ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A11D1	I2	[redacted]	(b)(6)-4 UNK		M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
	264	2	9	UNK

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
NA	2	1340	NA (b)(6)-4

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

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION YEAR	NO
I2				✓

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0	ICW1	UNK

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

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
24		031005

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
ABAA		031003

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYMMDD)
		031003

FOR LOCAL USE

DX: NASAL FX

DX 8020
E8859
Proc 2171 (b)(6)-2 [redacted]
Trauma 9
Inj 231

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK
[redacted] (b)(6)-2	[redacted] (b)(6)-2

DA FORM 3585 MAR 89

ABU GHARAIB MEDICAL TRANSFER REQUEST FORM

DATE OF REQUEST: 02 OCT 03

REQUESTOR: SFC [redacted] / LTC [redacted]
(b)(6)-2 (b)(6)-2

ISN #: _____

COMPOUND: #4

PRIORITY: ASAP

LITTER (AMBULATORY) (CIRCLE)

(b)(6)-4
[redacted]

DESCRIPITION OF INJURIES:
Possible detached retina

* Requesting ophthalmological evaluation

NUMBER OF MEDICAL PERSONNEL ACCOMPANYING: 2

DATE OF TRANSFER: _____

TIME OF TRANSFER: _____

DESTINATION: _____

POC AT DESTINATION: _____

ANTICIPATED LENGTH OF TRANSFER: _____

EQUIPMENT REQUESTS:

NOTE: COORIDINATION IS ALSO REQUIRED THROUGH MOVEMENT CONTROL FOR A TRIP TICKET.

(b)(6)-2

Dear Dr. [redacted]

Good morning R EYE

a case of a posteriorly dislocated cataractous lens with Traumatic iridodialysis & ↗ IOP poorly controlled on antiglaucoma medicines.

Your opinion about consideration of PPV.

[redacted] (b)(6)-2

[redacted] (b)(6)-2

[redacted] (b)(6)-2

Thanks

(b)(6)-2

Dear Dr [redacted]

The patient with traumatic iridodialysis (4-6) and (9-11) posterior dislocation of cataractous lens, vitritis and high IOP

The retina, optic disc & macula seems normal

I think he can benifit from Trabeculectomy + vitrectomy + scleral fixed IOL (Putting an AC IOL is not favourable.).

Scleral fixation IOL is not available.

Best regards [redacted], (b)(6)-4

[redacted] 9.10.2005

please clear [illegible]

In waiting for surgery on Wensday

15/10/03 put him on

1. Timoptic
2. alphagan
3. atropine
4. ~~[illegible]~~ Dexamethasone
5. Diamox tab
6. Antibiotic - steroid ointment

} Topical

& follow him up regarding his disc in Jan.

Thanks.

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

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

9/10/2003

[redacted] (b)(6)-2

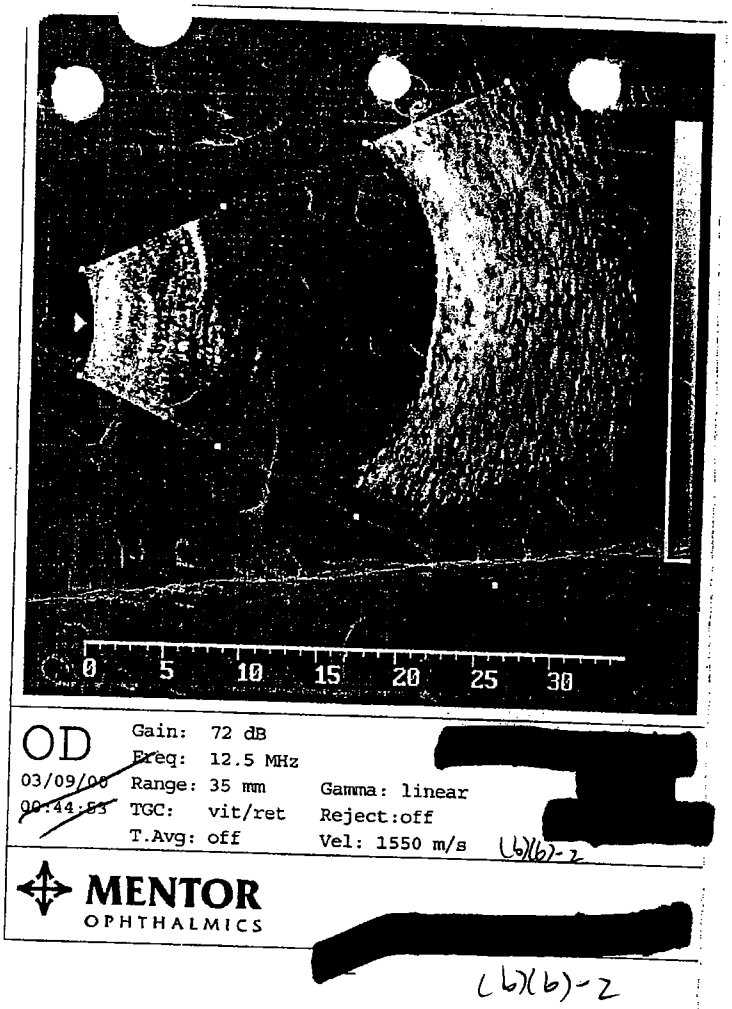
- Cat changes
- clear vit
- No RD

NO 24

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

R	L
35	20

[redacted] (b)(6)-2



[redacted] (b)(6)-2

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

Camp 4

Diag:- Traumatic Cataract, Traumatic Mydriasis
Need Refferal to the Hospital
to be examined by Indirect ophthalmoscope
or 3 mirror (Goldmman) to
exclude Retinal Detachment ??

[redacted] (b)(6)-4

(b)(6)-2

INPATIENT TREATMENT RECORD COVER SHEET

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

(b)(6)-4

1. REGISTER NUMBER [redacted]			2. NAME (Last, First, MI) [redacted] (b)(6)-4		3. GRADE N/A
4. SEX M	5. AGE unk	6. RACE Z	7. RELIGION unk	8. N/A	9. N/A
					10. PREVIOUS ADMISSION NO
11. FMP 99	12. SSN (b)(6)-4 [redacted]		13. ORGANIZATION N/A		14. WARD ICW 1
15. FLYING STATUS N/A	16. RATING/ DSG	17. DEPT/ BEN K78	18. BRANCH/CORPS N/A	19. UIC/ZIP	20. TYPE CASE N31

ADMISSION REMARKS

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from ER	22. HOURS OF ADMISSION	23. CLINIC SERVICE: ABEA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: Unk	25. TYPE DISPOSITION: 50	26. DATE OF DISPOSITION: 10 Oct 03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): Unk	27b. TELEPHONE NO.: Unk	28. DATE OF THIS ADMISSION: 3 Oct 03
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] (b)(6)-2		30. DATE OF INTIAL ADMISSION

ADMITTING OFFICER: [redacted] (b)(6)-2

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

Phacoanaphylaché Glaucoma

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	8	8

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	8	8

SIGNATURE OF [redacted] (b)(6)-2 Dr [redacted]

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

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

EDITION OF 1 AUG 78 IS OBSOLE[redacted]

USAPPC V1.10

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

see SF600

PHYSICAL EXAMINATION

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

SIGNATURE OF PHYSICIAN	DATE	IDENTIFICATION NO.	ORGANIZATION

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

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

[redacted] (b)(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

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

(b)(6)-4

#[redacted] is an Iraqi patient who presented with an one month history of blunt trauma to his right eye. Exam revealed a white eye 2+ cell in anterior chamber, large iridodialysis 8-11 o'clock lens subluxed onto inferior retina, +2 vit cells & pigment. corneal edema

Pt placed on Timoptic, Alphagan & Xalatan & 80mg Prednisone (1mg/kg). following day IOP decreased to 18 edema of cornea started resolving Over next 24 hours IOP slowly increased back up to 50's Added oral Diamox / Trusopt IOP now in 40's.

Ddx Diagnosis : ? Aphakic Glaucoma.

& traumatic TM failure

vs. Phacoanaphylactic (doubt - not enough inflammation)

Plan: referral for trabeculectomy or filtration device placement together with lens removal.

[redacted] (b)(6)-2

LTC

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

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

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

USAPA V2.00

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

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

(R) Aphakic [redacted] (b)(b)-2
+10 plate
& sel VA
E.S: (b)(b)-2
[redacted]

WA
R. Cibl m +10 DS 6 1/2
L. 6.6
L gl for near

WA [redacted] (b)(b)-2
please put him on 1) full anti glaucoma cover
2) steroid drops
3) Antibiotic drops.
To come back for planning ~~to~~ surgery.
Pl. Thank

R | L
39 | M
(b)(b)-2 [redacted]
8/10/2003
12.30 PM
WR

A case of Traumatic dislocation of (R) lens posteriorly with complicated increase in the IOP
Needs to be controlled medically as much possible & then surgery to remove the dislocated cataractous lens & probably vitrectomy.

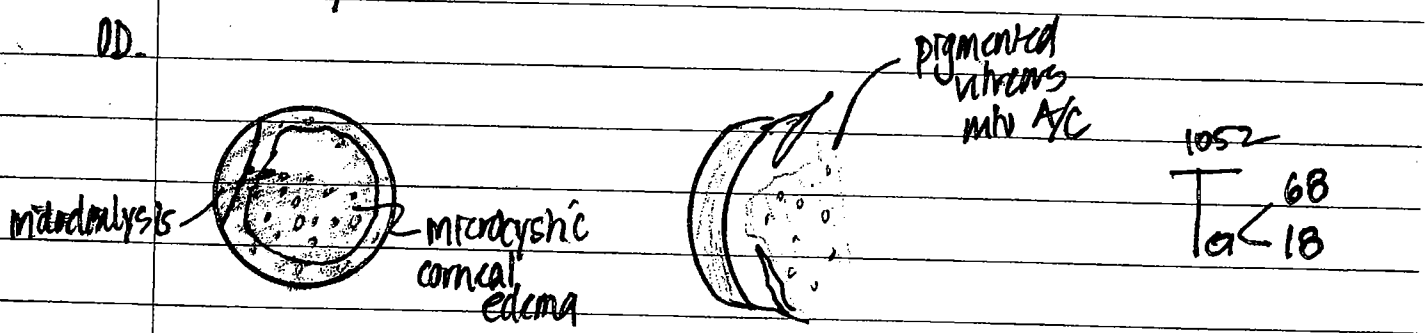
STANDARD FORM 600 (REV. 6-97) BACK

Dr. [redacted]
(b)(b)-4

MEDCOM - 20849

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
02 OCT 03	S- Pt. was referred + transfered to Iraqi Clinic from Compound for evaluation opth.
	O- Pt. appears to have a film covering his eyes.
	A. R/o Retinal detachment r/o glaucoma.
	PLAN - This Referral is from [redacted] (b)(2)-2
	The attached is referral from Iraqi [redacted] (b)(6)-2 (b)(6)-2
3 OCT 03	Accident in Basra - during demonstration states he was hit by plasma shot by US. now vision clouded OD only.
OD.	

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

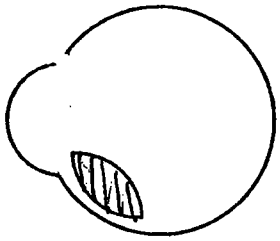
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* | REGISTER NO. | WARD NO.

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

Comp 4

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

USAPA V2.00



DFE: lens subluxated is sitting on retina inferiorly

vit: +2 cells/+3 pigment.

Disc - 0.4x0.4

macula - poor view cannot R/O CME

V/P - ØPD @ present

Imp: Severe blunt trauma to OD
ō traumatic mydriasis
" iridodialysis
c̄ lens rupture & subluxation c̄ ↑IOP/inflammation
2° corneal edema from ↑IOP.

Plan: Admit to hospital
Prednisone 60mg per day
Timoptic/Xalatan qhs
bid bid
Coordinate for P.P lensectomy.

(b)(6)-2

[redacted]

(b)(6)-2

(b)(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
3 Oct 03 1200	- Assumed care of pt. A+O x3. Transfer from EMT ambulatory Dx. Blunt trauma to (R) eye. Redness noted pupil dialated non reactive to light. Ø photosensitivity noted. Lungs clear HRRR. Active BS x 4 quads. Ø c/o pain or discomfort Will cont to monitor — [redacted] (b)(6)-2
1500	One time eye drop order given 5 min interval Redness of (R) eye clearing up. States having improvement of eye sight Will cont to monitor — [redacted] (b)(6)-
30Oct03	1900 = VSS, A+OX3, resting in bed comfortably, Ø s/s irritation to (R) eye, continuing eye gtts around the clock OD, no remarkable problems c̄ vision @ this time. Continue to monitor for any acute Δ's. — [redacted] (b)(6)-2
4 Oct 03	0615 VSS, A+OX3, pt has Ø c/o pain @ this time, pt given drops as per orders, Ø c/o vision or eye pain. restraints x2 in place Ø skin breakdown Ø circulation — [redacted] (b)(6)
	(1705) I concur c̄ above assessment. — [redacted] (b)(6)-2
4 OCT 03 2205	VSS. NO. Provided eye drops to (R) eye. No c/o pain. Sightless still @ this time. Poorly light sensitive with pupils sufficient. — [redacted]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME (b)(6)-2 [redacted] | SPONSOR'S ID NUMBER (SSN or Other)

LAST | FIRST | MI

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

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

[redacted]

(b)(6)-4

PROGRESS NOTES
Medical Record

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

(b)(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
EPW	[redacted]		

DATE	NOTES
5 Oct 03	0615 assumed care of pt, pt A+O x3, VSS, pt has Ø c/o pain at this time, pt voiding in BR under own power without difficulty, pt receiving eye drops as per order, all care complete, Restraints x2 restraints in daily ⊕ circulation. Will continue to monitor. Spc [redacted] (b)(6)-2
5 Oct 03 1200	I concur c above. Pt resting quietly in bed. No acute distress. Will continue eye drops & po meds. Pt denies pain @ this time. — [redacted] (b)(6)-2
5 OCT 03 2041	VSS. AO. OOB to Ambulate c difficulty and emptied own urine. Light yellow quantity sufficient. Ø s/s infection or skin breakdown. [redacted] (b)(6)-2
06 OCT 03 0625	Pt Awake A&O x3. LSCTA ⊕ S/2 present. ⊕ BS x4 quads [redacted] (b)(6)-2 Pt has No c/o at this time. ⊕ Rales in all extremities [redacted] (b)(6)-2 2 point restraints. Will cont. to monitor — [redacted] (b)(6)-2 Spc PWM6
6 OCT 03	1930: VSS, A+O x3, Ø c/o pain, Ø vision problems upon assessment, Ø s/s irritation/redness to ⊕ eye. Continuing eye gtts around the clock, x2 restraints when in bed, ⊖ skin breakdown noted. Ambulates PRN to use BR/exercise in hall c difficulty. Continue to monitor. — [redacted] (b)(6)-2
6 OCT 03	2030: Dr [redacted] (b)(6)-2 here, stated pt's eye pressure ↑, Order to give Aphagan gtts 1 x 00/11 q5mins apart & Timoptic 1 gtts x 00/11 5 mins apart. Administered. Pt's ⊕ eye appears greenish colored.

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10/6/03	S: Pt denies pain, Eye quiet
	O: 4/c WM $\overline{Tar}^{58}$
	Conj sinj
	K ⊕ microcystic edema
	A/c grossly quiet, ⊕ vit in A/c ∅ cornea touch
	IRIS dilated
	A/P ① ↑ IOP $\bar{s}$ significant inflammation ~~? steroid responsi~~ [redacted] (b)(6)-2
	~~though not on steroids when he presented with ↑IOP~~ [redacted] (b)(6)-2
	Aphakic Glaucoma vs. $\bar{p}$ traumatic TM failure
	Plan: Diamox 250mg po qid.
	Timoptic, Xalatan, Alphagan q5min x III
	↓Pred to 40mg po qD
	to see civilian ophth tomorrow [redacted] (b)(6)-2
	for surg consultation to [redacted] (b)(6)-2
	remove lens / filter surgery (b)(6)-2 [redacted], LTC

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

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

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

REGISTER NO.	WARD NO.

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

USAPA V2.00

...HORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
6OCT03	2030 - continued - Will continue to monitor for acute S's. (b)(6)-2 [redacted] LPN/AN
6OCT03	Pt Awake A&O x3. LS CTA (B) (+) BS x4 quads. S1 S2 present Pt voiding spontaneously qs c/o. Pt Denies pain OD gtts continue. Will continue to monitor. (b)(6)-2 [redacted] Spec 91WM6
8OCT03 0125	VSS. OD appears slightly reddened, round & reactive, tears well. Cont ē OD gtts TX. Sclerally light yellow wine, quantity sufficient. (b)(6)-2 [redacted] RN
8OCT03 1030	Received pt resting in bed, VSS, tol PO, ambs and amb independently. (+) BM, SVQS. Am shower provided. Compliant w/ care. OD slightly reddened this am, pupil round & reactive. Will cont gtts per MAR and PO meds per MAR. ∅ complaints of pain @ this time. Restraints per CPW protocol, ∅ skin breakdown noted, will cont to monitor pt. ∅ other remarkable assessments @ this time. [redacted] LPN (b)(6)-2
8OCT03 2000	VSS. AO. OD round & reactive ē slight redness. Tears well. ∅ c/o pain @ this time. Ambulated w/ ease and steadiness. Sclerally light yellow wine QS. (b)(6)-2 [redacted] RN

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

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

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

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
(1930) 9ØCTØ3	Pt a/o, VSS, Ø complaints @ this time. OD c̄ some redness, round & reactive. eye gtts cont. voiding adeq. cyu, amb x1 s̄ difficulty. 2 pt restraints on s̄ compromise to skin or circulation. (NPO p̄ mn). will monitor (b)(6)-2 [redacted] 9/1WMb
10 OCT 1200	Received pt resting in bed, VSS, a&Ox3, pt upset @ NPO status this am. MD then cancelled surgery @ iraqi hospital + pt was able to eat, food provided + situation explained, pt cont to be upset, and refused food first (did eat a small amt later). Pt gtts for OD cont and meds cont, OD slightly red, pt is slated for d/c to iraqi hosp w/ surgery pending. Ø other remarkable assessments at this time, restraints per EPW protocol, Ø breakdown noted. Will cont to monitor. (b)(6)-2 [redacted]
10 OCT 03 1945	Pt A+Ox3, VSS, LS CTA(B), (+) BSx4, S1 S2 present, voiding well, eye drops treatment cont, Ø c/o pain or discomfort, pending d/c to iraqi hospital tomorrow, 2 pt restraint, Ø skin breakdown or poor circulation noted. (b)(6)-2 9/1W [redacted] (b)(6)-2

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

[redacted] (b)(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10/10/03	Pt admitted for sig ↑IOP's, sig blunt trauma c̄ 2° lridodialysis, sphincter tears, lens subluxation & prob TM dysfunction pt placed on maximum medical therapy. Sent to Iraqi hospital for surgery. Twice returned c̄ request to place pt on glaucoma Rx (pt already on). Rx x 1½ wks prior to consult. ~~Surgery postponed until Wed. Needs glaucoma surgery ASAP~~ D/C back to prison hospital awaiting surgery Zantac 150mg po bid. Meds ~~cosopt Tgtts OD bid~~ [redacted] (b)(6)-2 alphagan Tgtts OD bid Xalatan Tgtts OD qhs Diamox 250mg i̇ tab po qid Pred Acetate Tgtts OD [redacted] TID (b)(6)-2 D/C ~~Ocuflox Tgtts OD qid~~ [redacted] (b)(6)-2 space gtts 5 minutes apart. (b)(6)-2 Prednisone [redacted] po qD (b)(6)-2 D/C [redacted] ~~Atropine Tgtts OD BID~~ ~~Pt NPO p̄ midnight on Tuesday 14 Oct 03~~ ~~Wednesday 15~~ PT NOW REFUSES SURGERY On ~~Tuesday~~ [redacted] (b)(6)-2 ~~Oct 03 pt to be transported to Al-Hatham hospital for eye surgery. Post op care @ Ibn Sina hospital~~ [redacted] (b)(6)-2 [redacted] (b)(6)-2 ~~POC is undersigned.~~ REFUSES SURGERY ~~coordinate c̄ S5 for time of surgery~~ [redacted] (b)(6)-2 ~~please send medical paperwork c̄~~ (b)(6)-2 [redacted] LTC ~~patient~~ [redacted] (b)(6)-4 OVER ~~* Pt will require steroid taper after surgery (po Prednisone)*~~

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

TAPER PREDNISONE OVER 1 MONTH
DECREASE TO 20MG PREDNISONE X 1 WK
15 MG "
10 MG "
5 MG " THEN D/C [redacted] (b)(6)-2
D/C ZANTAC WITH PREDNISONE

PRED ACETATE
~~1 TAB PO TID X 1 WK~~ [redacted] (b)(6)-2
BID X 1 WK
qD X 1 WK
THEN D/C

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10/11/03	Pt on MMT for glaucoma to include Cosopt, α gan, Xalatan & oral Diamox. anti-inflammatory - topical steroids / oral Pred n.
	Pt has been sent to Civilian hospital x 2 for glaucoma surgery, both times returned: request addl'l medical therapy.
	Pt notified w/o surgery he will go blind. Pt still desires d/c to prison to facilitate his released. As pt is painfree I am unsure he appreciates the risk, but as he is aphakic (functionally blind) the difference may be academic. Civ. hospital w/ I have 101's for placement. CTL not avail either. (b)(6) - 27
Ia < 55	Dr [redacted] to come today. Will explain situation again. It is possible that our lack of supplies (surgical) + ∅ glaucoma specialist & similar pblms in Civilian sector may result in no real options available for patient [redacted] (b)(6) - 2

HOSPITAL OR MEDICAL FACILITY	STATUS	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] Hospital

(b)(6) - 4

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

USAPA V2.00

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10/11/03	TALKED C̄ IRAQI DOCTOR -- PT SCHEDULED
	FOR SURG WED, PLAN ~~PATE~~ GLAUCOMA &
	RETINAL SURGERY (b)(6)-2
	[redacted]
	(b)(6)-2
10/13/03	TALKED C̄ PT YESTERDAY
	PT DESIRES D/C → NO SURGERY
	UNDERSTANDS HE MAY GO BLIND
	STILL WANTS D/C
	WILL TAPER OFF MEDS

STANDARD FORM 600 (REV. 6-97) BACK

USAPA V2.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
11 Oct 03	0900 VSS Alert & Oriented. [redacted] Escorted [redacted] down stairs to Optham clinic by MP's. (b)(6)-2 [redacted] Consumed Regular diet. OOB → BR ad lib. Continue on multi eye stitch. Awaiting d/c to prison hospital. [redacted] (b)(6)-2 2LT
11 OCT 03 1945	Pt A+O×3, VSS, LS CTA(B), (+)BS×4, cont gtts Therapy, voiding well, awaiting d/c to EPW Camp. ∅ c/o pain or discomfort. 2 pt restraint S s/sx of complications. (b)(6)-2 [redacted] (b)(6)-2 [redacted] 9W
12 Oct 03 0800	VSS Alert & Oriented. Denies HA, blurred vision or dizziness @ this time. Tolerating regular diet. OOB ad lib. Awaiting d/c to prison hospital. No acute care needed. Continue Multi eye stitch to OD. (b)(6)-2 [redacted]
	[redacted] See translation

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

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

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

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

Translation Bates page Medcom 20861:

I refused to have surgery for the right eye. 10/12/2003

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
12OCT03 1830	Pt A+O x3, VSS, Ø c/o pain or discomfort, LS CTA (B), (+)BS x4, abd soft flat non tender, cont eye drops treatment, 2 pt restraint ∃ complications. (b)(6)-2 [redacted] 91W
13OCT03	(1400) Assumed care of pt @ 0000 ∃ report from night shift. Pt alert, speaking Arabic. VSS. Ø c/o pain. Cont. OD gtts as ordered. Pt OOB to BR for personal hygiene. Amb well. Ø c/o dizziness/N/V. Tol. reg diet well. Voiding ∃ diff. (+)BM. 2 point restraints in place ∃ s/sx complications. Awaiting trans. to Iraqi hospital. (b)(6)-2 [redacted]
13OCT03 1915	Pt A+O x3, VSS, LS CTA (B), (+)BS x4, S_1 S_2 present, abd soft flat non tender, denies pain or discomfort, cont. eye tx, 2 pt restraint in place ∃ complications, conducted personal hygiene, OOB → BR. (b)(6)-2 [redacted] 91W (b)(6)-2 [redacted]
14OCT03	(1320) Assumed care of pt @ 0000 ∃ report from night shift. Pt alert, speaking Arabic. VSS. Ø c/o pain cont OD gtts as ordered. Pt amb well. Ø c/o dizziness/N/V. Tol. reg diet well. Voiding ∃ difficulty. 2 point restraints in place ∃ s/sx complications. Will continue to monitor. (b)(6)-2 [redacted]
	(1745) Pt refusing OD gtts, d/t not being d/c'd today. monitoring. (b)(6)-2 [redacted]
(1900)	Pt alert, VSS, Ø c/o pain, still refusing eye gtts, tol dinner well. LCTAB, (+)BS x4, HRRR, amb ⊘ voiding ∃ defficulty. Restraints on while un fed

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

(cont)

*

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
10/13/03	PT ADMITTED FOR ↑IOP ⫽ BLUNT TRAUMA HAS BEEN MEDICALLY MANAGED. WAS SCHEDULED FOR SURGERY. NOW REFUSES SURGERY DESPITE HERNIUM IN PRISON UNDERSTANDS REFUSAL WILL RESULT IN BLINDNESS OD.
	MEDS: PREDNISONE 20MG PO qD x ↑WK
	15 "
	10 "
	5 MG PO qD x ↑WK
	THEN D/C
	ZANTAC 150MG PO BID — D/C WITH PREDNISONE
	PRED. ACETATE ↑GTTS OD BID x 3 DAYS
	↑GTTS OD qD x 3 DAYS ⇒ THEN D/C
	DIAMOX 250MG ↑ TAB PO QID
	XALATAN ↑ GTTS OD qHS
	ALPHAGAN ↑ GTTS OD BID
	PT TO ⅦU HERE IN 4-6 WKS.

(b)(6)-2 [redacted]

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

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY

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

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

[redacted] | WARD NO.

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1989)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10/13/03	PT C̄ HX EYE PROBLEMS P̄ BLUNT TRAUMA. NEEDS GLAUCOMA SURGERY. PT NOW DESIRES SURGERY WILL REINSTITUTE PREVIOUS MEDS AND CONTINUE COORD. C̄ SS (DISREGARD PREVIOUS NOTE).

PLAN:

PREDNISONE 40MG PO QD.
OCUFLOX T̄ GTTS OD QID
PRED ACETATE T̄ GTTS OD QID
ATROPINE T̄ GTTS OD QD
COSOPT T̄ GTTS OD BID
XALATAN T̄ GTTS OD QHS
ALPHAGAN T̄ GTTS OD BID
DIAMOX 250MG T̄ TAB PO BID
ZANTAC 150MG PO BID

- DRUPS SPACED 5
- MINUTES APART.

(*) TO EL-HATTAM EYE HOSPITAL WEDNESDAY BEFORE 0900 FOR EYE SURGERY. 10/15

(*) NPO P̄ MIDNIGHT TUESDAY 10/14.

WILL TAPER MEDS P̄ OP. PT WILL RETURN TO IBN SINA HOSPITAL POST-OP. MAY REQUIRE POST-OP EVAL @ EL HATTAM HOSPITAL FOR SELECTIVE SUTURE REMOVAL WITH LASER IN IMMEDIATE P̄ OP PERIOD.

(b)(b)-2 [redacted]

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

(REV. 5/1999) BACK .00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
14OCT (1900)	S compromise to skin or circulation will mon utor. (b)(6)-2 [redacted] 9lwm
(2100)	Pt tells Dr. [redacted] (b)(6)-2 (thru translator) that he does not want surgery, & states that he just wants to go back to camp tomorrow. Pt refuses all eye gtts, because he says they're no good without the surgery. Importance of gtts explained, pt still refuses. Will monitor [redacted] 9lwm
15OCT03	(0925) Assumed care of pt @ 0000 ~~p~~ report from night shift. Pt alert, speaking Arabic. VSS. ¢ c/o pain. Pt amb well. Pt cont to refuse OD gtts. Will take po meds. Tol. reg diet well. Voiding S difficulty. 2 point restraints in place S sisx complications. (b)(6)-2 Awaiting trans. to EPW camp. monitoring. [redacted] (1440) Pt Dic to EPW camp ambulatory escorted by MPs. (b)(6)-2 [redacted]

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

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

REGISTER NO. | WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 10 Oct | 11 Oct | 12 Oct | 13 Oct | 14 Oct 03 | 15 OCT 03

19 | HOUR: 08 20 | 0 24 | 8 1 9 | 8 1 9 | 8 1 8 2 2 | 8

PULSE (O) / TEMP. F (•)

105°, 104°, 103°, 102°, 101°, 100°, 99°, 98.6°, 98°, 97°, 96°, 95°

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

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD: 16 | 19 | 18 | 18

BLOOD PRESSURE: 138/81 | 142/77 | 128/63 | 112/62 | 128/78 | 111/69 | 144/76 | 134/76

81 | 77 | 77 | 72 | 95

97.3 | 97.8 | 97.6 | 97.2

HEIGHT: | WEIGHT →

98% | 98% | 98% | 98% | 98% | 98% (RA) | 98% | 98% | 98% (RA)

RA

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

[redacted] (b)(6)-4

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY: 3 OCT, 4 OCT, 5 OCT, 6 OCT, 7 OCT 03, 8 OCT, 9 OCT 03

19 HOUR: 1200, 1820, 0615, 0615, 0, 1905, 18, 0, 1

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

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

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

142/76	137/81	134/82		140/88		145/80			
H76		P 63	135/82	P 63	144/77		119/60	135/63	137/63	135/64	136/82
T 97.8		T 97.7	83	T 98.0	71		76			77	
96%	O2	SpO2	95	SpO2	96		95			96	
RA	98%	95%	96	97	97% O2	98%	96%	98%	96%	98%	97%
	RA					RA		RA	RA		RA
											97%
											(RA)

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

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

Admit to ICW1
Dx: Phacoanaphylactic glaucoma ~~#5~~ 2° to
(b)(6)-2 ~~Phac~~ [redacted] Blunt trauma
Condition stable
Vitals routine
ALL: NKDA
Diet Regular

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

noted 30 Oct @ 1500 [redacted] (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

Activity: per SOP
Meds:
Prednisone 80mg po qDay
Zantac 150mg po bid
Pred Acetate 1 gtts OD q2°
Muro 128 oint OD qid

Timoptic 1 gtts OD bid

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

Alphagan 1 gtts OD bid
Xalatan 1 gtts OD qhs
Atropine 1 gtts OD bid

(b)(6)-2

awaiting surgery [redacted]
Hatham hospital [redacted] (b)(6)-2
(b)(6)-2 [redacted] LTC

PATIENT IDENTIFICATION

noted 30 Oct @ 1500 [redacted] (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

Timoptic 1 gtts OD q5min x II
Alphagan 1 gtts OD q5min x II
Xalatan 1 gtts OD q5min x II
(b)(6)-2 [redacted]

240 ✓ [redacted] LT/AN 30 Oct 03 1900 (b)(6)-2 [redacted] LTC (b)(6)-2

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

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

PROGRESS NOTES

DATE	NOTES
10/4/03	Ophth-Inc
	IOP - 68 on admission
	treated c̄ Pred 80mg/day
	timoptic/αgan/Xalatan q5min x 2
	this am IOP=18
	A/C 1+ cell
	+2 vit cell c̄ pigment
	eye white, + corneal edema.
	Imp: post phacoanaphylactic though eye is not as bad as I would expect - much better today
	Plan CPM
	awaiting surgical removal
	[redacted] (b)(6)-2
	(b)(6)-2

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

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

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

USAPA V1.00

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

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

DATE OF ORDER 10/6/03 | TIME OF ORDER 2012 HOURS | LIST TIME ORDER NOTED AND SIGN

(1) Decrease Prednisone to 40mg po qday.

(2) Diamox 250mg 1 tab po qid.

(3) Timoptic q5min x II
Alphagan 1gtts OD q5min x II

6 OCT 03 2030

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

DATE OF ORDER [redacted] | TIME OF ORDER [redacted] (b)(6)-2 HOURS

~~[redacted] 1gtts OD q5min x II~~

D/C Xalatan

Add Trusopt 1gtts OD [redacted] (b)(6)-2

(b)(6)-2

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

6 OCT 03 2030

PATIENT IDENTIFICATION (b)(6)-2

DATE OF ORDER 10/13/03 | TIME OF ORDER 0715 HOURS

PREDNISONE 20MG PO qD
D/C OCUFLOX
D/C ATROPINE
PRED ACETATE 1 GTTS OD BID
D/C COSOPT
D/C TO PRISON HOSPITAL [redacted] (b)(6)-7 (b)(6)-2

Noted [redacted] 13 Oct 03 0720

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 10/13/03 [redacted] 0835 HOURS OTC

(1) PT NOW DESIRES SURGERY
(2) INCREASE PREDNISONE TO 40MG PO qD
RESTART OCUFLOX 1 GTT OD QID
ATROPINE 1 GTTS OD qD
COSOPT 1 GTTS OD BID
PRED ACETATE 1 GTTS OD QID
D/C TO PRISON HOSPITAL [redacted] (b)(6)-2

Notified [redacted] 13 Oct 03 0829 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION [illegible] WHICH MAY BE USED [redacted] (b)(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

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

DATE OF ORDER	TIME OF ORDER ____ HOURS	LIST TIME ORDER NOTED AND SIGN
D/C timoptic, trusopt		
start cosopt 1 gtts OD bid		
Continue alphagan 1 gtts OD bid		
Xalatan 1 gtts OD qhs		
Continue Diamox 250mg 1 tab po qid		
Ocuflox 1 gtts OD qid		
Pred Acetate 1 gtts OD qid.		

PATIENT IDENTIFICATION

[redacted] (b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER ____ HOURS	LIST TIME ORDER NOTED AND SIGN
NPO p midnight [redacted]		(b)(6)-2
9 OCT @ 2800 [redacted]		(b)(6)-2
D/C Mund 12K [redacted] (b)(6)-2		

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

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

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

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

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

(b)(6)-2 [redacted]

11/11 10OCT

NURSING UNIT | ROOM NO. | BED NO.

JAE | 0330 | 110CT03 [redacted]

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
10/10/03	0821 HOURS	
Resume Reg diet		
D/C to pnsom hospital today c̄ bedside		gHS
[redacted]		(b)(6)-2
(b)(6)-2		

PATIENT IDENTIFICATION (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER
	HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER
	HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER
	HOURS

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH 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. Oct Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 3	4	5	6	7	8	9	10	11	12	13	14	15
10/3/03	[redacted]	Convalescent, stable.	06	[redacted]												
		(b)(6)-2	18													
10/3/03	[redacted]	Vitals routine	06													
		(b)(6)-2	18													
10/3/03	[redacted]	Diet regular	06													
		(b)(6)-2	18													
			06													
30ct03	[redacted]	Activity: PER SOP	06													
		(b)(6)-2	18													

(b)(6)-1

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: Blunt trauma
Phacoanaphylachi glaucoma

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 10 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
30 OCT 03	[redacted]	Admit to ICU #1, Condition Stable	30 OCT 03			[redacted] (b)(6)-2
09 OCT 03	[redacted]	NPO p̄ midnight	09 OCT 03	0001	noted	[redacted] (b)(6)-2
10 OCT	[redacted]	Reg diet resume	10 OCT			
10 OCT	[redacted]	D/C to prison hospital today w/	10 OCT			
		bedside drops				
13 OCT 03	[redacted]	D/C to prison hosp	15			[redacted] (b)(6)-2
		(b)(6)-2				

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

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. 10 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 3	4	5	6	7	8	9	10	11	12
30Oct03	[redacted]	Timoptic ¹⁄₂ gtts OD BID	10	X	[redacted]								
			22	[redacted]									
30Oct03	[redacted]	Alphagan ¹⁄₂ gtts OD BID (continue)	10	X	[redacted]								
			22	[redacted]									
30Oct03	[redacted]	Xalatan ¹⁄₂ gtts OD qHS	22	[redacted]									
~~6Oct03~~	[redacted]	~~Diamox 250mg 1 tab PO QID~~											
6Oct03	[redacted]	↓ Prednisone to 40mg PO QDAY	10	/	/	/	[redacted]						
6Oct03	[redacted]	Trusopt ¹⁄₂ gtts OD TID	06			X	[redacted]						
			14			X	[redacted]						
			22				[redacted]						
6Oct03	[redacted]	Diamox 250mg 1 tab PO QID	06			X	[redacted]						
			12			X	[redacted]						
			18			X	[redacted]						
			24				[redacted]						
08 Oct03	[redacted]	Xalatan ¹⁄₂ gtts OD qhs	22	/	/	/	/	[redacted]					
08	[redacted]	Cosopt ¹⁄₂ gtts OD BID	10	/	/	/	/	[redacted]					
			22					[redacted]					

DIC 08Oct03

DIC 08Oct03

DIC 'd

DIC 08Oct03

Rewritten 10/11/03 [redacted]

Rewritten 10/11/03 [redacted]

(b)(6)-

ALLERGIES: ☐ YES ☑ NO

NKDA

PRIMARY DIAGNOSIS: Phacoanaphylactic glaucoma 2° to Blunt Trauma

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. 1

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79 — EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. — 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. Oct Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 3	4	5	6	7	8	9	10							
10/3/03	[redacted]	Atropine 1 gtts OD BID	10	X	[redacted]													
			22	[redacted]														
30Oct03	[redacted]	Prednisone 80mg PO QDAY	10	X	[redacted]													
30Oct03	[redacted]	Zantac 150mg po BID	10	X	[redacted]													
			22	[redacted]														
30Oct03	[redacted]	Pred Acetate 1 gtts OD Q2°	02	X	[redacted]													
			04	X														
			06	X														
			08	X														
			10	X														
			12	X														
			14	X														
			16															
			18															
			20															
			22															
			24															
30Oct03	[redacted]	Muro 128 oint OD qid	08	X	[redacted]													
			12	X														
			18															
			24															

Rewritten 6/11/03

D/C'd

Rewritten 6/11/03

D/C 30Oct03

D/C 10/31/03

(b)(6)-2

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: Blunt trauma
Phacoanaphylactic glaucoma

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO. 2

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. _____ Yr. _____

Order Date	Clerk/ Nurse	(b)(6)-2 SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
60ct03	[redacted]	Timoptic Q5min x II	60ct03	2030		[redacted] (b)(6)-2
60ct03	[redacted]	Aphagan ÷ gtts OD q5minx II (b)(6)-2	60ct03	2045		[redacted] (b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED													
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USAPA V1.00

CLINICAL RECORD

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

Mo Oct Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 34
10/3/03	[redacted] (b)(6)-2	Prednisone 80mg po q day	06	
10/3/03	[redacted] (b)(6)-2	Zantac 150 mg po BID	10	
			22	
10/3/03	[redacted] (b)(6)-2	Pred Acetate 1 gtts OD q 2°	06	
			08	
			10	
			12	
		(b)(6)-2	14	[redacted]
			16	
			18	
		(b)(6)-2	20	[redacted]
		(b)(6)-2	22	[redacted]
		(b)(6)-2	24	[redacted]
			02	
			04	
10/3/03	[redacted] (b)(6)-2	Muro 128 oint OD q id	06	
			12	
			18	
			24	
10/3/03	[redacted] (b)(6)-2	Timophic 1 gtts OD BID	10	
			22	
10/3/03	[redacted] (b)(6)-2	Alphagan 1 gtts OD BID	10	
			22	
10/3/03	[redacted]	Xalatan 1 gtts OD QHS	22	

Rewritten

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: Blunt trauma Phacoanaphylactic glaucoma

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO. 1

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. Oct Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES (b)(6)-2	Date to be Given	Time to be Given	Time Given	Initials
10/3/03	[redacted]	Timophic + gtts OD q 5 min x II	10/3/03		1500	[redacted] (b)(6)-2
10/3/03	[redacted]	Alphagen + gtts OD q 5 min x II (b)(6)-2	10/3/03		1500	[redacted] (b)(6)-2
10/3/03	[redacted] (b)(6)-2	Xalatan + gtts OD q 5 min x II	10/3/03		1500	[redacted] (b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
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USAPA V1.00

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 10 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 08	09	10	11	12	13	14	15
08 OCT 03	[redacted]	Alphagan 1 gtts OD	10	/	[redacted]						
	-----	BID	22	[redacted]							
08	[redacted]	Pred Acetate 1 gtts	06	/	[redacted]						
	-----	OD qid	12	/	[redacted]						
	-----		18	[redacted]							
	-----		24	[redacted]							
08	[redacted]	Ocuflex 1 gtts OD	06	/	[redacted]						
	-----	qid	12	/	[redacted]						
	-----		18	[redacted]							
	-----		24	[redacted]							
10/10/03 recopied	[redacted]	Atropine 1 gtt OD	10	/	/	/	[redacted]				
	-----	BID	22	/	/	/	[redacted]				
10/11/03 recopied	[redacted]	Zantac 150mg PO	10	/	/	/	[redacted]				
	-----	BID	22	/	/	/	[redacted]				
10/11/03 recopied	[redacted]	↓ Prednisone to 40mg	10	/	/	/	[redacted]				
	-----	PO QDay	X								
10/11/03 recopied	[redacted]	Diamox 250 mg	06	/	/	/	/	[redacted]			
	-----	1 tab PO QID	12	/	/	/	[redacted]				
	-----		18	/	/	/	[redacted]				
	-----		24	/	/	/	[redacted]				
10/11/03 recopied	[redacted]	Valantan 1 gtt OD	22			[redacted]					
	-----	QHS	X								
10/11/03 recopied	[redacted]	COSOPT 1 gtt OD	10	/	/	/	[redacted]				
	-----	BID	22	/	/	/	[redacted]				
13 OCT 03	[redacted]	Prednisone 20mg po qd	10	D/C 13 OCT 03							
13	[redacted]	Pred Acetate 1 gtts OD	10	Del 13 OCT 03							
	-----	BID	22								

see ⊿ below

D/C 13 OCT 03

see ⊿ below

D/C 13 OCT 03

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

(b)(6)-2

DA FORM 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. 10 Yr. 63

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 13	14	15	16
10/13	[redacted]	Increase prednisone	10	[redacted]			
	-----	to 40mg po ~~q~~ D	/				
10/13	[redacted]	Restart Ocuflox i gtt	06	/	[redacted]		
	-----	OD QID	12	[redacted]			
	-----		18	[redacted]			
	-----		24	[redacted]			
10/13	[redacted]	Atropine i gtts OD	10	[redacted]			
	-----	~~q~~ D	/				
10/13	[redacted]	Cosopt i gtts OD	08	[redacted]			
	-----	BID	20	[redacted]			
10/13	[redacted]	Pred Azethate i gtts	06	/	[redacted]		
	-----	OD QID	12	[redacted]			
	-----		18	[redacted]			
	-----		24	[redacted]			
06 OCT 63	[redacted]	Trusopt i gtts OD TID	06	/	[redacted]		
	-----		14	[redacted]			
	-----		22	[redacted]			
08 OCT 63	[redacted]	Alphagan i gtts OD BID	10	[redacted]			
	-----		22	[redacted]			
11 OCT 63	[redacted]	Zantac 150mg PO BID	10	[redacted]			
	-----		22	[redacted]			
11	[redacted]	Diamox 250mg i tab	06	/	[redacted]		
	-----	PO QID	12	[redacted]			
	-----		18	[redacted]			
	-----		24	[redacted]			
11	[redacted]	Xalatan i gtts OD qHS	22	[redacted]			

(b)(6)-2

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
Blunt Trauma OD

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO
PAGE NO. 3

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

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

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

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A 1 1 D 1	I Z	(b)(6)-4 [redacted]	(b)(6)-4 [redacted] (b)(6)-4		m

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
		Z	9	Unk

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
	N/A	~~99~~ 20	[redacted]

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

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø	ICW 1	Unk

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

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
5 Ø		Unk

23. DATE OF DISPOSITION (YYMMDD)	24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
Ø 3 1 Ø 1 Ø	A B E A		Ø 3 1 Ø Ø 3

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

FOR LOCAL USE

Dx: Phacoanaphylaché glaucoma

DX 9213
36565
36019
Trauma 9
Inj 989

(b)(6)-4 [redacted]

(b)(6)-2

ADMITTING OFFICER [redacted] Dr. [redacted] (b)(6)-2

SIGNATURE OF ADMITTING CLERK [redacted] (b)(6)-2 [redacted] (b)(6)-2 SPC, 9/6/0

DA FORM 3985 MAR [redacted]

(b)(6)-4

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

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

4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm
M	20Y	X	ISLAMIC			NO

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

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

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	12:06	ABA - GENERAL SURGERY

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	TRF-OTH	2003-10-15

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-10-03	[redacted] (b)(6)-2

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
[redacted] (b)(2)-2	2003-10-03	

31. Selected Administrative Data

Marital Status: Z DoB: [redacted]

In/Out Patient: Inpatient MOS:

33. Cause Of Injury: INJURED BY US SOLDIERS WHILE ATTEMPTING MURDER

34. Diagnosis / Operations and Special Procedures:

GSW ABDOMEN

Dx: 863.30
863.44
V44.3
E991.9
E991.2

Proc:
46.52
87.41
88.01

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	12	12

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	12	12

Signature of Attending Medical Officer

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

[redacted] (b)(6)-2

ɔmated Facsimile - DA FORM 3647, May 79

Referal Notes:

Age : 20 y.

address : [redacted]

(b)(6)-4

see translation

Dear Sir

This young man, presented to our hospital with a bullet? or Shell? in Lt lower abdomen.

Laporatomy finding:

1. Small bowel perforation (through & through) 80 cm from Doudenojejunal junction. Resection & end to end anastomosis in two layers.
2. through & through inj. to Sigmoid Colon, brought as Loop Colostomy.

he now have:

- N-G tube.
- 2 tube drains.
- urine (Foley's Catheter)

& till Now he didn't pass Flatus or stool.

he was put on:

- cefotaxim inj. : 1g X 3 I.V
- Flagyl : 500 mg X3 I.V infusion
- G/S : 7 units/24.

(b)(6)-4 [redacted] KCl 60 meq/24 h.

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

chief of Resident doctor.

3. 10. 03.

Translation Bates page Medcom 20884:

Address: [redacted] – 20 years- [redacted]

DEPARTMENT OF THE ARMY
12th Military Police Detachment (CID)
United States Army Criminal Investigation Command
Victory Camp, Iraq
APO AE 09335

CIRC-ABE

10 October 2003

MEMORANDUM FOR ALL PERSONNEL CONCERNED

SUBJECT: Request for Prisoner Hold

(b)(6)-4, (b)(6)-5, (b)(7)(c)-5 (b)(7)(c)-5 (b)(7)(c)-5
(b)(6)-4, (b)(6)-5 (b)(6)-4, (b)(6)-5

1. The 12th MP Detachment (CID) request that Mr. [redacted] (Pt. #[redacted] and Mr. [redacted] (Pt. #[redacted]) be held at the Abu Ghraib Prison facility until further notice. Both personnel are suspected of murdering a U.S. soldier in downtown Baghdad on 1 Oct 03. Mr. [redacted] and Mr. [redacted] were both detained due to them having gunshot wounds and matching the description of the shooter. Investigation is continuing to gather evidence for the prosecution of the individuals above for murder.

(b)(6)-4
(b)(6)-5
(b)(7)(c)-5

(b)(6)-4, (b)(6)-5
(b)(7)(c)-5

2. Point of contact is the undersigned at DNVT [redacted] or [redacted]
(b)(6)-1 (b)(6)-1

//Original Signed//
[redacted] (b)(6)-1
CW2, MP
Special Agent-in-Charge

FOR OFFICIAL USE ONLY

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

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

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

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

- [ ] Arson (I.P.C. 342)
- [ ] Solicitation of Fornication/Prostitution (I.P.C. 388)
- [ ] Rape/Indecent/Sexual Assaults/Acts (I.P.C. 393-98, 402)
- [x] Murder (I.P.C. 405)
- [ ] Aggravated Assault/Assault With Intent To Kill (I.P.C. 410)
- [ ] Maiming (I.P.C. 412)
- [ ] Simple Assault (I.P.C. 415)
- [ ] Kidnapping (I.P.C. 421)
- [ ] Burglary or Housebreaking (I.P.C. 428)
- [ ] Extortion/Communicating Threats (I.P.C. 430)
- [ ] Theft (I.P.C. 439)
- [ ] Destruction of Property (I.P.C. 477)
- [ ] Obstructing a Public Highway/Place (I.P.C. 487)
- [ ] Discharging Firearm/ Explosive in City/Town/Village (I.P.C. 495)
- [ ] Riot or Breach of Peace (I.P.C. 495(3))
- [ ] Other

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

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

Apprehending Unit:		Location Grid: [redacted]	
Date of Incident: (D/M/Y) 3 / 10 / 03 to / /	Time of Incident: 1430 hrs to hrs	Date of Report: (D/M/Y) / /	Time of Report: hrs

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

Total Number of Persons Involved 7 (list names/identifying info on reverse under "Additional Helpful Information")

[x] Vehicle Information	Vehicle Number ____ of ____ Vehicle(s)		Owner:
Make: [redacted]	Color: [redacted]	VIN:	
Model: (b)(6)-4	Type: (b)(6)-4	Plate No:	Number of People in Vehicle:
Year: [redacted] (b)(6)-4	Names of People in Vehicle: UNK		
Contraband/Weapons in Vehicle:			

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

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

Detaining Soldier's Name (Print): Last, First MI	Supervising Officer (Print): [redacted] (b)(6)-1
Signature:	Signature: [redacted] (b)(6)-1
Email: Unit Phone: Date: / /	Email: Unit Phone: Date: / /

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

Why was this person detained? Positively Identified as Killing SPC [redacted] by Surviving Soldier, SPC [redacted]
(b)(6)-4, (b)(6)-2 (b)(6)-4, (b)(6)-2
At 011930- 012000 Shot 2 U.S. Soldiers in Al Khadra area and was wounded and fled.

Who witnessed this person being detained or the reason for detention? Give names, contact numbers, addresses
SPC [redacted] [redacted]
(b)(6)-4, (b)(6)-2 (b)(2)-2
Unk Soldiers [redacted] who transfered from AL Yarmuk hospital.
WO1 [redacted], [redacted] (b)(2)-2
(b)(6)-4, (b)(6)-2

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

Who was with this person? Unk

What weapons was this person carrying? Unk

What contraband was this person carrying?

What other weapons were seized?

What other information did you get from this person?

Additional Helpful Information: See [redacted] Commander for additional Info. (b)(2)-2 (b)(6)-2
CALL [redacted] TOC IMMEDIATELY for ASSISTANCE
(b)(6)-2

MEDICAL RECORD	30 Oct 1300	ABBREVIATED MEDICAL RECORD

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

20 y/o shot in LLQ ? site before hosp 10 ct; operated at local hosp, txd c/o EPW status:
① SB perf 80 cm from lig Treitz - EEA
② perf sig → loop ostomy
AB cefotaxime/metronidazole

PHYSICAL EXAMINATION

WD & NAD
HEENT ⊖
chest clear
cv - RR (M)
abd

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

① SB EEA
② loop ostomy

[redacted]

SIGNA[redacted]	DATE 30 Oct	IDENTIFICATION NO.	ORGANIZATION

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

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

FIRST NAME

NOTES 3 October - 13 October 2003

Transfer summary

Pt a 20 y/o shot in abdomen, taken to Iraqi Hosp where perforated sigmoid was exteriorized as ostomy, and small ileum resected ~ 80 cm from lig Treitz. Patient admitted & stable vitals 120/70, 107, 20, 100°

Hct 43 WBC 7.4 plt 170 amylase 22 BR 1.1 normal electrolytes

Physical unremarkable other than clean dry midline incision, LLQ ostomy and small 1x2 cm wound beneath lower ostomy wafer.

Patient placed on pulmicort heparin 5000 BID and diet advanced slowly which he tolerated well. Sutures were removed at ~ 1 week, wound healing well. Wound below wafer clean with serosanguinous wet to dry. Patient is ambulatory and in 2 or 3 months can have colostomy take down.

To be discharged on reg diet, no meds, wound dressing change (2x2 cm gauze) 2x daily.

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

[redacted] (b)(2)-2

13 Oct '03

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

[redacted] (b)(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

30OCT03@1745 Received pt from ENT in stable condition. USS, NPO, NG to gravity, foley to gravity, wound drains x2 to LLQ, colostomy (loop) to RQ, ø BS, ø gas/flatus from colostomy. midline abd incision. Gauze dry bandaid over incision. Output: NG 250cc green bile; Foley 700cc dk yellow urine; wound drains 100cc total sang. Pt is NPO. IS Spo[redacted] (b)(6)-2 given to pt + taught, demonstrated use, able to raise dark blue ball 1/2way 50% of the time. LS rhonchi throughout, enc CDB. HRR. ø colostomy output at this time, stoma red in color. Pt able to reposition self + transfered self from wheel to bed w/o assist. IV to (R) ac patent + intact infusing D5 1/2NS + 20 meq of K w/o apparent problem. IV access to (R) wrist, HL, fluids well. Restraints per OPW protocol, ø breakdown noted. Oth[redacted] (b)(6)-[redacted] remarkable comments. Will con[redacted]

30OCT03@1300 Assumed care @1800, T: 101.0°, pt NPO, no meds given; pt A[redacted] c/o pain or discomfort + @ this time; NGT to gravity draining g[redacted] bile; FTG

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.

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

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(cont) draining QS, clear yellow urine; 2 wound drains to RLQ draining small amt of dark, reddish fluid; Colostomy bag intact, ⊖ stool, ⊖ flatus, ⊖ BS x 4 quads; midline dsg CDI; IS & CDB exercises encouraged, pt consistently inhaling 900-1200 cc/sec per IS; pt freely moving all extremities, N intact; PIV to (R) AC patent & infusing D5½ NS c̄ 20mEq KCl @ 125 cc/hr S/S/x infection/infiltration; Restraints in place, ⊕ circ ⊖ skin break ↓; cont to monitor [redacted] (b)(6)-2
4 Oct 03 0700 1000	Temp 100.8. Alert & Oriented. NG to gravity drain c̄ minimal green drainage. Lungs with rhonchi throughout fields Bilaterally. Uses incentive spirometer properly @ 900 cc/sec. Has wet non productive cough. Will continue to [redacted] (b)(6)-2 encourage ⊕ hx IS usage. Peripheral pulses +2. Abd soft tender to touch. ⊕ BS heard @ this time. Abd. non-distended. Colostomy stoma pink & moist. ⊖ output @ this time. Foley to gravity drain clear yellow urine. OOB ambulated down hallway accompanied by CID agent. Pt ambulated c̄ steady gait. (R) AC IV patent & intact infusing D5½ NS c̄ 20mEq KCl/L @ 125 cc/hr. Will continue care as planned. (L) LQ dry dsg intact — [redacted] (b)(6)-2 (b)(6)-2 2LT Hi
4 Oct 03 1400	With Dr [redacted] (b)(6)-2 assistance Abd drains, foley and NG tubes were d/c. Pt will remain NPO. No c/o pain or discomfort noted or voiced @ this time. Continues to use IS with productive cough noted with cloudy sputum. [redacted] (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
4 oct @ 2315	Assumed care @ 1800; T: 100.5°, HOB ↑, IS use enc. CDB exercises enc.; Temp retaken; 99.8°; pt A&O, NV intact, ⊖ C/O pain or discomfort (b)(b)-2 [redacted] @ this time; S, S2, LS Ronchi throughout (B); IS use encouraged, pt ~~abe~~ ~~to~~ consistently @ 900-1200 cc/sec, CDB, pt ↑ amb in Hall x1 for 10 min, Tol well ⊖ assistance; pt has productive cough, putting out, clear-white colored mucous; abd soft ⊖ TTP; ⊕ BS x4 quads, (b) ostomy intact, ⊖ stool, ⊖ flatus @ this time; ostomy site, Red, beefy & moist, PTG draining QS, clear yellow urine; PIV patent & intact infusing D5½NS ⊂ 20 Meq KCl ⊂ 4/SX infection/infiltration; Restraints in place, ⊕ circulation ⊖ skin breakdown will (b)(b)-2 [redacted] Cont to monitor
5 Oct 03 0930	USS. Alert & Oriented Peripheral pulses palpable. Lung sound with scattered Ronchi throughout but better than yesterday. O2 SAT 98% RA. IS used properly @ 1200 cc/sec Has productive cough ⊂ cloudy mucus. Will continue to encourage C+DB. Ambulate to BR with steady gait. will encourage time down hallway in front of room. Diet advanced to clear liquid per Dr [redacted] (b)(b)-2 BS hypoactive ⊖ gas/flatus noted in Colostomy bag. Dr [redacted] aware. No drainage

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME (b)(b)-2 LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or O[redacted] (b)(b)-2
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		Continue

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

REGISTER NO. | WARD NO.

EPW # [redacted]

(b)(b)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	(Continued) NOTES
5Oct03 0900	Need to Abd dry to old drainage tube sites. Voiding amber clear urine. Tolerating PO clear liquid. (D) FA IV patent & infusing DS½ NS c 20 mEq KCl/l @ 125cc/hr. Will continue care as planned - [redacted] (b)(b)-2 2CTN
5OCT.03 1945	Pt A+O×3, VSS, ø c/o pain or discomfort @ this time, IS @ bedside, encouraged use ⊕ BS, colostomy bag intact, midline abd incision sutures intact, incision appears good s̄ s/sx of infex, IV (D) FA patent infusing DS½ NS c̄ 20 mEq KCL @ 125cc/hr. ø s/sx of infex on pts of restraint. [redacted] (b)(b)-2 91W
6OCT03	(1645) Assumed care of pt @ 0700 p̄ report from night shift. Pt alert, speaking Arabic. VSS. ø c/o pain. Pt OOB this am to BR for personal hygiene. Amb well. Colostomy bag Δd this am d/t leakage from old bag. Wet→dry abd drsgs Δd - ø s/sx infection @ sites. IVFs SLd in IV in @ forearm. Pt adv. to reg diet - tol. well. Voiding s̄ difficulty. 2 point restraints in place s̄ s/sx complications. Will continue to monitor. [redacted] (b)(b)-2 (AJ)
6OCT.03	Pt A+O×3, VSS, medicated for pain c̄ 4mg MSO4, colostomy bag intact, midline abd incision sutures intact, abd dsg CDI, SL IV (R) FA intact, ø s/sx of infex or infiltration, voiding well, LS CTA (B), CBS ×4, ø skin breakdown or poor circulation on pts of restraint. [redacted] (b)(b)-2 91W

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

07OCT03 (1635) Assumed care of pt @ 0000 ~~p~~ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ MSO4 X1. Wet → dry dsgs to abd Δd this am. Colostomy bag intact c̄ loose brown stool, emptied by pt this am. Pt amb well. Tol reg diet. Voiding s̄ difficulty. 2 point restraints in place s̄ s/sx complications. Will cont. to monitor. (b)(6)-2 [redacted] (AW)

7OCT.03 2000 Pt A+OX3, VSS, colostomy intact, dsg on abd CDI, tol PO well, voiding s̄ diff, OBS x4, pain controlled c̄ percs, 2 pts restraint in place, ∅ s/sx of poor circulation or skin breakdown. (b)(6)-2 [redacted] (AW) (b)(6)-2 [redacted]

08OCT03 (1615) Assumed care of pt @ 0000 ~~p~~ report from night shift. Pt alert, speaking Arabic. VSS. ∅ c/o pain. Pt assisting c̄ colostomy care. Bag Δd today d/t leaking from old bag. Stool loose brown. Dsgs to abd Δd - ∅ s/sx infection. Pt OOB to BR this shift for personal hygiene. Amb well. Tol po well. Voiding s̄ diff. 2 point restraints in place s̄ s/sx complications. monitoring (b)(6)-2 [redacted] (AW)

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

[redacted] (b)(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
80ct03 1900	= VSS, ϕ clo pain, A+O X3, sutures to midline abdomen approximated, ϕ drainage noted, colostomy attached & intact putting out light brown semi solid stool, 2 2x2's vertically dressed to (R) abd quad CDI. OOB to chair S difficulty. x2 restraints when in bed, continue to monitor, ⊖ skin breakdown. [redacted] (b)(6)-2 (U/A)
29Oct03 0900	VSS. Alert & O x general. OOB → BR with help. Colostomy stoma pink & moist. Midline abdominal incision dressing dry & intact will change later this shift. Lungs clear BS (+) x 4 quad. Tolerating regular diet. Will continue care as planned [redacted] (b)(6)-2
1Oct03 2025	VSS. AO. Ad lib S/N. BS (+) x 4. Tolerating PO well. Colostomy putting out light brown liquid stool. Sutures C/D/I. 2x2 DSG's CDI. All other systems WNL. [redacted] (b)(6)-2
2Oct03	(1600) Assumed care of pt @ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs. Drsgs to abd ΔΔ. Colostomy bag intact c̄ small amount loose brown stool. Pt amb to BR for personal hygiene S̄ difficulty. Tol. reg diet well. Voiding S̄ difficulty. 2 point restraints in place S̄ Sx complications. Will cont. to monitor. [redacted] (U/A) (b)(6)-2

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
10/11/03 0123	VSS. AO. BS ⊕ x4. Colostomy intact and putting out minimal amount of soft formed brown stool. ⊕ pulses to all extremities. PSG intact to Abdomen. Wound is pink ō s/s infection. Sutures remain intact to abdominal incision. Voiding light yellow urine, quantity sufficient. (b)(6)-2 [redacted] AN
11 Oct 03 - 0700	- Assumed care of pt. A+O x 3. VSS Ø c/o pain or discomfort Lungs clear HRRR Active BS x 4 quads LLQ abd stoma beefy red vascular. Mid line abd ~~wound~~ incision open to air sutures removed this a.m. Ø evidence of active bleeding Ø s/s of infection Will cont to monitor (b)(6)-2 [redacted] 91WM (1710) I concur ō above assessment. (b)(6)-2 [redacted] WAC
11 Oct 03	2000: VSS, Ø c/o pain @ present, A+O x 3, midline abdomen wound open to air, Ø drainage noted, will continue to monitor for any drainage, colostomy intact putting out light brown semi solid stool ⊕ BS x 4, tolerate PO, adequate UOP via urinal @ BS, x2 restraints ō skin breakdown. Will continue to monitor. (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.

PROGRESS NOTES
Medical Record

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

[redacted] (b)(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
12 Oct 0700	Assumed care of pt. A+O x3 VSS Ø c/o pain or discomfort @ this time. Lungs clear ~~[illegible]~~ Active BS x4 quads. Ostomy to LQ of abd stoma vascular red. Care given self c̄ assistance Tolerates PO. Abd incision healing well Ø s/s of infection Afebrile Will cont to monitor (b)(6)-2 [redacted] RN
12Oct03	@2030 = VSS, A+O x3, managing pain c̄ percs as ordered, midline abdominal wound open to air & healing, Ø drainage seen, colostomy intact putting out light brown semi-solid stool → pt does own colostomy care, x2 restraints c̄ skin breakdown, Ø other remarkable findings. (b)(6)-2 [redacted] RN
12Oct03	Received pt resting on bed, VSS, tol PO, ambs. Reinforced colostomy care w/ pt. Am call provided. Colostomy to (2) LQ intact + putting out semi formed brown stool. No c/o pain @ this time. BS (+), midline surgical incision OTA w/ well approximated edges. Restraints per gen protocol, Ø breakdown noted. Ø other remarkable assessments @ this time. Will cont to monitor pt. (b)(6)-2 [redacted]
13Oct03	@ 1930 = VSS, Ø c/o pain, A+O x3, midline abd wound open to air & healing, Ø drainage noted, colostomy intact c̄ brown formed stool being put out, x2 restraints c̄ skin breakdown, Ø other remarkable assessment findings. Continue to monitor. (b)(6)-2 [redacted] RN

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
14 Oct 03 0700	- Assumed care of pt. cond. stable VSS OK for discharge to EPW camp. Remains afebrile abdominal surgical incision sutures removed healing well Ø s/s of infection. Ostomy to (L) UQ Abdomen vascular beefy red stoma. Self care colostomy change. Lungs CTA. HRRR Tolerate PO Ambulates I difficulty (b)(6)-2 [redacted]
14 Oct 03 2148	VSS. AO. Ø c/o pain at this time. BS (+) x4 and colostomy clean & intact. Abd DSG CDI to lower abdominal site. (+) pulses. 25 cc AB. Up to ambulate x1 for 30 min. I difficult and returned to bed. Pt. comfortably in bed. Jointly light amber urine, quantity sufficient. (b)(6)-2 [redacted]
15 Oct 03 0700	- Assumed care of pt. cond stable Lungs clear HRRR Active BS tolerating PO well Ambulates I difficulty. Ostomy to (L) UQ stoma vascular beefy red self care given. Surgical incision to abdomen healing Ø s/s of infection pt. remains afebrile. Will cont to monitor (b)(6)-2 [redacted]
	(AHD) I concur c̄ above assessment. (b)(6)-2 [redacted]
	(AHD) Pt D/C to EPW camp - ambulatory - escorted by MPs. (b)(6)-2 [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

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

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 03OCT03 | TIME: 1205

TRANSFERRING FACILITY: [redacted] (b)(2)-2

SEX: M

AGE: 20

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

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

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

CURRENT MEDICATIONS: Cefotaxim 3g, flagyl 500mg, KCl 60 meq

ALLERGIES: NKDA

INJURY OR OCCUPATIONAL ILLNESS			
ITEM	YES	NO	WHEN *(Date)*
IS THIS AN INJURY?		X	WHERE
INJURY/SAFETY FORMS		X	
HOW			

EMERGENCY ROOM VISIT	
DATE LAST VISIT	24 HOUR RETURN ☐ YES ☒ NO
TETANUS	
DATE LAST SHOT	COMPLETED INITIAL SERIES ☐ YES ☒ NO

CHIEF COMPLAINT: Transfer from Iraqi Hos s/p laparotomy

CATEGORY OF TREATMENT

☐ EMERGENT
☐ URGENT
☒ NON-URGENT

TIME: 1206

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

VITAL SIGNS

TIME	1206				
BP	129/67				
PULSE	107				
RESP	20				
TEMP	100.1 (T)				
WT	—				

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE

DISPOSITION: ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

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

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATE

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

[redacted] (b)(6)-4

[redacted] (b)(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

NSN 7540-01-075-3786

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

TEST RESULTS

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

S. 20 yo EPW S/P laparotomy tranferred from Iraqi Hosp. Pt sustained GSW to abdomen - had surgery yesterday @ Iraqi hosp. Ø C/O pain.

O. Pt arrived via FIA, AAD, Ø resp distress, A+O×3

HEENT - NG tube to gravity c̄ bag, 150cc out green stuff.
Chest - Rhonchi in all lobes heard.
Heart - RRR Ø murmurs
Abd - TTP in all quads. Presents c̄ 2 wound drains ~30cc out, NGT to gravity ~ 150cc out, colostomy ~Ø output, Foley c̄ 1000cc out.
Ext - WNL cap refill <2secs

CONSULT WITH	TIME	ACTION

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

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

DIAGNOSIS

CODES

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

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

Ward/Section:	REQUESTING PHYSICAN:	L/
LAST, FIRST,MI.	DATE	TIME

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10
RBC		4.7-6.1 x10
Hgb		14-18 g/dl(M) 12-16 g/dl(F)
Hct		42-52%(M) 37-47%(F)
MCV		80-94 fi(M) 81-99 fi(F)
Plt		130-500 x10³ verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs

Urinalysis

TEST	RESULT	REF. RANGE
Color	Yellow	N/A
App	Clear	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	Trace	Negative
SG	1.010	N/A
Bld	Trace	Negative
pH	8.0	N/A
Prot	neg	Negative
Urob	0.2	0.2-1.0
Nit	neg	Negative
Leuk	neg	Negative
HCG		Negative

(b)(6)-4

ID: [redacted]
WB

03-10-03
13:20

			Patient Limits	
WBC	8.6	x10^3/uL	4.5	10.5
RBC	5.05	x10^6/uL	4.00	6.00
Hgb	14.2	g/dL	11.0	18.0
Hct	45.3	%	35.0	60.0
MCV	89.7	fL	80.0	99.9
MCH	28.1	pg	27.0	31.0
MCHC	31.3 L	g/dL	33.0	37.0
Plt	282.	x10^3/uL	150.	450.
LY%	11.5 *L	%	20.5	51.1
LY#	1.0 *L	x10^3/uL	1.2	3.4

Macroscopic Urinalysis

Acetest - small
RBC - 2-4

CSF

l int			
ctigen		Negative	

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Blood Bank Unit Crossmatch

(MUST SUBMIT SF 518 WITHE EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

LAB ID NO.:

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/03/03 01:24 PM

Patient ID: [redacted] (b)(6)-4
Test Name :PT
Test Result:= 17.4 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.4
Calculated INR = 1.78
Sample Type:citrated wh. blood
Test Date :10/03/03
Test Time :01:[illegible] PM
Card Lot :01[illegible]
Operator [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/03/03 01:26 PM

Patient ID: [redacted] (b)(6)-4
Test Name :APTT
Test Result:= 51.1 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :10/03/03
Test Time :01:24 PM
Card Lot :100208
Operator [redacted] (b)(6)-2

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

LAST, FIRST,MI. [redacted] (b)(6)-	4	DATE 03Oct03	TIME 1206	SSN/PEEUDO SSN: [redacted] (b)(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-1		
Drug of Abuse		

(Piccolo) Chemistry 12

======= PICCOLO =======
10/03/03 01:52 PM
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: (b)(6)-2 3142AA4
OPER # [redacted] DR #: 000
SERIAL #: [redacted]
....(b)(6):4.....

ALB	3.1*	3.3-5.5	G/DL
ALP	63	26-84	U/L
ALT	♦♦♦	10-47	U/L
AMY	21	14-97	U/L
AST	74*	11-38	U/L
TBIL	1.1	0.2-1.6	MG/DL
BUN	♦♦♦	7-22	MG/DL
CA++	8.9	8.0-10.3	MG/DL
CHOL	88*	100-200	MG/DL
CRE	1.0	0.6-1.2	MG/DL
GLU	97	73-118	MG/DL
TP	6.2*	6.4-8.1	G/DL

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

BUN – 11

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^{+}	136	128-145 mmol/l
K^{+}	3.3	3.3-4.7 mmol/l
CL^{-}	105	98-108 mmol/l
tCO2	26	18-33 mmol/l

REMARKS:

REPORTED BY: (b)(6)-2 [redacted]	DATE: 10-03-03	LAB ID NO.:

Ward/Section: ICW1	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
[redacted] (b)(6)-4	30 CT	2130	[redacted] (b)(6)-4

(b)(6)-4

ID: [redacted]
WB

03-10-03
22:39

			Patient Limits	
WBC	7.4	x10^3/uL	4.5	10.5
RBC	4.83	x10^6/uL	4.00	6.00
Hgb	13.5	g/dL	11.0	18.0
Hct	43.8	%	35.0	60.0
MCV	90.6	fL	80.0	99.9
MCH	27.9	pg	27.0	31.0
MCHC	30.8 L	g/dL	33.0	37.0
Plt	170. *	x10^3/uL	150.	450.
LY%	11.4 *L	%	20.5	51.1
LY#	0.8 *L	x10^3/uL	1.2	3.4

Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Macroscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: (b)(6)-2 [redacted]	DATE: 30 Oct 03	LAB ID NO.:

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

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

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

Misc. Chemistry		
TEST	RESULT	REF. RANGE
Tropoin-1		
Drug of Abuse		

======= PICCOLO =======
10/03/03 11:04 PM
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
LIVER PANEL PLUS
DISC LOT #: (b)(6)-2 3154AA7
OPER #: [redacted] DR #: 000
SERIAL #: [redacted] (b)(6)-4

ALB	3.1*	3.3-5.5	G/DL
ALP	61	26-84	U/L
ALT	29	10-47	U/L
AMY	27	14-97	U/L
AST	60*	11-38	U/L
TBIL	1.1	0.2-1.6	MG/DL
GGT	9	5-65	U/L
TP	6.3*	6.4-8.1	G/DL

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

======= PICCOLO =======
03/10/03 22:36
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: (b)(6)-2 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted] (b)(6)-4

GLU	119*	73-118	MG/DL
BUN	8	7-22	MG/DL
CRE	0.8	0.6-1.2	MG/DL
CK	1616*	39-380	U/L
NA+	~~***~~	128-145	MMOL/L
K+	3.9	3.3-4.7	MMOL/L
CL-	99	98-108	MMOL/L
tCO2	23	18-33	MMOL/L

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

Na 136

REMARKS:

REPORTED BY: (b)(6)-2 [redacted]	DATE: 3Oct03	LAB ID NO.:

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
#[redacted] (b)(6)-4				13 October	_____ HOURS	
				may be transferred to facility if		[redacted]
				colostomy care arranged		
				wound dressing change (2x2 gauze		[redacted] (b)(6)-2
				1-2x daily		
NURSING UNIT	ROOM NO.	BED NO.				1720
KW#1	2	D[redacted]		13 OCT 03 1930 [redacted] (b)(6)-2		13 [redacted]

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

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

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

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

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

NURSING UNIT: ICW 24° | ROOM NO.: 0840 | BED NO.: [redacted]

DATE OF ORDER: 4 Oct | TIME OF ORDER: 1400 HOURS | LIST TIME ORDER NOTED AND SIGN

1 DC abd drain, chg
2 DC foley
3 DC NG
4 NPO

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

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

Noted 5 Oct 03 0840 [redacted] (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 5 Oct 03 | TIME OF ORDER: 0840 HOURS

1 Clear liquid diet (b)(6)-2

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

[redacted] (b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER: 06 Oct 03 | TIME OF ORDER: 1200 HOURS

DC IVFs

Adv diet to req.

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

[redacted] (b)(6)-2

NURSING UNIT: 24° | ROOM NO.: 0130 | BED NO.: 7 Oct 03 [redacted] (b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER: 7 Oct 1100 | TIME OF ORDER: HOURS

1 DC MS
2 Permit 1-2 po q 4 pm
3 DC IV
4 VS q shift

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

URSING UNIT: 24° | ROOM NO.: 0175 | BED NO.: 1150 8 Oct 03 [redacted] (b)(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW 1		

DATE OF ORDER 30 Oct TIME OF ORDER 1300 HOURS

LIST TIME ORDER NOTED AND SIGN

Admit ETN ward
Ind fair
Diet 003 chain BID
ambulate gd
VS - q 4h
Dx - 0 perech abd trauma

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

IV D5-1/2 NS 1000 cc at 125 cc/h
NG to gravity drain
Foley gd
red rubber abd drain - gravity
drain (L) LQ wound c̄ gauge gd

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

MS-2-4 mg IV q 2h pr pain
CBC 'lyte am 4 Oct
Tepain SQ 5000 ut q 12h

[redacted]

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4 [redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW 24 V	40+030	0220 [redacted]

DATE OF ORDER TIME OF ORDER HOURS

30 Oct 2100
CBC 'lyte LFT's now [redacted]
cancel 0400 lab

(b)(6)-2

(b)(6)-2

(b)(6)-2

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH 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. 10 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 3	4	5	6	7	8	9	10	11	12	13	14	15
10/3	[redacted]	Act: DDB chair	06 18	[redacted]												
	(b)(6)-2	BID. Ambulate q d	18 06	[redacted]												
10/3	[redacted]	VS q 4°	06 18	[redacted]												
	(b)(6)-2		18 06	[redacted]												
10/3	[redacted]	NG to gravity drain	06 18	[redacted]												
	(b)(6)-2		18 06	[redacted]												
10/3	[redacted]	Foley	06 18	[redacted]												
	(b)(6)-2		18 06	[redacted]												
10/3	[redacted]	Red Rubber abd	06 18	[redacted]												
	(b)(6)-2	drain - gravity	18 06	[redacted]												
10/3	[redacted]	Change DLD	10	[redacted]												
	(b)(6)-2	wound c gauze	/													
		q d	/													
04 10 03	[redacted]	NPO	06	[redacted]												
	(b)(6)-2		18	[redacted]												
Sat	[redacted]	clear liquid diet	06 18	[redacted]												
	(b)(6)-2		18 06	[redacted]												
06 10 03	[redacted]	Adv. diet to reg.	06	[redacted]												
	(b)(6)-2		18	[redacted]												
07 10 03	[redacted]	VS q shift	06	[redacted]												
	(b)(6)-2		18	[redacted]												

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Penetrating abd trauma

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: 1

PATIENT IDENTIFICATION:

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo Oct Yr 2003	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
10/3	[redacted]	Admit EPW Ward	10/3				(b)(6)-2
10/3	[redacted]	Condition, fair	10/3				(b)(6)-2
10/3	[redacted]	CBC, lytes am 4 Oct	10/4	0400	cancelled		(b)(6)-2
10/3	[redacted]	CBC, lytes, LFTs	10/3	2130	2130	[redacted]	(b)(6)-2
Ø4 OCTØ3	(b)(6)-2 [redacted]	D/C abd drains	Ø4 OCTØ3	—	1415	[redacted]	(b)(6)-2
Ø4	(b)(6)-2 [redacted]	D/C foley	Ø4	—	1415	[redacted]	(b)(6)-2
Ø4	(b)(6)-2 [redacted]	D/C NGT	Ø4	—	1415	[redacted]	(b)(6)-2
B	(b)(6)-2 [redacted]	May be transferred to facility of	B				
	(b)(6)-2	choice as soon as medically					
	----	cleared. Wound					
	----	dressing change (2x2) gauze					
	----	1-2x daily.					

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

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. 10 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 3	4	5	6	7	8	9	10	11	12	13	14	15
10/3	[redacted]	IV - D5½NS 1000cc	06	[redacted]												
(b)(6)-2	[redacted]	T 20meq KCL @125cc	18													
10/3	[redacted]	Heparin SQ 5000	06													
(b)(6)-2		q 12°	08	[redacted]												
			20													
		(b)(6)-2														
07 OCT 03	[redacted]	D/C MS	D/C	07 OCT 1145 [redacted]												
07	[redacted]	D/C IV	D/C	07 OCT 1145 [redacted]												
		(b)(6)-2														
		PRN Medication														
10/3	(b)(6)-2		Date	07 OCT 0845	07 OCT 2245	08 OCT 1115										
10/6	[redacted]	MS - 2-4mg IV q 2hr pen pain	Time	[redacted]												
			Dose	[redacted]												
	(b)(6)-2		Initial													
07 OCT 03	[redacted]	Percocet 1-II po q 4° pm	D/C	07 OCT 1730	07 OCT 2230	08 OCT 1730	08 OCT 2155	09 OCT N16	09 OCT 1030	10 OCT 1016	10 OCT 1924	11 OCT 0030	11 OCT 2115	12 OCT 2100		
			D/C	[redacted]												
			D/C	13 OCT 1030	13 OCT 2200											
			D/C	[redacted]												

(b)(6)-2

(b)(6)-2

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO PRIMARY DIAGNOSIS: Penetrating abd trauma

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. 1

PATIENT IDENTIFICATION:

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

A | Country Code.)

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

(b)(6)-4

3. REGISTER NUMBER (9–15): [redacted]

NAME (Last, First, Middle Initial): [redacted] (b)(b)-4

4. PAY GRADE (16–17):

5. SEX (18): M

6. DATE OF BIRTH (YYYYMMDD) (19–26): [redacted]

7. AGE AT ADMISSION (27–29): 2 0 4

8. RACE (30):

9. ETHNIC BACKGROUND (31):

RELIGION:

10. LENGTH OF SERVICE (32–34):

ETS:

11. FMP (35–36):

12. SOCIAL SECURITY NUMBER (37–45): [redacted]

ORGANIZATION (Active Duty Only):

13. MARITAL STATUS (46):

HOUR OF ADMISSION:

BRANCH / CORPS: (b)(b)-4

14. FLYING STATUS (47–49):

15. BENEFICIARY CATEGORY (50–52):

16. ZIP CODE OF RESIDENCE (53–61):

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):

WARD:

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE:

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code):

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY:

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE:

21. TYPE OF DISPOSITION (73–74):

22. MTF TRANSFERRED TO (75–80):

23. DATE OF DISPOSITION (YYYYMMDD) (81–88): 2 0 0 3 1 0 1 5

24. CLINIC SVC - ADMITTING (89–92):

25. MTF TRANSFERRED FROM (93–98):

26. DATE THIS ADMISSION (YYYYMMDD) (99–106): 2 0 0 3 1 0 0 3

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

28. MTF OF INITIAL ADMISSION (109–114):

29. DATE INITIAL ADMISSION (YYYYMMDD) (115–122):

FOR LOCAL USE

Dx: 86330, 86344, V443, E9912

Pr 4652, 8741, 8801

Inj Trauma 450 1

ADMITTING OFFICER (Signature, as required):

SIGNATURE OF ADMITTING CLERK:

DA FORM 2985, MAR 2000

EDITION OF MAR 89 IS OBSOLETE

USAPA V1.00

3. Register Number	Name (Last, First, MI)		4. Pay Grade	5. Sex
[redacted] (b)(6)-4	[redacted] (b)(6)-4		FGN	M
6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
[redacted]	20Y	X	9	ISLAMIC
10. Length of Service	ETS	11. FMP	12. Social Security Number	
		99	[redacted] (b)(6)-4	
Organization (Active Duty Only)		13. Marital Status	Hour of Admission	Branch / Corps:
		Z	12:06	
14. Flying Status	15. Beneficiary Category		16. Zip Code of Residence:	
	K78-PRISONER OF WAR/INTERNEES			
17. Unit Location	18. MOS	19. Trauma	Prev. Admission	
		DIS	NO	
20. Source of Admission	Ward:	Name / Relationship of Emergency Addressee		
Direct from ER	ICW1	Address of Emergency Addressee		
Name and Location of Medical Treatment Facility: 0580 - [redacted] No Install Provided (b)(2)-2		Telephone Number of Emergency Addressee		
21. Type of Disposition	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD)		
TRF-OTH		2003-10-15		
24. Clinic Svc - Admitting	25. MTF Transferred From	26. Date this Admission (YYYYMMDD)		
ABA - GENERAL SURGERY		2003-10-03		
27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission		
		2003-10-03		

FOR LOCAL USE

1st admis

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: GSW ABDOMEN

Procedure Narrative(s):

Cause of Injury Narrative: INJURED BY US SOLDIERS WHILE ATTEMPTING MURDER

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

'omated Facsimile - DA FORM 2985, MAR 2000

Automated Facsimile

IN..TIENT TREATMENT RECORD C..ER SHEET

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

(b)(b)-4

1. Register Nbr	2. Name					3. Grade	Admission Remarks
[redacted]	[redacted] (b)(b)-4						
4. Sex M	5. Age 22Y	6. Race Z	7. Religion UNKNOWN	8. LnthOfSvc	9. ETS	10. PrevAdm NO	
11. FMP 20	12. SSN [redacted]	13. Organization (b)(b)-4				14. Ward ICW1	
15. FlyStatus N/A	17. Dept / Ben K78-PRISONER OF WAR/INTER		18. BranchCorps	19. UIC / ZIP		20. Type Case DIS	
21. Source of Admission Direct from ER			22. Hour Of Adm: 14:33	23. Clinic Service AEA - ORTHOPEDICS			
24. Name/Relation of Emergency Addressee			25. Type Disp TRF-OTH	26. Date of Disp 2003-10-10			
27a. Address of Emergency Addressee			27b. Telephone No	28. Date This Adm: 2003-10-04		AdmittingOfficer: [redacted] (b)(b)-2	
29. ReportingMTF [redacted] - Iraq (b)(2)-2				30. Date Init Adm 2003-10-04		32. Units Blood Components	

31. Selected Administrative Data

Marital Status: Z DoB: [redacted]

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

GSW LEFT SHOULDER

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
Ø	Ø	Ø	Ø	6	6

35. Total Days This Facility

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

Signature [redacted] Officer [redacted] (b)(b)-2 [redacted] of PAD or Medical Records Officer [redacted] (b)(b)-2 [redacted] (b)(b)-2

(b)(b)-2

Automated Facsimile - DA FORM 3647, May 79

[redacted] (b)(b)-4
(b)(7)(c)-5 ; (b)(b)-5

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

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

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

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

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

- ☐ Violation of Curfew
- ☐ Illegal Possession of Weapon
- ☒ Assault/Attack on Coalition Forces: SHOOTING AT U.S. FORCES
- ☐ Theft of Coalition Force Property
- ☐ Trespass on Military Installation or Facility
- ☐ Photographing/Surveiling Military Installation or Facility
- ☐ Obstructing Performance of Military Mission
- ☐ Other

Apprehending Unit: [redacted] (b)(2)-2 | Location Grid: | Date of Report: (D/M/Y) / / | Time of Report: hrs

Date of Incident: (D/M/Y) 4/10/130 to / / | Time of Incident: 1300 hrs to hrs

(b)(b)-4
(b)(b)-4
(b)(7)(c)-5
(b)(b)-5

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

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

☐ Vehicle Information Vehicle Number ____ of ____ Vehicle(s) | Owner:

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

Contraband/Weapons in Vehicle:

☐ Property/Contraband ☐ Weapon | Photo Taken of Suspect with Weapon/Contraband. Yes/ No

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

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

Detaining Soldier's Name (Print): CONTACT UNIT BILCP Last, First MI	Supervising Officer's Name (Print): Last, First MI
Signature:	Signature:
Email: [redacted] Date: / /	Email:
Unit Phone:	Unit Phone: Date: / /

(b)(6)-1
(b)(7)(c)-1

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

22 YO. ♂ SUSTAINED GSW TO (L) SHOULDER. IRAQI INSURGENCE.

(Θ) PMH

(Θ) NDS

(Θ) ALLERGIES

LAST P.O. 0600

PHYSICAL EXAMINATION

FRONTAL & TRANSLUM SOFT TISSUE WOUND POSITIVE (L) SHOULDER GSW POSTERIORLY, TRAV EXITED LATERALLY AS POSTERIORLY. NEV INJURY EVIDENT

WOUNDS WRAPPED
WRISTS - BILATERAL
LEGS - CLEAN
[illegible] AND PULSES

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

(A) GSW (L) SHOULDER

(P) IV FLUIDS, NS

[redacted] (b)(6)-2

SIGNATURE OF P[redacted]	DATE 8 OCT 03	IDENTIFICATION NO.	ORGANIZATION

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

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

4/x-7 03
1939

Ortho Op Note

Pre-Op Dx - GSW (L) shoulder
Post-Op Dx - Same
Procedure - I+D (L) shoulder
Surgeon - [redacted] (b)(b)-2
EBL - Min
BWIS - 1000 LR
Findings - Through and through wound through deltoid muscle. No bone involvement. Minimal necrotic muscle. Irrigated 3 liters through and through, then packing wound closed on person. Deltoid defect closed with 0-vicryl but otherwise skin wound left open.
PLN: IV Ancef Repeat I+D [redacted] (b)(b)-2
[redacted] (b)(b)-2
CDR M

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] (b)(b)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
30 OCT 03	Pre-Op Dx - GSW (L) shoulder
1400	Post Op Dx - same
	Procedure - I&D, DPC (L) shoulder
	Surgeon - [redacted] (b)(6)-2
	Anes - MAC
	Blood - 350 cc
	Fluids - Wound closed in layers
	Plan - Discharge to GPH camp in 2 days
	[redacted] (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
4 OCT 03	③ Pt. was seen raising a handgun from behind other Iraqi's who were throwing rocks at coalition forces. When he stepped out from behind & raised pistol, he was ~~shoot~~ shot by US soldier in (B) arm. shoulder.
	⓪ wound cleaned & dressed c̄ gauze bandage.
	VS taken at the scene were stable, not recorded by 91W.
	(B) hand FAROM & fingers NN/I
	- transported to [redacted] for x-rays & further eval. (b)(2)-2
	✱ x-rays show sig schapel to (B) shoulder c̄ poss. intra capsular involvement
	Ⓐ ① FSW (B) shoulder (b)(2)-2
	- transfer of care to orthopedic surg @ [redacted] for surgical debridement of wound.
	[redacted] (b)(6)-2
	[redacted] (b)(6)-2
	1LT [redacted] MC PROFIS Physician (b)(2)-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.

[redacted] (b)(6)-4

[redacted] (b)(6)-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4/OCT/03 2120	Received pt. from ICW #3. AO. Speaking small english & Arabic. Pt. showing and provided blankets. (P) pulse to LUE and CR ≤2 sec. Warm to touch. BS (+) x4, ±SCL AB. S,S,. 2 IV's in LUE and LR @ 125 cc/hrs. PERRLA. Started on IV AB and placed NPO & NL for surgery on 5 OCT 03. (b)(6)-2 [redacted]
5 Oct 03 0500	VSS Alert + Oriented OOB ambulated to BR with steady gait. Tolerated Reg diet for Breakfast IV saline lock (R) FA and SL present to (R) hand. Both saline lock patent and intact. (L) Shoulder dsg w/ptx to posterior area. small serosanguinous drainage to dsg. Lungs clear. BS (+) x4 abd soft non distended. Peripheral pulses palpable. Will continue plan of care. [redacted] (b)(6)-2 RN
5 OCT. 03 1930	Pt A+O x3, VSS, LS CTA (B), (+) BS x4, tol PO well, SL to (R) Hand + (R) FA, intact ∑ s/sx of infex or infiltration, dsg to (L) shoulder CDI, ∅ noted drainage, denies pain @ this time, able to move fingers, radial pulses equal (B), ambulates ∑ difficulties.

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

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

[redacted] (b)(6)-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
Cont.	voiding well, ø s/sx of poor circulation or skin breakdown on pts of restraint. [redacted] (b)(6)-2
06OCT03	(1640) Assumed care of pt @ 0600 ¯ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled ¯ Tylenol. Drsg to ⓛ shoulder CDI. Pt remains NPO for surgery today. Pt OOB this am to BR for personal hygiene. Amb well. Voiding ¯ difficulty. IVF infusing @ TKO into IV in ⓡ forearm ¯ s/sx infection/ infiltration. 2 point restraints in place ¯ s/sx complications. Will cont. to monitor. [redacted] (b)(6)-2 (1800) Pt not on surgery schedule. Given reg diet. [redacted] (b)(6)-2
6 OCT. 03	Pt awake, A+O x3, VSS, LS CTA ⓑ, ⊕ BS x4, OOB to BR, pain controlled ¯ percs, dsg ⓛ shoulder CDI, IV HL ⓡ FA intact, flushes well, ø s/sx of infex or infiltration, voiding well, ø skin breakdown or poor circulation on pts of restraint. [redacted] (b)(6)-2 [redacted] (b)(6)-2
07OCT03	(1630) Assumed care of pt @ 0600 ¯ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled ¯ Percs. Pt amb in hallway well. s/s in ⓡ forearm dlcd - catheters intact. 20g IV started in ⓛ forearm flushes well ¯ s/sx infiltration. Drsg to ⓛ shoulder Δd - wet → dry to exit wound. Tol. reg diet well. Voiding ¯ difficulty. 2 point restraints in place ¯ s/sx complications. Will continue to monitor. [redacted] (b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK
☆ U.S. GPO: 1998-432-786/75236

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES (b)(6)-2
9OCT03	0001 = IVF's initiated P/T NPO p MN. — [redacted]
9OCT03	VSS. Alert & oriented. OOB → BR for
0500	AM care. Pt NPO i O/C for OR this AM.
	(L) FA IV patent & intact. OOB → BR
(b)(6)-2	[redacted] ad lib. (R) Shoulder dry, dry & intact.
	Peripheral pulses +2. Voiding without difficulty
	quantity sufficient. Awaiting pickup for
	OR. Will continue care as ordered [redacted] (b)(6)-2
9OCT03	VSS Received from PACU Alert & oriented
1730	(L) Shoulder dry, dry & intact. (L) FA IV patent
	& intact infusing LRS 150cc/hr. Voiding clear
	yellow urine. Regular diet given for dinner
	Tolerating well. Will report to next
	shift of pt's condition [redacted] (b)(6)-2
9OCT03	VSS. AO - Epidural, warm to touch @ UE. Ds4 cpI
2013	E mild c/o pain and provided I percocet. Voiding QS
	light yellow urine — [redacted] (b)(6)-2
10OCT03	(1050) Assumed care of pt c/o report from night
	shift. Pt alert, speaking Arabic. VSS. Pain controlled
	c Tylenol. Drsg to (L) shoulder Δd this am. Sutures
	CDI. SL in (L) forearm flushes well s̄ s/sx infection/
	infiltration. Tol. reg diet well. Voiding s̄ difficulty.
	Pt OOB to BR this am for personal hygiene. Amb
	well. 2 point restraints in place s̄ s/sx complications.
	Will continue to monitor. Awaiting D/C to EPW camp.
	(b)(6)-2 [redacted]
	(1620) Pt d/c to camp - amb - escorted by MS [redacted]

STANDARD FORM 509 (REV. 6/1999) BACK
USAPA V1.00

(b)(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
7OCT.03 1945	Pt A+O x3, VSS, OOB to ambulate, dsg to (R) shoulder CDI, pain controlled c̄ percs, HL IV (L) FA intact ~~infusing~~ [redacted] (b)(6)-2 ∅ s/sx of infex or infiltration, abd soft flat nontender, voiding s̄ diff, 2 pt restraint in place c̄ ∅ s/sx of poor circulation or skin breakdown, LS CTA(B), (+)BS x4. (b)(6)-2 [redacted]
∅8OCT∅3	(1640) Assumed care of pt @ ∅600 p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Tylenol. Drsg to (R) shoulder Δd wet→dry. Pt OOB to BR for personal hygiene this am. Amb well. Tol reg diet well voiding s̄ difficulty. 2 point restraints in place s̄ sx complications. Will cont. to monitor. (b)(6)-2 [redacted]
8Oct03	1845: VSS, ∅ c/o pain @ present time, A+O, speaks Arabic to communicate, dsg to (L) shoulder CDI, OOB & ambulates s̄ difficulty, x2 restraints when in bed, ⊖ skin breakdown noted, IV HL ISG to (L) FA flushed & patent, continuing IV Ancef. Continue to monitor for acute Δ's. [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	(b)(6)-2

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
10 Oct 03	Ortho Discharge Note
	22 yo male sustained (L) shoulder through and through GSW on 9 oct 03. Went to OR 9 oct 03, I+D done. DPC done 9 oct 03.
	Plan: Every other day dressing changes. Sutures out 17 Oct 03. Keflex 250 mg QID x 10 days #40. Percocet 1-2 P.O. Q 4-6 hrs prn #20
	[redacted] (b)(b)-2
	[redacted] COL MC (b)(b)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] (b)(b)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER

TREATMENT FACILITY [redacted] (b)(2)-2

RECORDS MAINTAINED AT

PATIENT'S [redacted] DUTY STATION (b)(6)-4

STREET ADDRESS

CITY

STATE

ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)* 09 OCT 03

TIME 1625

TRANSPORTATION TO FACILITY MEDEVAC

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

CURRENT MEDICATIONS: Ø

ALLERGIES: PtD 17163

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

CHIEF COMPLAINT: GSW (L) shoulder

CATEGORY OF TREATMENT		VITAL SIGNS					
☐ EMERGENT	TIME 1625	TIME	1625				
☐ URGENT		BP	128/68				
	INITIALS [redacted] (b)(6)-2	PULSE	66				
☐ NON-URGENT		RESP	16				
		TEMP	100.7				
		~~WT~~					

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

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY		TIME	PATIENT'S RESPONSE
1731	lyctr Anct (b)(6)-2	[redacted]			(b)(6)-2
1731	Tetanus (b)(6)-2				(b)(6)-2

DISPOSITION: ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

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

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

[redacted] (b)(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

MEDICAL RECORD	**PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT** For use of this form, see AR 40-66; the proponent agency is The Office of the Surgeon General.
1. AGE: 22 HEIGHT: WEIGHT: 67 Kg	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): NKDA 3. PREVIOUS SURGERY [ ] NO [X] YES (type): Inguinal hernia repair

4. PROPOSED SURGICAL PROCEDURE:

I&D (L) shoulder GSW

5. ADDITIONAL INFORMATION: Last PO: 0600 Medical Hx: Ø Implants: Ø Medications: Ø
Jewelry removed: yes/no Family waiting: yes/no
(+) watch

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

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

[redacted] (b)(6)-4

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; shock; previous surgery	✓ Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	✓ Check for support stockings or ace wraps. If none, check with doctors. ✓ Check that safety straps are correctly applied. ✓ Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. ✓ Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to sedation; pain; injury E.2. ✓ Potential discomfort due to injury; pain	✓ Pt. will be transferred to OR table without difficulty. ✓ Pt. will not experience unnecessary physical discomfort.	✓ Have sufficient people available for transfer. ✓ Insure proper body alignment. ✓ Allow patient to lie in position of comfort while waiting for surgery. ✓ Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. ✓ Disminished visual perception due to being injury; sedation; F.2. ✓ Potential for decreased communictaion due to language barrier; sedation F.3. Potential injury due to dentures. No dentures	✓ Pt. will be made aware of surroundings prior to anesthesia induction. ✓ Pt. will be transferred safely to OR table. ✓ Pt. will be able to understand instructions. ✓ Minimize danger of injury during intraop period.	✓ Introduce self. Keep pt. informed as to where he/she is and what is happening. ✓ Inform pt. in which direction to move and assist if necessary. ✓ Speak clearly and slowly. ✓ Address pt. from either side. ✓ Validate pt.'s understanding of verbal communications. o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS. Or continuation of above interventions.

10. OR [redacted] IT/AN (b)(b)-2 4 OCT 03 DATE

11. POSTOPERATIVE EVALUATION:

Pt. s̄ s/s of distress
Drsg - CDI

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)	13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)
[redacted] IT/AN (b)(b)-2 DATE: 4 Oct 03 TIME: 1740	[redacted] IT/AN (b)(b)-2 DATE: 4 OCT 03 TIME: 1940

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

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING
VIA litter BY anesthesia

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

3. DATE 9 OCT 03 TIME PATIENT ARRIVED IN SUITE —

4. PATIENT IN ROOM (b)(6)-2 TIME 1545 NUMBER 1-2 (3)

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted], 9TD (b)(6)-2	RELIEF SCRUB	(b)(6)-2
ASSIGNED CIRCULATOR	CPT [redacted], 66E (b)(6)-2	RELIEF CIRCULATOR	Maj [redacted] - EOC

7. POSITION AND POSITIONAL AIDS *(Specify)* arms @ side

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

COMMENTS:

8. SKIN PREPARATION

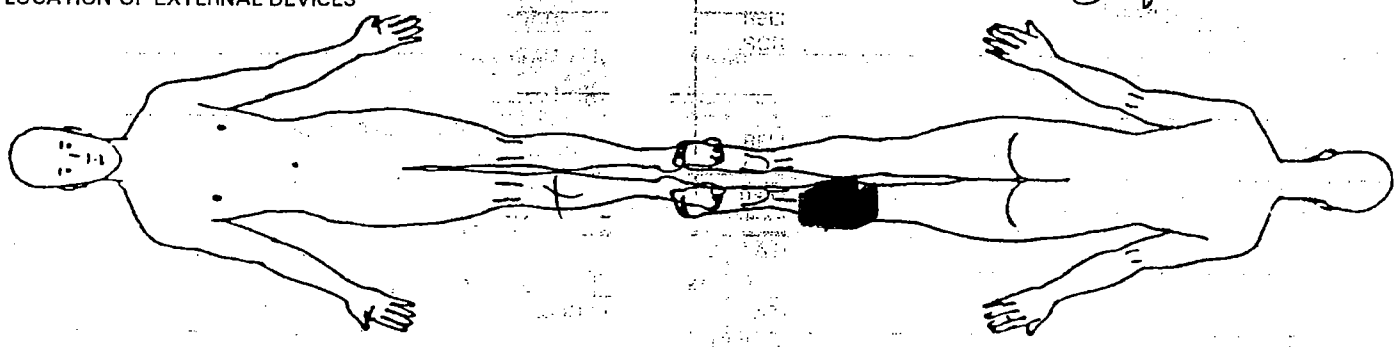
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine / Betadine
SITE: (L) Shoulder BY WHOM: (L) [redacted] CPT [redacted] (b)(6)-2
SITE: — BY WHOM: —

COMMENTS: no pooling of prep noted

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

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

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

[redacted] (b)(6)-4

9 OCT 03

[redacted] (b)(2)-2

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):
0.9% 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)*
~~ABD PAD~~ 99
Tape
4x8d58

19. ADDITIONAL INFORMATION
WC I (b)(6)-2
Surgeon: [redacted]
Anesthesia: Maj [redacted] / General
(b)(6)-2

20. OPERATION(S) PERFORMED
I & D (L) shoulder, DPC

21. PATIENT TRANSFERRED TO ICU3 (b)(6)-2 (b)(6)-2 TIME 1640 METHOD

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

MEDICAL RECORD

INTRAOPERATI UMENT

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

1. PATIENT TRANSPORTED TO OPERATING
VIA Litter BY Anesthesia

2. PATIENT IDENTIFIE ORD REVIEWED AND PROCEDURE
VERIFIED BY ILT [redacted] (b)(6)-2

3. DATE 4 OCT 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 1820 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: (b)(6)-2 S/P GSW (L) shoulder
NKDA, NPO P [redacted] 0600

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] 91D (b)(6)-2	RELIEF SCRUB	SPC [redacted] 91D (1905) (b)(6)-2
ASSIGNED CIRCULATOR	ILT [redacted] 66E (b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) Pt. lateral on padded OR table. RUE on padded arm board - axillary roll (R) axilla. LUE on padded arm holder. Pillow between legs

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

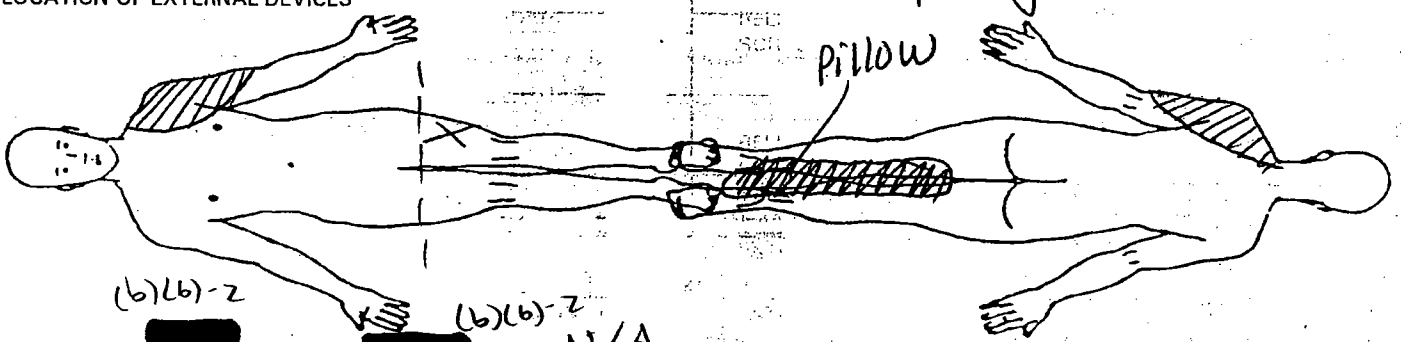
COMMENTS: Normal anatomic body alignment maintained

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Betadine/Betadine
SITE: (L) shoulder BY WHOM: ILT [redacted] (b)(6)-2
SITE: BY WHOM:
COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad [redacted] -- S [redacted] N/A = = = Tourniquet ▨ - prep

INITIAL: PFC [redacted] ILT [redacted] (b)(6)-2

C = Correct I = Incorrect

10. COUNTS

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

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

[redacted]
(b)(6)-4

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

☒ ESU NO: VL Force 40 CUT: 30 COAG: 30
GROUND PAD: BRAND VL REM Polyhesive II
LOT NO: 68245 · Exp 2005-02

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. 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
N/A					

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

OTHER ORDERS	TIME	CARRIED OUT BY
N/A		

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM 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. 3/8" Penrose drain	2.	3.
SITE	1. (L) shoulder wound	2.	3.

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

19. ADDITIONAL INFORMATION (b)(6)-2 GETA WC: III
SURGEON: Dr. [redacted]
ANESTHESIA: MAJ [redacted]
(b)(6)-2

DA5179 Initiated.

20. OPERATION(S) PERFORMED I&D GSW (L) shoulder

21. PATIENT TRANSFERRED TO PACU TIME SEE DA 7389 METHOD Litter c O2

22. REGISTERED NURSE SIGNATURE (b)(6)-2 [redacted] 11T/AN

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 4 OCT 03 | 5 OCT | 06 OCT 03 | 07 OCT 03 | 08 OCT 03 | 09 OCT 03 | 10 OCT 03

19 | HOUR: 9 | 19½ | 20 | 20 | 18½ | 0 | 8

PULSE (O) | TEMP. F (°) | TEMP. C

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

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE: 126/46; 118/64; 114/57; 100/44; 123/50; 118/64; 127/69; 112/47; 119/56; 109/53; 119/56

60; 127/62; 61; 70; 66; 40

58.2; 98.5; 98.3; 98; 141.

HEIGHT: | WEIGHT → 141.8A; 98; 98.6; 97°

Record special data only when so ordered: Oc; 02 Sat; 99(RA); 98%; 97(RA); 96%; 98(RA); 95%; 97(RA); 99(RA)

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

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

LAST, FIRST, MI. [redacted] (b)(6)-4	DATE 04 Oct	TIME 1630	SSN/PSEUDO SSN: [redacted] (b)(6)-4

(Hematology) CBC

ID: [redacted] (b)(6)-4 ... 03
WB 17:40

			Patient Limits	
WBC	15.1 H	x10^3/uL	4.5	10.5
RBC	5.55	x10^6/uL	4.00	6.00
Hgb	16.0	g/dL	11.0	18.0
Hct	51.6	%	35.0	60.0
MCV	92.9	fL	80.0	99.9
MCH	28.9	pg	27.0	31.0
MCHC	31.1 L	g/dL	33.0	37.0
Plt	406.	x10^3/uL	150.	450.
LY%	19.1 *L	%	20.5	51.1
LY#	2.9 *	x10^3/uL	1.2	3.4

Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

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

LAST, FIRST, MI. [redacted] (b)(6)-4	DATE 040ct	TIME	SSN/PSEUDO SSN: [redacted] (b)(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
tCO_2		18-33 mmol/l

======= PICCOLO =======
04/10/03 17:40
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: (b)(6)-2 3141AA4
OPER #: [redacted] (b)(6)-2 DR #: 000
SERIAL #: (b)(6)-4 [redacted]

GLU	92	73-118	MG/DL
BUN	9	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	900*	39-380	U/L
NA+	130	128-145	MMOL/L
K+	4.1	3.3-4.7	MMOL/L
CL-	101	98-108	MMOL/L
tCO2	20	18-33	MMOL/L

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

REMARKS:

REPORTED BY: [redacted] (b)(6)-2	DATE: 10-2-03	LAB ID NO.:

MEDICAL RECORD — ANESTHESIA

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

DRUG	(Unite)	MEDICAL RECORD
Versed	(mg)	3/2
Fent	( )	150
Lido Propofol	( )	40/150
Vec	( )	10mg
	( )	
	( )	
VOLAT AGENT Forane	% del	1.5 / /
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	8 / /

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

FLUIDS

LINE site			
(R) 18ga	LR	☐ Warmed	A to A ga 900
(R) 16ga	NS	☐ Warmed	200
		☐ Warmed	
		☐ Warmed	

LOSSES

EST BLOOD LOSS	50
URINE –	0

TOTALS — TOTAL FLUID — TOTAL URINE

FLUIDS - SUMMARY

CRYSTALLOID–

COLLOID–

BLOOD–

REMARKS-

Code drugs with numbers, events with letters

1820 in OR monitors applied.
1830 RSI & cervicoid
1845 RLD & axillary roll, head (R) arm pressure point tracked
personal belongings ~~with~~ watch wallet clothes put in bag by OR nurse
Reglan 10mg
1925 Reversal 5mg Neostigmine 1mg Robinul
1930 spont Resp oral suction, purposful movement extubated to PACU. 1940 Report given

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT 75 (KG) LB

HEMATOCRIT:

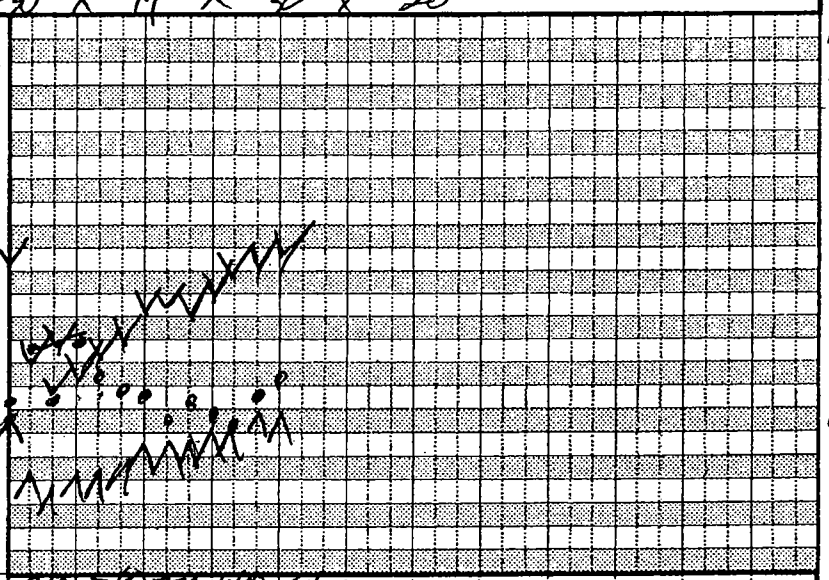
INITIAL DATA: BP – 133/67 HR – 74

EQUIP CHECK OK?– (Y) N

PATIENT CHECK OK for PROCEDURE? TIME – 1745

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

TIME → 30 X 19 X 30 X 20



VENTILATION

VT – ml	810	710	710	400	51
f – breaths/min	18	9	9	9	12
Peak inf pres / PEEP	17	19	19	19	
MODE– S(pon), A(ssist), C(on)	C	C	C	C	S

MONITORS / ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	30	32	32	31	42
BP / oth	FIO2 (Frac or %)	.59	.59	.59	.59	.59
ART line	SpO2 (%)	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR
Gas analyzer	TEMP- site Skin	36°		36°	X	
	N-M Block (T/4)					
Warming blkt						
Conv warmer						

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

RECOVERY AT 1942 — PACU / ICU ____ (Specify) — OTHER 95.2 (O)

CONDITION: ~~Alert~~ Resp. ~~Resp.~~ Resp. adequate

RESP– 17 SpO2– 98 BP– 126/56 HR– 87

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1736	1820	2000
	Ready	Begin	End
PROC	1830	1850	1928

PROCEDURES and CPT Codes

I&D (L) arm GSW

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

[redacted] (b)(6)-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

GETA – RSI & cervicoid pressure

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments 8.5 ET placed one attempt 3 miller blade. Grade 1 view. (+) ETCO2 BBS secured @ 24cm teeth

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

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

PROCEDURE LOCATION OR 1

DATE 10/4/03

PAGE 1 OF 1

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 20934

22 y/o S/P GSW (L) Shoulder PMH HX I&D 10/4 GA & conus MP II, NKA Ancef 0600, Percs. KPN BICTA, HARRRDA
II T. NPO p MN VS -, -64-16 112/47 97% SpO2 KH

MEDICAL RECORD - ANESTHESIA

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

NKDA

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

DRUG (Units)																		
Midazolam (mg)	2.5																	
Fentanyl (mcg)	<150>																	
Propofol (mg)	<100>																	
( )																		
( )																		
( )																		
VOLAT AGENT: Sevo % del	2.5	3.0	2.5	2.5 X														
% e.t.																		
AIR L/Min																		
N2O L/Min																		
O2 L/Min	2	2	2	2	10													

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

FLUIDS

LINE site 18G (L) AX Warmed	ARS#		200														
☐ Warmed	(900)																
☐ Warmed																	
☐ Warmed																	

LOSSES: EST BLOOD LOSS; URINE -

TOTALS	TOTAL EBL
2.5	<50
200	
100	TOTAL URINE
	Ø

FLUIDS - SUMMARY

CRYSTALLOID- 300

COLLOID- Ø

BLOOD- Ø

REMARKS

Code drugs with numbers, events with letters

(1) Pre-op sedation to OR, monitors O2

(2) SU >8 + <30 BP, 20 liter + to PACU. Report to nurse. OA removed @ the pt.

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: 75 KG LB

HEMATOCRIT: 51 10/4

INITIAL DATA: BP- 111 158; HR- 72

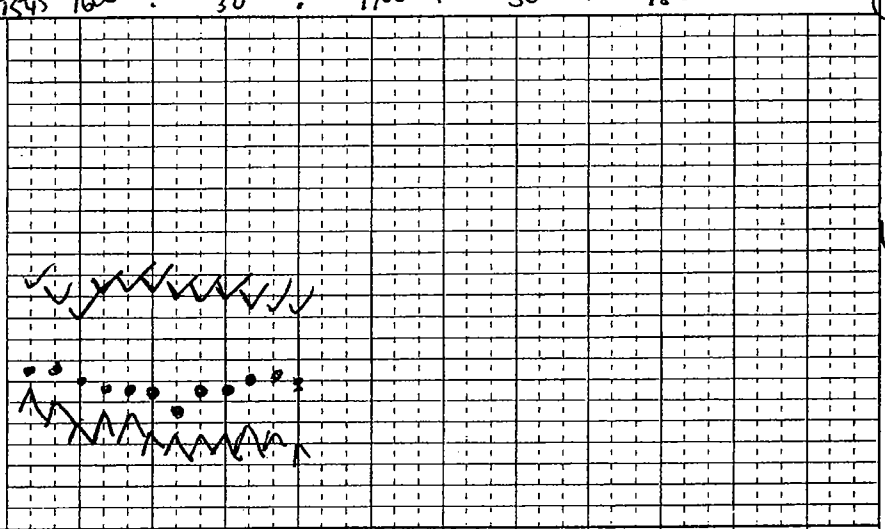
EQUIP CHECK OK?- Y N

PATIENT RECHECK OK for PROCEDURE? [redacted] TIME- 1530

(b)(6)-2

TIME → 1545 1600 . 30 . 1700 . 30 . 1800

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



VENTIL

	1545	1600	30	1700
VT - ml	—	500	370	340
f - breaths/min	—	13	10	9
Peak inf pres / PEEP	—	—	—	—
MODE - S(pon), A(ssist), C(on)	S	S	S	S

MONITORS/ACCESSORIES

		1545	1600	30	1700
BP/Auto Cuff	ET CO2 (torr)	+	44	53	54
BP/oth	FIO2 (Frac or %)	0.51	0.51	0.51	0.49
ART line	SpO2 (%)	99	99	99	99
Steth- PC/ES	ECG	SR	SR	SR	SR
Gas analyzer	TEMP-site Available				
	N-M Block (T/4)				
Warming blkt	✓ x 1 Blanket	→	→	→	
Conv warmer					

Mark with letters & symbols, explain under REMARKS — EVENTS → (1) Out turned 45° (2)
Position

RECOVERY AT 1645

PACU ICU _____ (Specify)

OTHER _____

CONDITION: Stable awake

RESP- 20 SpO2- 98

BP- 143/62 HR- 84

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1530	1545	1650
	Ready	Begin	End
PROC	1555	1608	1638

PROCEDURES and CPT Codes: I&D & DPL (L) shoulder wound

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GMA

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

[redacted] W&I Bed 2C

(b)(6)-4

(b)(6)-2

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* OA-10cm

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

A [redacted] CRNA

PROCEDURE LOCATION: 1

DATE: 9 Oct 03

PAGE 1 OF 1

[redacted] (b)(6)-2

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

Age 32 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

ASA Physical State 1 (2) 3 4 5 E
WT: 75 kg KG/LB HT: ____ IN.
ALLERGIES: NKDA

PROPOSED PROCEDURE: ____
SURGICAL SERVICE: ____
NPO SINCE: ____

NPO since 6am

HABITS:
TOBACCO: 2 pd
ETOH: ∅
DRUGS: ∅

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) ____
( ) ____
( ) ____
( ) ____
( ) ____
( ) ____

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

LABORATORY STUDIES:

HB/HCT: 16 / 51.6
U/A: ____
OTHER: ____

130	101	9	92
4.1	20	1.1	

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT

PAST SURGICAL/ANESTHETIC
Inguinal hernia as child
Dent tech complications

PHYSICAL EXAMINATION

BP 120/68 HR 66 R 16 T ____
Pain Scale 0-10 ____
HEENT - Teeth poor dentition
Trachea midline
TMJ/Neck ____
Oropharnyx MP ⊠
Nares ____
CHEST: CTA (3)
CARDIAC: RRR S M/R/G
EXTREMITIES: ____
IV Access: 19 g
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since ____

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

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

The patient/legal guardian seems to understand and agrees. Questions answered.

Signed: ____ Date: ____ Time: ____ Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

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

SEDATION KEY:

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

..EDICAL RECORD - DOCTOR'S ORDER..

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
9 Oct 03 1650	POST ANESTHESIA ORDERS (circled Items)		
1	VS q 5 min X 15 min, then q 15 min until discharge.		
2	Supplemental oxygen. PRN SaO2 < 95%		
3	Morphine / Meperidine ____ ~~mg IV slow~~ and 2 mg q 3-5 min prn pain for a		
	max dose of 10 mg.		
4	Zofran 4 mg IV prn N/V q 15 min, ~~may repeat x~~		
5	Metoclopramide 10 mg IV prn N/V x 1.		
6	Droperidol____mg IV prn N/V x 1.		
7	Phenergan____mg IV prn N/V x 1.		
8	Benadryl 25-50mg IVP q1 hr prn, itching while in PACU.		
9	IVF: NS @ TKO cc/hr.		
10	Discharge from recovery status when PACU discharge criteria met.		
	[redacted] CRNA/MAJ		
	(b)(b)-2 (b)(b)-2		

PATIENT IDENTIFICATION

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

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

Diagnosis: _____

Height: _____ Weight: _____ Diet: _____

Allergies: _____

Nursing Unit	Room No.	Bed No.	Page No.
PACU [redacted]			1 of 1

MEDCOM FORM 688-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE (b)(2)-2 MC V1.00

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 4 OCT 03 TIME OF ORDER: 1650 HOURS

LIST TIME ORDER NOTED AND SIGN

1. ADMIT ICW-1
2. S/P GSW (L) SHOULDER
3. VS Q8H
4. NPO
5. BED REST
6. IV LR at 125 cc/hr.
7. MSO4 2-8 mg IVP Q 1-4 hrs PRN.
8. TO OR. IN AM

[redacted]

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)-4

[redacted]

NURSING UNIT: ICW#1 | ROOM NO. | BED NO.

DATE OF ORDER: 4 OCT 03 TIME OF ORDER: 1730 HOURS

10. TO ICW-1
2. S/P GSW (L) SHOULDER
3. CLEANING BED
4. VS Q8H
5. UP AS LIB PER EPW RESTRICT
6. REGULAR DIET
7. IV LR at 125 cc/hr NSP LOCK

PATIENT IDENTIFICATION

(b)(6)-2

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: WILL TAKE P.O. WHEN TIME OF ORDER: HOURS

8. ANCEF 1 Gm IVP Q 8 hrs
9. TYLNOL 650 mg P.O. Q 4 hrs PRN
10. PERCOCET, 1-2 P.O. Q 4-6 hrs PRN
11. MSO4 2-8 mg IVP Q 1-2 hrs PRN
12. NPO after midnight SEPT 03 for OR 6 OCT 03

[redacted]

(b)(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

8OCT03 2000 [redacted]/[redacted]

(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.
ICW#1	2	C

DATE OF ORDER: 8OCT03 (b)(6)-2 TIME OF ORDER: 2000 HOURS (b)(6)-2 LIST TIME ORDER NOTED AND SIGN

V.O. + DR [redacted] / HLT [redacted]

NPO p MN [redacted] (b)(6)-2 [redacted]/AN

(b)(6)-2

(b)(6)-2 [redacted]/AN 8OCT03 0100

PATIENT IDENTIFICATION

(b)(6)-2 [redacted] Noted 10OCT03

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 10 OCT03 TIME OF ORDER: 0750 HOURS

1. Discharge for CPW camp
2. Keflex 250 mg Q 6h x 10 days
3. Percocet 1-2 PO Q 4-6 hrs prn #20
3. Dressing change every other day

(b)(6)-2 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

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

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			↓	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] (b)(6)-4				9 OCT 03 _____ HOURS	
			(1)	Resume previous orders	
			(2)	Regular Diet	
			(3)	N° 2 IV at 150 cc/hr. Hep Lock when taking PO. WDR.	
NURSING UNIT	ROOM NO. (b)(6)-2	[redacted] NO.	(4)	Order T Gro NPB Q 8 hrs x 3 days, then begin Keflex 250 mg QID PO	
PATIENT IDENTIFICATION				DATE OF ORDER / TIME OF ORDER [redacted]	
				(b)(6)-2 [redacted]	
				(b)(6)-2 [redacted]	
NURSING UNIT	ROOM NO.	BED NO.			
PATIENT IDENTIFICATION				DATE OF ORDER / TIME OF ORDER _____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.			
PATIENT IDENTIFICATION				DATE OF ORDER / TIME OF ORDER _____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.			

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH 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. 10 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 4	5	6	7	8	9	10						
4	[redacted]	VS: Routine	6	X	[redacted]											
		(b)(6)-2	18	[redacted]												
4	[redacted]	up and lib per	6	X	[redacted]											
(b)(6)-2		EPW protocol	18	[redacted]												
4	[redacted]	Regular diet	6	X	[redacted]											
		(b)(6)-2	18	[redacted]												
10 OCT 03	[redacted]	Dsg change every	10	/	/	/	/	/	/	[redacted]	/		/		/	
(b)(6)-2		other day														

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO	PRIMARY DIAGNOSIS: GSW (L) shoulder	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO PAGE NO:

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 4677. 1 OCT 78 — PREVIOUS EDITIONS MAY BE USED. — USAPA V1.00

Tme ~~100~~ 100 ns Tme 1000 ns

Verity by initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)					Mo 10 Yr 2003
Order Date	Clerk Nurse	(b)(b)-2 SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
4	[redacted]	admit ICWL, Pain	04 Oct 03	—	—	[redacted]	(b)(b)-2
(b)(b)-2 4	[redacted]	NPO F MN 50CT for OR 60903	50CT	2359	2359	[redacted]	(b)(b)-2
(b)(b)-2 80CT03	[redacted]	NPO p MN	90CT03	0001		[redacted]	(b)(b)-2
9CT	(b)(b)-2 [redacted]	Resume Previous orders	9CT	1800	1800	[redacted]	(b)(b)-2
10 OCT03	(b)(b)-2 [redacted]	Discharge to EPW camp					
	(b)(b)-2						

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. 10 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 4	5	6	7	8	9	10					
4	[redacted]	LR@125cc/hr	6	X	[redacted]										
(b)(6)-2		HL when tol p.o well	18	[redacted]											
4	[redacted]	Ancef + gm IVPB	6	X	[redacted]										
(b)(6)-2		Q8°	14	X	[redacted]										
			22	[redacted]											
9oct	[redacted]	LR @ 150cc/hr													
(b)(6)-2		Hep lock when	06					[redacted]							
		taking P.O well	18												
		Ancef													
9oct	[redacted]	Ancef + gm IVPB	06						[redacted]						
(b)(6)-2		Q8° x 3 doses	14						3						
		then begin	22					[redacted]							
9oct	[redacted]	Keflex 250mg	06												
(b)(6)-2		QID P.O	12												
			18												
			24												
10 OCT 03	[redacted]	D/C meds: Keflex 250mg QID Percs 1-2 po q4-6° prn		10 OCT 03 Rx to pharmacy											[redacted]
(b)(6)-2		PRN meds:													
4	[redacted]	Tylenol 650mg po	D/T												
(b)(6)-2		Q4° prn	P/I	[redacted]											
4	[redacted]	Percocet 1-2 po	D/T												
(b)(6)-2		Q4-6° prn	P/I	[redacted]											
4	[redacted]	MSO4 2-8mg IVP	D/T												
(b)(6)-2		Q1-2hrs prn	P/I												

Pre-op order

(b)(6)-2

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW (L) shoulder

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

22 yr

Date: 4 Oct 03
Time In: 1944
Allergies: NKDA
Pre-op V/S: 133/67 174
Procedures: 1 R (B) shoulder Cosh

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

OR Intake: Crystalloid 1000 Colloid Ø
OR Output: UOP Ø EBL 50
Meds/Times: 5 mg Versed 100mc Fent 1940

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

Pre Op Meds

History

Time	1944	1954	1959	1964	1969	1974
SaO2	99	96	99	97	99	99
FiO2						
Methods	RA	RA	RA	RA	RA	RA
240						
220						
200						
180						
160						
140						
120						
100						
80						
60						
40						
20						
RR	27	10	14	16	10	14
T	98.2				98.5	
Time						
Pain (0-10)						
LOS						

Pacu Intake

Time	Solution	Amount	Site	By	Infused
2154	NS LR	900	Hore	IV	100 cc

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

V/S
X = A-line BP
˙ = Cuff BP
= Pulse

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

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

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

(b)(6)-2 [redacted] 9 Lumb

(Continue on reverse)

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 4 OCT 03

[redacted]'S IDENTIFICATION (For typed or written entries give: middle; grade; date; hospital or medical facility)

Name — last,

[redacted]

(b)(6)-4

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

DA FORM 4700, MAY 78 WAMC OP 17

Previous edition is obsolete

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

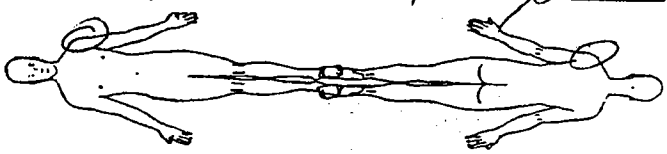
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 1949	(L) Shoulder	Bulky	Ø
30' 2149	(L) Shoulder	Bulky	Ø
60'			
D/C	(L) Shoulder	Bulky	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
2135	NSR	Ø	Ø

NURSING NOTES

Pt Admitted to PACU @ 1749. S/P I&D (L) Shoulder PARS 8 O_2 97 on RA. Dressing CDI Pt still unconscious, arousable to painful stimuli —— SPC [redacted] (b)(6)-2

Pt Transferred to ICW1 by SPC [redacted] (b)(6)-2 VIA Litter report given to LT [redacted] (b)(6)-2. PARS 10 x 9 —— SPC [redacted] (b)(6)-2

Discharge Criteria:
Date: 11 OCT 02 **Time:** 2135 **PARS:** 9
BP: 124/58 **T:** **HR:** 60 **RR:** 20 **SaO2:** 98
Pain Level at D/C (0-10): Ø
Intake: 100cc NS **Output:** Ø
Additional Data: Ø
Transferred To: ICW1
Report Given To: LT [redacted] (b)(6)-2
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: SPC [redacted] (b)(6)-2
V Recovery [redacted] (b)(6)-2

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1712	Helen	2mg MSO4	IV			[redacted]
						(b)(6)-2

NURSING NOTES

Male Iraqi EPW admitted to PACU S/P IHD (C) should closure 1:0 2 98% on RA. VS. IV (L) Hem NS @ TKO Patch Rt AHO. — [redacted] SSG/CA

(b)(6)-2

NEUROVASCULAR

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

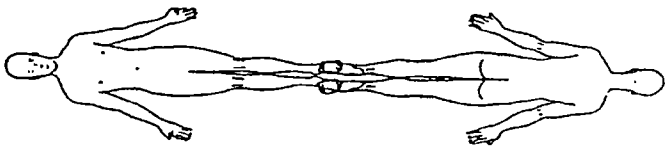
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm			
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

Discharge Criteria:
Date: 20 Apr 03 Time: 1720 PARS: 10
BP: 143/61 T: HR: 70 RR: 20 Sa02: 98
Pain Level at D/C (0-10):
Intake: Output: Ø
Additional Data: —
Transferred To: ICW 1
Report Given To: IC [redacted] (b)(6)-2
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: SSG [redacted] (b)(6)-2
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 90ct03
Time In: 1650
Allergies: NKDA
Pre-op V/S: 11/58 72
Procedures: I+D Shoulder drainage

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

OR Intake: Crystalloid 200 cc Colloid
OR Output: UOP 0 EBL 450cc
Meds/Times:

ASA II
75kg
HCT 51
200mcg Fent
2.5 Var

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds History

Time	1650	1655	1700	1705	1710
SaO2	97	98	98	98	98
FIO2	RA	RA	RA	RA	RA
Methods					
240					
220					
200					
180					
160					
140	^	^	^	^	^
120					
100					
80	•				
60	✓	✓	✓	✓	✓
40					
20					
RR	25	14	16	28	15
T	96				

Time									
Pain (0-10)									
LOS									

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

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

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 090ct03

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

[redacted] (b)(6)-4

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

(b)(2)-2

Admission and Coding Information

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

1. Reporting MTF 0580 [redacted]	2. MTF Loca IZ			
3. Register Number [redacted] (b)(6)-4	Name (Last, First, MI) (b)(6)-4 [redacted]		4. Pay Grade	5. Sex M
6. DoB (YYYYMMDD) [redacted]	7. Age at Admission 22Y	8. Race Z	9. Ethnicity Z	Religion UNKNOWN
10. Length of Service	ETS	11. FMP 20.	12. Social Security Number [redacted] (b)(6)-4	
Organization (Active Duty Only)		13. Marital Status Z	Hour of Admission 14:33	Branch / Corps:
14. Flying Status N/A	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES		16. Zip Code of Residence:	
17. Unit Location IZ	18. MOS	19. Trauma DIS	Prev. Admission NO	
20. Source of Admission Direct from ER	Ward: ICW1	Name / Relationship of Emergency Addressee Address of Emergency Addressee		
Name and Location of Medical Treatment Facility: 0580[redacted] Iraq; No Install Provided (b)(2)-2		Telephone Number of Emergency Addressee		
21. Type of Disposition TRF-OTH	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2003-10-10		
24. Clinic Svc - Admitting AEA - ORTHOPEDICS	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-10-04		
27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission 2003-10-04		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: GSW LEFT SHOULDER

880.00
E991.2
83.65

Procedure Narrative(s):

Cause of Injury Narrative:

(b)(6)-2

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

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

Automated Facsimile DA FORM 2085, MAR 2000

9	10	11	12	13	14	15

4. PAY GRADE: 16 17

5. SEX: 18

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

7. AGE AT ADMISSION: 27 28 29

8. RACE: 30

9. ETHNIC BACK-GROUND: 31

RELIGION

10. LENGTH OF SERVICE: 32 33 34

ETS

11. FMP: 35 36

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

ORGANIZATION (Active Duty Only)

13. MARITAL STATUS: 46

HOUR OF ADMISSION

BRANCH / CORPS

14. FLYING STATUS: 47 48 49

15. BENEFICIARY CATEGORY: 50 51 52

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

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

18. MOS: 64 65 66 67 68 69 70

19. TRAUMA: 71

PREV. ADMISSION YEAR

☐ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 72

WARD

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION: 73 74

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

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

24. CLINIC SVC - ADMITTING: 87 88 89 90

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

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

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

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

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

FOR LOCAL USE

Dx: 88000
E9012

Pr 8604

ADMITTING OFFICER (Signature, as required)

SIGNATURE OF ADMITTING CLERK

DA FORM 2985, MAR 89

EDITION OF MAY 79 IS OBSOLETE

USAPPC V1.00

dng Trauma

[redacted] (b)(6)-4

Automated Facsimile

(b)(6)-4

PATIENT TREATMENT RECORD COVER SHEET

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

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

4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm
M	35Y	X	ISLAMIC			NO

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

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

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	14:33	AEA - ORTHOPEDICS

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	HOME	2003-10-10

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-10-04	[redacted] (b)(6)-2

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
0580[redacted] - Iraq (b)(2)-2	2003-10-04	

31. Selected Administrative Data

Marital Status: Z DoB: [redacted]

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

I & D R SHOULDER

880.10
E991.2

86.28 (10/4/03)
81.96 (10/4/03
86.28 (10/8/03)
86.59 (10/8/03)

DX
88010
E9912

PROC
8628
8659.

I IN
0 450

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
Ø	Ø	Ø	Ø	6	6

35. Total Days This Facility

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

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

[redacted] PAD or Medical Records Officer: (b)(6)-2 MAJ [redacted] (b)(6)-2

Automated Facsimile - DA FORM 3647, May 79

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

35 Y.O. INJ(s) ↑ SHOT IN (R) SHOULDER WAS
SEEN MILK TODAY. SUSPICIOUS FOR IED
⊖ PMH
⊖ KDS

NKDA

(b)(6)-2

⊖ TOBACCO [redacted] 0900

PHYSICAL EXAMINATION

HEENT - WNL
NECK - SUPPLE
CHEST - CT
EXT 1x1 cm WOUND SS x 2, OVR (R) ANTERIOR
SHOULDER, N-V INTACT.

+ IN SUS THREATS (R) SHOULDER PROBABLY EXIT WOUND
INTO CHEST CAVITY.

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

(A) GSW - (R) SHOULDER
(B) IED (R) SHOULDER

[redacted] (b)(6)-2

SIGNATURE OF [redacted]

DATE	IDENTIFICATION NO.	ORGANIZATION
9 OCT 03		

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

REGISTER NO.	WARD NO.

[redacted] (b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
4 OCT 03 @1930	Pt admitted from EMT GSW (R) shoulder. (L) ac c̄ LR @ 125cc/hr. NPO. Interpreter explained NPO status & OR tonight. (R) shoulder 4x4 dsg applied to entrance wound. no exit wound noted VSS. Plan: monitor until OR. [redacted] (b)(6)-2
4 OCT 03 @1945	Pt released to OR staff. Placed on litter. (b)(6)-2 [redacted] CPT
4 OCT 03 @ 2300	Pt received from PACU, placed in bed, 2 pt restraints on, s/sx of skin/circulation compromise. Drowsy, but awakens to verbal stimuli. LS CTA, Sats 97% RA. (L) ac IV intact c̄ LR @ 125cc/hr. (+) BS, due to void by 0600. Tol sips of po H_2O. (R) shoulder c̄ bulky dsg CDI, sling & swath in place. (+) CMS to RUE. Plan: monitor pain, monitor NV status, IV abx as ordered. (b)(6)-2 [redacted] CPT
5 OCT 03 0900	VSS Alert & Oriented Consume Regular diet for breakfast Tolerated well. (L) AC IV Saline lock patent/intact. (R) Shoulder dressing intact c̄ drsg/swath in place. Lungs clear BS (+) x 4 quad. Abd. soft non distended Perineal

HOSPITAL OR MEDICAL FACILITY

SPONSOR'S NAME	STATUS	DEPART./SERVICE (b)(6)-2	RECORDS MAINTAINED AT [redacted] 247th
	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

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

[redacted] (b)(6)-4

REGISTER NO. | WARD NO.

(Continued)

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)
05OCT03	(continue)
0900	pulses palpable. Refused to ambulate @ this time. Will attempt again later. Will continue plan of care (b)(6)-2 [redacted] 2LT AN
5OCT03 2015	Pt resting in bed, A+O X3, VSS, denies pain @ this time, LS CTA (B), (+) BS x4, dsg on (R) shoulder CDI, SL (L) AC intact, tolerating PO well, able to [redacted] (b)(6)-2 move fingers (B), radial pulse equal (B), voiding ~~s~~ diff, abd soft flat non tender, ø s/sx of poor circulation or skin breakdown on pts of restraint. (b)(6)-2 [redacted] 91W
06OCT03	(1700) Assumed care of pt a) 0600 ~~p~~ report from night shift. Pt alert, speaking Arabic. VSS. ø c/o pain. Dsg to (R) shoulder Δd. staples intact. Penrose drain draining small amount sero-sang drainage. Ace wrap in place around (R) arm to immobilize. Pt OOB to BR this am for personal hygiene. Amb. well. Pt able to move fingers on (R) hand. Cap refill <3secs. SL in (L) forearm flushes well ~~s~~ s/sx infection/infiltration. Tol. reg diet well. Voiding ~~s~~ difficulty. 2 point restraints in place ~~s~~ s/sx ~~infection~~ [redacted] (b)(6)-2 complications. Will continue to monitor. (b)(6)-2 [redacted] 2LT AN
6OCT03	Pt awake, speaking arabic, VSS, c/o pain + headache, medicated ~~c~~ 2 percs as per orders, dsg (R) shoulder CDI, pt OOB to BR, ambulates ~~s~~ diff., SL (L) FA patent, flushes well, ø s/sx of infex or infiltration, pt able to move fingers

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE** | AUTHORIZED FOR LOCAL REPRODUCTION

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
4Oct03	(S) Shot by US Forces attempting to control a riot of >30,000 Iraqi civilians. Was seen throwing rocks at Iraqis and coalition forces trying to control the mob.
	(O) VS taken at the scene were stable – not recorded by medics (91W) – thru'g thru GSW to (L) dorsal shoulder & back with sig (Θ) deltoid tissue damage. dressed c̄ gauze bandage
	(A/P) (1) GSW (L) dorsal shoulder – X-rays taken demonstrate Ø intrarticular trauma and no fx of (L) shoulder
(b)(2)-2	– pt transported to [redacted], and transfered to orthopedic surgeon's care.
(b)(6)-2	[redacted]
(b)(6)-2	CPT [redacted] MD [redacted] PROFESS surgeon
	(b)(2)-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.

[redacted] (b)(6)-4

(b)(6)-2

[redacted] (b)(6)-4

[redacted] (b)(6)-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	Orthopedic Op Note
4 OCT 03 2145	Pre-Op Dx - GSW (R) shoulder, with intra-articular fragment
	Post Op Dx - Same
	Procedure: I+D (R) shoulder with arthrotomy
	Surgeon: [redacted] / [redacted] (b)(6)-2
	EBL - 400 cc's (b)(6)-2
	IV fluids - 1300 crystalloid.
	Findings - 2 GSW's to (R) shoulder through deltoid, into glenohumeral joint. Both bullet fragments removed. Extra-articular fragment not found. Capsular wound extended to improve joint visualization. No bony involvement of joint surface. Irrigated 6 liters. Closed over penrose drain, after closing capsular extension with #2 prolene.
	Plan: IV antibiotics, observation, sling and swath. Consider repeat I+D

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

(b)(6)-2

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

REGISTER NO.	WARD NO.

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

PROGRESS NOTES
Medical Record

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

MEDICAL RECORD | **PROGRESS NOTES** | AUTHORIZED FOR LOCAL REPRODUCTION

DATE	NOTES
Cont.	cap ref <3 sec, radial pulses equal (B), ø skin breakdown or poor circulation on pts of restraint. (b)(6)-2 [redacted] gw CPT (b)(6)-2
07OCT03	(1650) Assumed care of pt @ 0000 ~~p~~ report from night shift. Pt alert, speaking Arabic. VSS. ø c/o pain Drsg to (R) shoulder ~~Δd~~ this am. Ace wrap in place to immobilize (R) arm. SL in (L) forearm flushes well ~~s~~ s/sx infection/infiltration. Amb well. Tol reg diet. Voiding ~~s~~ difficulty. 2 point restraints in place ~~s~~ s/sx complications. Will cont. to monitor. (b)(6)-2 [redacted] gw
7OCT.03 2015	Pt asleep but easily aroused, denies pain, IV SL (L) FA intact, flushes well, ø s/sx of infex or infiltration, dsg on (R) shoulder CDI, sling + swath in place to immobilize arm, voiding well, cont. abx therapy, 2 pt restraint in place, ø s/sx of poor circulation or skin breakdown. (b)(6)-2 [redacted] gw CPT (b)(6)-2

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

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

REGISTER NO.	WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
8 Oct 03 0715	Author Op Note Pre-Op Dx - GSW (R) shoulder Post-Op Dx - same Procedure - I+D (R) shoulder GBL - MIV Surgeon [redacted] (b)(6)-2 Findings - Wound clean, down to capsule. No necrotic tissue, Closed in layers over a penrose drain
	[redacted] (b)(6)-2 [redacted] (b)(6)-2 [redacted] CDR
080CT03	(1645) Assumed care of pt @ 0000 IP report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs. Pt to OR this am for I/D (R) shoulder. Drsg CDI. Ace wrap in place to immobilize (R) arm. Pt tol. reg diet well. Voiding s̄ difficulty. 2-point restraints in place s̄ sisx complications. Will cont. to monitor. (b)(6)-2 [redacted] CDR
8Oct03	1900 = VSS, A+O x3, ¢ c̄ pain, Drsg to (R) shoulder CDI c̄ Ace wrapped around chest & back intact, IV HL 18G to (L) FA flushed & patent, Continuing IV Antibx around the clock, up ad lib s̄ difficulty, UOP adequate, tolerate PO, x2 restraints when in bed, (-) skin breakdown, will

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

MEDICAL RECORD | **PROGRESS NOTES** | AUTHORIZED FOR LOCAL REPRODUCTION

DATE	NOTES
8OCT03@	1900 (continued) ~~will~~ continue to monitor. [redacted] (b)(6)-2
9OCT03	VSS Alert & oriented. OOB ambulated to
0800	BR. Tolerating Regular diet. (L) FA Saline lock patent & intact. (R) Shoulder Dsg dry & intact. Sling & pouch in place to (R) Shoulder Peripheral pulses +2 (R) hand fingers: capillary refill < 3Sec. Lungs clear bilateral. Abd soft non distended BS (+) X4 quad. Will continue care as planned [redacted] (b)(6)-2
9OCT03	VSS. AO. (+) pulse to RUE & CNS intact. DSG intact to
2035	(R) shoulder. Voiding light amber urine quantity sufficient. Ad onto septum NVI. Applied warm compress to LUE & tenderness @ infiltration site. [redacted] (b)(6)-2
10OCT03	(1025) Assumed care of pt @ 0000 p report from night
	shift. Pt alert, speaking Arabic. VSS. Pain controlled
	c Percs. Dsg to (R) shoulder Δd this am by MD.
	Staples CDI. Ace wrap in place to immobilize (R) arm/
	shoulder. SL in (R) forearm flushes well ∃ S/Sx
	infiltration/infection. (L) forearm remains swollen/
	tender @ old IV site. Pt OOB to BR for personal
	hygiene. Amb well. Tol. reg diet well. Voiding ∃

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

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

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

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

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10OCT03 (1025)	(cont.) difficulty. 2 point restraints in place & sx complications. Awaiting D/C to EPW camp. Will continue to monitor. (b)(6)-2 [redacted] (1620) D/C to camp - ambulatory - escorted by MPs. (b)(6)-2 [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

MEDICAL RECORD | **PROGRESS NOTES** | AUTHORIZED FOR LOCAL REPRODUCTION

DATE	NOTES
10 Oct 03	Orthe Discharge Note
	35 YO. sustained GSW to (R) shoulder 4 Oct 03. Taken to OR, fragments removed from glenohumeral joint at I&D done. Capsule closed. Repeat I&D 8 Oct 03. Wound clean, closed over a drain. Drain removed 10 Oct 03. Discharge today.
	PLAN: Dressing change every other day. Staples out 7 days. Keflex 250 mg Q 6h x 10 days. #46. Percocet 1-2 PO Q 4-6 hrs prn #20. Sling and swath x 3 weeks.
	(b)(6)-2 [redacted] (b)(6)-2
	COL MC

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

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

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

[redacted] (b)(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER | TREATMENT FACILITY [redacted]

RECORDS MAINTAINED AT (b)(2)-2

PATIENT'S HOME ADDRESS / DUTY STATION

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

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)* 4 Oct 03 | TIME 1457

TRANSPORTATION TO FACILITY

SEX: M

AGE: 35

DUTY/LOCAL PHONE: AREA CODE | NUMBER

HOME PHONE: AREA CODE | NUMBER

MILITARY STATUS

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

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS: pt denied

ALLERGIES: pt denies

CHIEF COMPLAINT

INJURY OR OCCUPATIONAL ILLNESS

ITEM	YES	NO	WHEN *(Date)*
IS THIS AN INJURY?			
INJURY/SAFETY FORMS			
HOW			WHERE

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☒ NON-URGENT

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

INITIALS

VITAL SIGNS

TIME	1444				
BP	123/72	121/69			
PULSE	91				
RESP	16				
TEMP	99.1				
WT	75				

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	☒ ① arm

☐ PULSE OX 100%

ORDERS

☐ MONITOR ☐ ECG

TIME	ORDERS	BY	CO	TIME	PATIENT'S RESPONSE
1100	(b)(6)-2 [redacted]	[redacted]	[redacted]		(b)(6)-2
1600	[redacted]				(b)(6)-2
	(b)(6)-2 [redacted]	(b)(6)-2	(b)(6)-2		

DISPOSITION

☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

DISPOSITION QUARTERS /OFF DUTY

☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE

☐ IMPROVED ☐ UNCHANGED

☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

PATIENT'S IDENTIFICATION

(For typed or written entries, give: Name – last, first, middle; ID no. (SSN or other); hospital or medical facility)

EPW

[redacted] (b)(6)-4

AP

Lat

NS clavicle view R shoulder

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

STANDARD FORM 558 (REV. 8-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

NSN 7540-01-075-3786

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

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

See ortho admit note

[redacted] (b)(6)-2

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

MDS, MC

FP/Spot

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

DIAGNOSIS

CODES

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

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

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: 35
HEIGHT: 74 cm
WEIGHT: 75 kg

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): NKA

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

4. PROPOSED SURGICAL PROCEDURE:
I & D Rt. Shoulder

5. ADDITIONAL INFORMATION: Last PO: 1000 hrs Medical Hx: ∅ Implants: Medications:
Jewelry removed: yes/no Family waiting: yes/no

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

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

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

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION X Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; shock; previous surgery	ϕ Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	o Check for support stockings or ace wraps. If none, check with doctors. ϕ Check that safety straps are correctly applied. ϕ Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. ϕ Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. X Potential impairment of mobility due to sedation; pain; injury E.2. X Potential discomfort due to injury; pain	ϕ Pt. will be transferred to OR table without difficulty. ϕ Pt. will not experience unnecessary physical discomfort.	ϕ Have sufficient people available for transfer. ϕ Insure proper body alignment. ϕ Allow patient to lie in position of comfort while waiting for surgery. ϕ Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. X Disminished visual perception due to being injury; sedation; F.2. X Potential for decreased communictaion due to language barrier; sedation F.3. Potential injury due to dentures.	ϕ Pt. will be made aware of surroundings prior to anesthesia induction. ϕ Pt. will be transferred safely to OR table. ϕ Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	ϕ Introduce self. Keep pt. informed as to where he/she is and what is happening. ϕ Inform pt. in which direction to move and assist if necessary. ϕ Speak clearly and slowly. ϕ Address pt. from either side. ϕ Validate pt.'s understanding of verbal communications. little or no English o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS. Or continuation of above interventions.

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

(b)(6)-2 [redacted] CPT/AN 4 Oct 03 DATE

11. POSTOPERATIVE EVALUATION:

Bovie site: intact
Dsg.: C&D
Resp: Spontaneous

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)	13. ~~PRE~~OPERTIVE EVALUATION PREPARED BY (Signature and Title)
(b)(6)-2 [redacted] CPT/AN	(b)(6)-2 [redacted] CPT/AN
DATE: 4 Oct 03 TIME: 5	DATE: 4 Oct TIME: 2154

MEDCOM - 20964

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 IDENTIFICATION REVIEWED AND PROCEDURE VERIFIED BY [redacted] CPT/AN

3. DATE 4 Oct 03 TIME PATIENT ARRIVED IN SUITE 1949

4. PATIENT IN ROOM TIME 1949 (b)(6)-2 [redacted] NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Proper body alignment maintained

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

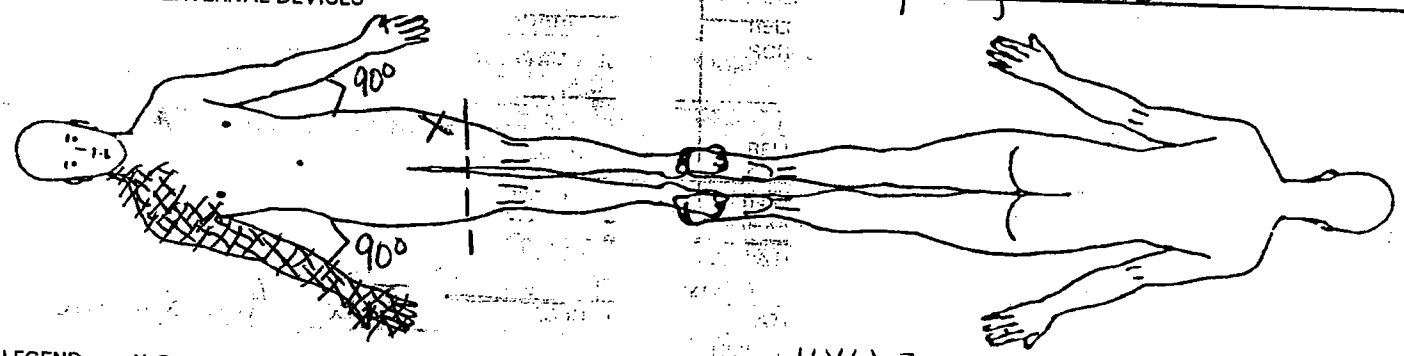
PREP SOLUTION *(Specify)* Betadine scrub/sol'n

SITE: Rt. arm & shoulder BY WHOM

SITE: BY WHOM: [redacted] (b)(6)-2

COMMENTS: No pooling of fluids

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C = Correct I = Incorrect Initial C [redacted] / [redacted] (b)(6)-2

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

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

[redacted] (b)(6)-4

EPW

Age 35

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

☒ ESU NO: Force 40 RBB 10239S 50/50

GROUND PAD: BRAND REM Valleylab

LOT NO: 68245

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

13. PROSTHESIS, IMPLANTS [redacted] NO IF YES NAME: ID NUMBE[redacted] FACTURER

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
None		

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

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	3/8" Penrose		
SITE	Rt. shoulder		

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs
ABD
~~Coverall~~ Tape Ace swathe

19. ADDITIONAL INFORMATION

Surg: [redacted] (b)(6)-2 Anesth: [redacted] (b)(6)-2 CRNA Type: General

20. OPERATION(S) PERFORMED

I & D Rt. Shoulder GSW

21. PATIENT TRANSFERRED TO PACU TIME 2256 METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] CPT/AN (b)(6)-2

REVERSE OF DA FO[redacted]79-1, OCT 87 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: aids

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

3. DATE: 08 OCT 03 TIME PATIENT ARRIVED IN SUITE: —

4. PATIENT IN ROOM TIME: 0600 NUMBER: 2-2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS: Pt placed on padded OR table c (L) arm on armboard

8. SKIN PREPARATION

HAIR REMOVAL: ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

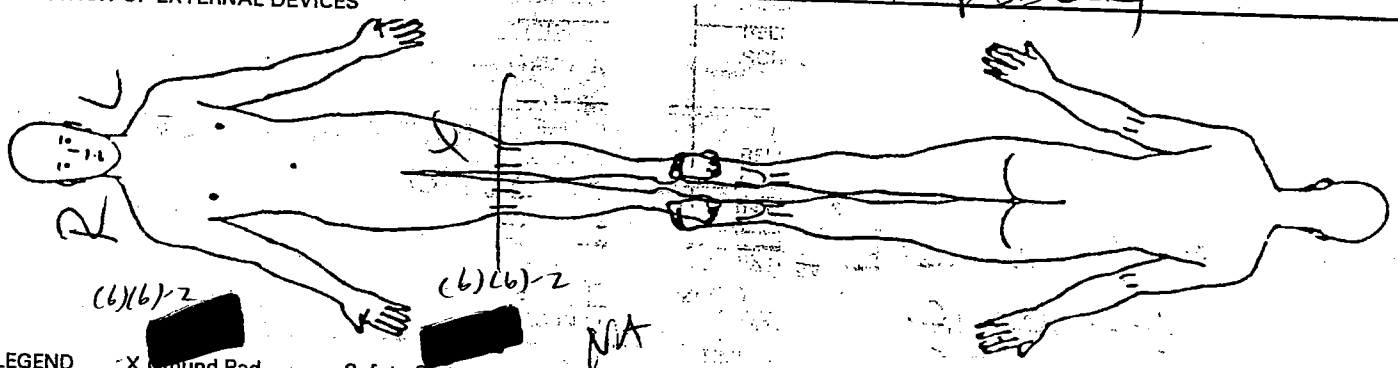
PREP SOLUTION (Specify): Betadine / Betadine

SITE: (R) shoulder BY WHOM: [redacted] (b)(6)-2

SITE: BY WHOM:

COMMENTS: 6 prepping

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
Sponge	☑ Yes	☐ No			
Needle Sharp	☑ Yes	☐ No		C	C
Instrument	☐ Yes	☑ No			
Other	☐ Yes	☑ No			

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

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

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

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

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

☒ ESU NO: R8B 10239S 30/50

GROUND PAD: BRAND: Kelly/b

LOT NO: (2005-04 Exp) 7011

☐ ESU NO:

GROUND PAD: BRAND:

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

13. PROSTHESIS, IMPLANTS ☐ ☑ NO IF YES NAME: ID NUMBER [redacted] IFA [redacted] IRER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

18. DRESSING/IMMOBILIZATION *(Specify)* staples

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

TYPE/SIZE	1. 3/8" Penrose	2. 3/16" [redacted]	3. (b)(6)-2
SITE	1. (R) shoulder	2. (R) [redacted]	3.

19. ADDITIONAL INFORMATION

[redacted] (b)(6)-2 Pt c/o blisters (tape) noted preop

[redacted] (b)(6)-2 (R) axillary near nipple.

Dressing D+I

Postop Bone sutures D+I

Sleepy

gets

20. OPERATION(S) PERFORMED

I+D (R) shoulder

21. PATIENT TRANSFERRED TO PACU TIME 0645 METHOD bed

22. REGISTERED NURSE SIGNATURE [redacted] (b)(6)-2

REVERSE OF DA FORM [redacted] OCT 87

USAPA V1.00

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR OCT 2003 — DAY — HOUR

PULSE (0) — TEMP. F (•)

TEMP. C (Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)- 4

STANDARD FORM 511 (REV. 7–95) BACK

Ward/Section: Emt	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI. # [redacted] (b)(6)-4	DATE 4 Oct	TIME 1700	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		
RBC		
Hgb		
Hct		
MCV		
Plt		
Lymph		
(Hem		
Segs		
Bands		
Lymph		
Atyp		
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

(b)(6)-4

ID: [redacted]
WB

04-10-03
17:48

			Patient Limits	
WBC	8.7	x10^3/uL	4.5	10.5
RBC	4.25	x10^6/uL	4.00	6.00
Hgb	12.8	g/dL	11.0	18.0
Hct	39.6	%	35.0	60.0
MCV	93.1	fL	80.0	99.9
MCH	30.0	pg	27.0	31.0
MCHC	32.3 L	g/dL	33.0	37.0
Plt	61. L	x10^3/uL	150.	450.
LY%	18.3 *L	%	20.5	51.1
LY#	1.6 *	x10^3/uL	1.2	3.4

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Pet		Negative
		N/A
		Negative
		N/A
		Negative
		0.2-1.0
		Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: (b)(6)-2 [redacted]	DATE: 4 OCT 03	LAB ID NO.:

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

LAST, FIRST, MI. (b)(6)-4 [redacted]	DATE	TIME	SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
AL		
AL		
A		
A		
T		
B		
C		
C		
C		
C		
T		

```
======= PICCOLO =======
04/10/03              17:47
REFERENCE RANGE:      MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: (b)(6)-2 3141AA4
OPER #[redacted]      DR #: 000
SERIAL #: [redacted]
.........(b)(b)-4.........
GLU   100   73-118   MG/DL
BUN    13   7-22     MG/DL
CRE   1.0   0.6-1.2  MG/DL
CK   802*   39-380   U/L
NA+   131   128-145  MMOL
K+    4.0   3.3-4.7  MMOL
CL-   104   98-108   MMOL
tCO2   21   18-33    MMOL

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
		7-22 mg/dl
		8.0-10.3 mg/dl
		0.6-1.2 mg/dl
		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
B		3.3-5.5 g/dl
P		26-84 u/l
T		10-47 u/l
TY		14-97 u/l
T		11-38 u/l
IL		0.2-1.6 mg/dl
GT		5-65 u/l
		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
A^+		128-145 mmol/l
+		3.3-4.7 mmol/l
L⁻		98-108 mmol/l
CO_2		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
(b)(6)-2 [redacted]	4/04/03	

(b)(6)-2

Ward/Section: ICW#1	REQUESTING PHYSICAN [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)		
LAST, FIRST,MI. [redacted] (b)(6)-4	DATE 50CT03	TIME 0500	SSN/PSEUDO SSN: [redacted] (b)(6)-4	

[redacted]

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10
RBC		4.7-6.1 x10
Hgb		14-18 g/dl(M) 12-16 g/dl(F)
Hct		42-52%(M) 37-47%(F)
MCV		80-94 fl(M) 81-99 fl(F)
Plt		130-500 x10³ verified
Lymph %		20.5-51.1%

[redacted]

Segs	71	Mono	8
Bands	4	Eos	1
Lymph	14	Baso	
Atyp	2	Imm	
RBC Morph			

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

Urinalysis

TES	
Colc	
Apr	
Glu	
Bili	
Ket	
SG	
Bld	
pH	
Pro	
Uro	
Nit	
Lei	
HC	
Cell Count	

(b)(6)-4

ID: [redacted] 05-10-03
WB 05:04

			Patient Limits	
WBC	8.9	x10^3/uL	4.5	10.5
RBC	4.16	x10^6/uL	4.00	6.00
Hgb	12.7	g/dL	11.0	18.0
Hct	38.5	%	35.0	60.0
MCV	92.5	fL	80.0	99.9
MCH	30.5	pg	27.0	31.0
MCHC	33.0 L	g/dL	33.0	37.0
Plt	188.	x10^3/uL	150.	450.
LYZ	21.2 *	%	20.5	51.1
LYW	1.9 *	x10^3/uL	1.2	3.4

Misc. Serology

ST	RESULT	REF. RANGE
		Negative
o		Negative

Microbiology

ce		
n		
Bld		Negative
ylori		Negative
o sites		
aria		
P		
er		

Macroscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

Directigen		Negative	ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICW 1	ESTING PHYSICIAN [redacted] (b)(6)-2	LA ATORY RESULT FORM (ct to the Privacy Act of 1974)
LAST, FIRST,MI. [redacted] (b)(6)-4	DATE 6 OCT 03 / TIME 1845	SSN/FEEDO SSN: [redacted] (b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10
RBC		4.7-6.1 x10
Hgb		14-18 g/dl(M) 12-16 g/dl(F)
Hct		42-52%(M) 37-47%(F)
MCV		80-94 fi(M) 81-99 fi(F)
Plt		130-500 x10³ verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

(b)(6)-4

ID [redacted]
WB

06-10-03
05:03

			Patient Limits	
WBC	10.4	x10^3/uL	4.5	10.5
RBC	4.37	x10^6/uL	4.00	6.00
Hgb	13.2	g/dL	11.0	18.0
Hct	40.7	%	35.0	60.0
MCV	93.1	fL	80.0	99.9
MCH	30.1	pg	27.0	31.0
MCHC	32.4 L	g/dL	33.0	37.0
Plt	190.	x10^3/uL	150.	450.
LYZ	....	%	20.5	51.1
LY#	——	x10^3/uL	1.2	3.4

Misc. Serology

TEST	RESULT	REF. RANGE
PR		Negative
Mono		Negative

Microbiology

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

Macroscopic Urinalysis

Blood Bank

Cell Count		MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED	
Directigen		Negative	ABO/Rh

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

MEDICAL RECORD - ANESTHESIA

For u[illegible] is form, see AR 40-66; the proponent agency is th[illegible]

NKDA

(b)(6)-2

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION												
DRUG (Units)												
Propofol (mg)	200											
Sux (mg)	80											
Fentanyl (mcg)	<200>		50									
MSO4 (mg)			6	4	4							
( )												
( )												
VOLAT AGENT — 1.5% del / % e.t.	1.5	1.5	2.0	2.0	1.5	1.5	1.0	X				
AIR L/Min												
N2O L/Min												
O2 L/Min	10	2	2	2	2	2	2	2	10			
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS												

FLUIDS												
LINE site 18G (L) A ☐ Warmed	LR#1	—			#2							
☐ Warmed												
☐ Warmed												
☐ Warmed												
LOSSES — EST BLOOD LOSS				50	100	200						
LOSSES — URINE -				Ø								

TOTALS	TOTAL EBL
200	250 [redacted] 400
80	
250	TOTAL URINE
14	Ø

FLUIDS - SUMMARY
CRYSTALLOID- 1300 mL
COLLOID- Ø
BLOOD- Ø

(b)(6)-2

REMARKS

Code drugs with numbers, events with letters PLTS 61 [redacted]

(1) Pre-opassessment Phenergan 25mg IV

(2) OR monitors O2 induced; eyelids taped OP + soft bite block

(3) TO > 4mL/kg; RR > 8 + < 30 BPM Responsive OP instructions Extubated S complications

(4) TO PACU Report to nurse

(b)(6)-2

PHYS STATUS	TIME
(1) 2 3 4 5 (E)	1945 2000 . 30 . 2100 . 30 . 2200
BODY WEIGHT: (KG) LB 75	SYMBOLS: BP by cuff V ^ ; Heart rate ● ; Resp rate ; BR (transduced) ; TOURNIQUET T—T ; ANES- X-X ; PROC- ⊙-Ø
HEMATOCRIT: 39	
INITIAL DATA: BP- 131/80	
HR- 84	
EQUIP CHECK OK?- (Y) N	
PATIENT RECHECK	
OK for PROCEDURE? [redacted]	
TIME- 2130	

(b)(6)-2

VENTIL	1945	2000	30	2100	30	2200			
VT - ml	720	720	750	750	750	750	560	500	270
f - breaths/min	8	10	10	9	8	8	6	6	10
Peak inf pres / PEEP	—	17	18	18	18	19	16	13	X
MODE - S(pon), A(ssist), C(on)	S	C	C	C	C	C	C	C	S
MONITORS/ACCESSORIES									
BP/Auto Cuff — ET CO2 (torr)	40	36	34	30	30	31	35	43	60
BP/oth — FIO2 (Frac or %)	0.57	0.57	0.57	0.57	0.58	0.58	0.58	0.54	0.50
ART line — SpO2 (%)	100	100	100	100	100	100	100	100	100
Steth- PC/ES — ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer — TEMP-site available			max 35.3	35.2	35.3	35.1	35.2	35.1	X
N-M Block (T/4)	BS	+							
Warming blkt	X	Wool Blk							
Conv warmer									
EVENTS (Mark with letters & symbols, explain under REMARKS; Position)	(1)	(2)						(3)	(4)

RECOVERY AT	2154
PACU / ICU ____ (Specify)	
OTHER	T-95.1
CONDITION:	Stable, OA
RESP- 20	SpO2- 98%
BP- 120/61	HR- 67
ANESTHESIA / PROCEDURE TIMES	T-95.1 Ax

	Start	Room	End
ANES	1930	1945	2205
	Ready	Begin	End
PROC	1955	2022	2135

PROCEDURES and CPT Codes:
I+D (R) shoulder

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA RSI Cricoid

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
Dx1 MAC 3 Grade/view 8.0 ETT stylette, 23cm teeth + BBS, Suct ETCO2 10mL air cuff

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

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

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

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

PROCEDURE LOCATION: 2 (2)
DATE: 4 Oct 03
PAGE 1 OF 1

DA FORM 7389, FEB 1998 COPY 2 - A[illegible]HESIA PROVIDER USAPA V1.00

MEDCOM - 20974

NKDA

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)	
Propofol	(mg)	300
	( )	
Fentanyl	(cc)	5
	( )	
	( )	
	( )	
VOLAT AGENT Forane	% del	2-3 — 1
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	8-4-3-4

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

FLUIDS

LINE site LR (8)		
	☐ Warmed	1000
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES: EST BLOOD LOSS; URINE -

TOTALS	TOTAL EBL
300	—
5cc	TOTAL URINE
	—

FLUIDS - SUMMARY: CRYSTALLOID- 800; COLLOID- —; BLOOD- —

REMARKS — Code drugs with numbers, events with letters

Bed / Chart
Reviewed. TO OR
Induction. Pre-o2
Smooth induction
Endotracheal tube
Sx. LMA O/C
TO Recovery

PHYS STATUS: (1) 2 3 4 5 E

BODY WEIGHT: 75 (KG) LB

HEMATOCRIT:

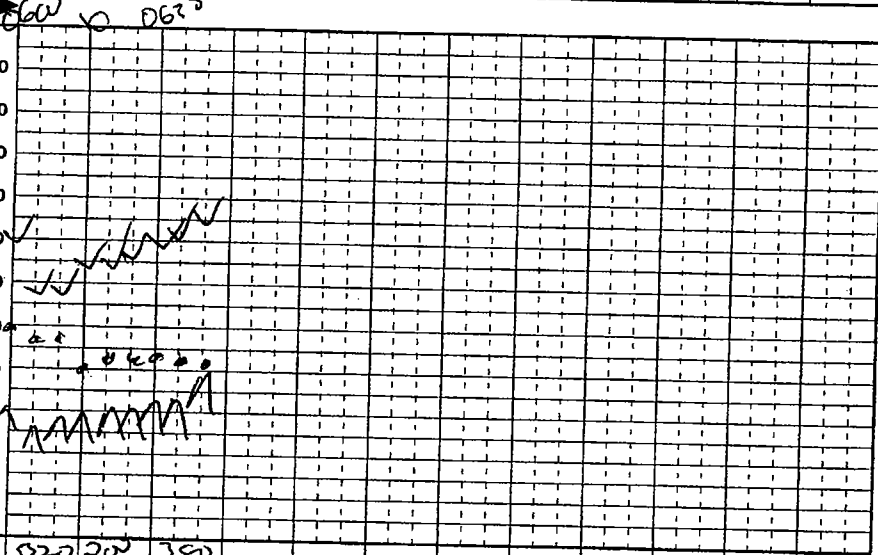
INITIAL DATA: BP 118/56; HR- 90

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE ✓ TIME- 0550

TIME → 0600 to 0620

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



VENTIL

VT - ml	520	200	380
f - breaths/min	12	8	12
Peak inf pres / PEEP			
MODE - S(pon), A(ssist), C(on)	S/A	A/S	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	48	52	60
BP/oth	FIO2 (Frac or %)	.63	.63	.63
ART line	SpO2 (%)	100	100	100
Steth- PC/ES	ECG	SR	SR	SR
Gas analyzer	TEMP-site SQ	97	97	97
	N-M Block (T/4)			
Warming blkt				
Conv warmer				

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

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

CONDITION: RESP- 10 SpO2- 95% BP- 135/72 HR- 89

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0550	0600	0650
	Ready	Begin	End
PROC	0605	0620	0641

PROCEDURES and CPT Codes:

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

[redacted] (b)(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comme* #4.0 LMA Tame (+) B-ss (+) ETCO2 [redacted] (b)(6)-2

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

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

PROCEDURE LOCATION: OR #2

DATE: 8 OCT 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 — MEDCOM - 20975 — COPY 2 - ANESTHESIA PROVIDER — USAPA V1.00

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

Age 35 DAYS MOS YRS

Sex (✓) MALE ( ) FEMALE

PROPOSED PROCEDURE: I&D (R) shoulder

SURGICAL SERVICE: ortho

NPO SINCE:

NPO since

10am

ASA Physical State 1 2 3 4 5 E

WT: 75 KG/LB HT: ____ IN.

ALLERGIES: NKDA

HABITS:

TOBACCO: Ø

ETOH: Ø

DRUGS: Ø

CURRENT MEDICATIONS:

( ) = ordered as premed

( )

( )

( )

( )

( )

( )

PREMEDICATIONS:

None Yes (@ ____ Hrs) /CC

____ . ____ mg IV IM PO

____ . ____ mg IV IM PO

____ . ____ mg IV IM PO

LABORATORY STUDIES:

HB/HCT: ____ / ____

U/A:

OTHER:

8.7 > 12.8 / 39.6 < 61

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT

PAST SURGICAL/ANESTHETIC

Ø

PHYSICAL EXAMINATION

BP 123/72 HR 91 R 16 T ____

Pain Scale 0-10 ____

HEENT - Teeth poor dentition

Trachea midline

MP III TMJ/Neck freely

Oropharnyx

Nares

CHEST: CTA (B)

CARDIAC: RRR S1/S2 (-)

EXTREMITIES:

IV Access: 18G (L) A

Ulnar Filling:

BACK:

OTHER:

NPO Since

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

RSI

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

The pa[redacted] (b)(6)-2 [redacted]derstand and agrees. Questions answered.

Sig[redacted] CRNA/MA Date: 4OCT03 Time: 2000 Hrs

POST-A[redacted]ESIA EVALUATION AND NOTE (NON ASU)

{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward)

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

SEDATION KEY:

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

WAMC Form 2300 (Revised) 15 Mar 01 MCXC-DOS

MEDCOM - 20976

PATIENT RECORD COPY

Previous edition is obsolete

☆U.S. GPO: 2000-[illegible]

518-124

MEDICAL RECORD

NSN 7540-00-634-4159

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)* 1 ML

REMARKS:

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

- [x] TYPE AND SCREEN
- [ ] CROSSMATCH

DATE REQUESTED 04oct03

DATE AND HOUR REQUIRED 1740 04oct03

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* B

DIAGNOSIS OR OPERATIVE PROCEDURE GSW to R shoulder

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

SIGNATURE OF VERIFIER [redacted] (b)(6)-2

DATE VERIFIED 04oct03

TIME VERIFIED 1740

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN

CROSSMATCH

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [x] NO RECORD

SIGNATURE OF PERSON [redacted] (b)(6)-2

DONOR

ABO

Rh

RECIPIENT

ABO A

Rh POS

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

REMARKS:

DATE 4oct03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*

AT *(Hour)* ON *(Date)*

IDENTIFICATION

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

1st VERIFIER *(Signature)*

2nd VERIFIER *(Signature)*

PRE-TRANSFUSION

TEMP. PULSE BP

DATE OF TRANSFUSION TIME STARTED

POST-TRANSFUSION DATA

AMOUNT GIVEN ML

TIME/DATE COMPLETED/INTERRUPTED

REACTION

- [ ] NONE
- [ ] SUSPECTED

TEMPERATURE PULSE BLOOD PRESSURE

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

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

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

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

SIGNATURE OF PERSON NOTING ABOVE

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

SEX M

WARD EMT

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

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

MEDCOM - 20977

Medical Record Copy

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
	10-07-03 2200 POST ANESTHESIA ORDERS (circled Items)		
1	VS q 5 min X 15 min, then q 15 min until discharge.		
2	Supplemental oxygen. PRN SaO2 <95%		
3	Morphine / Meperidine ~~mg IV now~~ and 2 mg q 3-5 min prn pain for a max dose of 10 mg.		
~~4~~	~~Zofran ____ mg IV prn N/V q 15 min, may repeat x ____.~~		
5	Metoclopramide 10 mg IV prn N/V x 1.		
~~6~~	~~Droperidol ____ mg IV prn N/V x 1~~		
~~7~~	~~Phenergan ____ mg IV prn N/V x 1.~~		
8	Benadryl 25-50mg IVP q1 hr prn, itching while in PACU.		
9	IVF: LR @ TKO cc/hr.		
10	Discharge from recovery status when PACU discharge criteria met.		
	[redacted] CRNA/MAS (b)(6)-2 (b)(6)-2		

PATIENT IDENTIFICATION

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

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

Diagnosis: _____

Height: _____ Weight: _____ Diet: _____

Allergies: (b)(2)-2

Nursing Unit	Room No.	Bed No.	Page No.
PACU, [redacted]			1 of 1

MEDCOM FORM 688-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE

MC V1.00

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 4 OCT 03 TIME OF ORDER: 1639 HOURS

LIST TIME ORDER NOTED AND SIGN

1. ADMIT ICW-1
2. DX - GSW (R) SHOULDER
3. CONDITION - STABLE
4. VS - ROUTINE
5. BED REST
6. NPO
7. IV - LR 65 125 cc/hr HOURS
8. TO OR TONIGHT
9. MSO4, 2-8 mg IV Q 1 hr PRN

[redacted]

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 4 OCT 03 TIME OF ORDER: 2145 HOURS

1. TO ICW-1
2. S/P 140 (R) SHOULDER
3. CONDITION - STABLE
4. VS - ROUTINE
5. UP 60 LBS PER EPW ROUTINE
6. SLING + SWATH (R) SHOULDER
7. RESTRICTED DIET

PATIENT IDENTIFICATION

[redacted]

(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

8. IV - LR AT 150 cc/hr. HOLD LOCK WHEN TAKING P.O. WELL
9. TYLENOL 650 mg P.O. Q 4 hrs PRN
10. PERCOCET 1-2 P.O. Q 4-6 hrs PRN
11. ANCEF 1 GRAM IVPB Q 8 HRS
12. CIPROFLOXACIN 400 mg IVPB Q 12 HRS
13. MSO4 2-8 mg IV Q 2 HRS PRN
14. CBC WITH DIFF IN AM,

[redacted]

(b)(6)-2

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

#[redacted]

(b)(6)-4

DATE OF ORDER: 07OCT03 TIME OF ORDER: 1600 HOURS

LIST TIME ORDER NOTED AND SIGN

NPO p MN for surgery

08OCT07

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

(b)(6)-2

(b)(6)-2

[redacted]

(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.
ICW#1	2	E 24

/0145 8OCT03

PATIENT IDENTIFICATION

DATE OF ORDER: 08 OCT 03 TIME OF ORDER: 0715 HOURS

(1) Resume previous orders

(2) Regular diet

(3) IV - LR 68 125 cc/hr, Hep Lock with 1 strong P.O. with

(4) SWAG and SWATH (R) arm

(b)(6)-4 Noted

NURSING UNIT	ROOM NO.	BED NO.
24 [redacted]	[redacted]	

8OCT03 1900

PATIENT IDENTIFICATION

(b)(6)-2

DATE OF ORDER TIME OF [redacted] HOURS (b)(6)-2

(b)(6)-2 [redacted] 502 m

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

NURSING UNIT	ROOM NO.	BED NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

(b)(b)-2 [redacted]

NURSING UNIT | RO[redacted] | BED NO.

Noted [redacted] 10 OCT 03 0820

DATE OF ORDER 10/10/03 | TIME OF ORDER 0870 HOURS | LIST TIME ORDER NOTED AND SIGN

1. Discharge to EPW camp
2. Keflex 250 mg Q 12 x 10 days #40
3. Percocet 1-2 PO Q 4-6 hrs prn #20
4. Every other day dressing changes

(b)(b)-2 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

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

CLINICAL RECORD | **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. 10 Yr. 2003

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED (INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION)												
				4	5	06	07	08	09	10	11					
4	[redacted]	VS routine	6	X	[redacted]											
		(b)(6)-2	18	[redacted]												
4	[redacted]	up ad lib per	6	[redacted]												
(b)(6)-2		EPW routine	18	[redacted]												
4	[redacted]	Sling & swath (R)	6	X	[redacted]											
(b)(6)-2		shoulder	18	[redacted]												
4	[redacted]	regular diet	6	X	[redacted]											
(b)(6)-2			18	[redacted]												
10 Oct 03	[redacted]	Every other day dressing	10	/	/	/	/	/	/	[redacted]	/		/		/	
(b)(6)-2		ΔS														

(b)(6)-

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: HD (R) shoulder

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)					Mo 10 Yr 2003	
Order Date	Clerk Nurse	(b)(6)-2 SINGLE ACTIONS		Date to be Done	Time to be Done	Time Done	Initials	
4	[redacted]	Admit IWM#1, stable		04 OCT03	—	—	[redacted]	(b)(6)
(b)(6)-2 4	[redacted]	CBC i diff in Am.		5 OCT	0430	—	[redacted]	(b)(6)-2
(b)(6)-2 07 OCT03	[redacted]	NPO D MN for surgery 08OCT03		08 OCT03	0001	—	[redacted]	(b)(6)
(b)(6)-2 08 OCT03	[redacted]	Resume previous orders		08	—	—	[redacted]	(b)(6)-
(b)(6)-2 10 OCT03	[redacted]	Discharge to EPW camp						

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

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. 10 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 4	5	6 07 08	9	10	11	12
(b)(6)-2 4	[redacted]	LR @ 150cc/hr.	6	X [redacted]						
		HL when taking	8	[redacted] DC 08OCT03						
		pr well *	X							
(b)(6)-2 4	[redacted]	Ancef + gm IVPB	8	X [redacted]						
		q8°	16	X [redacted]						
			24	[redacted]						
(b)(6)-2 4	[redacted]	Ciprofloxacin 400mg	10	X [redacted]						
		IVPB q12°	22	[redacted]						
(b)(6)-2 08 OCT03	[redacted]	~~LR @ 125cc/hr~~, hep	06	// // // [redacted]						
		lock when taking po	18	// // // [redacted]						
		well								
(b)(6)-2 10 OCT03	[redacted]	DC meds: Keflex 250mg QID		/ 10OCT03 RX to pharmacy [redacted]						
		Percl-2 po q4-6° prn								
(b)(6)-2		* PRN meds *								
4	[redacted]	Tylenol 650mg po	D/T/							
		q4° prn								
(b)(6)-2 4	[redacted]	Percocet 1-2 po q4-	D/T/							
		6° prn								
(b)(6)-2 4	[redacted]	MSO4 2-8mg IVP	D/T/							
		q2° prn								

(b)(6)-2

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: HD (R) shoulder

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

USAPA V1.00

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 4 OCT 03
Time In: 2208
Allergies: NKDA
Pre-op V/S: B1/80 / 84
Procedures: I&D R shoulder

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

OR Intake: Crystalloid 1200 LR Colloid
OR Output: UOP 0 EBL 400
Meds/Times: 250 mg Ket. 200 IV morph

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds

History

Time	2201	2210	2215	2220	2225	2230
SaO2	96%	99%	99%	99%		
FiO2						
Methods	RA	4L O2	RA	RA		
240						
220						
200						
180						
160						
140						
120	V	V	V	V		
100						
80		^	^	^		
60	^	^	^	^		
40						
20						
RR	12					
T	98.4		96.4			

Time									
Pain (0-10)									
LOS									

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused
2208	NS	600	OAC	IV	600

X-rays:

Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	0	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	1	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	Ø	Ø	1
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	6	8	10

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

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

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

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

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

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 4 Oct 03

[redacted] IDENTIFICATION (For typed or written entries give: Name – last, middle; grade; date; hospital or medical facility)

[redacted] (b)(6)-4

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

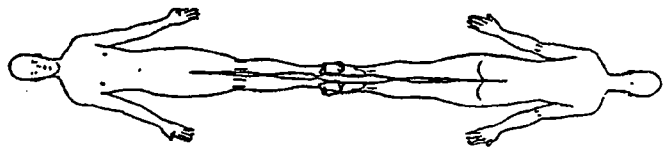
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(R) Shoulder	Bulky	0
30'	(R) Shoulder	Bulky	0
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

NURSING NOTES

PT Admitted to PACU S/P I&D (R) shoulder. PARS 6. ORAL AIRWAY IN PLACE O. @ 96% RA (b)(b)-2
Dressing CDI w/ Penrose Drain - SP[redacted]
(2) Depat gm to ICO2. RN [redacted]
(b)(b)-2

Discharge Criteria:
Date: Oct 13 **Time:** 2254 **PARS:** 10
BP: 120/70 **T:** 96.4 **HR:** 77 **RR:** 20 **Sa02:** 95
Pain Level at D/C (0-10):
Intake: [redacted] (b)(b)-2 **Output:** 0
Additional Data: 0
Transferred To: [redacted] (b)(b)-2
Report Given To: [redacted] (b)(b)-2
Transferred Via: W[redacted] Gurney Ambulance
Transferred By: [redacted] (b)(b)-2
Cleared IAW Recovery [redacted] (b)(b)-2
Signatu[redacted]

WAMC OP 173-E

MEDICATIONS

Allergies:

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	Ø ARM	LRDM	+	+	B	C	Pk
15'							
30'							
45'							
60'							
90'							
D/C							

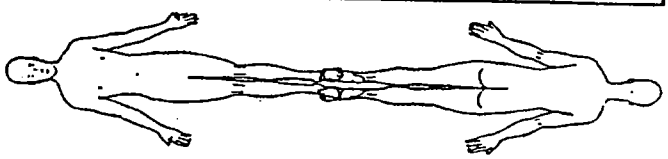
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(R) shoulder	bulky	Ø
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0600	SR	Ø	Ø

WAMC OP 173-E

NURSING NOTES

Pt to recovery room from OR via litter s/p I & D, washout (R) shoulder. Bulky dressing to (R) shoulder intact. IV of LR infusing into (L) arm. Ø s/s of Redness or swelling to site. VSS, NV/s (L) intact. Ø c/o. [redacted] (b)(6)-2

NOTHING FOLLOWS

Discharge Criteria:
Date: 8 OCT 03 Time: 0715 PARS: 9
BP: 139/60 T: 97.6 HR: 80 RR: 14 Sa02: 96
Pain Level at D/C (0-10):
Intake: 100 Output: Ø
Additional Data:
Transferred To: ICU #[redacted]
Report Given To:
Transferred Via: W/C [redacted] (b)(6)-2
Transferred By: [redacted]
Cleared IAW Recovery Room [redacted]
Charge Nurse Signature: [redacted] (b)(6)-2

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date):

Date: 08 OCT 03
Time In: 0650
Allergies: NKD
Pre-op V/S: 110/69 80
Procedures: to wash out of (R) shoulder

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 800 Colloid
OR Output: UOP 0 EBL min
Meds/Times: 5 fent 1 midazolam

Drains: Hemovac, NG, JP, T-tube, Foley, TLS (Penrose)

Airway: Nasal, Oral, ETT, Trach, Other (Mask)

Pre Op Meds / History

Time	0650	0655	0700	0705
SaO2	94	92	94	94
FIO2				
Methods	M	RA	RA	RA

240, 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20

RR: 13 13 18 20
T: 97.6

Pacu Intake

Time	Solution	Amount	Site	By	Infused
0650	LR	300	L arm	OR	700

X-rays:
Labs:

Post-Anesthesia Recovery score

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

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

Time	
Pain (0-10)	
LOS	

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

(Continue on reverse)

(b)(6)-2 PREPARED BY (Signature & Title): [redacted] 1LT AN

DEPARTMENT/SERVICE/CLINIC: ICU 117

DATE: 8 OCT 03

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

[redacted] (b)(6)-4

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

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

[redacted] (b)(6)-4, (b)(6)-5, (b)(7)(c)-5

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

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

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

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

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

- ☐ Violation of Curfew
- ☐ Illegal Possession of Weapon
- ☒ Assault/Attack on Coalition Forces SHOOTING AT U.S. FORCES
- ☐ Theft of Coalition Force Property
- ☐ Trespass on Military Installation or Facility
- ☐ Photographing/Surveilling Military Installation or Facility
- ☐ Obstructing Performance of Military Mission
- ☐ Other

Apprehending Unit: [redacted] (b)(6)-2 | Location Grid:

Date of Incident (D/M/Y): 4/18/03 to / / | Time of Incident: 1300 hrs to hrs | Date of Report (D/M/Y): / / | Time of Report: hrs

(b)(7)(c)-5, (b)(6)-5, (b)(6)-4

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

(b)(7)(c)-5
(b)(6)-5
(b)(6)-4

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

☐ Vehicle Information Vehicle Number _____ of _____ Vehicle(s) | Owner:

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

Contraband/Weapons in Vehicle:

☐ Property/Contraband ☐ Weapon | Photo Taken of Suspect with Weapon/Contraband. Yes/ No

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

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

Detaining Soldier's Name (Print): Contact BTL CPT Last, First MI	Supervising Officer's Name (Print): Last, First MI
Signature: (b)(6)-1	Signature:
Email: [redacted] Date: / /	Email: / Date: / /
Unit Phone:	Unit Phone:

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

Why was this person detained? Throwing rocks at coalition forces. Sustained GSW to shoulder - transfered to [redacted] for treatment & wounds. (b)(2)-2

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

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

Who was with this person?

What weapons was this person carrying?

What contraband was this person carrying?

What other weapons were seized?

What other information did you get from this person?

Additional Helpful Information:

(b)(2)-2

Admission [illegible] Coding Information

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

1. Reporting MTF 0580 - [redacted]	2. MTF Loca[illegible] IZ			
3. Register Number (b)(6)-4 [redacted]	Name (Last, First, MI) [redacted] (b)(6)-4		4. Pay Grade FGN	5. Sex M
6. DoB (YYYYMMDD) [redacted]	7. Age at Admission 35Y	8. Race X	9. Ethnicity 9	Religion ISLAMIC
10. Length of Service	ETS	11. FMP 20	12. Social Security Number [redacted] (b)(6)-4	
Organization (Active Duty Only)		13. Marital Status Z	Hour of Admission 14:33	Branch / Corps:
14. Flying Status	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES		16. Zip Code of Residence:	
17. Unit Location	18. MOS	19. Trauma DIS	Prev. Admission NO	
20. Source of Admission Direct from ER	Ward: ICW1	Name / Relationship of Emergency Addressee Address of Emergency Addressee		
Name and Location of Medical Treatment Facility: 0580 - 28th CSH - Iraq; No Install Provided		Telephone Number of Emergency Addressee		
21. Type of Disposition HOME	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2003-10-10		
24. Clinic Svc - Admitting AEA - ORTHOPEDICS	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-10-04		
27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission 2003-10-04		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: I & D R SHOULDER

Procedure Narrative(s):

Cause of Injury Narrative:

(b)(6)-2

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

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

Automated Facsimile

(b)(6)-4

INPATIENT TREATMENT RECORD COVER SHEET

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

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

4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm
M	24Y	X	UNKNOWN			NO

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

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

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	19:00	ABA - GENERAL SURGERY

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	TRF-OTH	2003-11-02

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-10-04	[redacted] (b)(6)-2

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
[redacted] - Iraq (b)(2)-2	2003-10-04	

31. Selected Administrative Data

Marital Status: Z DoB: [redacted]

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

GSW ABDOMEN

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	30	30

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	30	30

Signature of [redacted]	Signature of PAD or Medical Records Officer
[redacted] (b)(6)-2	[redacted] MAJ [redacted] (b)(6)-2 [redacted] (b)(6)-2

Automated F[redacted] DA FORM 3647, May 79

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

[illegible]

PHYSICAL EXAMINATION

[illegible]

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

[illegible]

SIG [redacted]	DATE [illegible]	IDENTIFICATION NO.	ORGANIZATION

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

[redacted] (b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
04OCT03	(b)(2)-2 Department of the Army [redacted] (32)
1400	CH

NARRATIVE SUMMARY

DIAGNOSIS: - Fistula in Thigh, Prolonged ileus, Malnutrition

PROCEDURES: 22Sept03 - Ex Lap/ADHESIOLYSIS/J-tube placement

HISTORY OF PRESENT ILLNESS: 25 yo IRAQI male who was shot while attacking US Forces in Kirkuk 30AUG03 and was taken to the 250th FST. He received 4 GSW and underwent Exp Lap w/ (R) Hemicolectomy, and ileostomy, Mucous fistula, SP tube. He also had a large (R) buttock wound. (L) hip soft tissue wound. He was transferred here on 15 Sept03.

(b)(2)-2

HOSPITAL COURSE: The patient became intolerant of food shortly after arrival here at [redacted] and developed a SBO from dense adhesions. He underwent exp lap/adhesiolysis and placement of Feeding Jejunostomy tube (16Fr Mallinckrodt) on 22Sept03. He initially did well but became intolerant of TF and po diet on 01OCT03 - and again was made

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] (b)(6)-4

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

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

DATE [redacted]

NOTES

HOSPITAL COURSE (CONTINUED): NPO and TC stopped. An ileus pattern was seen and NGT decompression begun. Pt has had a persistent leukocytosis (23K) but no fever. His vital signs overnight still have gone to greatly diminished amounts and liquid stool.

DISPOSITION: Transfer to [redacted] for further evaluation - Abdom CT Scan.

RECOMMENDATIONS: CT Abdomen.

MEDICATIONS: IV Fluids.

(b)(6)-2 [redacted]

(b)(6)-2 [redacted] MD
MAJ, MC USA
CHIEF, DOS

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

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
5OCT03 0445	Pt admitted to ICW #1 from ER, BP-107/63 P-67 T-96.7 SPO2%-99%, pt lethargic, easily aroused, IV central line (R) scl infusing LR @ 75 cc/hr, ø s/sx of infex or infiltration, colostomy bag intact on (R) lower quad, bag empty, J tube infusing 30cc/hr of Jevity, NG tube to LIS in place draining greenish fluid, dsg over abd CDI, ø c/o pain @ this time, IS @ bedside, decub ulcers on hips (B) covered c̄ dsg's CDI, dsg on (L) inner thigh CDI, dsg on (R) flank CDI, foley to gravity draining cly urine, pt on 2 pt restraints s/sx of poor circulation or skin breakdown. (b)(6)-2 [redacted] GIW
5OCT03 0800-	- Pt AtOx3. VSS Lungs clear to ~~auscul~~ (b)(6)-2 [redacted] all fields anteriorly and posteriorly. HRRR S1 S2 present. Active BS. Ostomy to (R) upper quad brown liquid stool. stoma beefy red vascular. (L) side of abdomen stoma open to air moist ø stool noted. NG tube LIS in place draining green bile fluid Superpubic cath to gravity drainage light yellow urine. Jevity @ 30 cc to catheter (L) lower quad abdominal insertion

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

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

[redacted] (b)(6)-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
Cont	Midline surgical incision abdomen healing minimal drainage 4x4 dressing applied. IVF LR@75cc/hr to (R) subclavian central line care given 5 Oct 03. GSW x2 (L) flank and (L) posterior thigh. healing wet → dry dressings applied. Active BS poor nutrition. Consult to dietary. MSO4 5mg given for pain will cont to monitor (b)(6)-2 [redacted] grievance.
5Oct03 @	2100: VSS, Ø c/o pain @ present time, A+O, follows signal commands well, verbalizes needs in arabic, NGT to LIS ~~draining~~ suctioning dark greenish liquid, Q4 flushes to NGT, verified placement → (+) placement, marked NGT @ (R) nare entrance, feeding tube intact, insertion site on (L) UQ running feeding @ 30cc/ via Alaris pump. (R) SC CL intact running LR@75cc/ 5 difficulty, site c̄ Dsg CDI, Ø s/s infection/irritation. Colostomy site to (R) quad intact - putting out brown liquid stool - stoma site beefy red & healthy appearance. Stoma to (R) quad beefy red - not putting out anything, Ø colostomy bag, new dsg placed over site CDI (dry). Midline Abdominal incision has one small section dehisced - packed c̄ wet 2x2 & covered c̄ Dry 4x4. Duoderm applied to wound (ulcer?) to (L) thigh (inner). W→D Dsg Δ'd to (R) butt/hip area CDI - open flesh wound - beefy red - Ø drainage or bleeding assessed. Pt. is NPO, (+) BS x4

STANDARD FORM 600 (REV. 6-97) BACK

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

continued quads, NGT flushes (irrigates) ∃ difficulty.
5Oct03 @ 2100 Pt's gown Δ'd after D&g Δ's, precautions to prevent decub ulcers / further breakdown, (B) LE's elevated to keep heels off of pressure, LABS QAM (CBC & chem 8), reinforced IS while awake. POC = Pain Management, Wound Care / Preventive Wound Measures, Palliative Measures, ↑ independence, infection control, IV antibiotics. Will continue to monitor for acute Δ's throughout shift. — [redacted] (b)(6)-2 WJN

Addendum: x2 restraints when in bed, ⊖ skin breakdown, ~~FTG draining~~ SP cath intact (cath care done ∈ alcohol) (b)(6)-2 draining clear yellow urine. — [redacted] WJN

6Oct03 @ 1700 Received pt resting in bed, VSS, NPO, a+o x3. Pt NG to suction putting out greenbile, colostomy (R) LQ liquid stool brown, Drg to (R) buttock + (L) thigh/hip Δ'd, serosang drainage, foul odor to buttocks. tolerating feeds cont after CT procedure @ 30cc/hr to J-tube, SP cath - clear yellow urine, abdominal drainage bright yellow drainage

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)*

EPW # [redacted]

(b)(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
cat	emc IS, amb to w/c for procedure transfer. ⊕ ⊠ flushes easily. LR infusing @ 75cc/hr. [redacted] (b)(b)-2
1001103@ 2330	nursing assumed care of pt @ 1800. VSS. Alert, speaking Arabic. LS CTA, IS encouraged, ⊕ BS, void per SP catheter clear/yellow urine. (R) subclavian CL c̄ LR @ 75cc/hr & IV Abx; flushes well, dsg Δ'd per sterile technique. ML abd incision healing well. (R) LQ ostomy c̄ brown liq stool, LUQ ostomy c̄ ∅ output covered c̄ damp 4x4 & dsg. GT c̄ tenity @ 300cc/hr, 10cc residual ✓ @ 2300. GT & SP cath insertion sites red c̄ slight purulent drainage noted around cathe. Will notify MD in AM. Site care provided c̄ NS & ½ strength H2O2. Small 1cm x 1.0cm wound @ ML c̄ WTD dsg → sm amt of greenish tissue noted. Pigtail insertion site covered & line secured to leg. (L) hip 4.0cm x 2.0cm wound WTD dsg → healthy granulating tissue noted. (R) buttocks wound 10.0cm x 6.0cm WTD dsg → healthy granulated tissue noted. (R) hip small 2.0cm x 2.0cm healing wound OTA. (L) inner thigh dsg c̄ duoderm CDI. NGT to LIS c̄ minimal green liquid output noted, flushed ok c̄ difficulty. Pt restraint on ⊠ sx of skin or circulation compromise. Pt refused to ambulate this P.M. Plan: pain control, emc AMB. Addendum: Pigtail abscess drain to foley bag yellow-green chunky fluid. Will monitor. [redacted]

STANDA[redacted]RM 509 (REV. 5/1999) BACK

(b)(b)-2 USAPA V1.00

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

7OCT03 @0545 shift totals

outs: urine = 1350cc; NG = 1050cc; abscess = 350cc; stool (ostomy) = 1100

ins: LR = 1900cc; NG irrigation = 150cc; Jevity = 450cc

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

7OCT03 0800 VSS. Alert & Oriented. Lungs clear Bilaterally. BS (+) all quadrants, tender to touch, non distended. Foley patent intact & draining clear yellow urine. NG to LCS draining greenish drainage. Abscess draining thick yellow drainage. Jevity @ 30cc/hr. HOB ↑. (R) SC IV intact & patent infusing LR @ 75cc/hr. Will continue plan of care. No clots or decompensation noted or voiced. [redacted] 2CT RN

(b)(6)-2

7OCT03 Radiol.

(L) paracolic catheter drainage measures 350cc c/w likely communication of (L) paracolic gutter/cath with enteric contents. CT w/contrast through catheter planned for 8OCT PM [redacted] MD (b)(6)-2

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
7 OCT 03 1440	Pt OOB ambulated to hallway to get on stretcher, transported to CT SCAN per Dr [redacted] (b)(6)-2 [redacted] (b)(6)-2
(b)(6)-2	Tube feeding D/C as ordered by Dr [redacted] (b)(6)-2 [redacted]
7 OCT 03 @ 2015	Assumed care of pt @ 1800. Sleeping, but awakens to voice, speaking Arabic. LS CTA, enc IS. (+) BS, hypoactive, (R) colostomy c̄ brown-green liquid stool. NG to LIS, green liquid output. NG flushed q4° as ordered. GT to LLQ clamped, flushes well, Ø residual. LLQ pigtail draining abscess c̄ yellow-green thick fluid noted. SP cath draining yellow urine. Tube care provided to all tubes. ML incision OTA, healing well; sm 1.0cm x 1.0cm wound @ ML c̄ WTD dsg, slight purulent drainage noted. (L) UQ stoma covered c̄ dsg, Ø output noted. (L) hip & (R) buttocks dsg WTD Δ'd, both c̄ healthy granulating tissue. (L) inner thigh duoderm CDI. Medicated c̄ percocets (per OT) & MSO4 IV c̄ good pain relief noted. Plan: NPO for SX in AM, tube care, 1+0S cont, IVFs as ordered, encourage AMB & IS. 2pt restraint on while in bed s/ SX of skin or circulation compromise. WILL continue to monitor. [redacted] (b)(6)-2

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DATE	NOTES
8OCT03 0800	Daily I&O Totals (7OCT03) Ins: Jenty = 210cc IVFs/meds = 2300cc Irrigation = 180cc 2490cc Outs: Urine = 1550cc NGT = 1400cc Colostomy = 500cc Abscess = 850cc 4300cc (b)(6)-2 [redacted] CPT (b)(6)-2 [redacted]
8OCT03 0800	VSS. Alert & Oriented. Lungs Clear ~~Bilateral~~ BS (+) but hypoactive. NG draining greenish drainage. Colostomy stoma pink & moist. Dry dry & intact to Abscess and GT tube. Abscess draining bile colored drainage. (R) Buttock & Thigh dry dry & intact will change later during this shift. GT flushed without difficulty (R) subclavian clv patent & intact infusing 2NaCl 75 cc/hr. HOB ↑ 30°. Will continue care as planned. (b)(6)-2 [redacted] 2CPT
8OCT03 @2145	Assumed care of pt @1800. VSS. C/o generalized abdominal pain, MS04 given c good relief noted. LS CTA, (+) BS, Jenty @ 30 cc/hr to PEG. NGT D/C'd, tol small amts of clears. M incision

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
30CT03 2145	(cont'd) healing well s̄ exception small 1.0cmx 1.0cm wound c̄ NTD drsg, purulent drainage noted. LUQ stoma s̄ output, RLQ stoma c̄ brown-green liquid stool per colostomy. LLQ pigtail drain for abscess c̄ green thick liquid. (totals, see I+O's) SP cath c̄ clear yellow urine draining. Tube care provided to all tubes. (R) SC central line infusing s̄ s/sx of infection. (L) hip c̄ (R) buttocks drsg Δ'd per MD. (L) inner thigh duoderm CDI. Plan: monitor GI status & toleration of clears, monitor pain control, monitor I+O's. (b)(6)-2 [redacted] CPR
	addendum: Rpt restraints on s̄ s/sx of skin/circulation compromise. [redacted] CPR (b)(6)-2
90CT03 @0500	24 totals I+O's
	Ins: Jenny = 330cc IV = 2400cc PO = 440cc 3170cc
	Outs: Urine = 1250 NG = 550 (d/c'd) Colostomy = 550 Pigtail = 200 (ø dayshift recording)
	(b)(6)-2 [redacted] CPR

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DATE	NOTES
9 Oct 03 1500	VSS. A&O able to make needs known. Cardiovascular & Pulmonary system intact. (+) BS. Jevity ~~via~~ (b)(6)-2 [redacted] 30cc on pump per gastric tube. Voiding cloudy yellow urine quantity sufficient via foley. Skin warm & dry. Abscess drain to gravity draining brown cloudy drainage (L) Lip & buttock drsg Δ done. (D) lip c̄ small amount purulent drainage. Colostomy (L) c̄ brown liquid ~~drainage~~ (b)(6)-2 [redacted] stool. (R) stoma pink s̄ output. Drsg Δ'd. (L) inner thigh wound c̄ purulent drainage. Duoderm applied. Pt medicated c̄ MSO4/5mg IVP for C/O pain @ 0830 & 1240. Will continue to monitor (R) subclavian central line patent LR @ 75 cc. Drsg Δ done — (b)(6)-2 [redacted] MAG
9 Oct 03 1507	Pt ~~2~~ - 2pt restraint s̄ skin/circulation compromise. (b)(6)-2 [redacted] MAG
9 Oct 03 1945	Assumed care @ 1800, VSS, pt A&O speaking arabic (b)(6)-2, S, S2, LS CTA (R); (+) BS x 4, Jevity @ 30 cc on (b)(6)-2 [redacted] IVAC pump via G-tube; ~~pt~~ FTG draining QS, dark yellow, cloudy urine; abscess drain to gravity draining dark cloudy fluid; colostomy bag draining brown liquidy stools, pt performs own colostomy care, stoma pink, moist, s̄ s/sx infection; all drsgs Δ, minimal purulent drainage to all; pt c̄s & MSO4 for pain; CL patent, infusing LR @ 75 cc s̄ s/sx infection/infiltration; cont to monitor

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DATE	NOTES
10 OCT 03 1130	Assumed care of Pt at 0600 hrs. Pt Awake A&O. SP cath draining cyu c̄ sediment. TF c̄ Feed @ 30cc hr. CL via subclavian Flushed & Patent. (L) hip Drsg Δ. wound appears pink on the outer edge of wound. Tissue grey in the center. (R) Buttock Drsg Δ'd. Wound beginning to tunnel superiorly. Pigtail wound drain in abdomen Drain minimal amounts of Bloody fluid c̄ heavy sediment Pt c/o pain. Controlled c̄ percocet and MSO4. (b)(6)-2 [redacted] 91WM6
10oct03@2115	Assumed care @ 1800; All VSS, pt A&O, pain controlled c̄ percocet; SP tube patent, draining QS, clear, yellow urine, free of sediment; G-tube patent, infusing Jevity @ 30 cc/hr; CL patent infusing LR @ 75 cc/hr ∅ s/sx infection/infiltration; dsg to (L) hip Δd, min. drainage noted, (R) buttock dsg Δd, ⊖ drainage noted; dsg to (b)(6)-2 [redacted] medial aspect of (L) thigh Δd c̄ duoderm, excessive amt of purulent drainage noted, wound cleaned & duoderm wound (b)(6)-2 [redacted] replaced; dsg to old stoma site Δd, stoma wet & pink, ⊖ drainage, ⊖ s/sx infection; colostomy intact, pt performs own colostomy care; abscess drain patent, draining thick yellow fluid; cont to monitor. (b)(6)-2 [redacted]
11 OCT 03	Assumed care @ 0600 [redacted] LS CTA (B). ⊖ BM x4 quads pain controlled c̄ percocet. (b)(6)-2 [redacted] Jevity feed @ 30 cc/h. CL infusing LR @ 75 cc/hr. Drsg to (L) hip, sacrum, (L) thigh CDI. LS CTA (B), S_1, S_2 present. ⊖ BS x4 quads colonostomy LLQ. Pain controlled c̄ MSO4. Will continue to monitor. (b)(6)-2 [redacted] 91WM6
	(1510) I concur c̄ above assessment. [redacted]

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DATE	NOTES
(2100) 11OCT	Pt alert, VSS, pain controlled c percocet, [redacted] intact draining dark yellow urine. Foley draining cyu. CL patent infusing LR @ 75cc/hr. ⊖ redness or edema noted. (R) buttock, (L) thigh drsg Δ'd. (minimal drainage). Jevity infusing @ 30cc/hr. 2pt restraints on 5 compromise to skin or circulation. Will monitor — [redacted] q1hr. Colostomy draining informed. Brownish yellow.
12OCT 0530	BM. pt performs own colostomy care. — [redacted] abscess drain c 200cc all white, thick yellow citrus smelling drainage. Pt consumes OJ often during the day. ⊖ tube flushed (residual 3cc). Tacamet infusing @ this time. Will monitor — [redacted] q1hr.
12OCT03 0945	Assumed ~~pt~~ care of Pt @ 0600. Pain controlled c percocet & MSO4.
(1920)	Pt awake, VSS, c/o severe pain to abd. (site of abscess drain). 5mg MSO4 given c noted relief. CL patent & infusing LR @ 75cc/hr. ⊖ edema or redness noted. Foley draining adeq. cyu. Jevity

(b)(6)-2

(b)(6)-2

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(b)(6)-2

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
12OCT@ (1920)	infusing @30cc/hr. colostomy intact, stoma pink/moist. Drsg Δ'd. Restraints on 5 compromise to skin or circulation. Will monitor (b)(6)-2 [redacted] 91WM6.
13OCT03 1510	Pt Awake. Pain controled c̄ MSO4 & percocet. CCT. Drsg to (L) hip (R) Buttocks Δ. Pig tail Draining Dark citrus smelling Fluid c̄ sediment. S/P cath Draing Yellow urine c̄ sediment. Jevity Feed @30 cc/h. CL Patent. Will continue to monitor. (b)(6)-2 [redacted] Spc. 91WM6
13OCT03 @2300	Assumed care of pt @1800. VSS. C/O pain, Percs given c̄ good relief noted. MI abd [redacted] incision (b)(6)-2 healing well. Colostomy c̄ brown liquid stool. LUQ stoma covered c̄ 4x4 drsg. SP cath draining c/y urine. Pigtail drain c̄ green drainage. CT c̄ Jevity @30cc/h. Tube care provided. Tol reg diet well. CL flushes well c̄ good blood return noted. ~~Plan~~ (R) buttocks & (L) hip drsg Δ'd. Plan: pain control, monitor GI status. Hos. [redacted] (b)(6)-2
14OCT03	Radiology. (L) Abscess/J-tube removed after CT demonstrated no significant pancreatic fluid collect as d/w Dr. [redacted] (b)(6)-2 Ø complic EBL Ø. (b)(6)-2 [redacted] MD

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
14OCT 2215	(CONT) – (R) subclavian line dsg CDI, line flushes well, (+) blood return on distal port. LR @ 150cc/° continues. Plan: pain control, enc po intake, enc OOB to AMB, IV abx as ordered. 1 pt restraint on 5 S/Sx of skin/circulation (b)(6)-2 [redacted] CPT
15OCT 0115	– Pt c/o pain to groin area. Pt voided through urethra clear yellow urine, approx 200cc. Will monitor. (b)(6)-2 [redacted] CPT
15OCT03 0900	USS alert & oriented OOB → chair for Breakfast, AM & Colostomy care. Tolerated well. (R) subclavian line intact & patent. w/ D/dry later this shift as ordered. Lungs clear BS (+) x4 quad. Abd – soft non-distended. Colostomy stoma pink & moist. – Peripheral pulses palpable +2. Supra pubic cath draining cloudy yellow urine. Ambulated in hallway without assist. Will continue care as planned. (b)(6)-2 [redacted] 2CT AT
15OCT03 1015	Pt's supra pubic cath clamp. Informed Pt to void in urinal ~~at~~ (R) urinal @ BS within reach. (b)(6)-2 [redacted] 2CT AT
15OCT03	Radiology. (L) paracolic/lj drain removal site intact.
	(b)(6)-2 [redacted] MD
	(b)(2)-2 [redacted]

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DATE	NOTES
14 OCT 03 0700	- Assumed care of pt. A+O x3. VSS. Medicated prior shift Ø c/o pain or discomfort @ this time. Breakdown stage II ® buttocks dressing Δ'd wet to dry. (L) hip bony stage II' 2x2 minimal drainage 2x2s applied. Lungs clear HRRR. Suprapubic cath to (L) LQ of abd. Feeding tube in place 30cc Jevity infusing ® subclavian site patent Ø s/s of infection. On call CT this AM will cont to monitor (b)(6)-2 [redacted] SCWMC
1000-	Pt ambulated to CT ⊆ difficulty (L) abscess hip J-tube removed. Jevity tube feedings per MD will resume tomorrow c/o pain medicated c̄ percocet II tabs for relief. Will cont to monitor (b)(6)-2 [redacted] SCWMC
14OCT03 @2215	Assumed care of pt @1800. Alert, speaking arabic. VSS. c/o abd pain, medicated c̄ Percocets c̄ good relief noted. LS CTA. ⊕BS x4 quads. LUQ stoma ⊆ output covered c̄ Drsg CDI. RLQ stoma c̄ brown liquid stool. ML incision OTA, healing well. G-tube clamped (for bowel rest). SP cath draining clear yellow urine. Tube care provided, dsgs applied. Smount of yellow drainage noted around CT tube. ® buttock dsg Δ'd, (L) hip dsg Δ'd, both c̄ smount of brown drainage noted. (CONT)

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DATE	NOTES
15 Oct 03 1700	Pt has voided twice [redacted] via urethra c̄ suprapubic cath clamped. Upon unclamping suprapubic p̄ voids < 30cc of urine noted. Will inform Dr. [redacted] (b)(6)-2 (b)(6)-2 [redacted] 2CTB (b)(6)-2
15Oct03 2010	= VSS, A+O×3, ∅ c/o pain @ present time, CL to (R) SC running LR @ 75cc/° c̄ difficulty, SP cath clamped → residual ✓'s post-void c̄ urinal → monitoring UOP c̄ residual. Feeding tube intact & plugged → flushed & patent. Dsg's over SP cath site & TF site Δ'd, dehiscence to midline abd wound c̄ ∅ drainage, covered c̄ Dsg CDI, Dsg's to (R) buttock & (L) hip CDI, Δ'ing BID. (+) BS × 4 quads, tolerates PO well, ×2 restraints c̄ skin breakdown noted. Pt. does own colostomy care PRN. ∅ other remarkable assessment findings. POC: Wound Mgt, Pain Management, I&O's. Continue to monitor. — [redacted] (b)(6)-2
16OCT03 1200	Assumed care of Pt. VSS. SP cath plugged. CL Flushed Patent 75cc/h LR. JT Feed Tube plugged. LLQ Colostomy CDI Draining Loose brown Stool. S1S2 Present. LS CTA (B) (+) BS × 4 quads. Pt Ambulato

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(b)(6)-2 X1 Today. OOBTC for 1 hour. SP cath [redacted] fell out of LRQ. Dr (b)(6)-2 [redacted] replaced and sutured in place. Antibiotic continue[redacted] will cont. to monitor. (b)(6)-2 [redacted] Sp, PWMB
16OCT03 @2030	Assumed care of pt @1800. VSS. alert speaking Arabic. LS CTA, (+)BS x4 quads, RLE colostomy c̄ brown liquid stool noted. LUQ ostomy c̄ dsg, Ø output noted. SP cath draining to foleybag clear yellow urine. Midline abd incision healing well. Tol reg diet well c̄ good appetite noted. G Tube clamped. (R) buttocks wound ; (L) hip wound WTD dsg Δ'd, both c̄ brownish-serous drainage noted. (R) SC central line c̄ dsg CDI, flushes well, (+) blood return. 2pt restraints on 5' S/sx of skin/circulation compromise. Pt ↑ AMB c̄ min. assist. Plan: enc activity, enc po intake, enc independence c̄ colostomy care, cont ABX as ordered, pain control. (b)(6)-2 [redacted]
17OCT03 @0115	Pt colostomy leaking under seal around stoma. Old bag removed, skin cleaned, new bag placed. Pt ↑ to BR to wash up. Buttocks dsg Δ'd DIT soiling outer layer of dsg c̄ colostomy leak. Will monitor. [redacted]
17 oct 03 0200	- Assumed care of pt. A+O x3 VSS. Ø c/o pain or discomfort @ this time. ADL care given. Encouraged to ambulate ward. Dressing to (R) buttocks wet + dry CDI. Dsg to (L) hip wet + Dry CDI Ø active bleeding noted. Residual check of suprapubic cath and penis cont. clamped @ this time. IVF and ABx tx discontinued. Δ'd to PO meds. Will cont to monitor. [redacted]

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DATE	NOTES
17Oct03 1000-	Suprapubic catheter clamped for residual check void 250 cc per urethra into urinal. Foley to gravity unclamped 100 cc residual output. Cath left unclamped. Will cont to monitor (b)(6)-2 [redacted] (174Φ) I concur c above assessment (b)(6)-2 [redacted]
17OCT03 @1845	Per instructions by Dr [redacted] (b)(6)-2, pt's SP cath left to drain to foley bag. Will retry bladder training tomorrow. (b)(6)-2 [redacted]
17OCT03 2300	assumed care of pt @1800. VSS, c/o abd pain. percs given c good relief noted. Alert, speaking arabic. TSCTA, Φ BS x4 quads, tol reg diet well. LUQ stoma s drainage covered c disp. RLQ colostomy c brown semi-solid stool. Ostub clamped. SP cath to foley bag c clear yellow urine. Voiding through urethra at times, approx 100-200 cc ea void. Tube care provided: (R) buttocks wound s (L) hip wound drsgs Δd WTD, both c brown drainage noted on drsgs. (L) inner thigh wound OTA. PAT amb s assistance in hallway. Pt demonstrating good colostomy care. Plan: monitor pain control, monitor GI status, 2pt restraints m s s/sx of skin/circulation compromise. (b)(6)-2 [redacted] CPT

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DATE	NOTES
18 Oct 03 0700	-Assumed care of pt. A+O x 3. C/O pain to abdominal area lungs clear, HRRR. Active BS tolerating PO well Colostomy site beefy red vascular. able to do self care without assistance. Inactive stoma (L) side ∅ drainage minimal oozing dressing applied. Dsg to (R) buttock wet → dry stage II increased ambulation Q2° position changes to promote proper healing. (L) hip stage II healing wet to dry dsg intact. Superpubic cath to gravity light yellow urine. Also voids per urinal through his urethra. Resume residual checks today. strict I+O's will cont to monitor (b)(6)-2 [redacted]
1	(1455) I concur c above assessment. (b)(6)-2 [redacted]
18 Oct 03 @2330	assumed care of pt @ 1800. VSS. C/O small amt of abd pain controlled c Percocets. LS CTA, (+) BS, tol reg diet c good appetite, void per SP cath / urethra. Instructed by Dr [redacted] to clamp SP cath & monitor voids. See I+O's sheet. Minimal residual noted @ this time. LUQ stoma c drsg & no output; RLQ colostomy c brown semi-formed stool. Vaseline gauze drsg to LUQ ostomy. G tube clamped WTD drsg to (R) buttocks & (L) hip, greenish drng noted from both wounds. (L) inner thigh normal CTA, encrusted over, healing well. Tube care provided. Pt ↑ amb c difficulty. Pt demonstrating good ostomy care techniques. Pt restraint on c skin or circulation compromise. Plan: ↑ amb ↑ independence, PO ABX as ordered, monitor voids & residuals. (b)(6)-2 [redacted]
19 Oct 03 @0215	Residuals checked through night. (See I+O's). For 3 voids each had residual of <50cc after draining for 30 minutes. Will monitor. [redacted] (b)(6)-2

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DATE	NOTES
	[redacted] (b)(6)-2
	Cont ~~S/P~~ SP tube in place, colostomy bag intact, pt voiding in urinal c/y urine, dsg on abd CDI, medicated for pain c̄ 2 percs, 2 pt restraint in place s̄ s/Sx of complications.
	(b)(6)-2 [redacted] 9mm
	(b)(6)-2 [redacted]
21 oct 0700	- Assumed care of pt. A+O x3. VSS c/o pain medicated c̄ relief. Lungs clear. HRRR Active BS feeding tube to (L)UQ abdomen clamped tolerating PO well. Voiding QS clear yellow urine per urethra Residual checks cont' SP catheter remains clamped (L)Q of abdomen. Colostomy self care (R)UQ. Stoma (L)LQ. inactive vaseline gauze CDI Ø s/s of infection remains afebrile. Decub to (R) buttock (L) hip dsg Δ wet → dry CDI will cont to monitor (b)(6)-2 [redacted] 9mm.
21 oct 1400	- Notice pt is having minimal leakage around SP catheter removal site. 4x4 sponge dsg in place. Pt cont to void per urethra s̄ difficulty Ø evidence of bladder distention (b)(6)-2 [redacted] 9mm

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DATE	NOTES
21OCT.03 1900	Pt A+O x3, VSS, OOB to ambulate, self colostomy care, colostomy bag intact, (R) buttock + (L) hip dsg's Δ'd, (b)(6)-2 [redacted] ~~wounds~~ ulcers healing well, dsg's on abd CDI, J-tube LUQ clamped ø s/sx of infex, pain controlled c̄ percs, LS CTA (B), active BS, 2 point restraint s̄ s/sx of complications, (b)(6)-2 [redacted] 9IW
1915	Abd non distended soft [redacted], voiding s̄ diff c/y urine amount sufficient. Tol PO well. (b)(6)-2 [redacted] 9IW
	(b)(6)-2 [redacted]
22OCT03 (1210)	Assumed care of pt @ ~~0000~~ p̄ report from night shift. Pt alert, speaking Arabic. VSS. ø pain controlled c̄ percs. Pt OOB to BR for personal hygiene and amb in hallway s̄ difficulty. Wet → dry dressings to (R) buttock and (R) hip Δd. ø s/sx infection @ wound sites. Dsg to inactive stoma in LUQ Δd. Stoma pink and moist s̄ drainage noted. Colostomy bag intact - pt doing own colostomy care. Jevity tube feeding started @ 40cc/hr into J-tube in LUQ. J-tube flushed s̄ difficulty. ø s/sx complications from tube feeding. Pt tol. reg diet well. Voiding s̄ difficulty. 2 point restraints in place s̄ s/sx complications. Will cont. to monitor. [redacted] (b)(6)-2

STANDARD FORM 509 (REV. 5/1998) BACK

USAPA V1.00

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
22 OCT03	Assumed Pt care @ 1800. Pt A&O LS CTA (B)
2030	S_1 S_2 Present. (+) BS x4 quads. Stoma pink wet & ∅ s/sx of infection. Draining Brown loose stool. Tube feeding Jevity @ 40cc/hr. J tube flushed & Patent. Colostomy bag intact. Pt performs own care. Will continue to monitor [redacted] (b)(6)-2
2300 OCT03	(b)(6) Assumed care of pt w/ report from night shift. Pt alert, speaking Arabic VSS. Pain controlled c̄ Percs. Pt amb well. Colostomy bag Δd this am. drsg to inactive stoma CDI. Wet→dry drsgs to (L) hip, RUQ, and (R) buttock Δd. ∅ s/sx infection w/ wound sites. J-tube flushes s̄ difficulty. Jevity infusing @ 100cc/hr s̄ difficulty. Tol. reg diet well. Voiding s̄ difficulty. 2 point restraints in place s̄ s/sx complications. Will cont. to monitor. (b)(6)-2 [redacted]
24 OCT03	Assumed care of pt @ 1800 hrs. 23 OCT 03.
0020	Pt completed colostomy self care. LS CTA (B), S_1 S_2 present. (+) BS x4 quads. J tube flushed & patent sutured in (R) LQ. (−) s/sx of infection. Running Jevity feed @ 40 cc/hr. Drsg Δ'd to Buttocks, (L) hip & (L) RUQ Stoma. pain controlled

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME		MIDDLE	NUMBER

DATE	NOTES
24 OCT 03 cont.	percocet will continue to monitor [redacted] (b)(6)-2 Spc 91WM
24 OCT 03 0700	- Assumed care of pt A+O x3. VSS Ø c/o pain or discomfort @ this time. Lungs clear HRRR Active BS Good appetite Jevity to feeding tube ⓛUQ @ 40 cc/hr per alaris pump. Colostomy to ⓡUQ of abdomen self care stoma vascular beefy red. Urinating ad's ī difficulty ⓡ buttock stage II healing pink ⓛ hip stage II healing wet + dry dsg Δ CDI will cont to monitor (b)(6)-2 [redacted]
24 OCT 03 @2200	assumed care of pt @ 1800. VSS. c/o pain to ML abd incision, Percocets given ī good relief noted. ML incision healing well, RLQ colostomy ī brown liquid stool output; colostomy bag Δ'd D/+ leakage, new bag applied ī pt assist. LUQ stoma ī vaseline gauze, Ø output noted. G tube ī Jevity @ 40cc/h, tol well, Ø residual noted. Jevity bottle & IV Δ'd this pm. ⓡ buttocks & ⓛ hip dsgs Δ'd, skin and bowel drainage noted. Pt ↑ amb ī difficulty, 2pt restraints m̄ s/sx of skin/circulation breakdown. Plan: enc po intake, enc amb, enc independence. (b)(6)-2 [redacted]
25 OCT 03 @0800	Pt voided x3 ī total of 900 cc of clear yellow urine ī difficulty. Jevity cont @ 40cc/hr. (b)(6)-2 [redacted]
25 OCT 03 0700	- Assumed care of pt A+O x3. VSS Ø c/o pain or discomfort Lungs CTA HRRR Active BS Colostomy to ⓡUQ slight irritation to tape site redness. Instructed to leave of 15 mins q change. Self care, Urinating ad's per urinal ambulates ī difficulty to bathroom. ⓡ buttocks and left hip wet & dry dsg change CDI stage II healing well Ø s/s of infection will cont to monitor [redacted] (b)(6)-2

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
25 OCT 03 @ 2300	assumed care of pt @ 1800. VSS, no c/o. alert, speaking Arabic. LS CTA, ⊖ BS to/regdiet & Jevity @ 400cc/hr per GT tube. ⊘ residuals noted from G tube. RLQ colostomy ⊃ light brown liquid stool. LUQ ostomy ⊘ output noted, vaseline gauze dsg intact. Voiding per urinal ⊃ difficulty. Pt ↑ amb, during nsg colostomy care. ⓡ buttocks & ⓛ hip wound healing. greenish drainage noted from ⓡ buttocks wound. WTD dsgs completed. 2 pt restraints on while in bed ⊃ S/Sx of skin/circ. compromise. Pain: cont po Abx, ceu po intake, ceu Amb, ceu independence. Will cont. to monitor. — [redacted] (b)(6)-2
26 OCT 03 0700	Assumed care of pt. AO x3. VSS. Denies pain. Lungs CTA. HRRR. Active BS. colostomy to ⓛ UQ. Self care stoma vascular. ⓡ [redacted] (b)(6)-2 stoma inactive vaseline gauze 4x4 dsg in place. Feeding tube to ⓛ LQ of abdomen. Jevity 40cc/hr. Tolerates PO well good appetite. Urinating DS. per urinal ambulates ⊃ diff. Will cont to monitor — [redacted] (b)(6)-2
27 OCT 03 @ 1400	VSS. AO. S'd colostomy. Mouth & intact. S'd DSG's to ⓛ hip and ⓡ buttock. Both wounds diminished in size and pink. ⊖ s/s infection. Voiding light yellow urine quantity sufficient. S. skin intact ⓕ. Ambulated on ward x1 for 1° and performed colostomy care. [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME: LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)
				(b)(6)-2

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST N	NI	NUMBER

DATE	NOTES
27OCT03 @2140	assumed care of pt @ 1800. VSS. C/o ML abd pain. ML incision healed, RLQ colostomy c̄ brown liquid output, LLQ stoma covered c̄ vaseline gauze, due to be Δd tomorrow. Jevity @ 40cc/° per GT, tol well c̄ Ø residual. Ⓡ buttocks dsg; Ⓛ ~~buttock~~ ever hip wound healing, dsg Δd WTD, some green drainage noted to buttocks. Pt ↑ amb, tol well. Void per urinal s̄ difficulties. Plan: monitor enc po intake, monitor dsgs; TF. Pt restraints on s̄ S/Sx skin/circulation comp. MM monitor. (b)(6)-2 [redacted]
28 OCT 03 0700	Assumed care of pt - sleep yet easily arousable A+O x3. VSS Ø c/o pain or discomfort. Lungs CTA HRRR Active BS colostomy to Ⓡ Qua self care stoma varicular good appetite. Ⓡ buttock dsg Δ 4x4 wet to dry Ⓛ hip dsg change stage II healing Ø s/s of infection remains Afebrile Will cont to monitor (b)(6)-2 [redacted] Garage,
29oct03@	Assumed care @ 1900; AWVSS; pt A&O, pain controlled c̄ pr c's; All dsgs Δd Ⓛ drainage noted to hip, minimal drainage to buttock; pt performed own Colostomy care; Jevity to G-tube @ 40 cc/hr s̄ ~~[illegible]~~ complications; pt ~~[illegible]~~ to BR; Restraints in place, Ⓡ c̄ vac. Ⓛ skin breakdown ↓ cont to monitor (b)(6)-2 [redacted]
29OCT03@1600.	Assumed care of pt. @ 0600. V.S.S. except BP 95/46. Pt. encouraged to drink water, pt. compliant. G-Tube flushed, Jevity infusing @ 40cc/°. W→D DRSNG to Ⓛ hip & Ⓡ buttocks Δ'd; front drainage to old DRSNG. Colostomy intact. Pt. ambulates well, steady gait. Pt. medicated ~~to~~ [redacted] with ÷ (b)(6)-2 percocet for pain x 2. (b)(6)-2 [redacted] 2LT, AN
29OCT03@1800.	All other assessments WNL, pt. in 2 point restraints, Ø signs of skin breakdown. (b)(6)-2 [redacted] 2LT, AN

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

[redacted]

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES (b)(6)-2
29 OCT 03 2300	Assumed care of Pt @ 1800. Pt A&O / c/o Pain controlled c̄ percs. Pt completed [redacted] colostomy care. Wound to Buttock Δ'd Drsg t[redacted] (b)(6)-2 Drsg to (L) hip Δ'd. VSS. Will cont to monitor (b)(6)-2 [redacted] Spc 91WM6
30 OCT 03 @ 1400	Assumed care of pt. @ 0600, V.S.S. A&O, ∅ c/o of pain at this time. W&D DRSNG to (L) hip Δ'd, Scant drainage. W&D DRSNG to stage II decub to (R) buttock, moderate thick yellow drainage. Old stoma site cleaned & new petroleum gauze applied. New colostomy bag @ bedside. Pt. will Δ bag when old bag is full. Pt. ambulates well c̄ difficulty in hallway. All other assessments WNL. Pt. in 2-point restraints, ∅ signs of skin breakdown. Will cont. to monitor. (b)(6)-2 [redacted] 2LT, AN
30 OCT 03 @ 1440	Pt. given ⅓ Percocet for c/o pain. Pt. receiving feeding @ 40cc/° via PEG-tube. (b)(6)-2 [redacted] 2LT, AN
30 OCT 03 2200	Assumed care of Pt @ 1800. A&O. Percocet controlls pain. Drsg to R Buttocks Δ'd. Wound appears Red, granulated and Health. Drsg to L hip Δ'd. Wound is smaller than last Few days. All but ½ inch area is (b)(6)-2 [redacted] closed. Pt completed colostomy care. Ambulated For 20 min. J Tube Flushed + Patent. 40 cc's Jevity via J Tube. Will cont-

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.

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

PROGRESS NOTES
Medical Record

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

LAST NAME | FIRST N | T | NUMBE

DATE	NOTES
30 OCT03 cont	to Monitor. [redacted] (b)(6)-2 SGC 91WM6
31 Octo3	Assume care of PT @ 0600. A+O x3, VSS. C/O pain given 2 percocet. Ambulatory. Aed dsg on (L) hip c D.I and dsg on (R) side buttocks CDI. In 2pt restraint Ø signs of skin irritation. Will cont. to monitor. (b)(6)-2 91WSA [redacted]
1NOV03 @0245	assumed care of pt @ 1800. VSS, no C/O. alert, speaking Mandarin, LSCTA, (+)BS, colostomy c̄ chunky brown stool. RUQ stoma c̄ drsg CDI. (R) buttocks & (L) hip drsg Δ'd. GT clamped. Pt states (through interpreter) that MD said to stop TF. Pt refuses to let staff connect TF. Pt voiding per urinal. S/ dyspnea. 2pt restraints in wheelchair S/sx of skin/circulation compromise. Plan: pain control, monitor drsgs, clarify TF order MD. [redacted] (b)(6)-2
1NOV 03 0200	Assumed care pt. A+O x3. VSS Ø c/o pain or dis-comfort. Ambulating per ward s difficulty. Lungs clear HCK Active BS good appetite colostomy. (R) UQ stoma unscular self care. feeding tube to (L) abdominal wall clamped. (R) buttock and (L) hip stage II decub healing well. Ø s/s of infection Will cont to monitor (b)(6)-2 [redacted] Sgt.
2NOV @ 0200	assumed care of pt @ 1800. VSS, no c/o. (L) hip & (R) buttocks drsg Δ'd, healing well. LUQ stoma c̄ vaseline drsg, CDI. RLQ colostomy c̄ brown semi-forme stool, colostomy bag Δ'd. GT clamped. Tol regular diet well. ↑ amb to BR & in hallway s difficulty. 2pt restraints no S skin compromise. Plan: monitor pain, cont. enc independence [redacted]

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

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

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER | TREATMENT FACILITY [redacted] (b)(2)-2

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

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

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)* 4 Oct 03 | TIME 1905

TRANSPORTATION TO FACILITY medical

SEX: M

AGE: 24

DUTY/LOCAL PHONE: AREA CODE | NUMBER

HOME PHONE: AREA CODE | NUMBER

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			

MEDICAL HISTORY OBTAINED FROM

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS: ϕ

ALLERGIES: NKDA

INJURY OR OCCUPATIONAL ILLNESS

ITEM	YES	NO	WHEN *(Date)*
IS THIS AN INJURY?			
INJURY/SAFETY FORMS			WHERE
HOW			

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: med otx ϕ; svs HR ϕ

CATEGORY OF TREATMENT

☐ EMERGENT
☒ URGENT
☐ NON-URGENT

TIME: 1905

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

VITAL SIGNS

TIME	1905	~~0030~~	2330	0000	0030
BP	111/64	~~95/66~~	107/68	98/60	95/66
PULSE	88	~~80~~	62	78	80
RESP	16	~~19~~	18	18	18
TEMP	98.6		98.4	98.4	98.5
WT					

LAB ORDERS

☒ CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT
URINE C&S	☒ UA MSCC/CATH		☒ CHEM: Mixed
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 100% ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
2230	Fentanyl 50 mcg IV	[redacted]	[redacted]		(b)(6)-2
0000	Fentanyl 50 mcg IV				
0200	Fentanyl 50 mcg IV				
0300	Fentanyl 50 mcg IV				

DISPOSITION: ☐ HOME ☐ FULL DUTY

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

MODIFIED DUTY UNTIL | RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE | TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

[redacted] EPW

(b)(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

NSN 7540-01-075-3786

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

TEST RESULTS

CBC	SMAC	ABG/PULSE OX	RADIOLOGY
WBC H/H PLT	Na | Cl | Bun / Glu K | CO_3 | Cr	SUP 02 · PH · P02 PC02 · SAT · OTHER	Check if read by radiologist ☐ RESULTS
PT		U/A: DIP	EKG INTERPRETATION
APTT	BHCG · ETOH · GLU	U/A: MICRO	

PROVIDER HISTORY/PHYSICAL

24 y/o Iraqi ♂ here for eval c̄ LTC [redacted] (b)(6)-2

WBC / Hb / Hct / Plt

See H&P

Procedure: Central line   Sterile procedure
Indication: abd abscess/peripheral difficulty
(R) subclavian: prepped x3 (povidone iodine/alcohol/iodine). placed c̄ some difficulty
V ly cleared, Line draws easily/flush is positioned. [illegible] TC.

[redacted] (b)(6)-2

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

DIAGNOSIS

CODES

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

[redacted] (b)(6)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4 Oct 03	0700		Pt ambulated to back to bathe himself, emptied 150cc semi-solid stool from ileostomy. R/U no longer patent, new 20G started to (L) FA. Pt drank 650cc fluid for breakfast - NG canister emptied (full) assessment performed (see DA4700). Will monitor - plan to evac to Baghdad then possibly Balad for TPN [redacted] SGT/LPN
	0900		Pt ambulated outside for a few minutes, upon returning c/o severe pain. MD @ bedside - 10mg MSO4 given IV - Will monitor for relief. [redacted] SGT/LPN (b)(6)-2 (b)(6)-2
	1100		All dressings Δd, pt Δd own ileostomy bag - emptied 50cc liquid stool, VSS - will monitor [redacted] SGT/LPN
	1300		Pt ambulated to get another Xray done - ate (drank) all of lunch. Pt c/o pain - 4mg MSO4 given. [redacted] SGT/LPN (b)(6)-2 (b)(6)-2
		1500	Pt resting ≤ c/o pain [redacted] SGT/LPN (b)(6)-2
		1700	Pt put on E-mycin IV q8° - Δd times for 7 days - First dose hung. Pt ≤ c/o pain or nausea. Will monitor. [redacted] SGT/LPN (b)(6)-2
		1730	Pt being transferred to Baghdad via litter - NG clamped. [redacted] SGT/LPN (b)(6)-2
6 OCT	CT Procedure		
1400.	(L) paracolic abscess drainage catheter placed w/o complication. 30cc serous, cloudy aspirated to Microbiology for culture. EBL ∅ Anesthesia: 20cc 1% lidocaine. No complications [redacted] (b)(6)-2 (b)(6)-2

OP [redacted]

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

STANDARD FORM 510 (REV. 7-91) BACK

MEDCOM - 21024

(b)(6)-2

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY: 5 OCT

MONTH-YEAR / DAY: 19 / 7 Oct / 8 Oct / 9 Oct / 10 / 11 OCT

HOUR: 0700 / 1130 / 0900 / 1130 / 0800 / 1130 / 1130 / 1130

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

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

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

VITAL SIGNS RECORDS

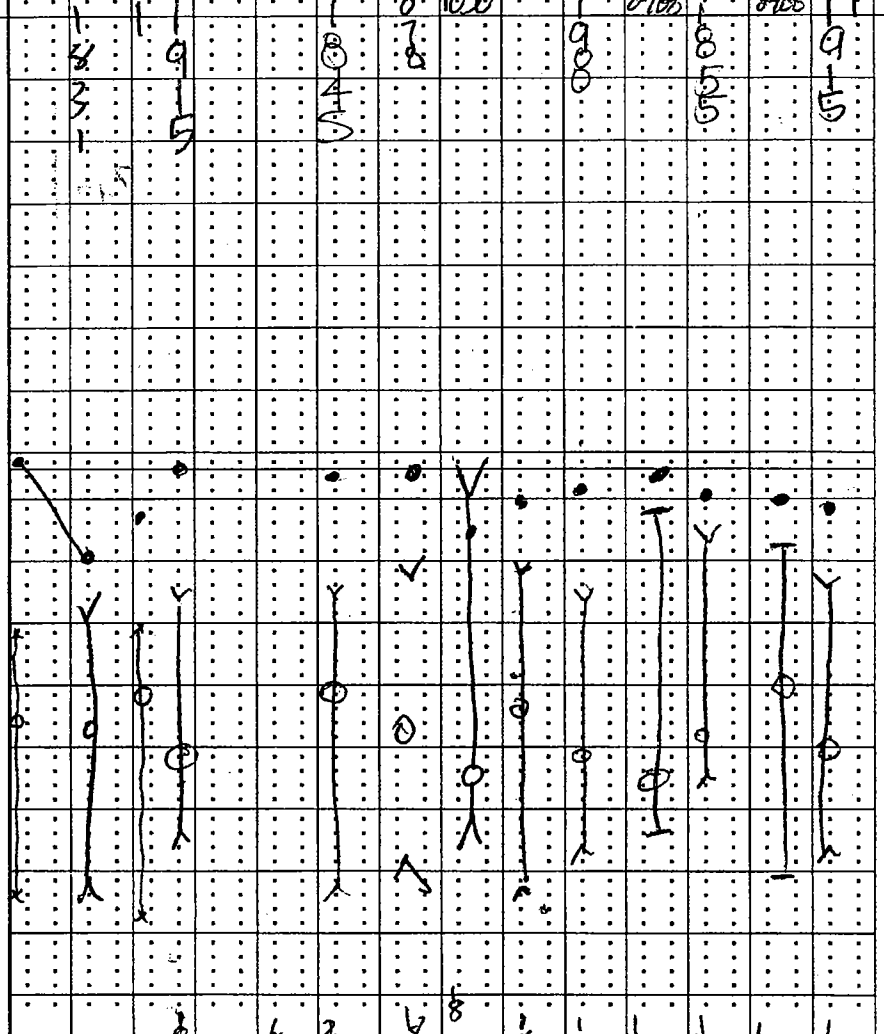
Medical Record

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY										
POST- DAY										
MONTH-YEAR OCT 03	DAY	12	13 OCT	14 OCT	15 OCT	16 OCT	17		18	
19	HOUR									

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



RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																		
POST- DAY																		
MONTH-YEAR OCT	DAY	19		20		21				22		23		24				
1992003	HOUR		1		20	0200	20			8	2	0	1	0	1			
PULSE (0)	TEMP. F (°)		3								0	7	8	1	9		TEMP. C	
	105°		8								0	0	0	3	8		40.6°	
180	104°													0	0		40.0°	
170	103°																39.4°	
160	102°																38.9°	
150	101°																38.3°	
140	100°																37.8°	
130	99°																37.2°	
	98.6°																37.0°	
120	98°																36.7°	
110	97°																36.1°	
100	96°																35.6°	
90	95°																35.0°	
80																		
70																		
60																		
50																		
40																		
RESPIRATION RECORD		16	8	8		16				8		14		12	18			
BLOOD PRESSURE		104/57	108/60	110/62	101/55	96/52	115/68			104/57	102/58	108/54	109/66	102/46	109/62			
		H 109		T 97	71	H 83	88				73		74					
		T 98°		H 84	97	T 98°	97				97.2		98					
HEIGHT: WEIGHT →		99%				99%					99%	98%	99%	99%	98%			
		RA		99%	99%	RA	98%			99 (RA)					RA			

(Centigrade Equivalents, for Reference only)

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY										
POST- DAY										
MONTH-YEAR	DAY	25	26	27	28	29	30	31		
19	HOUR	0200			0200					

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

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

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

RESPIRATION RECORD

	25	26	27	28	29	30	31
	18	18	18	18	14	14	14

Record special data only when so ordered

BLOOD PRESSURE	25	26	27	28	29	30	31
	111/59	109/66	115/58	93/42	93/45		91/37
	82	66	119/67	H 66	73		98.1
	98	98°		T 97°	98.1		76
HEIGHT: / WEIGHT →	92%	99%	97% 99%	95%	99%		
	RA	RA	RA	RA 97%	98% RA	92 RA	98%

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

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 NOV	DAY	2		2												
2003	HOUR															
PULSE (0)	TEMP. F (•)															TEMP. C
	105°															40.6°
180	104°															40.0°
170	103°															39.4°
160	102°															38.9°
150	101°															38.3°
140	100°															37.8°
130	99°															37.2°
	98.6°															37.0°
120	98°															36.7°
110	97°															36.1°
100	96°															35.6°
90	95°															35.0°
80																
70																
60																
50																
40																
RESPIRATION RECORD																
BLOOD PRESSURE																
HEIGHT:	WEIGHT →															
		02505	78%													
		Source	RA													

(Centigrade Equivalents, for Reference only)

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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VITAL SIGNS RECORDS

Medical Record

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

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ____ HOURS TO ____ HOURS | TOTAL HOURS COVERED | DATE 60ct03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
	Jevita TF		
↑1500	300cc/hr		
0600	450cc total		

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
1800		LR@75	12°shift	=	900cc
0600cc 0600		RL @ 75			1000 cc
		LR@75			900
					1900

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
50ct03 2200	NGT irrigation	30cc	30cc
60ct03 0200	NGT irrigation	30cc	60cc
60ct03 0600	NGT irrigation	30cc	90cc
60ct 1800	NG irrigation		60cc total
	NG irrigation x3/30cc		90cc
			150cc total

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

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OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
60ct03 0530	FOLEY 500cc	500cc			
60ct 1500	Foley	700cc			
70ct 0500	Foley	650			
		1850			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL
0545	1200cc	Dark Green Brown liquid	1200cc out
60ct03 1500	80	dark green	
70ct 0500	1000	dark green	1050

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS Abscess drain

TIME	AMOUNT	TYPE	ACCUM TOTAL
1600	150	bright yellow	150
70ct 0500	200	yellow	350

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL
60ct03 0130	green-brown	Loose c̄ chunks	600cc	600cc
60ct 1500	green brown	bron liquid	600cc	600cc
70ct 0500	brown	liquid	500	1100

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL
~~2300~~	~~10cc~~	Residual	
~~0000~~	~~20~~		
0500	10cc	11	20cc

GRAND TOTAL OUTPUT

06 70ct 10cc (total) 10cc

REMARKS

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

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

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 792, JAN 74

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM 00 HOURS TO 06 HOURS | TOTAL HOURS COVERED 24 | DATE 70CT03 - 80CT03

INTAKE

~~ORAL~~ Jevity

TIME	TYPE	AMOUNT	ACCUM TOTAL
0600	Jevity	30cc/hr	210
	d/c @ 1300		

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0600	75cc/hr	LR	900	1800	900
1000	100	Cipro	100	1100	1000
1200	100	Tagament	100	1300 ~~1100~~	1100
1800	100	Tagament	100	100	1200
2300	100	Tagament	100		1300
0600	100	Tagament	100		1400
LR 18	06	LR	900		2300

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
10	30 H_2O	30	30
14	30 H_2O	30	60
18	30 H_2O	30	90
22	"		
02	"		
06	"		180cc

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

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OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
1300	900	900			
1700	350	1250			
0500	350	1550			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL
1300	900	Green	900
1700	200	Green	1100
0500	300	greenish	1400

~~CHEST~~ Colostomy

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
1300	200	200			
1700	150	350			
0500	150	500			

~~EMESIS~~ Abscess

TIME	AMOUNT	TYPE	ACCUM TOTAL
1300	100	bile color	100
1700	400	bile color	500
05	350	green, chunks	850

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL
GRAND TOTAL OUTPUT			

REMARKS

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

[redacted] (b)(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 792, JAN 74

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM 00 HOURS TO 00 HOURS | TOTAL HOURS COVERED 24 | DATE 8-9 OCT 03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1900	water	200	200
1930	broth	120	320
0030	broth	120	440

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
1600	75cc/hr	LR	900	1800	900
1000	100	Cipro	100	1100	1000
1200	100	Tagamet	100	1300	1100
1800	100	Tagamet	100	1930	1200
2200	100	Cipro	100		1300
24	100	Tagamet	100		1400
06	100	Tagamet	100		1500
06	75cc/hr	LR	900		2400

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
10	Water	30	30
14	Water	30	60
18	Water	30	90

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

Jevity

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
1900	Jevity @ 30cc/hr	330cc	330cc

GRAND TOTAL INTAKE

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

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
1700	850	850			
0500	400	1250			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL
1700	450	Greenish	450
1900	100	green	550
		d/cd	

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS colostomy

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL
1700	~~350~~ green	liquid	350	350
05	"	"	200	550

OTHER OUTPUT Pigtail Abscess

TIME	AMOUNT	TYPE	ACCUM TOTAL
05	200	green/yellow	200
		daysheet ??	
		GRAND TOTAL OUTPUT	

REMARKS

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

[redacted] (b)(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 792, JAN 74

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET	FROM 00 HOURS TO 00 HOURS	TOTAL HOURS COVERED 24	DATE 9OCT1000

INTAKE

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

IRRIGATIONS *(N/G, Bladder, etc.)*			
TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

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

Jevity OTHER INTAKE			
TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0600-1800	Jevity (+) 30cc°	360	360
1800-0600	Jevity 3cc°	360	720
GRAND TOTAL INTAKE			

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

OUTPUT

URINE (Foley)

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0600-1200	900	900			
1200-1700	200	1100cc			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS Colostomy

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT Abscess Drain

TIME	AMOUNT	TYPE	ACCUM TOTAL
0600-1800	125	Cloudy brown drainage	125cc

GRAND TOTAL OUTPUT

REMARKS

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

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

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 792, JAN 74

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ____ HOURS TO ____ HOURS | TOTAL HOURS COVERED | DATE 13-OCT03

INTAKE

~~ORAL~~ (G-TUBE)

TIME	TYPE	AMOUNT	ACCUM TOTAL
12 OCT @ 0300	GTUBE (residual)	3CC	
1300	18-06 —	2CC	
1300	18-06 Jevity @ 300cc/h —	360cc	
	(residual = 5cc @ 2200)		
	residual = 2cc @ 0500		
	7cc total		

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
18-06	75cc/h	LR	900	06	900

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
~~2000~~ 1300	FLUSH GT	20cc	20cc
0500	" "	20cc	40cc

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

OUTPUT

URINE						NASOGASTRIC			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL
13 2100	1500	1500							
14 06	900	2400							

CHEST						EMESIS			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS colostomy

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL
3CCT 2000	brown liq	—	200	200
01000	"		300	500

~~OTHER OUTPUT~~ pigtail abscess

TIME	AMOUNT	TYPE	ACCUM TOTAL
18 06	75cc	green	75cc

GRAND TOTAL OUTPUT

REMARKS

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

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 792, JAN 74

MEDCOM - 21039

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM 06 HOURS TO 06 HOURS | TOTAL HOURS COVERED 24 | DATE 14OCT03 15OCT03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
2100	Ensure	200	
1830	H_2O	100	300
0100	H_2O	100	400

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
18-06	75cc/°	LR	900	06	900
2200	100cc	Cipro	100		1000
2400	100	Tagamet	100		1100
06	100	Tagamet	100		1200

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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