IV Q6° prn nausea

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 7 SED.

☆ U.S. GOVERNMENT PRINTING C

MEDCOM - 4169

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. 04 Yr. 05

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 11	12	13
11	(b)(6)-2	VS q shift	07	(b)(6)-2		
			19			
11		APO	07			Reg diet 12 Apr 05
			19	(b)(6)-2		
11		Strict BR	07			
			19			
11		HOB up 30°	07			
			19			
12		Regular Diet	20		(b)(6)-2	
			10	(b)(6)-2		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (R) Femur Fx - (L) heel wound

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

DA FORM 1 OCT 78 4677

EDITION OF 1 DEC 77 MAY BE USED.

MEDCOM - 4170

Zalupiec

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)				Mo 04 Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
11	(b)(6)-2	Admit to ICU 3	11	09:40		(b)(6)-2
11		Dgn: (R) Femur Fx, (L) heel wound	11	09:40		
11		Condition: Stable	11	09:40		
11		No dressing Δ until 13 Apr 03				
13 Apr 03		D/C IVF when tol. P.O.				

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

☆ U.S. GPO:1997-418-290/55267

CLINICAL RECORD	...RAPEUTIC DOCUMENTATION CARE ... (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 04 Yr. 07

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 11	12	13	14	15
11	(b)(6)-2	IVF NS / LR / D5NS D5 1/2NS To run	07	e4				
		@ ~~150~~ cc/hr Δ'd 100 cc/o	19					
11		Ancef 1 GM IV q 8 HRs X48°	02	(b)(6)-2			③ ⑤	
		p̄ 48° 13-15 Apr start	10				③ ⑥	
		PO Keflex. + DC Ancef.	18				④ ⑦	
		Gentamycin IV Q						
		Cefoxitin 2 gm IV q 8hrs						
		02 titrate to keep SPO2 >	07					
			19					
		Versed gtt 1-10mg/hr titrate to Ramsey	07					
		scale of	19					
		Fentanyl gtt start at 50mcg/hr titrate for	07					
		adequate pain control MAX Dose of	19					
		Vecuronium 1mcg/kg/min	07					
			19					
11	(b)(6)-2	~~Hepan'n 5000u SQ bi'd~~	~~06~~	(b)(6)-2				
			18	X	X			
11		Hepan'n 5000u SQ bi'd	10	(b)(6)-2				
			22					
11		HL IV q shift flush	00					
			12					
13Apr03		Keflex 250 mg Q:D						

HL IN 11 Apr 03

ALLERGIES: ☐ YES ☑ NO — NKDA

PRIMARY DIAGNOSIS: (E) Femur Fx, (L) heel wound

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

Treatment Facility: (b)(3)-1

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