[redacted] b(6)(4) Date: 11OCT

11OCT03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																							155/86	146/64	163/74	
NBP																										
TEMP																							97.1		97.8	
HR																							101	103	105	
RR																							21	22	21	
SaO2																							100	99	98	
FiO2																										
Source																							[redacted]			
MAP																							100			

b(6)(2)

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
IV																							125	125	125	
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE																							50	150	200	
GT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 21241

RECORD-SUPPLEMENTAL MEL

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

OTSG APPROVED (Date) QA Appr 8 Mar 89

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

SHIFT ASSESSMENT

		TIME: 0700 INITIALS: [redacted]	TIME: 1900 INITIALS:
NEURO	PUPILS	+2 PERRLA b(2)-2	PERRLA 3mm brisk
	SENSORIUM	A&O x3	A&Ox3, moves independently
	EXTREMITY MOVEMENT	purposeful movement x4	independent
	SEDATION	MSO4 2-8 NP 92° pm Pain	
	PAIN CONTROL	Pain Controlled c̄ MSO4	MSO4, Percocets
RESP	RESPIRATORY PATTERN	RR - 22 SPO2 - 96 on RA	RRR
	BREATH SOUNDS	Lung Sounds - CTA (B)	CTA B
	SECRETIONS	Ø secretions	Ø
	O2 SOURCE/FLOW/SAO2	Ø O2 - RA	RA > 95%
	VENTILATOR SETTINGS	Ø Vent	NA b(2)-2
CV	CARDIAC RHYTHM	HR - 121 BP - 159/67	RRR [redacted] ST, S1/S2
	CAPILLARY REFILL	Capillary Refill - ≤3sec	<3 sec x4
	PULSES	+4 Peripheral Pulses	+2 x4
	EDEMA	↓ Edema in Lower extremities	Ø
GI	ABDOMEN	Soft Flat Non tender Non distended	Sof, flat, nontender
	BOWEL SOUNDS	Bowel Sounds -> Hyperactive x4	(+)
	BOWEL MOVEMENT	Ø @ Present	(-)
	NGT/OGT	Ø NGT	NA
	TUBE FEDDINGS	Ø Tube feedings	NA b(2)-2
	DRAINS	Ø drains	NA [redacted] (L) Fem Hemovac
GU	VOIDING	Foley to gravity	Foley to gravity
	COLOR/CLARITY	Clear Yellow Urine Q.S.	Clear, Yellow
SKIN	COLOR	Normal For Race	Normal for Race
	INTEGRITY	No skin breakdown	Drsg to LLE CDI
		P/O For left knee Fx (open)	
ACCESS	#1 TYPE/LOCATION/SIZE	IV in Left Hand infusing NS. @	PIV (L) Wrist | (R) FA
	DRESSING CONDITION	125 c/hr ~~[illegible]~~ Flushes well No S/S	CDI | CDI
	IV FLUID/RATE	of infection, infiltration	NS @ 125cc/h | HL
	#2 TYPE/LOCATION/SIZE	A-Line in (R) wrist to monitor	A-Line (R) Radial
	DRESSING CONDITION	Reading well —	
	IV FLUIDS/RATE		NA

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC ICU #1, [redacted] b(2)-2

DATE 11 OCT 03

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

NAME: [redacted] b(6)-4 RANK: — AGE:

UNIT: [redacted] EPW GENDER:

STATUS: US: AD / CIV IRAQI: CIV / EPW

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

MEDCOM - 21242

DA FORM 4700, MAY 78

ICU1

Patients Name: [redacted] b(6)-4 EPW

Date: 11 OCT 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05
A-Line	↑	145/65		148/64		146/63		133/65		138/64		118/60		114/60	114/65	133/60	134/67	130/67	126/58	124/55	128/66	124/58	121/55	125/60	125/60
NBP [redacted]	157/78																	118/68							
TEMP	100.3			102.9		102.0		101.0		101.5		99.6				100.3								98.8	
HR	126	134		156		141		136		137		135		131	133	131	126	123	130	126	126	140	122	126	120
RR	37	17		21		28		31		21		19		22	13	26	20	21	24	16	32	12	18	16	18
SaO2	98	96		97		95		94		97		94		98	95	94	95	97	98	97	97	95	97	96	95
FiO2																									
Source	RA	RA		RA		RA		RA		RA		RA		RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
[redacted]																									

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
IVF	125	125	125	125	125	125	125	125	125	125	125	125		125	125	125	125	125	125	125	125	125	125	125	125	150
IVPB	50								50									50								50
NGT																										
[redacted]																										
		350	300	240	250	250	250	500	240	200	0	0		0		200			250			300		250		90
Total																										

TPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE	330	180	180	180	130	180	100	120	150	100	120	120		120 / 120	150 / 270	100 / 370	180 / 550	140 / 690	150 / 840	180 / 1020	200 / 1220	150 / 1370	150 / 1520	150 / 1670	150 / 1820	
NGT																										
STOOL																										
DRAIN																										
Leg →														300												
Total																										

MEDCOM - 21243

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA APPR 08MAR8

INITIAL SHIFT ASSESSMENT

		Time: 0700 Initals: [redacted]	Time: 2100 Initals: [redacted]
NEURO	Pupils	b(6)-2	b(6)-2
	Sensorium	A&O x3	A&O x3
	LOC / GCS	Purposeful movement, Follows Commands	Follows simple commands
	Meds →	MSO4 2-8 IVP q 1°	Percocet & MSO4
CARDIAC	Cardiac Rhythm	HR- 130 BP 121/72	RRR
	PRI: / QRS:		
	Pulse Strength	peripheal pulse - Strong x4	+2 pulses
	Cap Refil / JVD	Cap Refill - ≤3sec Ø JVD	cap refil ≤3 sec / Ø JVD
	Edema	Slight Edema	Slight edema
	Chest Pain	Ø chest pain	Ø chest pain
RESP	Respiratory Pattern	RR - 28 SPO2 - 95% on RA	RR 25-30 SPO2 97%
	Breath Sounds	Lung Sounds - CTA (B)	Clear Bilat
	Secretions	Ø secretions Ø cough	Ø
	Cough	Incentive Spirometer 10x q 1°	
SKIN	Color	Normal for Race	NTR
	Integrity	(L) Leg ORIF Dressing CDI	(L) LE ORIF c̄ hemorrac
	Backside	Ø breakdown	Drsg CDI
IV	Access Devices	I.V. to (L) wrist infusing N.S. @	PIV (L) wrist - Heplock
	Location	125cc/hr Flushes well	
	Condition	No S/S of infection - infiltration	
GI	Abdomen	Soft Flat Non-tender Non-	Soft, Non distended
	Bowel Sounds	distended BS- Normoactive	normoactive
	Stoma/Ostomy	Ø ostomy Ø stoma	Ø
GU	Device	Foley to gravity	Foley to grav
	Color / Clarity	dark yellow urine C.S.	dark yellow

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC: ICU3, [redacted] b(2)-2

DATE: 12 oct 03

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

[redacted] EPW b(6)-4

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

DA FORM 4700, MAY 78

USAPPC V2.00

Patients Name: EKW[redacted] b(6)-4 Date: 14 OCT US

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	125/72			134/64			124/61			126/57				129/64				120/71								
TEMP	99.4			99.6			100.8			100.2				99.7				100°								
HR	130			129			134			121				122				121								
RR	28			19			29			19				26				18								
SaO2																										
FiO2	95			95			96			95				96				97%								
Source	RA			RA			RA			RA				RA				RA								
MAP																										

TAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
	125	125	125	125	125	125	125	125	125	125	125	125		125						hourly						
B	50																									
PO	250	250	250																							
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE	125	120	200	200	200	200	200	300	300	400	360	150		150											2000	
NGT																										
STOOL																										
DRAIN	40																									
Total																										

MEDCOM - 21245

RECORD-SUPPLEMENTAL ME TA

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

OTSG APPROVED (Date) QA Appr 8 Mar 89

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

SHIFT ASSESSMENT		TIME: 0700 INITIALS: [redacted]	TIME: INITIALS:
NEURO	PUPILS	PERRL b(6)-2	
	SENSORIUM	A&O x 3	
	EXTREMITY MOVEMENT	purposeful movement x 4 Follows	
	SEDATION	Commands Ø Sedation	
	PAIN CONTROL	MSO4 2-8m IVP q1° prn pain	
RESP	RESPIRATORY PATTERN	RR- 28 SPO2- 97% on RA	
	BREATH SOUNDS	Lung sounds CTA(B)	
	SECRETIONS	Ø secretions	
	O2 SOURCE/FLOW/SAO2	Ø O2	
	VENTILATOR SETTINGS		
CV	CARDIAC RHYTHM	HR- 121 BP- 129/57	
	CAPILLARY REFILL	Capillary Refill ≤ 3 sec	
	PULSES	peripheral pulse: strong x4	
	EDEMA	Swelling noted to Extremities	
GI	ABDOMEN	Soft Flat Non tender	
	BOWEL SOUNDS	BS- Normoactive x 4	
	BOWEL MOVEMENT	Ø B.M.	
	NGT/OGT	Ø NGT Ø OGT	
	TUBE FEDDINGS	Ø Tube Feedings	
	DRAINS	Ø Drains	
GU	VOIDING	Voiding per Foley to gravity	
	COLOR/CLARITY	clear yellow Q.S.	
SKIN	COLOR	Normal for Race	
	INTEGRITY	S/P ORIF (L) Knee/Femur	
		No skin breakdown	
ACCESS	#1 TYPE/LOCATION/SIZE	IV in (L) wrist Heplocked	
	DRESSING CONDITION	No S/S of infection CDI	
	IV FLUID/RATE		
	#2 TYPE/LOCATION/SIZE		
	DRESSING CONDITION		
	IV FLUIDS/RATE		

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC
ICU #1 [redacted] b(2)-2

DATE

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

NAME: [redacted] b(6)-4 RANK: AGE:

UNIT: GENDER:

STATUS: US: AD / CIV IRAQI: CIV / EPW

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

MEDCOM - 21246

DA FORM 4700, MAY 78

ICU1

Patients Name: [redacted] b(6)-4 Date: 13 OCT

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05
A-Line																									
NBP	124/57			147/54			124/63																		
TEMP	98.7			99.9			100.1																		
HR	121			144			111																		
RR	28			18			21																		
SaO2	97%			100			99																		
FiO2	/			/			/																		
Source	RA			RA			RA																		
IV																									

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Tota
IVF	Heplocked																									
IVPB	50																									
NGT																										
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Tota
URINE	200	200	200	300 300		⊕ 100			1000			600														
NGT																										
STOOL				⊕																						
DRAIN	10cc																									
Total																										

MEDCOM - 21247

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

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

b(6)-4

1. Register Nbr	2. Name	3. Grade	Admission Remarks
[redacted]	[redacted]	FGN	

4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm
M	23Y	X	ISLAMIC			NO

11. FMP	12. SSN	13. Organization	14. Ward
99	[redacted]		ICW1

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

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	17:43	AEA - ORTHOPEDICS

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

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-10-06	[redacted] b(6)-2

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
[redacted] b(2)-2	2003-10-06	

31. Selected Administrative Data

Marital Status: DoB: [redacted] b(2)-4

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

L FEMUR FX W/ EX FIX,

DX: 82111
E9912

PX: 7965
7815
7865
7935

Trauma
9

Injury
569

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	9	9

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	9	9

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

[redacted]

MEDCOM - 21248

[redacted]

Automated Facsimile - DA FORM 3647, May 79

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

23 y/o ♂ collecting scrap metal outside Fallujah, shot by American forces. Taken to FST today.
IED ex fix

PMHx: ø
PSHx: ø
MEDS: ø
Allergies: NKDA
SocHx: ø TAB
FamHx: ø

PHYSICAL EXAMINATION

HEENT: WNL
chest: CTA
CVS: S1 S2
ABD: soft
Back: NT ø tenderness
Ext: 5x5 cm anteromedial thigh wound, open, Ex fix in place
lateral wound closed, compartment soft, 2+DP/PT, 5/5 EHL/FHL

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

(A) open (L) femoral shaft Fx ø Ex Fix

(P) Admit.

b(2)-2 b(2)-4

SIGNA[redacted]	DATE 10-6-03	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]			

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

CHRONOLOGICAL RECORD OF MEDICAL CARE

MEDICAL RECORD

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	SEX: M AGE: 23 WGT: 68 Kg HGT: 5' 7"
	ASA: (1) 2 3 4 5 E
	ALLERGIES: NKA
	CURRENT MEDICATIONS: Ø
	PROPOSED SURGICAL PROCEDURE: Ex Fix (L) Femur
	PAST MEDICAL HISTORY: Ø
	AIRWAY: Intact Mallampati (1) 2 3 4 Dentition Status: Intact
	RESPIRATORY: BBSH
	CARDIAC: $S_1 S_2$
	RENAL: Intact
	ENDOCRINE: Intact
	PROPOSED ANESTHESIA TECHNIQUE: General
	DISCUSSION OF RISKS AND BENEFITS:
	ANESTHESIA PROVIDER: [redacted] b(6)-2

HOSP[redacted] b(2)-2	STATUS	DEPART./SERVICE Anesthesia b(2)-2	RECORDS MAINTAINED A[redacted]WA
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR [redacted]	REGISTER NO. / WARD NO.

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(2)-4

MEDCOM - 21250

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

USAPA

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6 Oct 03	Admit to ICU Diagnosis: (L) femur fx V. Sigs: Persistent Allergies: NKDA Nursing: Reinforce dressing prn Diet: NPO IVS: 0.9 NS at 200 cc/hr Meds: Toradol 15 mg IV Q8° pm prn MSO4 2-4 mg IVP Q2° pm prn Special: Ensure check Pt needs assured quiet Pt needs independent [redacted] MAJ, MC b(6)-2 [redacted]

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

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

Iraqi Nat'l

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | b(6)-2 **PROGRESS NOTES**

DATE	NOTES
6OCT03 2300	Pt admitted to ICW#1, VSS, BP-122/63 P-84, T-98.3 R-20 SpO2% 98%, IV (D) hand intact infusing D 5½ NS @ 125cc/hr, Ex Fix to (L) thigh in place, dsg on (L) thigh covered ≈ ACE wrap, blood tinged around bottom pins, JP drain to LLE draining blood [redacted], foley to gravity draining c/y urine, Strict I's +OS, foley to be d/c in AM, pain controlled ≈ percs, LS CTA (B), (+) BS x4, S1 S2 present, able to move toes, cap ref <3 sec, pedal pulses equal (B), 2 pt restraint in place, ∅ s/sx of poor circulation or skin breakdown. [redacted] b(6)-2 [redacted]
7OCT03 0500	VSS Q4hrs & Q2hrs. (L) hand IV Saline lock. Pt consumed 85% of Breakfast. Lungs clear Bilateral. BS(+) x4 quadrants. Abd soft non distended. JP to LLE draining sanguinous fluids. Percocet given as schedule and effective for pain. Peripheral pulses +2. Capillary refill to (L) & (R) toes <3sec. Wound care as planned

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR NUMBER (SSN)
	LAST	FIRST	MI	[redacted]

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	
		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)*

b(6)-4

[redacted]

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 b(6)-2
7 Oct 03 1600	Voided 400 cc of amber clear urine without difficulty [redacted]
7 OCT 03 @2200	assumed care of pt @1800. VSS c/o pain to LLE, especially c̄ movement. Alert, speaking, Audibic, LSCTA, ⊕ BS, voiding per urinal s̄ difficulty, refusing OOB to AMBI crutches. LLE c̄ femur ex-fix, Kerlix wrap dsg c̄ sm amt of serosanguinous drainage around lower part of ex-fix. ⊕ CMS to LLE, ⊕ DP & ⊕ popliteal pulses +2. SP c̄ sanguinous drng, see I&O sheet for quantity for shift. Plan: monitor pain control & monitor IV status. npo pMN for SX tomorrow. 2pt restraint on s̄ S/SX of ~~infection/infiltration~~ SKIN or circulation compromise. [redacted]
8 Oct 03 0500	Return from PACU via stretcher alert & oriented USS. Transferred from stretcher to bed with max assist. Lungs clear Bilateral, BS ⊕ x4 quadrants Peripheral pulses palpable +2. (L) LE dsg dry & intact (L) exter fix in place. pin sites w/o drainage or crusting (L) IV Saline lock patent & intact. (L) lower extremity ⊤ on folded blanket Pt rests c̄ eyes closed. Will continue plan of care. b(6)-2 [redacted]
8 OCT 03 2100	assumed care of pt @1800. c/o pain to LLE, percocet given c̄ good relief noted. ⊕ CMS to LLE, ex-fix c̄ dsg c̄ sm amt serosanguinous drng noted. toe reg diet, voiding s̄ difficulty. ⊕ FA SR pushes well CONTD

STANDARD FORM 509 [redacted]
b(6)-2

MEDICAL RECORD | **PROGRESS NOTES**

DATE

6 OCT 03
1210 PT Enters E.R. with gunshot wound to Left thigh PT Alert PT Arrived with Bandage and split to (L) thigh PT had IV In (R) ARM N/S 1000 ml

12:15 B/P 125/65 P 104 R 18 T SPO2 100%

12:20 B/P 114/71 P 86 R 16 SPO2 100%

Allergies: Ø
Meds Ø
Hx Ø
FHX: Heart Dad Diabetics mom
SUR: Ø
Smoke (+)

PT given IV 1000 mL to (L) Hand ~~Pt given morphine 5 mg~~
PT given 1g Ancef At 1235
PT given 5mg morphine At 1225
EXRAYS Taken At 1245 of (L) thigh
PT give Morphin 5mg At 1245

1250 BP 130/56 HR 77

(Continue on reverse side)

REGISTER NO. | WARD NO.

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

[redacted] b(6)-4

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR, FPMR (41 CFR) 101-11.806-8
509-110

[redacted] b(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10-8-03	Op Note
	Preop Dx : Dysfunctn
	Postop Dx : Same
	Procedure : Exp Laph
	Surgeon : [redacted]
	Anesthesia : General mask
	EBL : ∅
	Fluids : 500cc
	Fulg : clear metal around
	Cx : ∅
	b(6)-2 [redacted]

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

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

REGISTER NO. | WARD NO.

[redacted]

MEDCOM - 21255

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

PROGRESS NOTES

MEDICAL RECORD	NOTES
DATE	
8OCT03 2100	(CONTD) - S S/SX of infection or infiltration. Plan: monitor pain control, monitor NV status. 2pt restraint m S S/SX of skin/circulation compromise. b(6)-2 [redacted]
8OCT03 2215	new IV 18G started in (R) FA, 2° old IV pulled out of arm. Old IV DC'd & catheter intact. Will [redacted] monitor. b(6)-2 [redacted]
9OCT03 0944	Received pt resting in bed, VSS, lol PO amb w/ crutches and 2 safetes to BR. BBM and am care provided. Ancef IVPBx cont. ⅟ percocet for pain. (L) thigh extx intact w/ bulky dsg intact, small amt serosang drainage @ lower pin site, gauze IV to (R) FA patent, flushes easily, ∅ swelling or redness noted. Pt needs reinforcement w/ crutches, etc. Will cont to monitor pt.
b(6)-2 [redacted]	[redacted]
9OCT03	2130 - VSS, ∅ pain, save 2 percs for pain, Dsg to (L) LE d'd, pin care done (+) serosang drainage from old dsg's, dsg d'd over pin sites, (L) LE ↑, neurovascular

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	WARD NO.
			REGISTER NO.	

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

[redacted]

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (RE
Prescribed by GSA/ICMR FPMR (41CFR) 101-11

DATE	MIDDLE INITIAL	ID NUMBER

NOTES

Nitacd, 2+ edema (L) LE, IV to (L) FA, continue Ancef IV. X2 restraints. ⊖ skin breakdown. Ambulate c̄ crutches as needed. Continue to monitor for acute Δ's. — [redacted]

10 Oct 03 0200 - Assumed care of pt. A+O x3. VSS ⊘ c/o pain or discomfort @ this time. (L) LE external fixator intact dsg wet → dry kerlix wrapped. Minimal drainage to dsg. Ambulates c̄ crutches s̄ difficulty. HL (L) FA patent IV ABX tx. Will cont to monitor — [redacted] b(6)-2

10 OCT 03 @2030 Assumed care of pt @ 1800. VSS. c/o pain to (L) femur, percocet given c̄ good relief noted. Pin care completed, WTD dsg to (L) inner thigh complete. Healthy granulating tissue noted. ⊕ circ to LE, +2 DP & popliteal pulses. (L) FA HL flushes well, ⊖ S/Sx of infiltration/infection. Pt ↑ amb in hallway c̄ crutches c̄ assist. c̄ interpreter reinforced NWB to LLE. Plan: IV ABX as ordered, pain control prn. Opt restraints on s̄ S/Sx of skin/circulation compromise. — [redacted] b(6)-2

11 Oct '03 pt. VSS, pt ambulated to BR c̄ some difficulty, changed dsg around pin which had some sero-sang drainage, pin care completed with [redacted] new bandage, used dsg Δ'd c̄ sero-sang drainage, ⊕ circulation, skin intact, no signs of infection, restraints x2 in place. — [redacted]

(1530) I concur c̄ above assessment. — [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

b(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

PROGRESS NOTES

MEDICAL RECORD

DATE	NOTES
080803	[redacted] b(6)-2
	Pre op Dx: (L) Femur Fx
	Post op Dx: same
	Procedure: ORIF (L) Femur, removal of ex fix
	Surgeon: [redacted] / [redacted]
	Anesthesia: [redacted] GETA
	EBL - 250 cc
	Fluids: 1500 cc
	Urine: 150 cc
	Complications: ø
	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	WARD NO.
		REGISTER NO.	

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

[redacted]

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1E
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)
USAPA V

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
10Oct03 @2115	assumed care of pt @ 1800. [redacted]. c/o pain to LE, but wants pain meds @ hs. Alert, speaking some English, LS CTA, ⊕ BS, voiding per urinal. LE femur ex fix in place, pin care completed ⓛ thigh drsg WTD Δ'd, x2 sm areas (<0.5cm each) of brown, o/w healthy granulating tissue noted. LE edematous in thigh area, ±2 DP & popliteal pulses, ⊕CMS. Pt 1 amb on crutches c̄ standby assist, reinforced NWB to LE (non-compliant). Plan: ↑ambulation, pain control, NPO p MN for sx tomorrow. 2pt restraints m̄ s/sx of skin or circulation compromise. Will continue to monitor. [redacted] b(6)-2
12Oct03 1716	Assumed care of pt @ 0600. VSS, A+Ox3. Ambulate c̄ crutches. Surgery was delayed till tommorrow, Pin care completed ⓛ leg. Drsg Δ on ⓛ thigh. No sign of infection at circuit site. Skin intact @ 2x restraints. Circulation, distal pulse present. ⓛ leg needs to be elevated. c/o no pain today. Will continue to monitor. [redacted] b(6)-2
12Oct2003 2015	Assumed care @ 1800; All VSS, pt A&Ox3, ⊕cms, brisk cap ref, ⊕pulses, NV intact; pt c̄ CB to amb in hall c̄ crutch assistance; Ex-fix to ⓛ LE in place, pin care completed c̄ pt assistance; drsg [redacted] to ⓛ LE C&DI; pt voiding c̄ difficulty per urinal; Restraints [redacted] in place, ⊕ circ. ⊖ skin breakdown; cont to monitor.

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME: LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other) [redacted] b(6)-2
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	REGISTER NO.	WARD NO.

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

b(6)-4

[redacted]

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/19
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(
USAPA V1

FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES ALL THIS PAGE - b(6)-2
13 Oct 03 1646	Assume care of PT @ 0600. VSS, went to surgery this morning. Ex fix was removed, replaced by ace bandage. PT hasn't been alert since arrival. Distal pulse present in ex legs. (L) thigh wound also wrapped in ace bandage. Will continue to monitor. ~~~ [redacted]
13 Oct 03 @ 2330	Assumed care @ 1800; All VSS, pt temp slightly ↑, cont to monitor; pt in apparent pain, II percs given, I 5mg MSO4 administered for BTP; dsg to (L) LE CDI I drainage noted; (+) CMS, +2 PP, brisk cap Ref to affected leg; FTC patent draining QS, clear, dark yellow urine, O P recorded; Restraint in place; (+) circ (-) skin breakdown, cont I pain control, cont to monitor ~~~ [redacted]
14 Oct 03	pt's shift
0823	Drowsy clean + dry. S/S: Ecl/Fate 2+DP/PT. [redacted] Well controlled. T: 99.6 105/78 P: 120 Sat 98% RA. OOB to chair.
14 Oct 03	Assume care of PT @ 0600. Seen by Dr, verbal order to remove foley. C/O pain given percocets every time. Urine is dark yellow color. Restraints in place, no skin irritation present. Will continue to monitor. ~~~ [redacted]
14 Oct 03 @ 2045	Assumed care @ 1800; All VSS, pt A&O x3, pain controlled I percs; dsg to (L) LE CDI I drainage noted; (+) CMS, +2 PP, brisk cap Ref; pt voiding QS, dark Amber urine, OP recorded; Restraints in place, (+) circ, (-) skin breakdown, Cont to monitor ~~~ [redacted]

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

NOTES

DATE	
10-15-03	Discharge Summary This is a 23 y/o Iraqi male who sustained gunshot wound to left leg 10-6-03. Initially stabilized with external fixator which was replaced with internal fixation 10-13-03. A bridge plating technique was used and the reduction is not anatomic. He has a medial thigh wound that should continue to receive wet to dry dressing changes. As his swelling subsides, this wound can undergo delayed primary closure. He should remain non-weight on his left leg ~~and~~ for a period of six weeks. From weeks 6-12 recommend toe touch weight bearing with progression to full weight bearing after twelve weeks depending on radiographic findings. Continue antibiotics until wound is closed. [redacted] b(6)-2

b(6)-4

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Patient)*	LOG NUMBER	TREAT[redacted]
		RECORDS MAINTAINED AT	b(2)-2

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRE[redacted] b(6)-4

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)* | TIME 1746

TRANSPORTATION TO FACILITY: AIR evac

SEX: M

AGE: 23

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: Q

ALLERGIES: NKDA

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INITIAL SERIES ☐ YES ☒ NO

CHIEF COMPLAINT: (L) leg pain.

CATEGORY OF TREATMENT

☐ EMERGENT
☐ URGENT
☒ NON-URGENT

TIME: 1746

INITIALS: [illegible]

VITAL SIGNS

TIME 1746					
BP 116/62					
PULSE 95					
RESP 22					
TEMP 97.1					
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

☐ MONITOR ☐ ECG
☒ PULSE OX 99

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

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

PATIENT/DISCHARGE INSTRUCTIONS

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

b(6)-4

[redacted]

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					SUP O2	PH	PO2	RESULTS	
	H/H					PCO2	SAT	OTHER		
	PLT									
PT					UIA	DIP			EKG INTERPRETATION	
APTT		BHCG	ETOH	GLU		MICRO		b(2)-2		

PROVIDER HISTORY/PHYSICAL

S) 23yo drug ↑ transferred to the [redacted] S/P GSW to (L) femur. Pt was seen @ 3ACR @ 1215 today. Pt underwent I & D of (L) femur wound and external fixator placement on (L) femur fx. JP drain was also placed. Pt A&O x 3 upon arrival (slightly groggy from meds). (+) popliteal & pedal pulses to LLE. — [redacted]

b(6)-2

(+) TOB

PMHx
∅

PSHx
∅

See ortho admit note

b(6)-2

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL S[redacted]ENT SIGNATURE AND STAMP

[redacted]

PR[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)*

[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
Oct 6		1528	VS T98' R 13 P 94 B/P 104/57 Sat 100% 4L O_2 Pt transferred to ICU from OR, pt had ~~two~~ irrigation & debridement (L) thigh, placement of Ext fixation to (L) femur. Foley patent, IV. O-9 patent. lung sound clear x4 Sgt [redacted]
		1540	Pt had 10% Demerol — Sgt [redacted]
		1635	400cc yellow urine sulphur [redacted] Sgt [redacted]
		1637	Pt awake for awhile after [redacted] question then enlight [redacted] Sgt [redacted]

b(6)-2

MEDICAL RECORD — INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY FST EMT
TIME PATIENT ARRIVED IN SUITE 1250 hrs.

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY 2LT [redacted] b(6)-4

3. DATE 06 OCT 2003

4. PATIENT IN ROOM TIME 1330 hrs. b(6)-2 NUMBER [redacted]

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Arabic Interpreter Required

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS:

8. SKIN PREPARATION

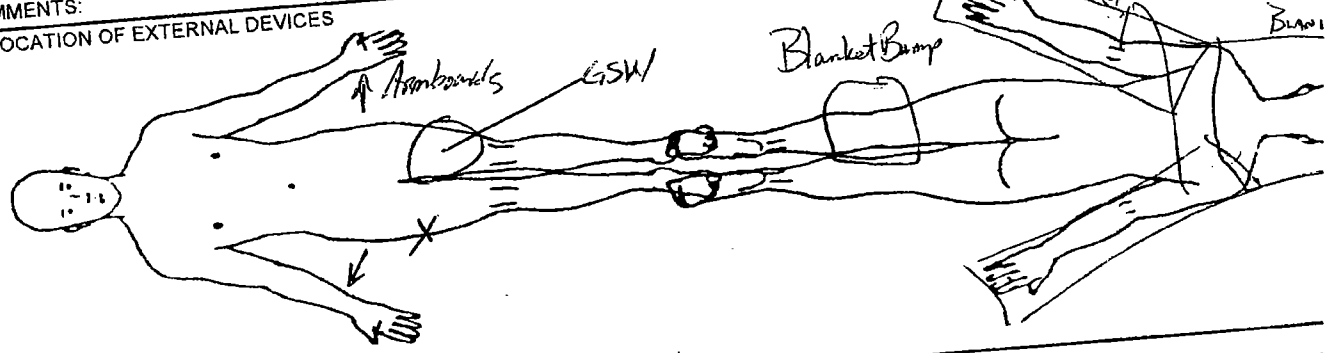
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

PREP SOLUTION (Specify) BETADINE SCRUB, DRAPER PAN BY WHOM: 2LT [redacted]
SITE: (L) LEG BY WHOM: b(6)-2
SITE:

COMMENTS:

COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap === Tourniquet

10. COUNTS

			C = Correct I = Incorrect		
			Other**	First Closing Count	Final Closing Count
Sponge	☒ Yes	☐ No			
Needle Sharp	☒ Yes	☐ No			
Instrument	☐ Yes	☒ No			
Other	☐ Yes	☒ No			

SCRUB SPC [redacted] b(6)-2
CIRCULATOR 2LT [redacted]

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

[redacted] b(6)-4

IRAQI NAT'L
DOB – [redacted] 23 y/o
[redacted]

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ N

☒ ESU NO: 500/B
GROUND PAD: BRAND 3M 1149
LOT NO: 2005-07

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

13. PROSTHESIS, IMPLANTS ☐ ☒ NO IF YES NAME: ID NUME IUFACTURER

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): NS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☒ NO ☐ IF YES, SITE (L) Femur

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	10mm FLAT JP		
SITE	(L) Thigh		

18. DRESSING/IMMOBILIZATION *(Specify)*
Xeroform Gauze
4x4 Dressings
Kerlix
ACE Wrap
External Fixator, (L) Femur

19. ADDITIONAL INFORMATION
START TIME: 1335 hrs.
END TIME: 1501 hrs.
EBL 100 mL

20. OPERATION(S) PERFORMED
Irrigation & Debridement (L) Thigh, Placement of External Fixator to (L) Femur

b(6)-2

21. PATIENT TRANSFERRED TO FST ICU TIME 1517 hrs METHOD LITTER

22. REGISTERED NURSE SIGNA [redacted]

MEDCOM - 21266

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA litter BY anesthesia

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

3. DATE 8 OCT 03 TIME PATIENT ARRIVED IN SUITE —

4. PATIENT IDENTIFICATION [redacted] TIME 0753 NUMBER 1-1 (1)

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: pt of english speaker. b(6)-2

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted] 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

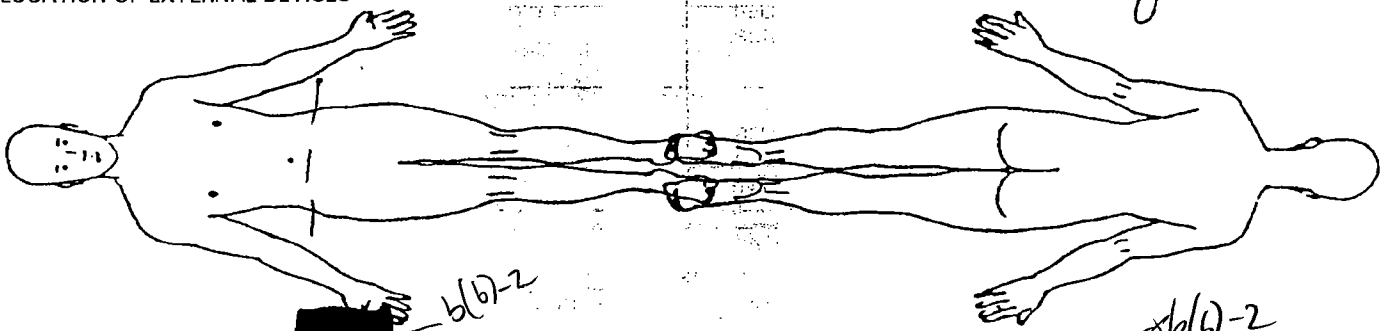
COMMENTS: b(6)-2

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Beta / Beta
SITE: L leg BY WHOM: CPT [redacted]
SITE: BY WHOM:
COMMENTS: no pooling of prep noted

9. LOCATION OF EXTERNAL DEVICES



b(6)-2 [redacted]

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

C = Correct I = Incorrect

10. COUNTS

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

b(6)-2

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

[redacted] b(6)-4

[redacted]

8 OCT 03

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

☒ ESU NO: [redacted] CUT CO AG
GROUND PAD: BRAND [redacted] E7507
LOT NO: 70011 2005-04

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

OTHER ORDERS	TIME	CARRIED OUT BY

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

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*

- splint
- Kerlix
- ace Wrap

19. ADDITIONAL INFORMATION

anesthesia:
CPT [redacted] CRNA

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

20. OPERATION(S) PERFORMED

I & D (L) femur

21. PATIENT TRANSFERED TO ICU 3 TIME MEDCOM - 21268 METHOD Litter

22. REGISTERED NURSE SIGNATURE

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATI[illegible] OM
VIA litter BY anesthesia

2. PATIENT IDENTI[illegible] RECORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] CPT/AN

3. DATE 13 OCT 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 0935 b(6)-2 NUMBER 1-1 (2)

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted] 91D / b(6)-2	RELIEF SCRUB	b(6)-2
ASSIGNED CIRCULATOR	CPT [redacted] 66E	RELIEF CIRCULATOR	MAJ [redacted] 66E (Skin prep) CPT [redacted] (1215-1300)

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

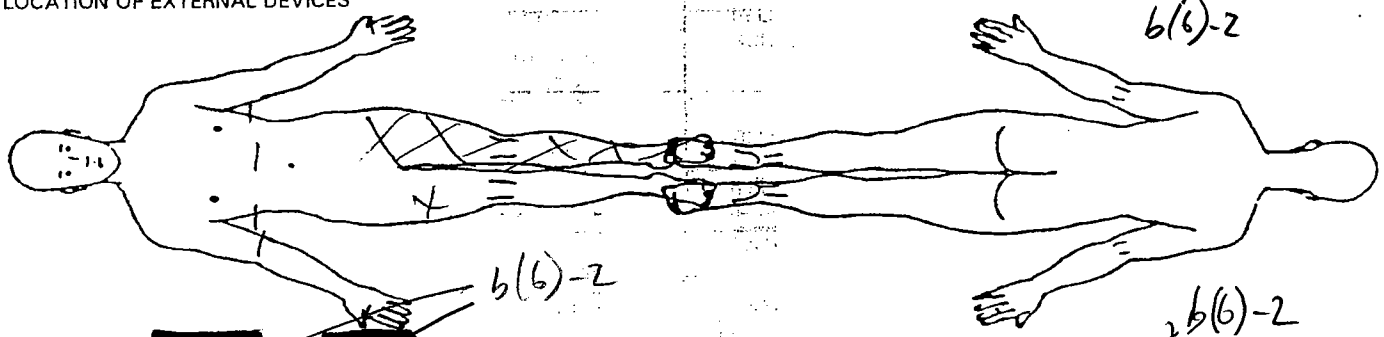
COMMENTS: bump placed under Left hip.

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO Dr. [redacted]
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR b(6)-2
☐ CLIP
COMMENTS: no nicks or cuts noted

PREP SOLUTION *(Specify)* Beta/Beta
SITE: Left leg BY WHOM: CPT [redacted]
SITE: BY WHOM: MAJ
COMMENTS: no nicks or cuts noted.

9. LOCATION OF EXTERNAL DEVICES



b(6)-2

LEGEND X [redacted] [redacted] Strap = = = Tourniquet XXX - prep.

b(6)-2

10. COUNTS initial

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes	☐ No	C		C	SSG [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

[redacted]

13 OCT 03

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

CUT 50 COAG 50

☒ ESU NO: Valleylab 105305
GROUND PAD: BRAND Valleylab E7507
LOT NO: 70016 2005-04

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ DIRECTOR NO:

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

Synthes DCP plates
Load# 0428502
14hole plate

Synthes ASIF SCREWS
Load # 0428502
4.5mm cortical 36x4 34x1
38x2 44x1

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 [redacted] b(6)-2

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1. 14 Fr. Foley to gravity	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

- fluffs
- kerlix
-

19. ADDITIONAL INFORMATION

Surgeons:
Dr. [redacted] b(6)-2
Dr. [redacted]

anesthesia: b(6)-2
MAJ [redacted] CRNA

20. OPERATION(S) PERFORMED

ORIF Left Femur

21. PATIENT TRANSFERRED TO ICU 3 TIME METHOD Gurney

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																	
POST-	DAY																
MONTH-YEAR	DAY	13 OCT		14 OCT 03													
19	HOUR																
PULSE (O)	TEMP. F (•)																TEMP. C
	105°																40.6°
180	104°																40.0°
170	103°																39.4°
160	102°																38.9°
150	101°																38.3°
140	100°																37.8°
130	99°																37.2°
	98.6°																37.0°
120	98°																36.7°
110	97°																36.1°
100	96°																35.6°
90	95°																35.0°
80																	
70																	
60																	
50																	
40																	
RESPIRATION RECORD		18		18	16												
BLOOD PRESSURE		126/68		135/78													
		T 98	124/75	T 98.3													
		H 98		H 123													
HEIGHT:	WEIGHT →																
		98%		96%	99%		L(6)-2										

(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.

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

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR 10/03 DAY 6 7 Oct 8 Oct 9 Oct 10 Oct 11 Oct 12 Oct 03

19 HOUR 21 0745 1 9 1 1200 1100 0000 1 0015 1 1

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

105° 40.6°

180 104° 40.0°

170 103° 39.4°

160 102° 38.9°

150 101° 38.3°

140 100° 37.8°

130 99° 37.2°

98.6° 37.0°

120 98° 36.7°

110 97° 36.1°

100 96° 35.6°

90 95° 35.0°

80

70

60

50

40

RESPIRATION RECORD

BLOOD PRESSURE

122/63		P101	110/62		116/60	86	124/66	125/63	122/	P 83	116/60	136/75	135/70
84		T 98.4		124/53		98/		H 88		T 98.2		T 98.3	97
98.9		5002				96		T 98°		96%		H77	97
		97						99%					98/
100%			98% RA	97%	98% RA		O_2 99% RA	RA			97% RA	98%	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

FLOWSHEET FOR VITAL SIGNS AND OTHER PARAMETERS

For use of this form, see AR 40-407; the proponent agency is the OTSG

WARD: ICU

DATE: Oct 6, 03

This form may be used for more than one day by drawing a heavy line and adding date. Insert column headings as required.

	PATIENT'S NAME [redacted]	T	P	R	B/P	SpO2		
1500	b(6)-4	98.1	94	19	124/57	100		
1528			81	18	129/59	100		
1533			72	23	121/66	100		
1543			78	16	134/55	100		
1600			83	18	136/60	100		
1615			88	14	134/61			

DA FORM 3950, JUN 91 Previous editions are obsolete. USAPPC V1.00

TWENTY-FOUR HOUR PATI[illegible]E AND OUTPUT WORKSHEET	FRO[illegible] HOURS TO [illegible] HOURS	TOTAL HOURS COVERED	DATE Oct 6, 03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
		NS OK	OL	1535	
1535	2	NS U-9			

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

PATIENT'S IDENTIFICATION (Or typed or written clinical group name, rank, first, middle; grade; date; hospital or medical facility)

[redacted]

b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

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

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JU[illegible]

*U.S. Government Printing Office: 1994 — 300-727/10425

OUTPUT

URINE						~~NASOGASTRIC~~ JP			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL
2200	1600cc	1600cc				0000	90cc	blood	90cc
0430	1000cc	2600cc				0550	75cc	blood	70cc
7/oct 1600	voided	400cc				7/oct			
1800	300	700				1800	25	Blood	25
2215	600	1300				2215	10	sanguinous	35
						8oct 0500	10	sanguinous	45

CHEST						EMESIS			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL

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 ____ HOURS TO ____ HOURS	TOTAL HOURS COVERED	DATE

INTAKE

ORAL				INTRAVENOUS					
TIME	TYPE	AMOUNT	ACCUM TOTAL	TIME STARTED	AMOUNT	TYPE *(Include Medications)*	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
						NS IV	1,000cc	0800	1,000cc
						Ancef	50cc	0340	1050cc

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

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

1 oct

OUTPUT

URINE						NASOGASTRIC			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL
2200	420	420							
0555	425	~~425~~ 845							
0930	450								
1723	473	923							
2245	425	1348							

CHEST						EMESIS			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS					OTHER OUTPUT			
TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL	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

b(6)-4 b(6)-2 b(6)-4

Ward/Section: EMT	REQUESTING PHYSICIAN: DOC [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted]	DATE 6/6/03 TIME 1750	SSN/PSEUDO SSN [redacted]

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3	Color	Yellow	N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App	Clear	N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu	Neg	Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili	Neg	Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket	Neg	Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG	1.010	N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld	Trace	Negative	H. pylori		Negative
(Hematology) Manual Differential			pH	7.0	N/A	Micro Parasites		
Segs		Mono	Prot	Neg	Negative	Malaria		
Bands		Eos	Urob	0.2	0.2-1.0	O & P		
Lymph		Baso	Nit	Neg	Negative	Other		
Atyp		Imm	Leuk	Neg	Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative	Rbc 1-5		

			CSF			Blood Bank
Spun Hematocrit		42-52% (M) 37-47% (F)				
Sed Rate			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED
Other			Directigen		Negative	ABO/Rh

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

b(6)-4 b(6)-2 b(6)-4

Ward/Section: EMT	REQUESTING PHYSICIAN: DDC [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted]	DATE 6 OCT 03 / TIME 1750	SSN/PSEUDO SSN: [redacted]

(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

======= PICCOLO =======
10/06/03 18:16
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: [redacted]
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	113	73-118	MG/DL
BUN	7	7-22	MG/DL
CRE	0.6	0.6-1.2	MG/DL
CK	1384*	39-380	U/L
NA+	135	128-145	MMOl/L
K+	4.3	3.3-4.7	MMOl/L
CL-	103	98-108	MMOl/L
tCO2	22	18-33	MMOl/L

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
UN		7-22 mg/dl
A^{++}		8.0-10.3 mg/dl
RE		0.6-1.2 mg/dl
A^{+}		128-145 mmol/l
+		3.3-4.7 mmol/l
L-		98-108 mmol/l
O_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
LB		3.3-5.5 g/dl
LP		26-84 u/l
LT		10-47 u/l
MY		14-97 u/l
ST		11-38 u/l
BIL		0.2-1.6 mg/dl
GT		5-65 u/l
P		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
O_2		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

ID: [redacted] 06-10-03
WB 18:14

			Patient Limits	
WBC	11.9 H	x10^3/uL	4.5	10.5
RBC	4.91	x10^6/uL	4.00	6.00
Hgb	13.7	g/dL	11.0	18.0
Hct	43.0	%	33.0	60.0
MCV	87.6	fL	80.0	99.9
MCH	27.8	pg	27.0	31.0
MCHC	31.8 L	g/dL	33.0	37.0
Plt	234.	x10^3/uL	150.	400.
LYM	13.1	%	20.5	51.1
LYM	1.6 *	x10^3/uL	1.2	3.4

NT COAG A. ALYZER V4.54
.005485 10/06/03 18:19

Patient ID: [redacted]
Test Name :PT
Test Result:= 12.7 sec.
RESULT OUT OF RANGE
Ratio = 1.0
Calculated INR = 1.07
Sample Type:citrated wh. blood
Test Date :10/06/03
st Time :18:18
d Lot [redacted]
erator : [redacted]

b(6)-4

DPOINT COAG ANALYZER V4.54
AL #005485 10/06/03 18:22

atient ID: [redacted]

b(6)-4

Test Name :APTT
Test Result:= 27.3 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :10/06/03
Test Time :18:19
Card Lot [redacted]
Operator : [redacted]

b(6)-4

516-108 NSN 7540-00-634-4156

MEDICAL RECORD | **OPERATION REPORT**

PREOPERATIVE DIAGNOSIS
GSW to (L) Thigh

SURGEON	FIRST ASSISTANT	SECOND ASSISTANT	
MAJ [redacted]	MAJ. [redacted]	PTC [redacted]	
ANESTHETIST CPT [redacted]	ANESTHETIST GENERAL		TIME BEGAN: 1308 hrs TIME ENDED: 1524 hrs.
CIRCULATING 2LT [redacted]	SCRUB NURSE SSG [redacted]	TIME OPERATION BEGAN 1335 hrs	TIME OPERATION COMPLETED 1501 hrs.

OPERATIVE D[redacted]
Open (L) femur fracture

b(6)-2

DRAINS *(Kind and number)*
1 10 flat bulb

SPONGE COUNT VERIFIED
2LT [redacted]

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION
NONE

OPERATION PERFORMED
Irrigation & Debridement (L) Thigh, Placement of External Fixator to (L) Femur

DESCRIPTION OF OPERATION *(Type(s) of suture used, gross findings, etc.)*

PROSTHETIC DEVICES *(Lot no.)* NONE

DATE OF OPERATION 06 OCT 2003

Pt given IV5 and general anesthesia. Pt intubated and Tygacil given IV. (L) leg prepped & draped. 1 + 0 wounds excised, DCB + necrotic tissue removed. Femur nailed inserted. External fixator applied. Wounds irrigated & drain placed. Dressings applied

b(6)-2

SIGNATURE OF SURGEON
[redacted], M.D.

DATE 6 Oct 03

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

REGISTER/I.D. NO.

WARD NO.

[redacted]
IRAQI NAT'L
DOB – [redacted] 23 y/o
NKDA

b(6)-4

OPERATION REPORT
Medical Record

STANDARD FORM 516 (REV. 5-83)
Prescribed by GSA and ICMR, FPMR 101-11.806-8

MEDICAL RECORD - ANESTHESIA

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

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

DRUG (Units)											
Propofol (mg)	200/50		50								
Sux (mg)	100										
Morphine (mg)				3		2					
Rocuronium (mg)					20			2.5/2.5			
Neostigmine (mg)								.5/.5			
Robinul (mg)											
VOLAT AGENT ISO % del	3	1.2	1.2	2.0	2.0						
% e.t.											
AIR L/Min											
N2O L/Min											
O2 L/Min	5	5	5	5	5	2.5	2.5	1	.5		

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

FLUIDS

LINE site											
(L) Hand ☐ Warmed	→	→	800	→	→	1000	NS →	→	→	→	800
#18 LR ☐ Warmed	→	→	600	→	→	→	→	→	→	→	1000
(R) Arm #18 NS ☐ Warmed											
☐ Warmed											

LOSSES EST BLOOD LOSS / URINE -

PHYS STATUS (1) 2 3 4 5 E

BODY WEIGHT 68 KG / LB

HEMATOCRIT

INITIAL DATA: BP- 132/50 HR-

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? TIME- 1505

TIME → 1245 1300 15 30 45 1400 15 30 45 1500 15 30

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

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

VENTIL

VT - ml										
f - breaths/min	16	10	10	23	22	14	14	14	14	14
Peak inf pres / PEEP										
MODE - S(pon), A(ssist), C(on)	S	C	C	S	S	C	C	C	C	C/S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)										
BP/oth	FIO2 (Frac or %)		72	72	80	80	71	48	48	48	44
ART line	SpO2 (%)	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG						97			97	
Gas analyzer	TEMP-site		97								
	N-M Block (T/4)										
Warming blkt											
Conv warmer											

TOTALS 300 / 100 / 3 / 20 / 5 / 1

TOTAL EBL 100

TOTAL URINE 500

FLUIDS SUMMARY
CRYSTALLOID- 2800
COLLOID-
BLOOD-

REMARKS
Code drugs with numbers, events with letters

1250 Pt. IDed. Hx & Allergies reviewed. Anesth Site Instruction given. 50mg IV Zantac & 12.5 IV Phenergan given (1308) IV Induction. #8 ETT placed & #3 MAC & difficulty c DL view. BBS bil & clear. Teeth Int (1355) Hct 34, Hgb K 3.9, Na 137, Glu BUN 9 b(6)-2 (1500) Pt. breathing regular, Sa 100% b(6)-2 (1518) Pt. breathing regular & swallow ETT pulled. Pt breathing & diffi (1524) Pt. to PA Report given.

RECOVERY AT PACU ICU 1534 (S)

OTHER

CONDITION: RESP- 19 SpO2- BP- 109/48 HR- 9

ANESTHESIA / PROCEDURE TIMES

	Start	Room
ANES	1250	1300
	Ready	Begin
PROC	1315	1335

Mark with letters & symbols, explain under REMARKS — EVENTS Position → Supine & pressure points padded

PROCEDURES and CPT Codes: External Fixation of (R) Femur

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: General

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: SEE Above Note

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

M, 23 yr

SURGEONS: [redacted] b(6)-2

ANESTHETISTS: [redacted] AN CRNA

PROCEDURE LOCATION: (2)

DATE: 10-6-0

PAGE 1

b(6)-2

23 y/o ♂ PMH ∅ PSH: L Fem Ex Fix 10/6 OSW L Thigh
NKA MPCI, Foo ↑ GEN ANES BICTA, ↑ APM 10/8/07
63 Kg 5'7" Anesfe 24 . cocult 98° - 80 - 110/70 Sa 98% [redacted] LTC

MEDICAL RECORD - ANESTHESIA

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

b(6)-2

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "1" = CONSTANT INFUSION																	
DRUG	(Units)																
Propofol	( )	100															
Fentanyl	( )	100/150															
	( )																
	( )																
	( )																
	( )																
VOLAT AGENT	Forane % del	1.5	1.5	X													
	% e.t.																
AIR	L/Min																
N2O	L/Min																
O2	L/Min	8	4	8													
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS		(1)	(2)	(3)													
FLUIDS — LINE site	☐ Warmed																
18g (2) WRIST	☐ Warmed	LR	—														
	☐ Warmed																
	☐ Warmed																
LOSSES — EST BLOOD LOSS																	
URINE -																	

TOTALS	TOTAL EBL
	MIN
	TOTAL URINE
	∅

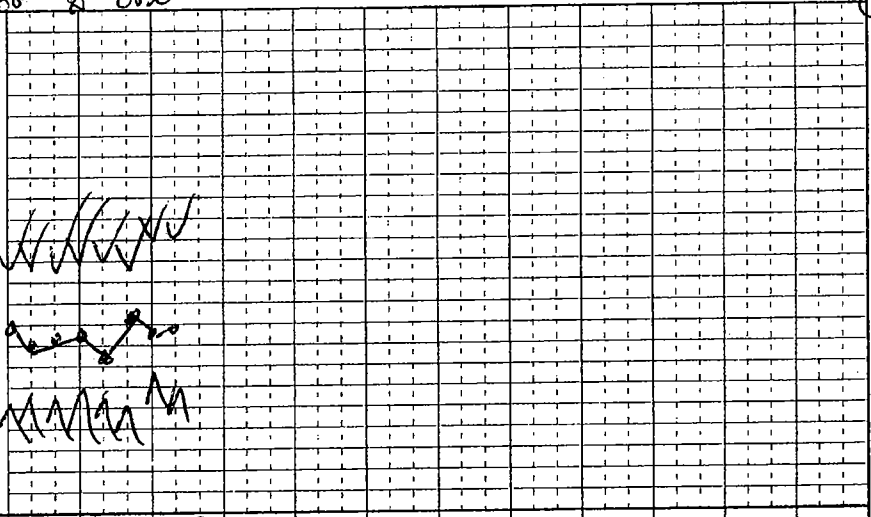
FLUIDS - SUMMARY
CRYSTALLOID- 300
COLLOID- ∅
BLOOD- ∅

REMARKS
Code drugs with numbers, events with letters
(1) PT ID IN ICU 2 Hx unchanged
(2) Kin-O2-MGA.
(3) OCR TO PACU

PHYS STATUS: 1 2 3 4 5 E
BODY WEIGHT: 68 (KG) LB
HEMATOCRIT: 43 g/10
INITIAL DATA:
BP- 119 152
HR- 87
EQUIP CHECK
OK?- Y N
PATIENT RECHECK
OK for PROCEDURE?
TIME-

TIME → 0800 0830

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



VENTIL			
VT - ml	460	420	500
f - breaths/min	12	7	11
Peak inf pres / PEEP	/	/	/
MODE - S(pon), A(ssist), C(on)	SV	SV	SV

MONITORS/ACCESSORIES				
✓ BP/Auto Cuff	✓ ET CO2 (torr)	46	60	49
BP/oth	✓ FIO2 (Frac or %)	0.68	0.68	0.68
ART line	✓ SpO2 (%)	100	100	100
Steth- PC/ES	✓ ECG	SR	SR	SR
Gas analyzer	✓ TEMP-site	Axil		
	✓ N-M Block (T/4)			
Warming blkt				
Conv warmer				

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

RECOVERY AT 0838
(PACU) ICU ____ (Specify)
OTHER
CONDITION: alert
RESP- 12 SpO2- 100
BP- HR- 90

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0738	0752	0840
	Ready	Begin	End
PROC	0753	0820	0839

PROCEDURES and CPT Codes:
I&D (L) FEMUR

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
GA - MASK

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
MASK ⊂ #90A

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

SURGEONS: [redacted] b(6)-2

ANESTHETISTS: [redacted] CPT CRNA

PROCEDURE LOCATION: 1-1
DATE: 8 OCT 03
PAGE 1 OF

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)												
MSO4	(mg)	2/2/4/2											
	( )												
	( )												
	( )												
	( )												
	( )												
VOLAT AGENT	% del	1.5	1.5	1.0	X								
ISO	% e.t.												
AIR	L/Min												
N2O	L/Min												
O2	L/Min	1 —	2 —	2 —	6								
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS →				(4)									

FLUIDS

LINE site													
18g LFA	☐ Warmed	1000 —	1400										
	☐ Warmed												
	☐ Warmed												
	☐ Warmed												

LOSSES

EST BLOOD LOSS	150 —	200											
URINE -	125 —	150											

TOTALS	TOTAL EBL
10	
	TOTAL URINE

FLUIDS - SUMMARY

CRYSTALLOID:

COLLOID: See Pg

BLOOD: one

REMARKS

Code drugs with numbers, events with letters

(4) Suctioned & extubated, to PAW stable.

PHYS STATUS: (1) 2 3 4 5 E

BODY WEIGHT: 68 (KG) LB

HEMATOCRIT: 40

INITIAL DATA:

BP- 113/53

HR- 80

EQUIP CHECK

OK?- Y N

PATIENT RECHECK

OK for PROCEDURE?

TIME-

TIME → 30 x 13 x 30 x 14 x 30 x 15 x

SYMBOLS:

BP by cuff V

Heart rate ∧

Resp rate ●

BR (transduced)

TOURNIQUET T—T

ANES- X-X

PROC- ⊙-⊘

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

VENTIL

VT - ml	720	340	350	380
f - breaths/min	8	16	12	18
Peak inf pres / PEEP	25	—	—	—
MODE - S(pon), A(ssist), C(on)	C	S	S	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	36	44	48	46
BP/oth	FIO2 (Frac or %)	0.8	0.8	0.8	0.8
ART line	SpO2 (%)	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR
Gas analyzer	TEMP-site S	35	35	off	
	N-M Block (T/4)				
Warming blkt					
Conv warmer					

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

RECOVERY AT

PACU ICU (Specify)

OTHER

CONDITION:

RESP- SpO2-

BP- HR-

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES			
	Ready	Begin	End
PROC			

PROCEDURES and CPT Codes:

ORIF lt femur

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

See page one

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

b(6)-2

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

CD [redacted] b(6)-4

23yo ♂

[redacted]

SURGEONS: [redacted]

ANE[redacted] MAJ CRNA

PROCEDURE LOCATION: 1

DATE: 10/13/03

PAGE II OF II

MEDICAL RECORD - ANESTHESIA

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

b(6)-2

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "1" = CONSTANT INFUSION

DRUG	(Units)												
Sufenta	(Mg)	5	15	15	5	10	5 [redacted]						
droperidol	(mg)	1.25											
propofol	(mg)	120					80						
vec	(mg)	10											
	( )												
	( )												
VOLAT AGENT Iso	% del	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5
	% e.t.												
AIR	L/Min												
N2O	L/Min												
O2	L/Min	6	1	1	1	1	1	1	1	1	1	1	1

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS → ① ② ③

TOTALS	TOTAL EBL
50	200
	TOTAL URINE
	150

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

FLUIDS

LINE site												
18g LFA ☐ Warmed	LR ↑	500	600	700	800	#2						
20g LW ☐ Warmed	DCd											
☐ Warmed												
☐ Warmed												

LOSSES

EST BLOOD LOSS												
URINE - Foley											150	125

REMARKS

Code drugs with numbers, events with letters

Pt b/chart. No Δ in status since prior anesth. Plan GETA.
① To room via litter, 50 mons, preO2
② I & I.
③ New IV placed.
④ [redacted] b(6)-2

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 68 KG LB

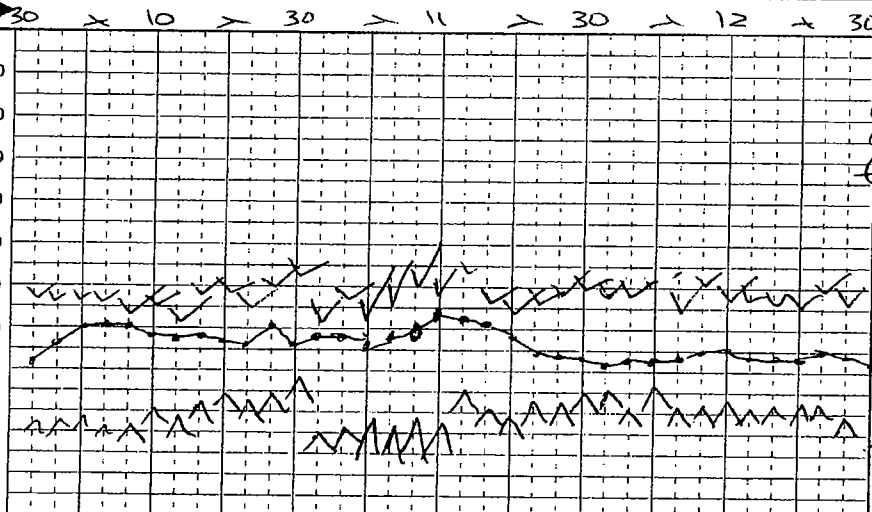
HEMATOCRIT: 40

INITIAL DATA: BP- 113/53 HR- 80

EQUIP CHECK OK?- Y N

PATIENT RECHECK OK for PROCEDURE? Y TIME- 0925

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



VENTIL

VT - ml	600	650	720	720	740	730	740	760	740	750	730	720
f - breaths/min	10	10	10	10	10	10	10	10	8	8	8	8
Peak inf pres / PEEP	21	22	22	23	23	23	24	24	24	25	24	23
MODE - S(pon), A(ssist), C(on)	C	C	C	C	C	C	C	C	C	C	C	C

HME

MONITORS/ACCESSORIES

BP/Auto Cuff — ET CO2 (torr)	38	36	34	31	35	35	33	31	33	34	37	36
BP/oth — FIO2 (Frac or %)	0.8	0.8	0.8	0.8	0.8	.8	0.8	0.8	0.8	0.8	0.8	0.8
ART line — SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES — ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer — TEMP-site S		35	35	35	35	35	35	35	35	35	35	35
N-M Block (T/4)								4/4				
									Succ			
Warming blkt												
Conv warmer												

Mark with letters & symbols, explain under REMARKS — EVENTS *Position* → O — 1 → → →

RECOVERY AT: PACU ICU _____ (Specify)
OTHER
CONDITION:
RESP- 12 SpO2- 99%
BP- 109/62 HR- 98

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0925	0935	1325
	Ready	Begin	End
PROC	0940	1020	1315

PROCEDURES and CPT Codes:
ORIF (L) FEMUR

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
GETA

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*
[redacted] b(6)-4 NKDA
[redacted]
ICW, 23 yo ♂ civ det

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* Eyes taped, DL x 1 3 trauma, ⊕ EtCO2, BUBB. Secured c-tape, soft bite block. 8.5 ETT, 3 mar, 23 cm. b(6)-2

SURGEONS: [redacted]

ANES[redacted] MAJ, CRNA

PROCEDURE LOCATION: OR 1
DATE: 10/13/03
PAGE I OF II

DIRECTIONS: The provider will DATE, TIME, and SIGN each order or set of orders recorded. Only one order is allowed per line. Nursing will list the time the new order(s) are noted and initial in the column provided. Orders completed during the shift in which they were written do not require recopying. They may be signed off, as completed, in the far right column.

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
	POST ANESTHESIA ORDERS (circled Items)		
1	VS q 5 min X 15 min, then q 15 min until discharge.		
2	Supplemental oxygen.		
3	Morphine / Meperidine 5 mg IV now and 5 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_____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 @ KVO cc/hr.		
10	Discharge from recovery status when PACU discharge criteria met.		
	[redacted]	CPT CRNA	
	8 OCT 03 0825		
	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: _____

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

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

b(2)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

NURSING UNIT: [redacted] BED NO.

DATE OF ORDER: 10-6-03 TIME OF ORDER: _____ HOURS

Admit ICW-1 Dr. [redacted]
(1) Femur Fx p Sx fix
Stable
- Routine vitals
- Ambulate c crutches on AM, NWB @ LE
- Record output of Drain q Shift
- D/C Foley in AM

LIST TIME ORDER NOTED AND SIGN

PATIENT IDENTIFICATION: 8/16/24 ICW#1

NURSING UNIT: 3gi / ROOM NO.: 2140 / BED NO.: 60CTOS

DATE OF ORDER: _____ TIME OF ORDER: _____ HOURS

- Regular Diet
- Ancef 1gm IVPB q8°
- D5½NS @ 125 c/hr, heparin in AM
- Percocet 1 p.o. q4°
- Dexamed 50-75 mg, IV q4° prn breakthrough
- Phenergan 12.5-25 mg IV q6° prn nausea
- Ambien 5 mg po q HS PRN [redacted] b(6)-2

PATIENT IDENTIFICATION: 9 60 [redacted] b(6)-2

NURSING UNIT: ROOM NO.: BED NO.:

DATE OF ORDER: 10-7-03 TIME OF ORDER: 1200 HOURS

Clarification of order
(1) Percocet 1 po Q4° prn pain
V.O Dr [redacted] b(6)-2

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

NURSING UNIT: [redacted] ROOM NO.: 3gi / BED NO.: 600 60CTOS

DATE OF ORDER: 10-7-03 TIME OF ORDER: 1800 HOURS

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

10-11-03 1730
NPO PMN

[redacted] b(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] b(6)-4	10-8-03	0830 HOURS	
	- ICW 1		
	- Routine vitals		
	- Ambulate c̄ crutches NWB RLE		
	- BID pin site care c̄ 50/50 peroxide/saline		
	- QD wet to dry dressing to medial thigh		
NURSING UNIT / ROOM NO. / BED NO.	- Regular Diet		
	- Replace IV		
PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
b(6)-2 noted [redacted] 080CT03 0925		HOURS	
	- Ancef 1gm IVPB q8°		
	- Percocet II po q 4°		
	- Phenergan 25 mg IVP q6° prn nausea		
	- Ambien 10mg po q HS.		
NURSING UNIT / ROOM NO. / BED NO. 2A° / 80CT 2120 [redacted]	[redacted]		b(6)-2
PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
EPW # [redacted] b(6)-4	10-12-03	1600 HOURS	
	Resume Regular Diet		
	NPO p̄ MN	b(6)-2	
	[redacted]		
NURSING UNIT / ROOM NO. / BED NO.			10/12/03 1600
PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
b(6)-4 [redacted]		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

NURSING UNIT	ROOM NO.	BED NO.
ICW 1		

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
13OCT03	1200 HOURS	
Admit ICW.		
Post ORIF (L) Femur		
- Bedrest today		
OOB to chair in AM		
- Incentive Spirometry		
- Routine vitals		
- Resource Dressing PRN		

13 Oct 03 1445

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
	HOURS	
- Foley to gravity. Record output q Shift		
- Regular Diet		
- IVF NS @ 125 c/hr, heplock IV in AM		
- Percocet 1 po q4° PRN		
- MSO4 2-8mg IVP q2° PRN breakthrough		
- Phenergan 25mg IVP q6° PRN nausea		

[redacted]

b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.
ICW 124°	13OCT03@2020	[redacted]

DATE OF ORDER	TIME OF ORDER	
	HOURS	
- Ambien 10mg po qHS		
- Ancef 1gm IVPB q8°		
- Levoquin 500mg IV qD		
- Lovenox 30mg SQ BID		
- XR portable PA/LAT pulm (L) Femur		

[redacted]

PATIENT IDENTIFICATION

[redacted]

b(6)-4

Noted

b(6)-2 [redacted]

NURSING UNIT	ROOM NO.	BED NO.
	15OCT0	0830

DATE OF ORDER	TIME OF ORDER	
10-15-03	0815 HOURS	b(6)-2
- Dressing change this AM		
- D/C to civilian hospital today		

[redacted]

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 6	7	08	9	10	11	12	13	14	15	16	17	18
6	[redacted]	Routine vitals	6	[redacted]												
			18													
6		AMB c crutches	6													
		NWB LLE	18													
6		Record output	6				DC		OP							
		of drain QS	18													
6		Regular diet	6													
			18													
08		Routine vitals	06			[redacted]										
			18													
08		Ambulate c crutches	06													
		NWB LLE	18													
08		BID pin site care c	06													
		50/50 peroxide/saline	18													
08		QD wet to dry dressing	06													
		Δ to medial thigh	18													
08		Regular diet	06													
			18													

b(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (L) femur fx c EX-fix

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

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo ____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
6	[redacted]	admit ICW-1, Dr [redacted] stable				
6	[redacted]	D/C Foley in Am	7 OCT.		0540	[redacted]
6	[redacted]	NIO: DTV @ _____		[redacted]		
7	[redacted]	NPO p MN	7 OCT	2359		
08 OCT 03	[redacted]	ICW#1	08 OCT 03	_____		[redacted]
11 OCT 03	[redacted]	NPO p MN	12 OCT 03	0001		
12 Oct	[redacted]	Resume Regular diet	10/12			
12 Oct	[redacted]	NPO p MN	10/12	2400		

	----	b(6)-2				

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

POST-OP

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 ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 13	14	15
10/13	[redacted]	Bedrest today. OOB	06 18	[redacted]		
	[redacted]	to chair in AM	18 06			
10/13	[redacted]	INCENTIVE SPIROMETRY	06 18			
	[redacted]		18 06			
10/13	[redacted]	ROUTINE VITALS	06 18			
			18 06			
10/13	[redacted]	Foley to gravity.	06 18			
		Record output q	18 06			
		SHIFT	/			
10/13	[redacted]	REGULAR DIET	06 18			
			18 06			
		b(6)-2				

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: POST ORIF (L) Femur

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: 1

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

Verify 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	
10/13	[redacted]	Admit ICW 1	10/13				
10/13		XR PORTABLE PA & LAT	10/13	[redacted]			
15 OCT03		Disg Δ this am		b(6)-2			
15		DC to civilian hospital today					
		b(6)-2					

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
10/13	[redacted]	Reinforce disg														
		prn														
		b(6)-2														

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 6	7	08	9	10	11	12	13
6	[redacted]	Ancef + gm IVPB	8		[redacted]						
	-----	Q8°	16								
	-----		24								
6	[redacted]	D5½NS @125cc/hr	6								
	-----	HL in AM (TOCT)	18								
6	[redacted]	Percocet #1 po Q4°	02								
	-----		06								
	-----		10								
	-----		14								
	-----		18								
	-----		22								
08 OCT 03	[redacted]	Heplock IV - flush q	06								
	-----	shift	18								
08	[redacted]	Ancef 1gm IVPB q8°	08								
	-----		16								
	-----		24								
08	[redacted]	Ambien 10mg po qHS	22								

b(6)-2

pre op

Med 7 OCT 03

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (L) femur fx c̄ ex-fix

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

b(6)-4

[redacted]

DISPENSING TIMES

PENCIL, CIRCLE MED TIMES

	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.

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. _____ Yr. _____

Verify by Initialing						
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
		b(6)-2 (all)				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
6	[redacted]	Demerol 50-75mg IV Q4° PRN Breakthrough	D/T/I													
6	[redacted]															
6	[redacted]	Phenergan 12.5mg-25mg IV q6° PRN	D/T/I													
6	[redacted]	Ambien 5mg po qHS PRN	D/T/I			pre-op										
10ct 0	[redacted]	Percocet 1/1 PO	D/I	10ct 2130	10ct 0700											
		Q4° PRN pain	D/I	[redacted]												
			I/E													
080003	[redacted]	Percocet 1/1 po q4° prn	D/T	8oct 1900	9oct 0011	9oct 0300		10oct 1815	10oct 1215							
			D/T	11 po	11	[redacted]										
080003	[redacted]	Phenergan 25mg IVP q6° prn nausea	D/T													
			D/I													

POST-OP

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 13	14
10/13	[redacted]	IVF NS @ 125cc/h	06	[redacted]	
	-----	Heplock IV in AM	18		
			06		
10/13	[redacted]	Ambien 10mg PO	22		
	-----	q hs	/		
10/13	[redacted]	Ancef 1gm IVPB	08		
	-----		16		
	-----		24		
10/13	[redacted]	Levaquin 500mg IV	10		
	-----	q D	/		
10/13	[redacted]	Lovenox 30mg SQ	10		
	-----	BID	22		
	-----	b(6)-2			

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: POST ORIF (L) Femur

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. 1

PATIENT IDENTIFICATION:

EPW# [redacted] b(6)-4

[redacted]

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. Oct Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
		b(6)-2 (all)				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
10/13	[redacted]	Percocet 1 po q 4° prn	Date	13 oct	14 oct	14 oct	14 oct	14 oct	14 oct							
			Time	1820	0020	0550	1240	1900	0150							
			Dose													
			Initial	[redacted]												
10/13	[redacted]	MSO4 2-8mg IVP q 2° prn break-through	Date	13 oct	13 oct											
			Time	1845	2045											
			Dose	5mg	5mg											
			Initial	[redacted]												
10/13	[redacted]	Phenergan 25mg IVP q 6° prn nausea														

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

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

OTSG APPROVED (Date)

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

Date: 8 OCT 03
Time In: 0838
Allergies: NKA
Pre-op V/S: 119/52 87
Procedures: EGD Femur

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 300 Colloid Ø
OR Output: UOP Ø EBL min
Meds/Times: 250 fent. / 100 propofol

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

Pre Op Meds

History

Time	0840	0845	0850	0900
SaO2	100	98	97	98
FiO2				
Methods	RA	RA	RA	RA
240				
220				
200				
180				
160				
140				
120	V	V	V	V
100	•	•	•	•
80			•	•
60	^	^	^	^
40				
20				
RR	16	18	24	14
T	97			
Time				
Pain (0-10)	[redacted]			
LOS				

Pacu Intake

Time	Solution	Amount	Site	[redacted]	Infused
0840	LR	600	L Arm		400
				b(6)-2	

X-rays: Labs:

Post-Anesthesia Recovery score

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

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

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

(Continue on reverse)

PREPAR[redacted] LPN b(6)-2 DEPARTMENT/SERVICE/CLINIC PACU DATE 8 OCT 03

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

b(6)-4

#[redacted]

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(L) Lg	LRTM	+	+	B	W	PK
15'							
30'							
45'							
60'							
90'							
D/C							

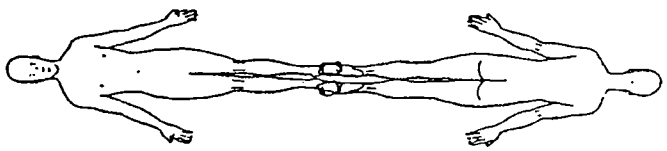
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) Lg	ACE, elt fix	min Around pins
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0840	SR	⊘	⊘

NURSING NOTES

Pt to recovery room from OR via litter s/p I&D (L) leg. Ext fix & ace wrap in-tact. Min. drainage noted to pin area. c/V restarted to (L) forearm LR infusing w/o s/s of hydroma/OR swelling. VSS. NV's in-tact. Will continue to monitor. [redacted]

b(6)-2

NOTHING FOLLOWS

Discharge Criteria:
Date: 8/9/13 Time: 0910 PARS: 9
BP: 109/48 T: 97.6 HR: 81 RR: 16 Sa02: 98
Pain Level at D/C (0-10):
Intake: 200 Output: -0-
Additional Data:
Transferred To: PACU
Report Given To: [redacted] b(6)-2
Transferred Via: W[redacted]mbulance
Transferred By: [redacted]
Cleared IAW Reco[redacted]
Charge Nurse Signature [redacted] ILT AN

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

DTSG APPROVED (Date)

Date: 13 OCT 03
Time In: 1320
Allergies: SULFA
Pre-op V/S: 113/53
Procedures: ORIF Femur

Anesthesia Type (Circle): General Spinal Epidural
IV Sedation Nerve Block
OR Intake: Crystalloid 1500 Colloid 0
OR Output: UOP 150 EBL 200
Meds/Times: Sufenta, MSO4

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

Pre Op Meds: History

Time	1320	1325	1330	1345	1400	1410
SaO2	97	98	100	99	99	98
FiO2						
Methods	RA	RA	RA	RA	RA	RA
240						
220						
200						
180						
160						
140						
120	V	V	V	V	V	
100	•	•	•	•	•	
80						
60	^	^	^	^	^	
40						
20						
RR	24	30	22	20		
T	97.9	98.2		98		
Time						
Pain (0-10)						
LOS	[redacted]					

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1320	LR	500	L ACM	[redacted]	500

X-rays: Labs:

Post-Anesthesia Recovery score

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

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

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

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

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

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: [redacted] LPN
DEPARTMENT/SERVICE/CLINIC: PACU
DATE: 13 OCT 03

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

[redacted] FPU [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
1355		MSO4 2mg	IVP			RL

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(L) leg	WDM	+	+	B	W	PK
15'							
30'							
45'							
60'							
90'							
D/C	(L) leg	WDM	+	+	B	W	PK

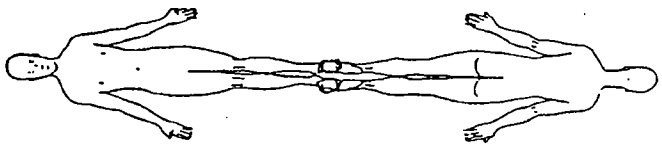
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) leg	long leg AC	-0
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1320	SR	-0	-0

NURSING NOTES

Pt to recovery room from OR via litter s/p ORIF (L) femur. Long leg AC wrap to (L) leg intact. ∅ drainage noted. ABVS intact. IVP LR infusing into (L) arm. ∅ s/s of hemorrhage. Dr. Dudley to bed. VSS. + c/o thirst. [redacted]

1355 - c/o pain. Medicated c [redacted] 2mg MSO4 [redacted]

b(6)-2

Continued on Flowsheet

Discharge Criteria:
Date: 13 Oct Time: 1480 PARS: 9
BP: 123/61 T: 97.3 HR: 92 RR: 26 Sa02: 99
Pain Level at D/C (0-10):
Intake: _____ Output: _____
Additional Data:
Transferred To: ICU #1 b(6)-2
Report Given To:
Transferred Via: W/C [redacted] Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Rec[redacted]-3
Charge Nurse Signature:

WAMC OP 173-E

AEROMEDICAL EVACUATION PATIENT RECORD

b(6)-4

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

6. AGE	7. SEX	8. WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION 91A-5F)	11. ACCEPTING PHYSICIAN	12. CITE/AUTHORITY NO.
M	Male / Female			AMBULATORY / LITTER X		

13. APPT/SURG DATE	14a. ORIGINATING FACILITY	15a. DESTINATION FACILITY	16. NUMBER OF ATTENDANTS
	[redacted]	[redacted] — b(2)-2	16a. MEDICAL: 0 / 16b. NON MED: 1
	14b. ORIGINATING FACILITY PHONE NUMBER	15b. DESTINATION FACILITY PHONE NUMBER	
	[redacted] b(2)-2		

17. DIAGNOSIS

GSW (L) thigh
S/P ex fix

18. X BATTLE CASUALTY | DISEASE | NON-BATTLE INJURY

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

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

20. PHYSICIANS ORDERS

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

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

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

20e. IV/BLOOD

20f. SPECIAL EQUIPMENT			
	SUCTION	TRACTION	ORTHOPEDIC BRACES
	NG TUBE	IV PUMP	CHEST TUBE/HEIMLICH
	STRYKER FRAME	TRACH	RESTRAINTS
	INCUBATOR	MONITOR X	IV TYPE
		FOLEY	OTHER (Explain in 23)
O_2		LITTERS	ROUTE:

VENTILATOR SETTINGS

20g. ALTITUDE RESTRICTION:

20h. RECORDS TO ACCOMPANY PATIENT

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

20i. MEDICATIONS/TREATMENTS

Ancef 1 Gm @ 1230

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE

See attached note [redacted] b(6)-2

23. ASSESSMENT/PROGRESS

DATE/TIME	NOTES

24. STAMP AND SIGNATURE OF ATTENDING PHYSICIAN

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF FORM 3899, MAR 95

MEDCOM - 21302

3. Register Number	Name (Last, First, MI)	4. Pay Grade	5. Sex
[redacted]	[redacted]	FGN	M

6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
[redacted]	23Y	X	9	ISLAMIC

10. Length of Service	ETS	11. FMP	12. Social Security Number	
	b(6)-4	99	[redacted]	

Organization (Active Duty Only)	13. Marital Status	Hour of Admission	Branch / Corps:
		17:43	

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
		BC	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 - 28th CSH - Iraq; No Install Provided	Telephone Number of Emergency Addressee

21. Type of Disposition	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD)
TRF-C-ICU		2003-10-15

24. Clinic Svc - Admitting	25. MTF Transferred From	26. Date this Admission (YYYYMMDD)
AEA - ORTHOPEDICS		2003-10-06

27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission
IZ		2003-10-06

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: L FEMUR FX W/ EX FIX,

Procedure Narrative(s):

Cause of Injury Narrative:

b(2)-2

Admitting Officer (Signature, as required)	Signatur
[redacted]	[redacted]

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3. Register Number	Name (Last, First, MI)		4. Pay Grade	5. Sex
[redacted]	[redacted]		FGN	M
6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
[redacted]	23Y	X	9	ISLAMIC
10. Length of Service	ETS	11. FMP	12. Social Security Number	
	b(6)-4	20	[redacted]	
Organization (Active Duty Only)		13. Marital Status	Hour of Admission	Branch / Corps:
			17:43	
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	
		BC	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:		Telephone Number of Emergency Addressee		
[redacted]				
21. Type of Disposition	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD)		
TRF-C-ICU		2003-10-15		
24. Clinic Svc - Admitting	25. MTF Transferred From	26. Date this Admission (YYYYMMDD)		
AEA - ORTHOPEDICS		2003-10-06		
27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission		
IZ		2003-10-06		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: GSW L FEMUR, EX FIX, L FEMUR

Procedure Narrative(s):

Cause of Injury Narrative:

b(6)-2

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

Automated Facsimile - DA FORM 2985, MAR 2000

ADMISSION AND CODING INFORMATION

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

1	2	3	4	5	6	7	8
A							

(State or Country Code.)

3. REGISTER NUMBER

9	10	11	12	13	14	15
[redacted]						

NAME (Last, First, Middle Initial)

4. PAY GRADE: 16, 17

5. SEX: 18

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

7. AGE AT ADMISSION: 27, 28, 29

8. RACE: 30

9. ETHNIC BACKGROUND: 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 [redacted]

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 (YYYYMMDD): 81, 82, 83, 84, 85, 86, 87, 88

81	82	83	84	85	86	87	88
2	0	0	3	1	0	1	5

24. CLINIC SVC - ADMITTING: 89, 90, 91, 92

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

26. DATE THIS ADMISSION (YYYYMMDD): 99, 100, 101, 102, 103, 104, 105, 106

99	100	101	102	103	104	105	106
2	0	0	3	1	0	0	6

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

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

29. DATE INITIAL ADMISSION (YYYYMMDD): 115, 116, 117, 118, 119, 120, 121, 122

FOR LOCAL USE

Dx 82111
E9412

Pr 7965
7815
7865
7935

Trauma
9

Injury
569

ADMITTING OFFICER (Signature, as required)

SIGNATURE OF ADMITTING CLERK

DA FORM 2985, MAR 2000

EDITION OF MAR 89 IS OBSOLETE

USAPA V1.00

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

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

1. Register Nbr	2. Name					3. Grade	Admission Remarks
[redacted]	[redacted] b(6)-4					FGN	
4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm	
M	29Y	X	ISLAMIC			NO	
11. FMP	12. SSN	13. Organization				14. Ward	
99	[redacted]					ICU2	
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		20:05	ABA - GENERAL SURGERY				
24. Name/Relation of Emergency Addressee		25. Type Disp	26. Date of Disp				
		TRF-OTH	2003-10-19				
27a. Address of Emergency Addressee		27b. Telephone No	28. Date This Adm:	AdmittingOfficer:			
			2003-10-07	[redacted] b(6)-2			
29. ReportingMTF			30. Date Init Adm	32. Units Blood Components			
[redacted] b(2)-2			2003-10-07				

31. Selected Administrative Data

Marital Status: Z DoB: [redacted]

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

PENETRATING WOUND R BACK LIVER LAC, HEMO/PNEUMO

860.5
867.1
893.1
891.1
879.7
873.0
E998

b(6)-2

54.11
34.04

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	13	13

35. Total Days This Facility

Absent Sick Days	Other Days	Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
Ø	Ø	Ø	Ø	13	13

Sig[redacted]Attend[redacted]Officer	Signature of PAD or Medical Records Officer
[redacted] DAVIS	[redacted]

Automated Facsimile - DA FORM 3647, May 79

70 q 2130

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

~30 y/o ♂ admitted c̄ fragment wounds of back
Meds Allo Sh? PMH?

PHYSICAL EXAMINATION 90/40 100 20

HEENT PERRL mouth OK airway ? appropriately GCS 15
small 2cm low occiput c̄ slight elevation of wound ~1cm
neck - non tender
chest - ↓ BS (R) chest c̄ bubbling from wound
cor - RRR S (A)
abd - non tender FAST none blood Murrion's pouch

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

pelvis - stable
rectal - good tone
extr - move all (R) 2nd toe lac 1cm
WBC 21.5 hct 44 pl 424 UA 1030
CXR - CT hole in SQ
abd CT - frag thru (R) iliac wing into bowel p-lap

~2 frag wounds

SIGNATURE [redacted]	IDENTIFICATION NO.	ORGANIZATION
PATIENT'S [redacted] *Name last, first, middle; grade; date; hospital or medical facility)*	REGISTER NO.	WARD NO.

b(6)-2

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE

NOTES 7 Oct - 19 Oct 2003

Transfer Summary

30 y/o admitted c̄ frag wounds to back, arrived with (R) chest tube 350 cc pleurovac, also 2 frag wounds of (R) hip; abdominal CT suggested penetration of (R) iliac wing with 1 fragment appearing to lay in bowel. Exploratory lap negative - no penetration or retro peritoneal hematoma.

Pt recovered rapidly and uneventfully from laparotomy, but after placing on water seal after 2 days lung collapsed; replaced on suction x 2 days, + collapsed again on water seal. Placed on suction again x 48 hr and small 1 cm apical pneumo appeared but did not progress and CT removed. Post removal XR still small apical pneumo. Has good breath sounds. Never had air leak, and drainage after initial 350 was less than 10 cc/day. No residual hemothorax, incision healed without infection.

Discharged with

frag wound R chest requiring chest tube for drainage of hemothorax

frag wound to (R) hip with negative laparotomy for suspected penetration

Will need suture removal from (R) chest in 5 days ~ 24 or 25 Oct

b(6)-2 [redacted]

b(2)-2 [redacted]

[redacted] b(6)-4

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

PROGRESS NOTES

DATE	NOTES
07Oct03 2130	Transferred from ER to ICU 2 via litter. tolerated well. pt S/P grenade schrapnel wounds to (R) chest (R) thigh + (R) buttock. Pending cat scan results. Rest, eyes closed easily aroused A+O x 3 Pupils 2mm brisk. color good. noted lg amt blood on sheets (+) noted wound posterior (R) chest. chest tube (R) lateral chest wall @ 350cc blood. To suction 20 sonometers suction. IV 16 G (L) AC, IV 18 G (R) FA patent. VS 104/52 P 105 R 22 SaO2 100% 10L O2. color good LS - (+) diminished bases c̄ wet LS (R) side. ABD soft (-) DTN (-) BS (-) rigidity. capillary brisk. will cont to monitor Foley to gravity dry clear yellow urine SGT [redacted] 9WMC
07Oct03 2145	— NG tubes placement (R) nare 16F by Dr [redacted] tolerated well. LIS drainage green bile c̄ sm amt noted dark blood. Type + screen per MD request. [redacted] pt Pending surgery tonight. SGT [redacted] 9WMC

RELATIONSHIP TO SPONSOR | LAST | SPONSOR'S NAME | 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 b(6)-2

PROGRESS NOTES
Medical Record

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

USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

b(6)-2 (all)

DATE	NOTES
07Oct03	- pt transfered via litter to OR for
2200	Surgery SGT [redacted] 91WM6
08Oct03	Transfered via litter to bed. S/P ex lap
0040	new CT placement. See DA form 4700
	for recovery SGT [redacted] 91WM6
08Oct03	- VS 139/77 P70 R20 SaO2 100% 10 Lo2 venturi
0200	T - 98.8 - to begin 1 unit PRBC. per MD order
	1 of 5306365 B pos exp 08Oct03. Confirmed
	lot by LT M. Jackowski RN. SGT [redacted] 91WM6
0205	136/74 P68 T98.6 Ø S+S of RX SGT [redacted] 91WM6
0210	137/81 P65 T98.3 Ø S+S of RX SGT [redacted] 91WM6
0215	139/78 P64 T98.4 Ø S+S of RX SGT [redacted] 91WM6
0220	140/78 P68 T98.1 Ø S+S of RX SGT [redacted] 91WM6
0225	140/79 P65 T98.1 Ø S+S of RX SGT [redacted] 91WM6
0230	138/80 P64 T97.9 Ø S+S of RX infusion
	Complete SGT [redacted] 91WM6
0245	138/78 P70 T97.8 Ø S+S of RX SGT [redacted]
0300	136/80 P65 T98 Ø S+S of RX f/u CBC
	drawn SGT [redacted] 91WM6
0630	Assumed care of pt for night shift report given by SGT
8Oct03	[redacted] W. Pt Alert. Peripheral (R) Subclavian area [redacted]
	CDI. Skin W+D to touch. (R) wrist A line intact. 18G (R)
	FA No S/S of infection noted to HL error. (L) FA IV HL. No
	S/S of infection noted. (R) wrist A-line secured. LR @ 100
	cc/hr via (R) IV FA. DSG (R) lat. chest tube + CDI. DSG Midline
	ABD CDI. DSG (R) chest tube to 25cm suction. (R) Aut
	DSG CDI. Foley to gravity & clear yellow urine.

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

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

DATE	NOTES
8 Oct 0030	Op note Expl lap for apparent bowel perforation + free intraperit air seen on CT ⊖ lap ō retroperit hematoma SB, LB (cecum) nl ō iliac vessel lig ō hematoma seen in pelvis duo OK liver, diaphragm, spleen, stomach, pancreas OK ⊖ lap Ⓟ CT replaced 350 out old plasma fluid 3500 1 PRBC UO 700 [redacted] b(6)-2
8 Oct	S – O – USS Lt 37 p̄ ii ct 600 cc ō air bel CXR UO XLMT NG DC'd P – ↑ out [redacted] 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

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

DATE	NOTES
08 Oct 03 0630 (cont)	lung sounds course bil. (-) BS noted. ABD soft nondistended. (+) radial & pedal pulses bil. Cap refill < 3 sec @ finger nail & toenail beds bil. Will cont to monitor. [redacted]
0700	IV (L) & (R) FA D/c'd. (R) AC 18G restarted. LR ADD to D5NS = 20K @ 100cc/hr. Will cont. to monitor. [redacted]
0800	Alert. (R) wrist A line intact. lung sounds coarse (R) & (L) clear. (-) BS ABD soft nondistended. D5 NS = 20K @ 100cc/hr via (R) 18G AC. No s/s of infection noted. Will cont. to monitor. [redacted] b(6)-2
1030	DSG ADD Midline ABD - small amt bloody drainage noted on old DSG. Incision = staples c/d/i. No active bleeding or drainage noted. Covered = ABD pad. Secured = tape. (R) thigh area DSG left open to air. wound small @ ½cm x ½cm. No active bleeding or drainage noted. (R) lat chest DSG ADD - mod amt bloody drainage noted on old [redacted] b(6)-2
1400	Pt c/o (R) chest pain. It taught that part of the pain was due to the CT. Pt was given 1 percocet P.O. Pt lungs coarse (B), more so (R). VS 110/65-93-30 100.8 (ax) - 98% SpO2 on RA. CT draining serous fluid ∅ leaks. Dressing C/D/I so ABD to (R) flank. [redacted] 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)

[redacted] b(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203
USAP

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
08Oct03	1900 - Received report from outgoing shift. Pt awake alert Color good NAD VSS T-100.4 per la TOM. LS-diminished (R) side - CT - 25cm suction drg - 10cc blood for the hour SaO2 99% RA. ABD Soft drg midline CDI, BS hyperactive x 4. (-) Rigidity. Drg around CT CDI. Drg (R) anterior thigh small and serous drg noted. (R) buttock dry small and serous drainage noted. (R) radial line patent IV (R) AC, 18G Patent run D5 1/2 NS c 20K @ 100cc/hr. Foley to gravity drg light clear yellow urine. denies pain at this time. will cont to monitor SGT [redacted]
09Oct03 0100	Percocet II po for ABD pain VSS NAD drank 180cc H2O SGT [redacted]
09Oct03	0230 - OOB to chair X 1 1/2 hrs tolerated well VSS NAD pt washed, linen Δ, pajama changed back in bed at this time. SGT [redacted] 91WM6 b(6)-2(all)
09Oct03	0400 - noted on pt's tongue white irregular circular ~~shapes~~ lesions - pt denies pain will report to daysh ft to report to MD. SGT [redacted] 91WM6

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

PROGRESS NOTES

DATE	NOTES
9 Oct 03 0600	Assumed care of pt @ Night Shift, report given by Sgt [redacted] PERRLA 3mm. AA Alert. Skin w/d to touch. (R) lat. ↑ Chest DSG CDI. (R) lat (↓ 15 ↑ DSG) Chest tube DSG CDI. Chest tube to Suction (-25cm). Foley to gravity = clear yellow urine. (R) post. back DSG CDI. (R) Buttock DSG CDI. (R) ant. thigh DSG mod. amt bloody drainage noted. (R) AC 18G IV 5 5/5 ⊘ infection or infiltration noted. (R) 3rd toe = Sutures CDI. No active bleeding or drainage noted. D5NS @ 100cc/hr 20kcl @ 100cc/hr via (R) 18G IV patent. Will cont. to monitor. Lung sounds CTA. BS(+) in all 4 quads. Abd soft nondistended. Sgt [redacted]
9 Oct	S - o.q.
	O - x-ray TBS ō air
	abd - fm BS
9 Oct 03 0630	DC'd 16F Foley 9cc removed from bulb. Bulb intact. 100cc clear yellow urine removed from foley bag. DC'd (R) radial A-line, applied pressure for 5 min. Applied 2x2 & Secured tape. IV fluids ↑ 200cc/hr. Chest tube to water seal. All per MD Order. Will cont. to monitor. Sgt [redacted]
9 Oct 03 (Late entry) 0600 (cont)	A-line secured. A-line (R) radial intact. [redacted] DSG CDI.

RELATIONSHIP TO SPONSOR

SPONSOR'S NAME: LAST | FIRST | MI | (SSN or Other) [redacted] b(6)-2

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

#[redacted] 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
0800	DSG's Δ'd: (R) lat. chest DSG Δ'd - scant amt brown drainage noted on old DSG. Applied 4x4s & secured c̄ tape. (R) lat. chest tube DSG Δ'd - Mod. amt bloody drainage noted on old DSG. chest tube intact. applied sprozform gauze & 4x4s. Secured c̄ tape. (R) buttock DSG Δ'd - Mod amt brown drainage noted on old DSG. Applied nonadhering DSG & secured c̄ tape. (R) post. back DSG Δ'd - large amt bloody drainage noted on old DSG. Applied 4x4s & secured c̄ tape. (R) ant. thigh DSG Δ'd - Mod amt bloody drainage noted on old DSG. ~~Incision~~ Wound c̄ 3 sutures intact. No active drainage or bleeding noted. Applied 4x4s & secured c̄ tape. Midline DSG Δ'd - ~~Pt~~ scant amt brown drainage noted on old DSG. Incision c̄ staples CDI. No active bleeding or drainage noted. Covered c̄ nonadhering DSG. Secured c̄ tape. Will cont. to monitor. ii Percocet po given @ 0755. — Sp[redacted]
1030	Lung sounds clear (L) (R) ↓ slight rhonchi noted [redacted] lobes clear to lobes. BS (+) in all 4 quads. No BS in DSG. all CDI. SpO2 @ 99% R 23. IS used 3 ↑ c̄ 1st ball raised & 2nd raised @ 4's. IV 18G (R) AC WNL. No S/S of infection or complication noted. Will cont. to monitor — Sp[redacted]
1100	Pt assisted up to chair. SpO2 @ 95% ↓ sitting in chair. Will cont. to monitor R 27 ↓ sitting in chair. Sp[redacted]
~~1400~~ 1330	Pt assisted back to bed ∓ any problems noted. — Sp[redacted]
1400	Lung sounds clear bil. BS (+) in all 4 quads. 18G IV (R) AC WNL. No S/S of infection noted. Midline [redacted] DSG

STANDARD FORM [redacted] (REV. 6/1998) BACK

USAPA V1.00

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

DATE	NOTES
	CDI. (R) lat. chest CDI. (R) chest tube site (lat. & 1st DSG) CDI. Back DSG CDI. (R) thigh DSG CDI. (R) buttock DSG Δ & moderate amt bloody drainage noted on all DSG. Wound yellowish color approx @ 2cm x 2cm. Applied nonadhering DSG & secured w/ tape. (R) 3rd toe c̄ sutures CDI. No active bleeding or drainage noted. Will cont. to monitor. [redacted]
090ct03 1830	-VSS NAD received report from surgery Shift [redacted] b(6)-2 PT A+O x3 pleasant Eom/. color good. cap refill brisk NVI x 4. Drg ABD CDI, Drg (R) buttock CDI, Drg (R) thigh CDI back Drg CDI, CT to Water Seal ⊖ noted Drg on Dressing. LS CTA diminished RLL. ABD soft ⊖ DTN hypoactive BS. Sutures (R) 2nd toe intact. minimal dried blood noted NVI. - able to move unable to check cap refil. - toe warm to touch. IV 18G (R) FA intact/patent Run D5NS c̄ 20K @ 200cc/hr. spontaneous void will cont to monitor SGT [redacted] 91 mmHg b(6)-2
10 OCT 03 1147	Pt care assumed at 0600 hours. Pt A&O LS CTA (B) S1 S2 present. (R) Buttocks Drsg CDI (R) thigh Drsg CDI. Back Drsg CDI. CT to

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

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

#[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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USAPA V1.00

b(6)-2 (c11)

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	Water seal. No Drainage on Drsg noted. Am care completed. IV 18G in (R) FA. Infusing 125cc/h [redacted] Will continue to monitor
10Oct03@2045	Assumed care @ 1800; A&O x3, pt A&O, pain controlled c̄ percocet; pt void per urinal c̄ difficulty; SS2, LS CTA(B), equal & unlabored, IS enc. Q1° while awake; dsgs to (R) thigh (R) buttock & posterior CDI, ⊖ drainage; CT to H2O seal intact, ⊖ output; PIV patent infusing DS NS c̄ 20Meq KCL @ 200 cc/hr S/S/Sx infection/infiltration; Cont to monitor [redacted]
11OCT03	Assumed care of Pt @ 0600. VSS Pt A&O Pain controlled c̄ percocet. LS CTA (B) IS 10x day, DRS to (R) thigh (R) Buttocks, posterior CDI (-) Drainage. CT to (R) Flank CDI. CT To Water Seal minimal Drainage. PIV Patent infusing DS NS c̄ 20meqKCL @ 200cc/h. Will continue to monitor [redacted] Soc 91WM6
	(1310) I concur c̄ above assessment. [redacted]
11 Oct	
	Good BS CT output 125, ⊖ air leak, will review CXR possible pull tube back to 2cm, DCIV + IVAB [redacted] middle ear clear dy [redacted]
(2000)	Pt alert, temp 99, percocet given for pain. LCTAB ⊕ BS, HRRR, CT to (R) flank (to water seal) Drsgs to (R) thigh & buttock CDI. IV H2O. IS use encouraged. 2 pt restraint c̄ compromise to skin/circulation. voiding clear mod. yellow urine via urinal. Will monitor [redacted] 91WM6

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

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

DATE	NOTES
13OCT03 0230	Pt had 2 episodes ~~diarrhea~~ [redacted] diarrhea (watery + lrn). [redacted] 91WM6.
13 Oct	Sun CXR lung up generally c̄ air leak output [redacted] with rel Pody
13OCT03 1500	Pt Awake ~~Afebrile~~. CT to suction then to Water seal at 0930. Pt to Radiology for CXR c̄ Flat & upright Abd. IV started. LR @ 200 cc/h (L) FA & G. LS Diminished Lower lobes B/lat. S1 S2 present Pt tachycardic. ~~Pt~~ 2 episodes of emesis. LRN [redacted] this Sm. Will continue to monitor. [redacted] b(6)-2
13OCT03 2345	Assumed care of pt @ 1500. VSS, slightly febrile @99.0. Cont IS and IVFs @200 cc/hr. MD Δ'd Cx to Sxn, Serosanguinous drainage noted. Sats 96% RA no resp distress noted. LS CTA, but diminished (R)U. Refused ODB to amb 2° pain, Percocet given c̄ good relief noted. Tol sm amt of reg diet for dinner. Plan: monitor CT output, resp status, pain control, temperature. Opt restraints on 5 S/S of skin/circulation compromise. [redacted]

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

#[redacted] b(6)-4

REGISTER NO. | WARD NO. KWM

PROGRESS NOTES
Medical Record

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

b(6)-2 (011)

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
14 Oct 03 1100	VSS Alert & Orient. COB 7 BR and upon chg to PCXR with suction disconnected Dr [redacted] informed of 30 minutes without suction. Suction on @ this time. Dr [redacted] Bed. chest tube site dry and removed Abd staples and replaced = steri strips. Edges well approx to midline and incision. Lungs clear bilateral = diminished breath sounds to (R) LL. O2 SAT 97% RA Peripheral pulse +2. Tolerating Rec diet. (L) AC IV patent and intact infusing [redacted] 200cc/hr will continue care as planned [redacted] 2CT A
14 OCT 03 @ 2215	Assumed care of pt @ 1800. VSS, 96% pulseox on RA. Alert, speaking arabic LS ↓ bases, IS encouraged. (R) chest CT intact, dsg CDI; CT draining sero-sanguinous drainage. CT system intact, to cont. wall suction. ⊖ resp distress noted. Abd dsg CDI, ⊕BS, ↑ AMB to BR, ⊕BM – loose but controlled. Tol sm amt of regular diet, drinking H2O & juice. Voiding per urinal s difficulty. LR @ 200 cc/h to (L) FA IV. Plan: monitor resp status, CT system, pain control. will cont to monitor. 1pt restraints on 5 S/SX skin/circulation compromise. [redacted]
15 OCT 03 @ 0300	CT output approx 90cc of serosanguinous drainage noted in last 24. will monitor. [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

MEDICAL RECORD | AUTHORIZED FOR LOCAL REPRODUCTION

PROGRESS NOTES

DATE	NOTES
150ct03 1000	VSS Alert & Oriented. Lungs clear Bilaterally c ↓ (R) LL. CXR done & taken up stairs to OR per request of Dr. [redacted]. Chest tube to continuous portable suction. Drsg to CT insertion site dry & intact. Voiding clear yellow urine. OOB → BR from AM care. Consumed 40% of breakfast. Incentive Spirometer used properly @ 900-1200 cc/sec. Will continue to encourage use. Mid line Abd incision c edges well approximated, with steri strips in place & drainage noted from incision. Abd soft, non distended. BS (+) x4 quadrants. Peripheral pulses ±2 (L) AC IV patent infusing NS @ 200 c/hr. HOB ↑30. Will continue care as planned. [redacted] b(6)-2
150ct03 1700	~~Pt Has verbal threats via threatening to Suprapubic cath clamped. Both episodes upon unclamping suprapubic cath < 30cc of urine noted. Wrong pt. [redacted] UTA~~

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

b(6)-2 (all)

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
15OCT03 @2045	VSS, Ø/10 pain @ present time, A+O X3, Chest tube intact → insertion site (R) lung c̄ dsg over site CDI, ⊖ drainage on Dsg, drainage to H_2O seal, @ 1225cc upon start of shift, monitoring for further drainage, chest Xray done as ordered, lungs clear (B) but ↓ lung sounds to (R) lower lobe, O_2 sats @ 97% RA, Ø s/s resp distress. IV peripheral to (L) FA running LR @ 200 cc/h c̄ difficulty, Dsg to abdomen CDI, (+) BS X4 quads, X2 restraints c̄ spin breakdown. Continue to monitor for acute Δ's. — [redacted]
16OCT03 1230	Assumed care of Pt @ 0600. Pt denies pain. Chest tube intact @ insertion site. Dsg CDI. CT → H_2O seal. ~~⊖ Drainage~~ Drainage. LS (R) LL Dimi[redacted]shed, VSS LR @ 200 cc/h via 18g cath to (L) [redacted]. Will cont. To monitor. — [redacted] 91WM6
16OCT03 @2030	Assumed care of pt @1800. VSS. No c/o pain. Alert, speaking Arabic. (R) CT to water seal, Ø leaks noted, dsg CDI. CT secured to pt's flank & system secured to floor. LS CTA c̄ ↓ bases. IS encouraged. Pt ↑ amb in hallway c̄ assist. IVFs cont. Tol regular diet well. 2pt restraints on c̄ s/sx of skin or circulation compromise. Plan: monitor resp status, monitor CT & output, pain control. — [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

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

DATE	NOTES
17 Oct 03 0700	- Assumed care of pt. A+O x3 VSS lungs clear slight wheezing to ⓛUL. Water seal chest tube pulled per MD. Ø complications CXR ordered in 4°. PIV d/c'd. HRRR Active BS voiding per urinal ambulates ⊼ difficulty. Dressing to ⓡchest wall vaseline gauze 4x4 sponge dsg intact Ø bleeding noted Will cont to monitor [redacted] Grw me, b(6)-2
	(1525) I concur ⊼ above assessment. [redacted]
17 Oct 03 @2345	Assumed care of pt @1800. VSS, no c/o @ this time. c/o ⓡchest pain (healed c̄ insertion site) earlier this shift, Percocet given c̄ good relief noted. ⓡflank dsg CDI. O2 sats remain in hi 90s 96-98% on RA. Tol regdiet well. Void per urinal ~~qs~~ qen quantity sufficient. ↑ Amb in hallway s̄ assistance. Plan: CXR in AM, monitor pain control, monitor resp status, enc IS. 2pt restraint on s̄ s/sx of skin/circulation compromise. [redacted] CP b(6)-2
18 Oct 03 0700	- Assumed care of pt. A+O x3. Ø c/o pain or discomfort @ this time. Lungs clear. Dressing to ⓡchest wall tube side CDI Ø active bleeding noted. CXR this am complete @ bedside. HRRR - Active BS urinating per urinal QS. Ambulates ward s̄ difficulty Will cont to monitor [redacted] Grw me

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 NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	b(6)-2
18OCT03	(1500) I concur c above assessment. — [redacted]
18OCT03 @2015	assumed care of pt @ 1800. VSS. No C/O. LS CTA is encouraged, sats 97-98% on RA. Pt tol reg diet, ⊕ BS, void per urinal. Pt ↑ amb, took shower, ambs difficulty. ⊕ flank drsg (D). Plan: enc amb, monitor resp. Status. Ipt restraints on & S/Sx of skin/circulation compromise. Will monitor. — [redacted]
	b(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

b(2)-2

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER

TREATMENT FACILITY [redacted]

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY

STATE

ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)* 7 OCT

TIME 2015

TRANSPORTATION TO FACILITY

SEX M

AGE 30

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: Ø

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: SOB / BACK PAIN

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☐ NON-URGENT

TIME 2015

INITIALS

VITAL SIGNS

TIME	2105	2120	2145		
BP 93/65		98/58 (M)			
PULSE 107	109	107	123		
RESP 15	20	18	20		
TEMP			98.2 (R)		
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	

☐ PULSE OX

ORDERS

☐ MONITOR

☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE

DISPOSITION

☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

DISPOSITION QUARTERS /OFF DUTY

☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE

☐ IMPROVED ☐ UNCHANGED

☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO WHEN

I have received and understand these instructions.

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

PATIENT'S SIGNATURE

[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 21		127	100	14		SUP O2	PH	PO2	RESULTS	
H/H 14/44		3.8	24	170	1.4	PCO2	SAT	OTHER		
PLT 424										
PT						U/A DIP			EKG INTERPRETATION	
APTT		BHCG	ETOH	GLU		MICRO				

PROVIDER HISTORY/PHYSICAL

CT in @ 2045
Blood in chest
NG Tube c̄ oral contrast 2110
good post tibial & Pulse 2050
O2 10L NON rebreather
Foley Catheter @ 2030
Bilateral 18G (L) AC
18G (R) AC

45 mL ~~of~~ in chest 2055
200mL 2105

2045 100 mcg phentanyl
2045 2.5 mg Versed
2051 1gm Ancef (-) TOB

O: Head
(R) sup. shrapnel
(L) occipit
Lungs: ↓ BS (R)
Post chest (R) - 2 shrapnel wounds c̄ bubbly air.
Abd - soft nondistended
FAST > fluid
nonsignificant
(R) foot 3rd toe shrapnel injury.

A: (R) pneum/hemothorax
P: chest tube placed 38 Fr
50 cc blood out initially.

PMHx
-0-
PSHx
-0-
Last meal
1400
~~Allergies~~

b(6)-2

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP
[redacted]

PROVIDER [redacted] MASPM

DIAGNOSIS
See above

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

EPW

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: 30 HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): Ø NKDA 3. PREVIOUS SURGERY [ ] NO [ ] YES (type): ?

4. PROPOSED SURGICAL PROCEDURE:

pull? Exp Lap 300cc contrast CT via NG

5. ADDITIONAL INFORMATION: Last PO: 400 Medical Hx: ? Implants: ? Medications: ?
Jewelry removed: (yes)/no Family waiting: yes/no

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to traumatic injury; language barrier; family separation; surgical environment	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. ✓ 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.	✓ 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. ✓ 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.

[redacted] CPTAN 70CT03 DATE

11. POSTOPERATIVE EVALUATION:

Dressings D+I yes
Bowie site C+I yes
Breathing easily
Moves all extremity well

b(6)-2

12. PREOPERATIVE EVALUATION PREPARED BY (Sign [redacted] CPTAN

DATE: 70[redacted] TIME: 2235

13. PREOPERATIVE EVALUATION PREPARED BY ([redacted]

DATE: 70CT03 TIME: 0033

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.01

VIA litter TRANSPORTED TO OPERATING ROOM BY anes staff

3. DATE 20Oct03 TIME PATIENT ARRIVED IN SUITE

2. PATIENT IDENTIFICATION [redacted] VERIFIED BY [redacted]

4. PATIENT IN ROOM [redacted] TIME 2305

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: b(6)-2

NUMBER 2-1

b(6)-2

6. NURSING PERSONNEL

ASSIGNED SCRUB	Sp2 [redacted] 9-17	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

☑ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE

LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: Pt placed on padded OR table c arms on armboards < 90°

8. SKIN PREPARATION

HAIR REMOVAL ☑ YES ☐ NO

DONE BY: ☑ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☑ RAZOR ☐ CLIP

COMMENTS: Nicks

PREP SOLUTION (Specify) Betadine / Betadine

SITE: See #9

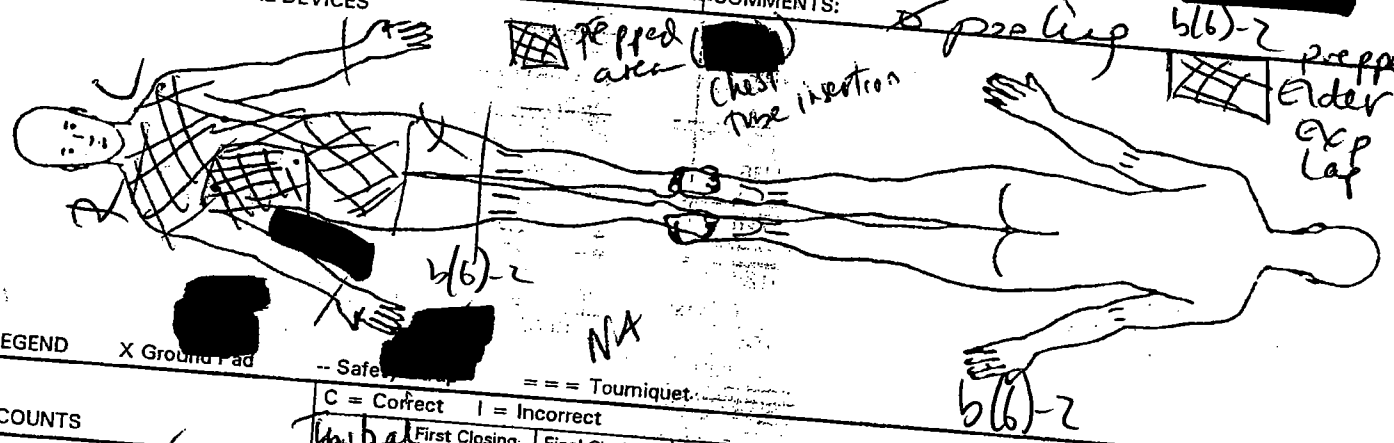
SITE: See #9

BY WHOM: [redacted]

BY WHOM: [redacted]

COMMENTS: Scrubing b(6)-2

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS C = Correct I = Incorrect

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

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

[redacted] b(6)-4

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

☑ ESU NO: VL Force R8B 10 30/30 40/40

GROUND PAD: BRAND VL Rem B/V II LOT NO: 70011

☐ ESU NO:

GROUND PAD: BRAND LOT NO:

☐ BIPOLAR NO:

A FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

13. PROSTHESIS, IMPLANTS ☐ YE ☑ NO IF YES NAME: ID NUMBE UFACTURER

b(6)-2 (all)

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. 36FR Chest tube	2.	3.
SITE	1. (R) axil	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

staples - 4x8 } Gx Cap
tape 2"
Xeroform c 2x2 silk tape

19. ADDITIONAL INFORMATION

[redacted]

b(6)-2 (all)

[redacted]

20. OPERATION(S) PERFORMED

Chest Tube Change OJT
Exp Lap

21. PATIENT TRANSFERRED TO ICU 2 TIME 0033 METHOD letter c O2 via paper

22. REG[redacted]D NURSE SIGNATURE [redacted] CPRN

REVERSE [redacted]

USAPA V1.00

PTS NAME: # [redacted] b(6)-4

DATE: 08 Oct 03

case 20040

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
BP INV																								
BP NIBP																		138/82	142/78	139/77	139/80	115/71	107/64	138/73
TEMP																O	O							
PULSE																		96		98	98	99		92
RESP																		68	64	70	65	68	72	71
SP02																R	R	22	20	20	18	19	20	15
FIO2																		100	100	100	100	100	99	100
																		102	102	102	102	RA	RA	RA
INPUT																								
IV																								
IVPB																								
blood																	2500	[redacted]	100	100	100	100	100	100
																				450				
PO																								
NGT																								
O.R. IN																								
SUB TOTAL																								
TOTAL																	2500		2600	3150	3250	3350	3450	3550
OUTPUT																								
URINE																								
NGT																								
STOOL																	700	[redacted]	280	150	200	150	250	300
CT																		0	30	50	30	0	40	30
O.R. OUT																								
SUBTOTAL																								
TOTAL																								
BALANCE																	700	-	280 / 980	200 / 1180	230 / 1410	150 / 1560	270 / 1830	280 / 2080

MEDCOM - 21330

PT's NAME: # [redacted] b(6)-4

DATE: 08 Oct 03

b(6)-2

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
BP INV	108/66	134/74	134/74	130/70	130/70	108/62	109/68	110/64	151/82	110/75	130/77	126/76	134/74	122/66	132/87	124/62	118/64	122/74	138/66	118/69	105	108	100	114
BP NIBP	108/66	100/65	100/67	100/60	100/57	114/68	110/50	112/72	109/65				116/74	115/68			120/78		124/56		74	68	58	68
TEMP	99.4	99.6	100.2	100.3	100.3	100.6	100.6	100.8	100.8 (A)	100.8	100.8	100.7	100.2	100.4		100.-	99.8		99.6		100.2		98.0	
PULSE	69	74	75	92	79	83	83	89	93	94	81	78	77	68	72	84	74	68	79	88	76	75	68	85
RESP	19	25	25	26	27	24	26	26	30	30	20	24	19	24	26	18	20	22	18	19	22	14	16	18
SP02	97	97	99	99	97	95	95	98	98	99	99	100	100	00	100	100	100	100	100	100	100	100	100	98
FIO2	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
ES		[redacted]																						
INPUT																								
IV	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
IVPB	150							100	50			100						100						
[redacted]																								
PO	440			60	30			60	60															
NGT																			150					
O.R. IN																								
SUB TOTAL																								
TOTAL	250	350	450	610	740	840	940	1200	1410	1510	1610	1810	1910	2010	2110	2210	2300	2500	2750	2850	2950	3050	3150	3250
OUTPUT																								
URINE	400	90 [redacted]	100	50	60	100	100	100	100	400	200	200	150	200	200	175	200	250	200	175	200	200	150	150
NGT																								
STOOL																								
CT	25	25	5	Ø	Ø	25	25	50	5	20	20	20	55	55	15	20	15	20	50	50	15	10	10	5
O.R. OUT																								
SUBTOTAL																								
TOTAL	425	540	605	665	715	840	965	1115	1220	1640	1860	2060	2070	2100	2215	2135	2145	2165	2175	2400	2615	2825	3085	3340
BALANCE																								

MEDCOM - 21331

PTS NAME #[redacted] b(6)-4 DATE 09 Oct 03

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
BP INV																								
BP MBP	91/48	101/	102/	108/	114/	105/	108/	102/	109/	106/	113/	110/	115/	113/										
TEMP	97.6	99.1	98.3	100.2	100.1	98.8	99.4	99.3	100.2	100.5	99.6	62	55	69										
PULSE	78	80	96	89	107	107	87	87	85	85	83	78	99.4	100.3										
RESP	13	20	21	26	23	25	17	20	19	17	20	18	90	90										
SP02	97	100	100	99	97	97	99	99	98	98	99	99	18	17										
O2	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	99	97										
I5													RA	RA										
[redacted]																								
INPUT																								
IV																								
IVPB	200	200	200	200	200	200	200	200	200	200	200	200	200	200										
	100																							
PO	60		60		240	100																		
NGT																								
O.R. IN																								
SUB TOTAL												100												
TOTAL	60	120		240																				
				360	460																			
PUT																								
URINE	100										560	760	960											
NGT			300																					
STOOL							250	300	250	550		450	275											
O.R. OUT																								
TOTAL																								
TAL	100		300				250		250	550		450	275											
ANCE							550	850	1100	1650		2100	2375											

b(6)-2

MEDCOM - 21332

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 160ct | 16 | 17 | 18

19 | HOUR: 1800 | 0600 | 1000 | 1400 | 1800 | 2000 | 0200 | 0700

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

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

(Centigrade Equivalents, for Reference only)

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

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

EPW

#[redacted] b(6)-4

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7–95) BACK

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

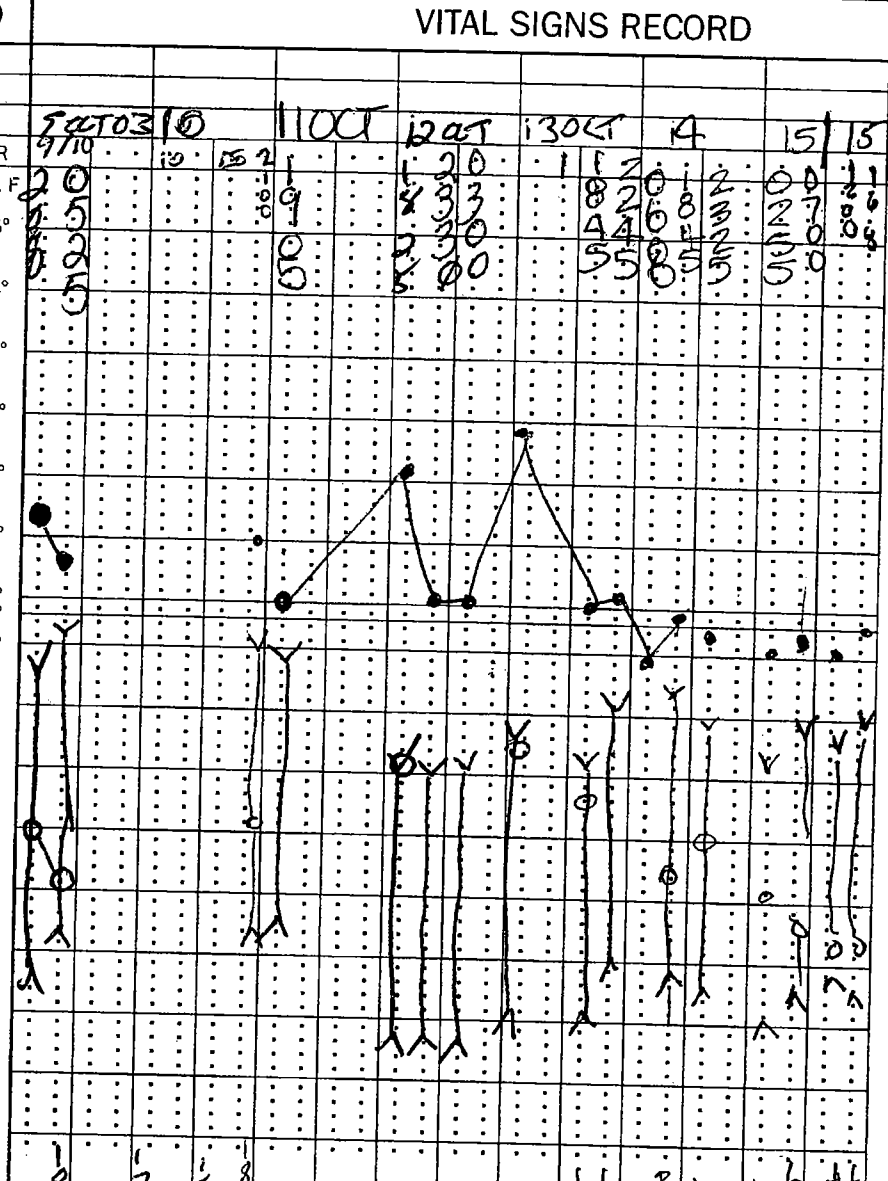
HOSPITAL DAY

POST- DAY

MONTH-YEAR OCT 03 DAY

19 HOUR

PULSE (0) — TEMP. F (°) — TEMP. C



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

MEDCOM - 21334

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

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0600	H2O	1000cc	1000cc

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
1800	200cc/°	LR IVF	2400cc	0600	2400cc

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

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
18-06 HOCT	1200	1200							
150CT 1806	800	800							
150CT03 2100	700cc	700cc							
2300	500cc	1200cc							
0045	500cc	1700cc							
0530	600cc	2300cc							

CHEST TUBE						EMESIS			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL
14 0600	45cc								
15 (06-06) 0600	90cc	90cc							
15OCT 03 1800 Start of shift →		@ 1225cc							
16OCT 03 0600	Ø	1225cc							

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

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
18-06	1200	1200			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0600 ~~1800~~	100	100	1800		
18-06	60	160			

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

REMARKS

GRAND TOTAL OUTPUT

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 ____ HOURS TO ____ HOURS | TOTAL HOURS COVERED | DATE 16 OCT 03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0600	H2O	500	500
1800	H2O	500	1000
1800	JUICE	180	1180

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0600	200	LR		1800	2400
1800	200	LR	2400		4800

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

#[redacted] b(6)-4

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

LAST, FIRST,MI. [redacted]		DATE	TIME		SSN/PEEUDO SSN:

b(6)-4

(Piccolo) Chemistry 12

RESULT	REF. RANGE
	3.5-5.5 g/dl
	26-84 u/l
	10-47 u/l
	14-97 u/l
	11-38 u/l
	0.2-1.6 mg/d
	7-22 mg/dl
	8.0-10.3 mg/
	100-200 mg/
	0.6-1.2 mg/d
	73-118 mg/d
	6.4-8.1 g/dl

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
tCO2		18-33 mmol/l

RI

RE

:

```
.DPOINT COAG ANALYZER V
RIAL [redacted] 10/07/03
```

b(6)-4

```
Patient ID: [redacted]
  Test Name  :PT
  Test Result:= 14.2 sec.
  Ratio = 1.2
  Calculated INR = 1.28
  Sample Type:citrated wh. blood
  Test Date  :10/07/03
  Test Time  :21:16
  Card Lot   [redacted]
  Operator
```

```
RAPIDPOINT COAG ANALYZER  V4.54
SERIAL [redacted] 10/07/03  21:21
```

b(6)-4

```
Patient ID: [redacted]
  Test Name  :APTT
  Test Result:= 29.9 sec.
  Sample Type:citrated wh. blood
  Test Date  :10/07/03
  Test Time  :21:17
  Card Lot   [redacted]
  Operator   [redacted]
```

b(6)-2

colo) Metlyte 8

RESULT	REF. RANGE
	73-118 mg/d
	7-22 mg/dl
	0.6-1.2 mg/dl
	39-380 /l (M) 30-190 /l (F)
	128-145 mm
	3.3-4.7 mmol
	98-108 mmol
	18-33 mmol/

```
======= PICCOLO =======
07/10/03              21:04
REFERENCE RANGE:        MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: [redacted]
OPER #: [redacted]      DR #: 000
SERIAL #: [redacted]
.......................
GLU   170*  73-118   MG/DL
BUN    14   7-22     MG/DL
CRE   1.4*  0.6-1.2  MG/DL
CK    137   39-380   U/L
NA+   127*  128-145  MMOl/L
K+    3.8   3.3-4.7  MMOl/L
CL-   100   98-108   MMOl/L
tCO2  24    18-33    MMOl/L

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

b(6)-4

b(6)-2

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

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

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10	Color	Yellow	N/A	RPR		Negative
RBC		4.7-6.1 x10	App	clear	N/A	Mono		Negative
Hgb		14-18 g/dl(M) 12-16 g/dl(F)	Glu	Neg	Negative	Microbiology		
Hct		42-52%(M) 37-47%(F)	Bili	Neg	Negative	Source		
MCV		80-94 fi(M) 81-99 fi(F)	Ket	Neg	Negative	Gram Stain		
Plt		130-500 x10³ verified	SG	1.030	N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld	~~Neg~~ small	Negative	H. pylori		Negative
(Hematology) Manual Differential			pH	6.0	N/A	Micro Parasites		
Segs		Mono	Prot	2+	Negative	Malaria		
Bands		Eos	Urob	0.2	0.2-1.0	O & P		
Lymph		Baso	Nit	Neg	Negative	Other		
Atyp		Imm	Leuk	Neg	Negative	Macroscopic Urinalysis		
RBC Morph			HCG		Negative	SSA - Trace Epi-5-10 Heavy-mucus		
Spun Hematocrit		42-52%(M) 37-47%(F)	CSF			Blood Bank		
Set Rate			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED		
Other			Directigen		Negative	ABO/Rh		

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

REMARKS:

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

Pato

b(6)-2

Ward/Section: ICU2	REQUESTING PHYSICAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST,MI. [redacted] b(6)-4	DATE 10 OCT 03	TIME 2245	SSN/PE[redacted]N: [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 x1(verified
Lymph %		20.5-51.1%

(Hematology) Manual Different

Segs		Mono	
Bands		Eos	
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

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

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:	DATE:	LAB ID NO.:

b(6)-2 b(6)-4

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

LAST, FIRST, MI. [redacted] b(6)-4	DATE 06 07 03	TIME 22 05	SSN/PEEUDO SSN: [redacted]

(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

TEST	RESULT	REF. RANGE

======= PICCOLO =======
07/10/03 22:58
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
BASIC METABOLIC
DISC LOT #: [redacted]
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-2 [redacted]

GLU	91	73-118	MG/DL
BUN	9	7-22	MG/DL
CA++	6.8*	8.0-10.3	MG/DL
CRE	0.7	0.6-1.2	MG/DL
NA+	133	128-145	MMOL/L
K+	4.1	3.3-4.7	MMOL/L
CL-	104	98-108	MMOL/L
tCO2	19	18-33	MMOL/L

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

(Piccolo) Metabolic Panel

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

b(6)-4 b(6)-2 b(6)-4

Ward/Section: OR	REQUESTING PHYSIC [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted]	DATE 7Oct03 / TIME 2350	SSN/DE [redacted]

(i-STAT)

TEST	RESULT	REF. RANGE
Na	142	138-146 mmol/dL
K	3.7	3.5-4.9 mmol/L
CI		98-109 mmol/L
pH	7.378	7.31-7.45
PCO2	37.4	35-45 mmHg (art) 41-51 mmHg (ven)
PO2	454	80-105 mmHg (art) N/A (ven)
TCO2	23	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	22	22-26 mmol/L (art) 23-28 mmol/L (art)
SO2	100	95-98%
BEecf	-3	(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca	1.11	1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct	23	38-51% PCV
Hgb	8	12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-1		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 /l (M) 30-190 /l (F)
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Metabolic Panel

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICU2	REQUESTING PHYSICAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)		
LAST, FIRST,MI. # [redacted] b(6)-4		DATE 08 Oct	TIME 0300	SSN/PEEUDO SSN:

(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 x1 verified
Lymph %		20.5-51.1%

(Hematology) Manual Differen

Segs		Mono	
Bands		Eos	
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

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

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: F/u after blood transfusion

REPORTED BY:	DATE:	LAB ID NO.:

b(6)-4 b(6)-2

Ward/Section: 1CU2	REQU[redacted]		LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI. [redacted]	0800	DATE / TIME 0430	SSN/PEEUDO SSN:

(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)

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		

CSF

Cell Count		
Directigen		Negative

Blood Bank (MUST SUBMIT SF 518 W REQ

UNIT		

PICCOLO
08/10/03 04:52
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: [redacted]
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]
b(6)-2

GLU	146*	73-118	MG/DL
BUN	10	7-22	MG/DL
CRE	1.0	0.6-1.2	MG/DL
CK	905*	39-380	U/L
NA+	131	128-145	MMOL/L
K+	4.3	3.3-4.7	MMOL/L
CL-	103	98-108	MMOL/L
tCO2	20	18-33	MMOL/L

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

b(6)-2

REMARKS: [redacted] met 8

REPORTED BY: DATE: 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)

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

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 /l (M) 30-190 /l (F)
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Metabolic Panel

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

b(6)-4 b(6)-2

Ward/Section: ICU2	REQUESTING PHYSICIAN: [redacted]			CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. # [redacted]		DATE 09/07	TIME 0400	SSN/PEEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
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 (art)

(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

(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^{+}		128-145 mmol/l
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
tCO2		18-33 mmol/l

======= PICCOLO =======
09/10/03 04:47
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: [redacted]
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-2 [redacted]

GLU	133*	73-118	MG/DL
BUN	8	7-22	MG/DL
CRE	1.3*	0.6-1.2	MG/DL
CK	1955*	39-380	U/L
NA+	127*	128-145	MMOL
K+	4.4	3.3-4.7	MMOL
CL-	100	98-108	MMOL
tCO2	23	18-33	MMOL

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

REMARKS:

REPORTED BY:

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

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

(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 x 10³ 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

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		

Macroscopic 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 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: Met-8 CBC

REPORTED BY:	DATE:	LAB ID NO.:

CHEMISTRY RESULT FORM
(Subject to the Privacy Act of 1974)

Ward/Section: ICW #1

REQUESTING PHYSICAN: [redacted] b(6)-2

LAST, FIRST, MI. [redacted] b(6)-4

DATE: 130ct

TIME: 1338

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
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 mm 23-28 mm
SO2		95-98%
BEecf		(-2) - (+3 mmol/L
AnGap		10-20 mr
Ca		1.12-1.32
BUN		8-26 mg
GLU		70-105 r
Creat		0.7-1.5 r
Hct		38-51%
Hgb		12-17 g

Misc. Chemistry

TEST	RESULT	REF. R
Tropoin-1		
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
		8.0-10.3 mg/dl
		00 mg/dl
		.2 mg/dl
		18 mg/dl
		.1 g/dl
		REF. ANGE
		18 mg/dl
		mg/dl
		.2 mg/dl
		30 /l (M) 90 /l (F)
		145 mmol/l
		.7 mmol/l
		08 mmol/l
		3 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^{+}		128-145 mmol/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^{+}	130	128-145 mmol/l
K^{+}	4.2	3.3-4.7 mmol/l
CL^{-}	94	98-108 mmol/l
tCO2	37	18-33 mmol/l

REMARKS: CBC + Lytes Please

REPORTED BY: [redacted]

DATE: 130ct03

LAB ID NO.:

b(6)-2

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 24 DAYS MOS YRS

Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE:
SURGICAL SERVICE: I&D (L) Arm & Leg
NPO SINCE: 1800

136/76 93

ASA Physical State 1 2 3 4 5 (E)
WT: 190 KG/LB HT: ____ IN.
ALLERGIES: NKA

HABITS:
TOBACCO: Ø
ETOH:
DRUGS:

CURRENT MEDICATIONS:
( ) = ordered as premed

( )
( )
( )
( )
( )
( )

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

LABORATORY STUDIES:

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

T&A
5 probs

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT
PAST SURGICAL/ANESTHETIC

T&A
Ø probs

PHYSICAL EXAMINATION
BP ___ HR ___ R ___ T ___
Pain Scale 0-10 ____
HEENT - Teeth ____
Trachea ____
TMJ/Neck ____
Oropharnyx ____
Nares ____
CHEST: ____
CARDIAC: ____
EXTREMITIES: ____
IV Access: ____
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since ____

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ (X) 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 [redacted] understand and agrees. Questions answered.

Signed: [redacted] b(6)-2 Date: 07 Oct 03 Time: 2020 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

SEDATION KEY:

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

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)																
Fentanyl	(mcg)				150	100											
Succinylcholine	(mg)		.4														
Vecuronium	(mg)					5											
Propofol	( )																
	( )																
	( )																
VOLAT AGENT: Iso	% del					1.3-1.0											
	% e.t.																
AIR	L/Min																
N2O	L/Min																
O2	L/Min					3-3-10-10											

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

FLUIDS

LINE site																	
16g IV (L) forearm	☐ Warmed																
RIJ 8.5Fr Cordis	☐ Warmed																
	☐ Warmed																
	☐ Warmed																

LOSSES: EST BLOOD LOSS; URINE - Foley

PHYS STATUS: 1 2 3 4 5 (E)

BODY WEIGHT: 50 KG / LB

HEMATOCRIT:

INITIAL DATA: BP- 82/42

HR-

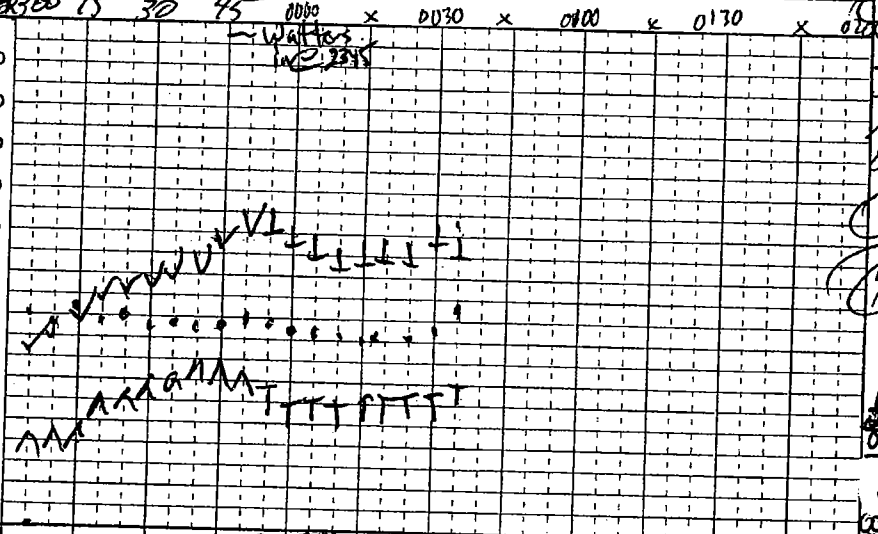
EQUIP CHECK OK?- Y N

PATIENT RECHECK OK for PROCEDURE? TIME-

TIME → 2300 15 30 45 0000 × 0030 × 0100 × 0130 × 0200

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

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



VENTIL

VT - ml					730	750	700	800
f - breaths/min					8	8	8	16
Peak inf pres / PEEP					16	16	16	
MODE - S(pon), A(ssist), C(on)					C	C	C	5

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)				37	35	36	35
BP/oth	FIO2 (Frac or %)	FM	.63	.63	.63	.73	.73	.73
ART line	SpO2 (%)		100	100	100	100	100	100
Steth- PC/ES	ECG	ST	ST	ST	ST	ST	ST	ST
Gas analyzer	TEMP-site							
	N-M Block (T/4)					2/4		1/4
								EST 0050
Warming blkt								
Conv warmer								

Mark with letters & symbols, explain under REMARKS — EVENTS Position → (1)

TOTALS: 250 — **TOTAL EBL**: min - 350 ECL

5 — **TOTAL URIN**: [redacted] 700cc b(6)-2

FLUIDS - SUMMARY

CRYSTALLOID- 2500cc

COLLOID- Ø

BLOOD- 1 unit

REMARKS

Code drugs with numbers, events with letters

(1) 4/5 Taken

(2) Induced
C-Norcuronium
Diprivan 120mg
Anectine 120mg
O2, Intubated

(3) Procedure begun

(4) 8.5Fr cordis RIJ Seldinger technique (sterile) (⊙) transduced / (⊙) comment
(R) radial Aline - 2345 ABG H2H 33/18 0000 Turn [redacted] b(6)-2

[redacted]
0015 Recovered c 50 [illegible] Dilaudid
0030 Extubated c [illegible], Awake to FCO c [illegible]
O2 - Resp to RW

RECOVERY AT 0040

PACU ICU 2 (Specify)

OTHER

CONDITION: Stable mask O2

RESP- 28 SpO2- 100 c NC

BP- 145/72 HR- 80

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	2245	2305	0045
PROC	Ready	Begin	End
	2320	2340	0035

PROCEDURES and CPT Codes: Ex lap

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

[redacted] b(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GETA

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

SURGEONS [redacted]

ANES[redacted] CRNA [redacted] MDA

[redacted] CRNA

b(6)-2

PROCEDURE LOCATION: OR 2

DATE: 7 Oct 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 — PART 2 - ANESTHESIA PROVIDER — USAPA V1.00

518-123

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

NSN 7540-00-634-4158

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 Unit ML

REMARKS:

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

DATE REQUESTED 7 Oct 03

DATE AND HOUR REQUIRED ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* [redacted] b(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE Ex Lap

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 [signature]

DATE VERIFIED 5/18

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR
ABO B
Rh Pos

RECIPIENT
ABO B
Rh Pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Comp

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

SIGNATURE OF PERSON PERFORMING TEST [redacted]

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

REMARKS: exp 14 Oct 03 b(6)-2

DATE 7 Oct 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

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

AT *(Hour)* 2300 ON *(Date)* 7 Oct 03

IDENTIFICATION

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

1st V[redacted] b(6)-2

nd VE[redacted]

RE-TRANSFUSIO[redacted]

MP. 37 PULSE 96 BP 122/65

TE OF TRANSFUSION 7 Oct 03 TIME STARTED 2359

POST-TRANSFUSION DATA

AMOUNT GIVEN All ML

TIME/DATE COMPLETED/INTERRUPTED 0010 8 Oct 03

REACTION
- [x] NONE
- [ ] SUSPECTED

TEMPERATURE 37 PULSE 95 BLOOD PRESSURE 125/65

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

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

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

SIGNATURE [redacted] b(6)-2

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

[redacted] b(6)-4

CRWA

M

WARD OR

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

518-123

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

NSN 7540-00-634-41

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 Unit ML

REMARKS:

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

DATE REQUESTED: 7 Oct 03

DATE AND HOUR REQUIRED: ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN (Print): [redacted] b(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: Ex Lap

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: see original 518

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: b(6)-4 [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR
- ABO: B
- Rh: Pos

RECIPIENT
- ABO: B
- Rh: Pos

TEST INTERPRETATION
- ANTIBODY SCREEN: N/A
- CROSSMATCH: Comp

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

SIGNATURE OF PERSON PERFORMING TEST: [redacted]

DATE

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

REMARKS: Exp 8 Oct 03 b(6)-2

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY (Signature): [redacted] b(6)-2

AT (Hour): 0000

ON (Date): 8 Oct 03

IDENTIFICATION

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

1st VERIFIER (Signature): SGT [redacted] b(6)-2 (WM6

2nd VERIFIER (Signature): [redacted] b(6)-2

PRE-TRANSFUSION [redacted]

TEMP. 98 | PULSE 70 | BP 138/77

DATE OF TRANSFUSION: 08 Oct 03

TIME STARTED: 0200

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

[redacted] b(6)-4

POST-TRANSFUSION DATA

AMOUNT GIVEN: 450 (all) ML

TIME/DATE COMPLETED/INTERRUPTED: 08 Oct 03

REACTION
- [x] NONE
- [ ] SUSPECTED

TEMPERATURE: 97.9 | PULSE: 64 | BLOOD PRESSURE: 142/80 (arterial)

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

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

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

SIGNATURE OF PERSON NOTING ABOVE: SGT [redacted] b(6)-2

SEX: M

WARD: OR

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

ICW1 (1200) thank you

NSN 7540-01-165-7234

519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
Portable CXR PA/LAT				ICW1	
	FILM NO.				PREGNANT ☐ YES ☐ NO
	REQUESTED BY (Rank, Name) Dr [redacted]				TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTER				DATE REQUESTED 12 Oct 03

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

Chest tube removed (R) side

b(6)-2

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*
17 Oct 03		

RADIOLOGIC REPORT

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

EPW#

[redacted] b(6)-4

Room 1

bed A

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
1 — MEDICAL RECORD

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

MEDCOM - 21354

NSN 7540-01-185-7294

Morning

519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
CXR - portable please		M	# [redacted]	ICW#1	
	FILM NO.				PREGNANT ☐ YES ☒ NO
	REQUESTED BY (Print) [redacted]				TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR				DATE REQUESTED 20OCT03 0400 please

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

b(6)-2 b(6)-4

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*
10/12/03		

RADIOLOGIC REPORT

Clin Note

1) RLL opacity
2) Small (R) Pneumothorax - (2cm - 3cm - (R) apex mass.)
3) (R) CT
4) sharpen.

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

[redacted] b(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
1 — MEDICAL RECORD

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

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 8 Oct TIME OF ORDER 0630 HOURS

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

1. Δ IV to D5 1/2 NS1000 w 20 mEq [redacted] at 100/h
2. DC NG
3. OOB chair BID
4. sips of water
5. Percocet 1-2 po q4 prn pain DC MS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER

6. CXR R arm 9 Oct also HO [redacted] b(6)-2
7. Nutrition to 25 cm [redacted]
8. OOB chair
9. IS b(6)-2

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 8 Oct 03 TIME OF ORDER 0905 HOURS

Δ IV to D5NS 1/2 20 mEq KCL @ 100 cc/hr

Vio Dr. [redacted] MC

Noted Sgt [redacted] b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER

11 Oct 1300 HOURS

1. Reg diet
2. DC IV + all IV meds
3. portable CXR now + 0400 120ct 03

Noted [redacted] 110ct03 b(6)-2 [redacted]

[redacted]

NURSING UNIT | ROOM [redacted]

DA FORM [redacted] 1 APR 79 [redacted] REPLACES ED [redacted] CH MAY BE USED. 110CT @ 2200

☆ U.S. [redacted] 1994-553-710

MEDCOM - 21356

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	LIST TIME ORDER NOTED AND SIGN
9 Oct 03	0630 HOURS	
1 DC A line done		
2 DC Foley done		
3 full liq diet		
4 CXR portable 10 Oct am		
5 Nystatin NC mouth + mouth [redacted]		
6 ↑ IV to 200/hr		
7 lyte 10 Oct		

b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.
ICW 1	24	

DATE OF ORDER	TIME OF ORDER	
9 Oct 03	0630 HOURS	
1 CT to water seal		
VO. Dr [redacted]		

b(6)-2

[redacted]

11 Oct 03 @ 0130

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW 1		

DATE OF ORDER	TIME OF ORDER	
13 Oct 0930	HOURS	
1 portable CXR 1600		
2 water seal		

[redacted]

b(6)-2

noted

PATIENT IDENTIFICATION

[redacted] b(6)-4

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW 1		

DATE OF ORDER	TIME OF ORDER	
13 Oct 1300	HOURS	
1 flat/upright CXR now evel for SBO and pneum		
2 IV LR at 200/hr		
3 CBC, lyte		

[redacted]

13 Oct 03 1300

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994-363-710

CLINICAL RECORD - 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			10/13	2030 HOURS	
			(P) CT to SXN		
			V.O. DR [redacted]	[redacted]	CPT b(6)-2
NURSING UNIT	ROOM NO.	BED NO.			
[redacted]					

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
b(6)-4 [redacted]	14 Oct 03 1100 [redacted] b(6)-2		14 Oct 03	HOURS	b(6)-2
			CXR now + am 15 Oct		[redacted]
			None		[redacted]
NURSING UNIT	ROOM NO.	BED NO.			
24P	14 Oct 03 @ 1945	[redacted]			

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
			16 Oct 0100	HOURS	
			CXR 0400		
	noted [redacted] b(6)-2				b(6)-2 [redacted]
NURSING UNIT	ROOM NO.	BED NO.			
24P	17 Oct 03 0200				

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

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994-563-710

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 Oct 0930	HOURS	[redacted]
			1	water seal		
			2	CXR at [redacted] b(6)-2		
NURSING UNIT	ROOM NO.	BED NO.				
ICW	[redacted]					

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

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

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

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.
KCWH1	[redacted] 1	A

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
190ct	0830 HOURS	[redacted]
discharge pt	[redacted]	

PATIENT IDENTIFICATION b(6)-2

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF	
	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 *(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 7	8	9	10	11	12
7OCT	[redacted]	DIET: NPO #18 NG TO	06	/	/	[redacted]			
		LIS	18			[redacted]			
7OCT	[redacted]	ACTIVITY: BEDREST	06	/		[redacted]			
			18			[redacted]			
7OCT	[redacted]	VS Q4°	06	/		[redacted]			
			18			[redacted]			
7OCT	[redacted]	(R) CT TO -20CM SUCTION	06	/		[redacted]			
			18			[redacted]			
7OCT	[redacted]	FTG DRAIN - CALL MD	06	/		[redacted]			
		IF UO < 60CC IN ANY	18			[redacted]			
		2 CONSECUTIVE HOURS	/			[redacted]			
7OCT	[redacted]	CT OUTPUT, IF >	06			[redacted]			
		500 CALL M.D.	18			[redacted]			
8OCT	[redacted]	O2 SATS MONITOR	06	/		[redacted]			
		≥ 90%	18	/		[redacted]			
8Oct03	[redacted]	OOB Chair BID	06	/		[redacted]			
			18	/		[redacted]			
8Oct03	[redacted]	Sips of water	06	/		[redacted]			
			18	/		[redacted]			
8Oct03	[redacted]	(R) CT to 25cm Suction	06	/		[redacted]			
			18	/		[redacted]			
8Oct03	[redacted]	LS	06	/		[redacted]			
			18	/		[redacted]			
9Oct03	[redacted]	Full liq diet	07	/	/	[redacted]			
			12	/	/	[redacted]			
			18	/	/	[redacted]			
9Oct03	[redacted]	CT to H2O Seal	06	/	/	[redacted]			

D/Cd 08Oct

D/Cd 08Oct

DS

A/d

Foley DC'd

CT to H2O Seal

D/Cd

CT to Water Seal

D/C'd 11Oct03

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: PENETRATING WOUND (R) BACK & PNEUMO/HEMO & LIVER PENETRATION (all) b(6)-2

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION:

[redacted] b(6)-4

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. Oct Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
07 Oct	[redacted]	admit to ICU 2 condition fair	07 Oct ~~2130~~	2130	2130	[redacted]
07 OCT	[redacted]	CONDITION: FAIR	7 OCT	—	—	[redacted]
07 OCT	[redacted]	CBC, LYTES, PORTABLE CXR	8 OCT	0400	0400	[redacted]
07 OCT	[redacted]	TYPE AND SCREEN	7 OCT	2145	2145	[redacted]
08 OCT	[redacted]	PORTABLE CXR NOW				[redacted]
8 Oct	[redacted]	CXR am 9 Oct also CBC	9 Oct	0400	0400	[redacted]
9 Oct	[redacted]	CXR 10 Oct 03 AM & lytes	10 Oct	0400		
11 OCT 03	[redacted]	Portable CXR now	11 OCT 03			
12 OCT 03	[redacted]	Portable CXR @ 0400 12 OCT 03	12 OCT 03	0400		
		b(6)-2				

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

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

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(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 11	12	13	14	15	16	17	18	19
01 OCT03	[redacted]	VS q4°	06	[redacted]								
			18									
02 OCT03	[redacted]	OOB to chair BID	06									
			18									
08	[redacted]	IS	06									
			18									
09 OCT03	[redacted]	CT to H2O seal	06									
		c̄ suction	18									D/C'D
11 OCT03	[redacted]	Reg diet	06									
			18									

b(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Penetrating Wound (R) back Liver Lac Hemo/Pneumo

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

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
11 OCT03	[redacted]	Portable CXR now	11 OCT03	—		
11	[redacted]	Portable CXR @ 0400 on 12OCT03	12 OCT03	0400	done	
13 Oct	----	Portable CXR @ 1600	10/13			
13 Oct	[redacted]	Flat & upright CXR now (Eval	10/13	1300	done	
	----	for SIRS & pneumonitis				
10/13	[redacted]	CBC, lytes	10/13		done	
10/14	[redacted]	CXR in AM 15Oct	10/15	0400	done	

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

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED												
				9	10	11										
9Oct03	[redacted]	CT to H20 Seal	18	[redacted]												
		b(6)-2														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

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

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 7	8	9	10
7OCT03	[redacted]	IV LR @ 100cc/HR	06	/		A	d
			18	[redacted]			
7OCT03	[redacted]	ANCEF 1GM IVPB	06	/	[redacted]		
		Q8°	14	/			
	-----		22	/			
8OCT03	[redacted]	CIMETIDINE 200MG	06	/			DCd 11OCT03
		IV Q6°	12	/			
	-----		18	/			
	-----		24	[redacted]			
8OCT03	[redacted]	D5 ½ NS c 20 meq KCL	06	/		A	d
	-----	@100cc/hr	18	/			
8OCT03	[redacted]	D5NS c 20 meq KCL	06	/		A	d
	-----	@100cc/hr	18	/			
9OCT03	[redacted]	D5NS c 20 meq KCL	06	/	[redacted]		DCd 11OCT03
	-----	@200cc/hr	18	/			
9OCT03	[redacted]	Mycostatin swish &	06	/	[redacted]		
	-----	swallow	18				

	-----	b(6)-2					

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: PENETRATING WOUND (R) BACK C PNEUMO/HEMO & LIVER PENETRATION

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted] b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. OCT Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
8OCT	[redacted]	T UNIT PRBCs NOW				
11 OCT03	[redacted]	D/C IV and all IV meds	11 OCT03			[redacted]
		b(6)-2				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
		MSO4 2-6mg	08Oct 0835 4mg [redacted]													
		IV q 1-2 hrs pr														
		PAIN														
8Oct03	[redacted]	percocet 1-2 po	1615 [redacted]	8Oct 2030	8Oct 0100 [redacted]	9Oct	9Oct 1255	9Oct 1820	[redacted]	10Oct 1000	10Oct 1330	10Oct 2225	11Oct 0150	11Oct 0817		
		q 4° prn pain	[redacted]													
		b(6)-2														

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

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

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 11	12	13	14	15	16	17	18	19
10/13	[redacted]	IV LR @ 200 cc	06	[redacted]			06	07	[redacted]			
		b(6)-2	18									
			18									
			06									

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Penetrating Wound (R) back Liver Lac Hemo/Pneumo

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION:

#[redacted] b(6)-4

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)					Mo. 10 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials	
11 OCT 03	[redacted]	D/C IV and all IV meds	11 OCT 03			[redacted]	
		b(6)-2					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION													
08 OCT 03	[redacted]	Percocet 1-2 PO q4° pm pain	D/T	11 OCT 1630	11 OCT 2100	12 OCT 0130	1130	[redacted]	12 OCT 2300	13 OCT 0500	1700	13 OCT 2100	14 OCT 0415	14 OCT 0915	15 OCT 0900	15 OCT 1730
			D/I	[redacted]												
08 OCT 03	[redacted]	Percocet 1-2 PO q4° PRN pain	D/T	1500 2215		1600 1345	1800 2015	17 OCT 1000	17 OCT 2015	18 OCT 1900	0100					
			D/I	[redacted]												
		b(6)-2														

[redacted] b(6)-4

MEDCOM - 21369

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

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: 08Oct03
Time In: 0040
Allergies: NKDA
Pre-op V/S: 82/42
Procedures: ex lap

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 2300 Colloid
OR Output: UOP 700 EBL 350
Meds/Times: 250 ICNT

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds History

Time	0040	0045	0050	0055	0100	0110	0125
SaO2							
FiO2							
Methods							
240							
220							
200							
180							
160							
140							
120							
100							
80							
60							
40							
20							
RR	16	15	18	18	18	20	18
T	96.5	97.1		98		98.4	
Time							
Pain (0-10)							
LOS							

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	1	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	1	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	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	/	/	/
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	7	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

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

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

DEPARTMENT/SERVICE/CLINIC: ICU 2

DATE: 08Oct03

(Continue on reverse)

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

Name – last, [redacted] b(6)-2

[redacted] b(6)-4

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

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

USAPPC V2.00

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
0235	-	MSO4	IVP	4mg	E	MZ

NEUROVASCULAR

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

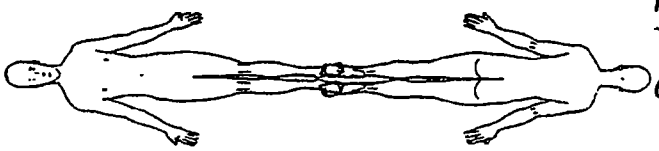
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	abd/R chest	bulky	Ø
30'	"	"	Ø
60'	"	"	Ø
D/C	"	"	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount
	See I+O		

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
		N/A	

WAMC OP 173-E

NURSING NOTES

b(6)-2

0040 - Transferred via litter to ICU2 s/p ex lap & chest tube replacement. pt. responsive to verbal (loud) pen la 2mm sluggish VS 138/82 p68 R22 SpO2 100% 10L venturi. report received from Dr [redacted] anesthesia present. Color good, pacu score 7. able to move all extremities. Cordis (R) jugular. blood tubing c̄ blood completed from OR still attached. site noted blood under site. 16G (L) AC patent Ru LR @ TKO 18G (R) PA heplock c̄ 3 way stopcock (R) radial a-line secured, functioning dry midline abd bulky CDI, DRG (R) lat chest wall c̄ CT @ 20cm suction @ 160cc blood in in pleural noted on arrival. Foley to gravity dry light yellow clear urine. will cont to monitor SBT [redacted]

0115 - unable to flush cordis Dr [redacted] notified. cordis b(6)-2 (a,4) removed tolerated well.

- cont SF 6DD SBT [redacted]

9 1 WMC

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

1. Reporting MTF	2. MTF Lo	Admission Coding Information
0580[redacted]	12 b(2)-2	For use of this form, see AR 40-400; the proponent agency is OTSG

3. Register Number	Name (Last, First, MI)	4. Pay Grade	5. Sex
[redacted]	[redacted] b(6)-4	FGN	M

6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
[redacted]	29Y	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	20:05	

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	ICU2	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	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD)
TRF-OTH		2003-10-19
24. Clinic Svc - Admitting	**25. MTF Transferred From**	**26. Date this Admission (YYYYMMDD)**
ABA - GENERAL SURGERY		2003-10-07
27. Location of Occurrence	**28. MTF of Initial Admission**	**29. Date of Initial Admission**
		2003-10-07

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: PENETRATING WOUND R BACK LIVER LAC, HEMO/PNEUMO

Procedure Narrative(s): T: 1 Inj: 448

Dx: 86239 86410 8605 8901 8771 8731 E999.9

PR: 5411 3402 4709 9927 9920.2

Cause of Injury Narrative: [redacted] b(6)-2

Admitting Officer (Signature, as req[redacted]

Signature of Admitting Clerk [redacted] SPC, 9/6/12

Automated Facsimile

IN-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	21Y	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	09:30	AEA - ORTHOPEDICS

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	TRF-OTH	2003-10-12

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-10-09	[redacted]

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
[redacted] b(2)-2	2003-10-09	

31. Selected Administrative Data

Marital Status: Z DoB: [redacted]

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

L LEG INJURY

Open (E) TIBIA Fx

DX: 1154.9
82362
73020

35. Total Days This Facility

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

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	4	4

[redacted] ding Medical Officer [redacted] b(6)-2

Signature of PAD or Medical Records Officer [redacted] b(6)-2

Automated Facsimile - DA FORM 3647, May 79

[redacted] b(2)-2

[redacted] **MEDICAL TRANSFER REQUEST FORM**

DATE OF REQUEST: 07 OCT 03 b(6)-2 b(2)-2

REQUESTOR: LTC [redacted] BN Surgeon

ISN #: 18811

~~COMPOUND~~: Correction Hospital

PRIORITY: ASAP

LITTER/(AMBULATORY) (CIRCLE) with crutches

DESCRIPTION OF INJURIES: Left tibia fracture 2° to GSW
Wears long-leg cast
* Requesting X-ray of LLE to assess healing status

NUMBER OF MEDICAL PERSONNEL ACCOMPANYING: Ø

DATE OF TRANSFER: 08 OCT 03

TIME OF TRANSFER: N/A

DESTINATION: [redacted] b(2)-2

POC AT DESTINATION: PAD

ANTICIPATED LENGTH OF TRANSFER: N/A

EQUIPMENT REQUESTS:

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

Followed by Iraqi surgeon

[redacted] b(6)-4

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

24 y/o Iraqi ♂ GSW (L) leg 2½ months ago - Treated & cast as opt in Iraqi hosp. x 2 months. EPW x 1 week

PMHx: ∅
PSHx: ∅
MEDS: pain
Allergy NKDA

PHYSICAL EXAMINATION

Height: WNL
Chest: CTA
Abd: soft
Ext: Mid shaft soft tissue loss c̄ exposed bone, decreased sensation, 2+DP/PT

XR: Mid shaft fibula bone loss

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

(A) Chronic Open (L) TIB/FIB Fx

(P) Admit

b(6)-2

SIGN[redacted]SICIAN	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted]			

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

b(6)-4

[redacted]

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 | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
07OCT03	S- Hx of tibia fracture 2° to gun shot. Has worn a long-leg cast for appr two months
	O Long leg cast on LLE c̄ wound window just below calf. Good pedal pulses
	[Wound care administered by an Iraqi surgeon]
	A Tibia fracture, Long leg cast } LLE
	P- X-rays LLE to asses status of healing
	[redacted] LTC MC
	b(6)-2

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

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

[redacted] ← b(6)-4

[redacted] b(2)-2

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)
	Discharge Summary
10-12-03	This patient has a chronic left tibia fracture with osteomyelitis and segmental bone loss. This injury and chronic condition is not reconstructable at any U.S. facility in country. The only reasonable option for this patient is below knee amputation. This patient has ~~repeatedly~~ steadfastly refused below knee amputation on numerous occasions. Therefore he can be treated as an outpatient with chronic suppressive antibiotics and long leg cast for several months. His fracture will not heal and he will have chronic osteomyelitis and ~~sub~~minimally functional extremity. Unless he requests below knee amputation, he does not require further inpatient orthopaedic care and outpatient follow up with Iraqi physicians at EPW hospital can be made in 2 months.
	[redacted] USD,
	b(6)-2
	b(6)-4

STANDARD FORM 600 (REV. 6-97) BACK

USAPA V2.00

[redacted]

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
11 OCT 03 0135	VSS. AO. 25 C2AB. HRR. ⊕ pulses to include ⊕ foot. c/o 7/10 pain to ⊕ leg and provided 4 mg MgO_4. NPO for Sp on 10/11/03 by Dr. Olivier. All other systems WNL. Voiding light yellow urine, sensation sufficient. b(6)-2 [redacted]
11OCT03	(1620) Assumed care of pt @ 0000 p report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ MSO4. Dsg to ULE CDI. Pt's surgery rescheduled for 12OCT03. Pt anxiore. Pt amb c̄ crutches s̄ difficulty. Tol. reg diet well. Voiding s̄ difficulty. 2 point restraints in place s̄ s/sx complications. SL in @forearm flushes well s̄ s/sx infection/infiltration. Will cont. to monitor. [redacted]
11Oct03@2000	VSS, Ø c/o pain @ this time, A+O x3, gets OOB & crutch walks s̄ difficulty, Dsg to ⊖LE CDI - reinforcing / S'ing PRN. NPO p̄ MN for OR tomorrow, initiating IVF's @ MN, HL to ⊕FA patent, x2 restraints when in bed s̄ s/s skin breakdown. Continue to monitor. b(6)-2 [redacted]
12OCT03	0910 Pt Transported to OR unbreaked we did not want BKA. Dr stated he would give IVN a cast & discharge home. Pt A&O VSS — [redacted] b(6)-2
12OCT03@1131	VSS, 98% O2Sat RA; HR 77; T-98.3; BP 112/57. NPO prior to OR and R after. Long cast in place ddli, amb indep on crutches. HL to ⊕arm patent. Restraints per equipment. b(6)-2 [redacted]

STANDARD FORM [redacted] ACK
USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
9OCT03	1720: Pt. admitted to ICW I from ER via wheel chair. VSS. Pt. A+OX3. Lung CTA. (+) BS X4 (+) pulses. +L in (R) upper arm patent to flush. Pt. NPO
b(6)-2 (o'll)	pending OR. [redacted] on (R) lower leg c/o. Edema to (R) foot. (-) Complaints @ this time [redacted] given
9 OCT 03	VSS. AO. (R) foot OTA c̄ dry, cracked skin c̄ (+) Z-smelly.
1927	(+) pulse to RLE and CVS intact. LSCTAB, HRR. NPO until Sx this PM. Provided blanket @ this time.
	[redacted]
10OCT03	(1055) Assumed care of pt w/ 0600 p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ MSO4. Drsg to LLE Δd this am. Three wounds on LLE draining small amount of sero-sang drainage. (+) pedal pulse equal bilat. Skin warm/dry to touch. Pt able to move toes. Pt OOB to BR c̄ crutches, for personal hygiene. Amb well c̄ crutches. Feet elevated in bed. SL in (R) ac flushes well s̄ S/Sx infection/infiltration. Tol. reg. diet well. Voiding s̄ difficulty. 2 point restraint in place s̄ S/Sx complications. Will continue to monitor. [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.

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

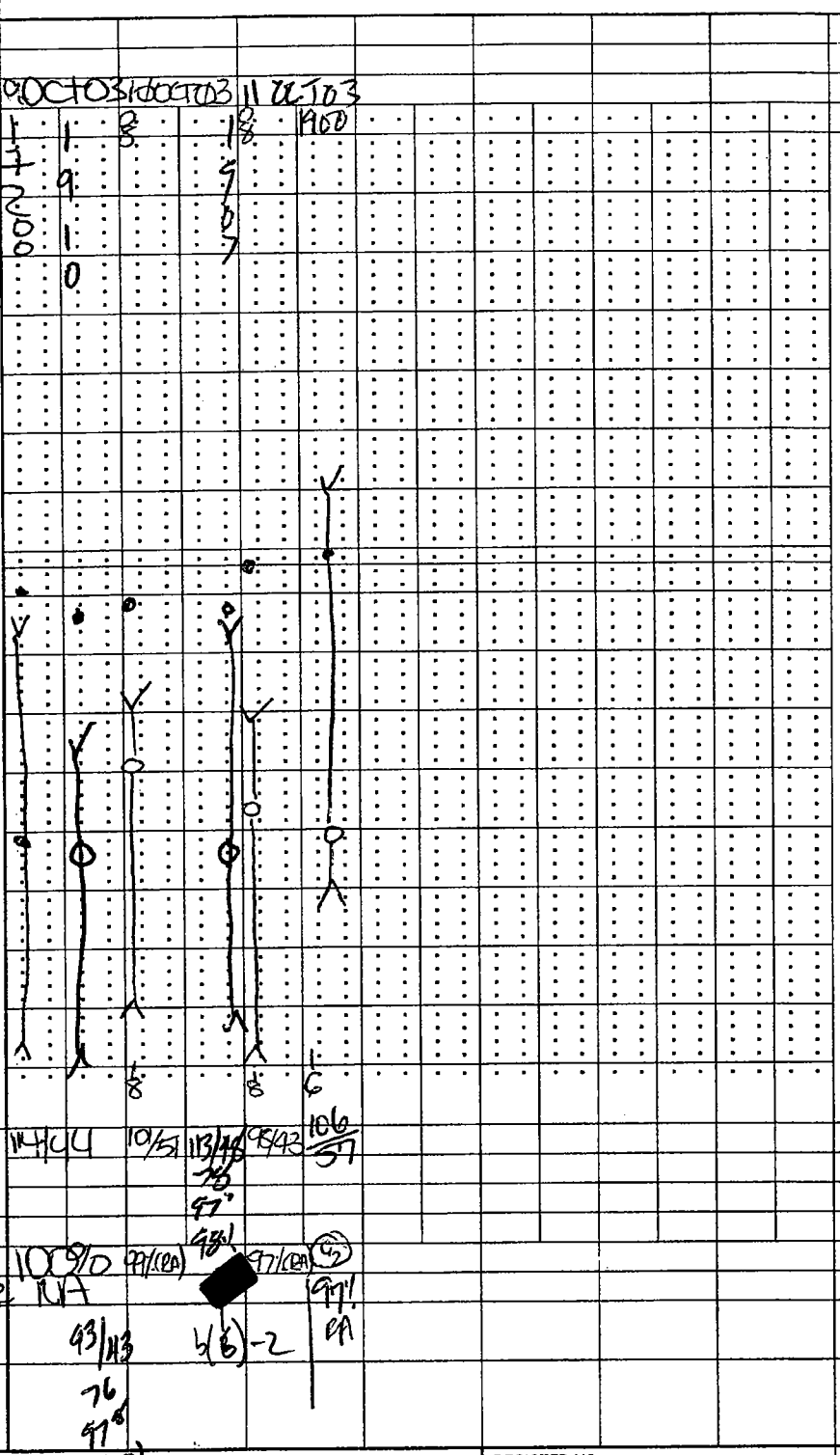
HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY | 19 | 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.

EPW # [redacted] b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

24yo Iraqi

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)
	( )
	( )
	( )
	( )
	( )
	( )
VOLAT AGENT	% del
	% e.t.
AIR	L/Min
N2O	L/Min
O2	L/Min

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

FLUIDS

LINE site	
	☐ Warmed
	☐ Warmed
	☐ Warmed
	☐ Warmed

LOSSES: EST BLOOD LOSS; URINE -

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: KG / LB

HEMATOCRIT:

INITIAL DATA: BP- ____/____ HR-

EQUIP CHECK: OK?- Y N

PATIENT RECHECK: OK for PROCEDURE? TIME-

TIME →

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

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

VENTIL: VT - ml; f - breaths/min; Peak inf pres / PEEP; MODE - S(pon), A(ssist), C(on)

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)
BP/oth	FIO2 (Frac or %)
ART line	SpO2 (%)
Steth- PC/ES	ECG
Gas analyzer	TEMP-site
	N-M Block (T/4)
Warming blkt	
Conv warmer	

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

TOTALS	TOTAL EBL
	TOTAL URINE

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

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

Vessel 2 yr Kentucky Tony
fr in pt refused BVR
end

RECOVERY AT

PACU ICU _____ (Specify)

OTHER _____

CONDITION:

RESP- SpO2-

BP- HR-

ANESTHESIA / PROCEDURE TIMES

ANES	Start	Room	End
PROC	Ready	Begin	End

PROCEDURES and CPT Codes: I&D

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

[redacted]

ICW, b(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

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

SURGEONS: [redacted] b(6)-2

ANESTHE[redacted]

PROCEDURE LOCATION:

DATE: 12 OCT 03

PAGE OF

b(6)-2

[redacted]

refused

pt

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

EPW [redacted] b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 10-9-03 TIME OF ORDER ____ HOURS

- Admit LCW - [redacted] - Dr [redacted]
- Operation ex ⓓ leg - osteo
- Stable
- Routine V. tals
- Reinforce Dressing ⓓ leg PRN
- Ambulate c crutches
- ~~Regular Diet~~

LIST TIME ORDER NOTED AND SIGN: NOTED 9OCT03 1700 [redacted] b(6)-2

PATIENT IDENTIFICATION

EPW [redacted] b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER ____ TIME OF ORDER ____ HOURS

- NPO now
- Heplock IV
- Demerol 50 mg IV q4° PRN pain
- Phenergan 25 mg IV q6° PRN nausea

[redacted]

PATIENT IDENTIFICATION

b(6)-2 (all)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 10/9/03 TIME OF ORDER 1940 HOURS

V.O. [redacted]

① Regular diet

② MSO4 q4-6° [redacted] pm [redacted] 10/9

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 10/10/03 TIME OF ORDER 1930 HOURS

① Percocet tabs ÷ - ÷ q4° PRN PO for pain

② NPO P MN

V.O. Dr. [redacted]

[redacted]

NURSING UNIT | ROOM NO. 2240 | BED [redacted] 0340

[redacted]

DA FORM 4256 ... 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			[redacted]	10-12-03	0900 HOURS	
				① D/C to EPW Hospital on CAMP ASAP		
					[redacted]	[redacted]
				b(6)-2	b(6)-2	10/12 1140
NURSING UNIT	ROOM NO.	BE				
ICW#1						

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

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

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

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

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
9 OCT	[redacted]	Admit ICW 1	9 OCT	DMW	E	[redacted]
9 OCT	[redacted]	DX: OPEN TIB FX (L) leg c̄ OSTEomyelitis	9 OCT	DMW	E	[redacted]
9 OCT	[redacted]	STABLE	9 OCT	—	—	[redacted]
10 OCT	[redacted]	NPO pMN	11 OCT	0000	—	[redacted]
12 OCT	[redacted]	D/C to EPW Hospital or camp				
	----	ASAP				
	----				b(6)-2	
	----	b(6)-2				

Order/ Exptr 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. 05

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 9	10	11	12
9 OCT 05	[redacted]	HEPLOCK IV	06	[redacted]			
	-----		18	[redacted]			

	-----	b(6)-2					

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: Open tib fx @ leg - Osteomylitis

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

EPW # [redacted] b(6)-4

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

DA FORM 1 FEB 79 4678 EDITION MEDCOM - 21385 ITIL EXHAUSTED.

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. OCT Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
		b(6)-2				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
9 OCT	[redacted]	Demerol 50mg IV	9 OCT 2030	10 OCT 1115	10 OCT 1515											
		q 4° PRN pain	50	50mg	50mg											
9 OCT		Phenergan 25 mg														
		IV q 6° PRN nausea														
10 OCT		MSO4 q 2-6° 2-8mg	D/T	10 OCT 0900	10 OCT 1000 2030	10 OCT 0840										
		PRN	D/I	5mg	2	5mg										
10 OCT		Percocet 5/325 PO	D/T	10/10 1930	11 OCT 1700	11 OCT 2115										
		q 4° for pain	D/I	2	1	2										

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

Admission and Coding Information

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

1. Reporting MTF	2. MTF Loca	3. Register Number	Name (Last, First, MI)	4. Pay Grade	5. Sex
0580 [redacted] b(2)-2	IZ	[redacted] b(6)-4	[redacted] b(6)-4	FGN	M

6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
[redacted]	21Y	X	9	UNKNOWN

10. Length of Service	11. FMP	12. Social Security Number	
ETS	99	[redacted] b(6)-4	

Organization (Active Duty Only)	13. Marital Status	Hour of Admission	Branch / Corps:
	Z	09:30	ARMY

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
		BC	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] Iraq; No Install Provided

Telephone Number of Emergency Addressee

21. Type of Disposition	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD)
TRF-OTH b(2)-2		2003-10-12

24. Clinic Svc - Admitting	25. MTF Transferred From	26. Date this Admission (YYYYMMDD)
AEA - ORTHOPEDICS		2003-10-09

27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission
		2003-10-09

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: L LEG INJURY

Procedure Narrative(s):

Cause of Injury Narrative:

b(6)-2

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

Automated Facsimile - DA FORM 2985, MAR 2000

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

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

1. Register Nbr	2. Name	3. Grade	Admission Remarks
[redacted]	[redacted] 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
99	[redacted] b(6)-4		ICU3

15. FlyStatus	17. Dept / Ben	18. BranchCorps	19. UIC / ZIP	20. Type Case
NO	K78-PRISONER OF WAR/INTER	ARMY		DIS

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	05:30	ABA - GENERAL SURGERY

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	TRF-OTH	2003-11-03

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

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

b(6)-2

31. Selected Administrative Data

Marital Status: Z DoB: [redacted]

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

S/P EX LAP WOUND DEBRIDEMENT

Dx		Proc
998.32		83.02
868.14		86.59
877.1		86.04
04.13		46.10
04.16	V44.3	88.40
00.83	E991.2	87.44
890.0		99.04 (4)
876.0		

b(6)-2

35. Total Days This Facility

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

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	[redacted]	0	25	25

Signature of Attending Medical Officer [redacted]

Signature [redacted]

Automated Facsimile - DA FORM 3647, May 79

MEDCOM - 21388

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
10 OCT 03	TRANSFER NOTE (CONT)
	AFTER INITIAL FLUID RESUSCITATION HE WAS TAKEN TO THE O.R. AT LAPAROTOMY THERE WAS NO INTESTINAL INJURY OR FECAL SPILLAGE, BUT HE HAS AN EXTENSIVE RETROPERITONEAL HEMATOMA. A DIVERTING SIGMOID END COLOSTOMY WAS DONE & THE (L) BUTTOCK WOUND WASHED OUT (NOTE - THERE IS STILL MILD/MOD OOZING FROM THIS WOUND). THE (R) KNEE WOUND HAS NOT BEEN ADDRESSED YET.
	IN SUMMARY, HE HAS AN EXTRAPERITONEAL RECTAL INJURY WHICH HAS BEEN DIVERTED, BUT HE WILL LIKELY NEED HIS RECTAL STUMP IRRIGATED & PRE-SACRAL DRAINS PLACED. HE HAS HAD 4 U PRBC TRANSFUSED POST-OP.
	[redacted] MST, MC
	b(6)-2

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

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10 OCT 03 (0330)	BRIEF OP NOTE PRE-OP DX: TRANSPELVIC GSW POST-OP DX: SAME, + EXTRAPERITONEAL RECTAL INJURY PROC: EX LAP, DIVERTING COLOSTOMY, (L) BUTTOCK WOUND IRRIGATION SURG: [redacted] b(6)-2 ANESTH [redacted] FLUIDS: EBL: < 100 mL UOP: FINDINGS: EXTENSIVE RETROPERITONEAL HEMATOMA w/ NO INTRAABDOMINAL FECAL SOILAGE, BUT (+) FECAL SPILLAGE FROM (L) BUTTOCK (EXIT) WOUND COMPLICATIONS: Ø CONDITION: GUARDED, TO PACU [redacted] MAJ, MC b(6)-2
10 OCT 03 (0400)	GENERAL SURGERY TRANSFER NOTE ~20 y/o IRAQI EPW SUFFERED GSW x 2 - ↓ THROUGH PELVIS + ↓ INTO (R) THIGH/KNEE. ON ARRIVAL HE WAS AWAKE + ALERT + HEMODYNAMICALLY STABLE. ON EXAM HE HAS AN ENTRANCE WOUND ON THE LATERAL (R) BUTTOCK + EXIT WOUND FROM LATERAL (L) BUTTOCK. FROM THE EXIT WOUND THERE IS GROSS FECAL SPILLAGE c/w RECTAL INJURY, + HE HAD (+) GROSS BLOOD ON RECTAL EXAM. INITIAL HCT = 39. ON THE (R) THIGH THERE IS A MID-LATERAL ENTRANCE WOUND + NO EXIT. THERE IS NO FEMUR FX, A RETAINED FRAGMENT BEHIND THE (R) KNEE, + INTACT PULSES DISTALLY. →

STANDARD FORM 509 (REV. 5/1999) BACK

*U.S. GPO: 2000-461-707/20307

#[redacted] b(6)-4 b(6)-2 (all

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
	[redacted]		

DATE	NOTES
11 Oct 03	1440 labs drawn per A-line sent [redacted]
	1520 labs received by Dr [redacted]
	orders received [redacted]
	1540 1st bag off LR c 15 meq @ 150 cc/hr [redacted]
	1710 Dr [redacted] @ bedside. update given. pt c [redacted] of Res. orders received. to extubate. pt placed [redacted]
	1720 Dr [redacted] transluxor @ bedside update given to pt. pt nods c respond to extubation. [redacted]
	1740 pt extubated. Dr [redacted] @ bedside along c RT. placed on 40% c humidicap SpO2 99%. RR 30s. LS (B) ESS CTA. [redacted]
	1750 [redacted] 25 mcg/hr. ø distress noted @ this time [redacted]
	1810 report given along c [redacted]
	1900: report received; pt recently extubated; RR 30; SaO2 98% on SM 40%; CTM; assessment complete & charted; HOB 30° [redacted] interpreter called to have pt understand post extub instructions and general medical condition; questions answered by interpreter [redacted]
2000	DHT NC due to gagging of pt; pt repositioned for comfort [redacted]
2100	drainage W→D due to bottles/dep wound packed c wet Kerlix; cover c ABD; ø hemorrhage; minimal drainage; (+) foul odor; ø purulent d/c; abdomen drainage dressing; cover c Kerlix - NS c d/I x small x1 stable open to lower cover; MD on to see pt; V.O. Fr tylenol 650 mg PO for temp > 101.5; Fentanyl 50 mcg bolus given for drug [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

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b(6)-2(all)

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
110ct03/0600	Report given. Dr [redacted] @ bedside, update given to Dr [redacted] RT HYER
	0600 pt remains on Dopamine [redacted] 3mcg/kg. tapered off. labs [redacted] placed on chart.
	0720 sx & scant amt of yellow white secretion per ETT/oral [redacted]
	0840 pt opens eyes to verbal stimulation, follows commands, does not breath over vent setting [redacted] & pain noted
	1025 left for surgery [redacted]
	1150 returned back from surgery [redacted]
	1155 hung 2u PRBCs. [redacted] [redacted] by 2 RN, SEE DA FORM [redacted] 4700 [redacted] continuous IV.
	1300 sx'd thick tinge color secretion [redacted] NGT, WS c greenish discharge noted. [redacted] Suctioned to 30cc. NS [redacted]
	1320 2nd u PRBCs completed [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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USAPA V1.0

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
Continual	(24a): nocturnal on s.t.t.; consistently reminded to keep O2 mask on [redacted]
	force; VPP WNL no new issues
	b(6)-2

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

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

REGISTER NO.

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[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
12 OCT 03	BRIEF OP NOTE
	PRE-OP DX: 1.) R/O ABD WOUND DEHISCENCE
	2.) PELVIC GSW S/P COLOSTOMY
	POST-OP DX: 1.) ABD WOUND DEHISCENCE
	2.) PELVIC GSW
	PROCEDURES 1.) ABD WOUND EXPLORATION
	2.) LAPAROTOMY
	3.) RETENTION SUTURE PLACEMENT
	4.) (L) PELVIC WOUND I/D
	SURGEONS: [redacted]
	ANESTH: [redacted] b(6)-2
	FINDINGS: 1.) SMALL MIDLINE FASCIAL DEHISCENCE
	2.) CLOSURE C RETENTION SUTURES;
	SKIN/SQ LEFT OPEN/PACKED
	3.) PURULENT (L) BUTTOCK/PELVIC
	COLLECTIONS DRAINED + CX'ED
	SPEC: BUTTOCK WOUND CX
	COMP: Ø
	DISP: TO ICU #3 b(6)-2
	IVF: 800cc UOP: 100 [redacted]
	MAJ, MC

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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b(6) -2(011)

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

12 Oct 03 / 0600 Assumed care. Report given. See ICU-3 Flowsheet for initial assessment. [redacted]
0620 Reinforced dressing on R/O area noted oozing of red blood.
0730 Trans Taylor @ bedside. Pt date given. Pt pt about NPO status & surgery [redacted]
0800 I.S. given. Pt given instruction of use. Pt completely aware [redacted]
1030 USS. oozing from med line. ABD incision. Apply more dressing [redacted]
1230 Temp 102. Pt Advil given [redacted]
c sins. Dr. Hsu. [redacted]
1440 Dr Davis @ bedside. Update given about medline site. Site orders received to watch site for continuous oozing [redacted]
1500 pt drsg A'ed. Pt's [redacted] will continue to monitor for additional drainage @ site [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID (SSN or Dt)
	LAST	FIRST	MI	[redacted]

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

b(6)-2 (a11)

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
12OCT03	1555 Taken to surgery on ICU bed. 1810 Report given. Pt remains in surgery [redacted]
12OCT03@(2100)	Pt returned from OR @ 1815. Placed on 3L [redacted] NC. Lines flushed and hooked up to fluids. NGT hooked up to LWS. Δ'd some sheets and placed burn pads underneath. Patient stable. Dr [redacted] stopped by to see pt. Put in Dobhoff through (L) nares. Upper abdominal X-ray done. Dobhoff to (L) of stomach. Dr [redacted] also checked in on pt. Continuing to monitor. [redacted]
(2100)	See DA Form 4700 OP 378 for assessment data. [redacted]
(0330)	Pts sats went down to 88-89% on 1L O2. Bumped back up to 3L. Sats up to 91-92%. Worked with Incentive Spirometer and cough deep breath. Assistance c̄ interpreter. Sats now up to 97-98%. Sleeping well. [redacted]
(0600)	Did dressing Δ to (R) thigh c̄ 4x4 & Abdover top. Tissue beefy red, healthy. Dressing Δ to (L) buttocks cheek. W-D c̄ 4x4 & 2x2 c̄ ABD over top. Fentanyl 7 to 100 mcg IVP for Dressing Δ. Pt worked on I.S. again. Not wanting to cough. Slightly uncooperative. [redacted]

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b(6)-2(all

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
13Oct03/0600	Assumed care. Report given SEE IVL-3 Sheet [redacted] RN
	0630 DR [redacted] @ bedside, [redacted]
	A&O. orders received [redacted]
	0700. Tylenol given per MGT [redacted]
	1030 pt left for surgery. [redacted]
	1210 Received from OR. [redacted]
	1310 buttock drsg A&O. oozing noted from wounds. pt refused to use I.S. CPT given to force coughing to clear secretions [redacted]
	1430 pt received O2 2L/min. SpO2 @ 99% - 99% [redacted]
	1650 new cummies pt placed for MGT. dk green drainage from wounds [redacted]
	1800 Report given [redacted]
13Oct03 1900	Alert x3 - VSS - on O2 2L/m via NC O2 @ 100%. IV @ LR @ 15 mg q K+ infusing @ 100 ml/hr. to (L) cordis, Fentyl infusing to (R) sub clavian @ 60 mcg is patent A-line pressure 109/63 - MAP 84. DRSS to mid-line Abd, (R) hip, (L) buttock are intact, (L) buttal has (cut)

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. 5/198
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USAPA V

[redacted] b(6)-4

b(6)-2 (011)

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
13Oct03 (Cont) 1400	1g Amts of drainy D&D @ 8° and Ao packed & soaked w/ NS. Daily to gravity drainy clear yellow urine. T-101° Tylenol 650mg q4hrs PRN N/G. — Sgt [redacted] 9/C22
13Oct03 2000	N/G and feeding Tube D/C'd per VO. from MD DR Davis. Airline accidentally dislodged, pressure applied dressed & taped. Subclavian line drsgs Δ'd both (R) and (L). — Sgt [redacted] 9/C22
13Oct03 2100	T-100° - VSS - Resting quietly, O2 on @ 2L/m SATS 94-96% via NC. Drsg Δ to Abd wound due scant amt of bloody drainage, (L) Buttock large Amt of light red drainage, (R) thigh mod amt of bloody drainage noted. — Sgt [redacted] 9/C22
14Oct03 2400	T-99.1 VSS - Ø c/o pain or discomfort. — Sgt [redacted] 9/C22
14Oct03 0300	T-99.5 VSS - Resting quietly. — Sgt [redacted] 9/C22
14Oct03 0400	T-101.5 - Tylenol elix 650 mg q4hrs PO. CBC Lytes drawn. Tolerating small amts of H2O. — Sgt [redacted] 9/C22

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MEDICAL RECORD	PROGRESS NOTES

DATE 15 Oct 1630 NOTES

Op note:
Pulse lavage, debridement, vac drain application
Fluid 800 EBL 50 Duration 1hr b(6)-2
Reapplication ostomy [redacted]

Post OSU: Tylenol 650 mg PO; prenex IV for [redacted]
for temp > 101.5; will have Day shift report ab[redacted]

16 Oct S - pain b(6)-2
O - febrile 101.5 P 100
mid line wound a little 'rosy' near ostomy wafer
which tends to get loose there Δ'd again now
vacu drain fct'g
WBC 14 (↑ from 8.0)
A - stable
P - cont vac drain re temp WBC + cleanliness [redacted] wound on
next change in 1-3 days in OR [redacted] b(6)-2

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

[redacted] b(6)-4

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 5/1999)
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b(6)-2 (c11)

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
16 Oct 03	Assumed pt care @ 0600. Pt sleeping comfortable in bed c̄ complains of pain. Given 5mg [redacted] O4. Changed Abd dressing + colostomy bag. Started T[redacted] fusing 200cc/hr. Will continue to monitor [redacted] ILT/AN
16 Oct 03 (2025)	Received report from [redacted] and assumed care of pt @ 1930. Pt resting in bed. See DA Form 4700 OP 37 for assessment data. Pt c/o pain in abdomen and legs. MSO4 given as ordered. Relieved pain [redacted] No needs @ this time. AN
(2115)	Pre-medicated pt c̄ 5mg MSO4. Δ dressing to ML abdomen w/ NS (2) 4x4's c̄ Abd over top. Δ'd (P) lateral thigh c̄ NS w→D (2) 4x4 δ (4) 4x4 over top. Pt tolerated ok. Moved pt up in bed. Gave sip of H2O. Checked backside. Vacuum on (P) buttocks [redacted] to vacuum. Dressing intact [redacted] AN
17 Oct 03 (0645)	Pt stable throughout night. Tmax 101.7. Tylenol given down to 101.°. Abdominal dressing Δ to done around 0400. Tolerated ok. Bed bath and foley care done @ 0430. Linen Δ'd. Pt stable @ this time. Report given to LT [redacted] AN
17 Oct 03	Assumed pt's care @ 0600. No [redacted] complaints @ this time. Pt is resting comfortable in bed. [redacted] 755 NPO to go to OR. Δ'd Abd dressing [redacted]
1605	Pt went to OR VSS temp 10[redacted] ILT/AN
1710	Came back from OR via Stretcher [redacted] 250mcg Fentanyl, 300cc Crystaloid, 98 urine output EBL 40cc.
1715	VS HR 80 BP 110/44 RR 18 O2 sat 97%
1730	HR 89 BP 111/52 RR 20 O2 sat 99%

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

b(6)-2 (911)

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
2000 15Oct03	assumed PT care @ 1800. shift assessment on Flow sheet. changed thigh dressing and abdominal dressing. Small amounts of blood from thigh dressing noted. old dressing had med amounts of brownish yellow exudate soaking thru. abdominal dressing changed w/o lifting colostomy NS soaked cotton with 4X4's then TAPE. wound appeared free from S/S of infection. SKIN on PT's back appeared Red w/ ~~[illegible]~~ groove from sheet in it. PT LIPS have multiple pustules on them. Bath given PT now resting comfortably ——— SPC [redacted]
15Oct03 2100	PT resting comfortably USS will continue to monitor ——— SPC [redacted]
15Oct03 2200	PT resting pain controlled w/ M.O.M. PT in NAD. SPC [redacted]
15Oct03 2215	Heparin shot given in (R) upper arm beneath deltoid toward front of arm. blue port on TRIPLE Lumen is not patent. ——— SPC [redacted]
15Oct03 2400	PT legs repos. due to pain PT sleeping ——— SPC [redacted]
16Oct03 0015	USS temp up to 100° still in PT's parameters. PT has edema in hands and feet. Raised legs & had PT cross arms [redacted] while sleeping. ——— SPC [redacted]
16Oct03 0130	PT's KUB for Tube placement done. X-RAY @ bedside. PT's legs repositioned again for pain. PT sleeping in NAD. — SPC [redacted]
16Oct03 0400	LABS drawn for 1 time order CBC & LYTES PT sleeping comfortably dressings CDI in NAD ——— SPC [redacted]
16Oct03 0430	PT's condition of LIPS, pustules, dry, passed on to Dr who responded he will look at it in the am ——— SPC [redacted]
16Oct03 0500	PT temp spiked to 101.8 Tylenol given will cont to monitor [redacted]
16Oct03 0550	PT temp ↓ to 101.4. PT sleeping comfortably. legs repositioned. 0600 meds run. ——— SPC [redacted]

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b(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
17Oct03	1745 US HR 87 BP 111/52 RR 14 [redacted] Pt.
	stable pain relieved ō 5mg MSO4. [redacted] 12L/AW
17oct03	Alert - x3 USS - T 100.6. MSO4 5[redacted] c/o wound pain.
1830	IV of D5½NS ō 40 KCL @ 40 ml/hr to ⓛ sub clav line is patent
	all ports flush easily. Drsgs to Abd midline, ⓡ thigh, ⓛ buttock
	CDI & drainage noted. b(6)-2 Sa[redacted]
18oct03	USS - MSO4 5mg IVP given @ 2230 for c/o ⓡ thigh and ⓛ buttock pain.
2400	Drsgs to ⓡ thigh, ~~ⓛ but~~ midline Abd. Δ'd - Abd dry had
	small amt of bright red bloody drainage - ⓡ thigh moderate amt
	of dk red drainage both repacked moist 4x4's soaked NS coval ō
	Abd pad. Tolerating TF well is @ 80 ml/hr per NGT. - Sat [redacted]
	b(6)-2
22Oct [redacted]	b(6)-2
	S -
	O - afeb 110/50 100 Lab 23 WBC/P 130
	Urine drain 1100 100 24 0
	wound clean 1.3 160 52 0
	A - stable b(6)-2 300 212 0
	P - continue 24 Oct 100
	↑ TF to 100/h [redacted] 1300

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
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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
10OCT03(2200)	Had one unit for pt to start. (2030) unable to Identify pt. Did another crossmatch & starting blood. No reaction @ this time. [redacted]

Unit #1	Temp	HR	BP		
started 2135	100.9	127	109/56	(agitated)	b(6)-2
2140	100.3	121	91/45	(calm)	
2145	100.0	120	89/43		
2150	99.6	117	94/44		
2205	100.4	111	90/41		
2220	99.9	121	90/43		
2235		122	73/35		
2250	99.8	131	86/44		

(2250) Pt's BP started to go down to SBP 70's & MAP 50. Stopped blood occassionally. Called Dr [redacted] instructed to finish the blood and decrease Dopamine to 3mcg/kg/min. LR bolus approx 750cc given to pt as ordered earlier. CVP's from 11→18 ~ blood & LR. Pt received 250cc NS ~ blood. [redacted]

Unit #2	Temp	HR	BP		Temp	HR	BP
(2300)	99.8	125	75/42	11OCT03 (0035)	99.0	118	92/53
2315	98.6	122	73/40				
2400	99.0	118	79/46				

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

DEPARTJSERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

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[redacted] b(6)-4

PROGRESS NOTES
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b(6)-2(011)

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
19Oct03	0800 4mg MSO4 IVP, 60 min DASG A'ed completed on [redacted]
19 Oct	SOPH T 102 x1 yesterday O - look better odn to wound culture E coli sen to cefpodx tol TF at 80/h A - stable P - wash out [redacted]
19Oct03	1010 [redacted] DASG A'ed, viewed by DR [redacted], along c leg pulses, orders received. 1020 blood panel drawn per CDR, sent to lab. [redacted] 1150 pick-up labs. [redacted] 1330 update to Sgt's pressure and pulses [redacted] 1530 labs reviewed by Dr [redacted] 1610 update given to Dr [redacted] [redacted] 1810 report given. [redacted]

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b(6)-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

18Oct03/0000 Report given. Temp 102.0 Tylenol given. Intended situation [redacted] is disguised [redacted]
0730 pt report & am care [redacted]
0840 DR [redacted] @ bedside. Update given. 9 new orders [redacted] received [redacted]
0955 OOB to chair c̄ assistance [redacted]
4mg MS04 IVP given for pain control. [redacted]
1005 Flushed Dobhoff. Recount [redacted]
10 FP @ 80cc/hr [redacted]
1135 pt vomited sitting up well. [redacted]
1355 RN back to bed pt did most of work. 1st dose ASA [redacted]
orders received from Dr [redacted]
1350 MS04 4mg IVP given c/o [redacted]
1630 Dose ASA on time [redacted]
1810 Report given. [redacted]
19Oct03/0600 Assumed care. Report given [redacted]
0730 am care given [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1999)
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[redacted] EPW

b(6)-4

[illegible] 2500 fluid

b(6)-2 (c4)

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
20 Oct 03	0600 Assumed care. Report given by [redacted] 0650 [redacted] @ bedside. Update given. [redacted] orders received. Bowel sounds @ bedside, pt in room [redacted] post surgery [redacted] 1100 c/o pain. MSO4 5mg IV [redacted] given. [redacted] 1220 Taken to Surgery. [redacted] 1347 returned from surgery. [redacted]
20 Oct 03	Nutrition Note
1430	PT c GSW in rectal area. Currently on Peratives TF @ 80cc/hr providing 2496 kcal/day + 128g Pro/day. Wt: 70 kg. ENN: 2100-2450 kcal/day (30-35 kcal/kg) + 91-105g Pro/day (1.3-1.5g/kg). Recommend TF formula Δ when Peratives runs out. Recommend Osmolite HN @ 100cc/hr to provide 2400 kcal/day + 106g Pro/day. [redacted] RD/LD
20 Oct 03	1420 Labs drawn & [redacted] per [redacted] sent to lab. [redacted] 1500 [redacted] assistance. MSO4 given 5mg IVP. [redacted] 1600 results given to Dr. [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.

FPW [redacted] b(6)-4

PROGRESS NOTES
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b(6)-2 (011)

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
20 Oct 03/1720	[illegible] @ bedside, instruction given to pt for [illegible] of pregnant bed sores [redacted]
	B/O Rapid given [redacted]
21 Oct 0645	
	S- pain
	O- afeb
	[illegible] TF at 80/h UO xLNT [illegible] 25 WBC 8
	wound clean [illegible] OIC
	A- stable
	P- q 2-3 cl [illegible] + [illegible] [redacted]
21 Oct 03 @ 0658	
	Received pt resting in bed, LOS, A&Ox3. Perrla, dehiscence intact + infusing perature @ 80 cc/hr w/o apparent complication, RR, HRR, see flowsheet for vitals, triple lumen to (L) subclavian patent + intact, ø redness or swelling noted @ insertion site. Mid line abd incision w/ drsg c/d/i, q 40 A; LUQ colostomy, stoma pink, ø stool @ this time. BS(+) x 3. (L) hip wound intact to cont suction. Pulses palpable in (B) UE + (B) LE, pt has positive bewiggle + push/pull strength w/ (B) LE. Drsg to (R) thigh c/d/i, foley + wound vac [illegible] LSCTA @ and equal rsl/fall [redacted]
0830	Abd midline wound w/ retention sutures. Drsg ⊿ w/ D, ø foul odor or bowel drainage noted small

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cont.
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b(6)-2 (all)

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
21 OCT 03 0830 cont	serosang. drainage noted on old dsg. @ high ∆ w/ small amt serous drainage noted, ∅ foul odor. Foley cat to drain dk yellow urine, collection w/ scant amt soft, formed stool. [redacted]
21 Oct 03	Pt sitting in chair, resting. [redacted] complaints verbalized this time. See flowsheet for assessment [redacted] PT
	1830: assem cplete; pt rstnd, tbd; [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.	

EPW [redacted] b(6)-4

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
230070Ø3	(1255) Pt admitted to ward via gurney from ICU3 in stable cond. Pt alert, speaking Arabic. VSS. Ø c/o pain. Vac. device to buttock drsg intact c̄ high cont. suction draining sm. amount of sero. sang. drainage. Drsg to midline abd incision Δd, wet → dry. Site s̄ s/sx infection. Binding straps intact. Osmolite tube feeding infusing into Dobhoff @ 100Ø cc/hr s̄ difficulty. IVFs infusing into triple lumen in @ SC s̄ s/sx infection/infiltration. Drsg to RLE CDI - changed in ICU this am. Tol reg diet. Foley draining quantity sufficient clear yellow urine. Foley Δd in ICU this am. 2 point restraints in place s̄ s/sx complications. Colostomy bag intact c̄ sm. amount loose brown stool. Bag emptied c̄ min. assist from pt. Will continue to monitor. b(6)-2 [redacted] AW
	(1720) Pt OOB to chair independently. Tol. well. Personal hygiene done by pt. Dobhoff cleaned in @ nare - tape reapplied. Monitoring. b(6)-2 [redacted] AW
(1955)	Pt OOB to chair, VSS, c/o pain, medicated c̄ ⅡⅠ Perc-ocet. vac device intact to buttock drsg c̄ high cont suction. midline abd drsg Δ'd (WTD). binding bands

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

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PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.
#[redacted] b(6)-4		ICW#1

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b(6)-2 (011)

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	intact. dophoff retaped to (L) nare. osmolite @ 100cc/hr infusing (L) SC triple lumen infusing D5 1/2 NS c 20meq KCl @ 40cc/hr. ⊖ edema or redness @ site. Drsg to (R) LE CDI. Foley draining QS cyu. Pt NPO p̄ 0400 for OR. 2 pt restraints on 5 compromise to skin or circulation.
24OCT03	Will monitor [redacted] 91WMe.
0400	Tube feeding turned off, IVF ↑ to 100cc/hr. dophoff flushed & capped ok. Monitoring [redacted] 91WMe.
24OCT03	Pt. received from PACU, S/P posterior to buttocks.
1300	Midline DRSNG to abdomen Δ'd moderate amount of yellow-red drainage, W→D DRESSING Δ'd Q4°. Colostomy bag Δ'd in OR, MD D/C'd NG tube. Pt. encouraged to eat full meal & drink Ensure c̄ every meal. Pt. ate 90% of meal & drank 1 can of Ensure. DRSNG to buttocks has high continuous suction, moderate amount of serosanguinous fluid. All other assessments WNL. [redacted]
24OCT03	Pt. OOB to chair. W→D DRSNG to midline abdomen
1700	Δ'd. Pt. offered Percocet for pain, Pt. refused. IV fluids D5 1/2 NS c̄ 20KCl @ 40cc/h. [redacted]
(2010)	Pt. a/o, VSS, c/o pain, premedicated c̄ 5mg MSO4 for drsg Δ (Q4°). colostomy bag intact. Ø leakage noted. high cont suction to buttocks c̄ bloody drainage. D5 1/2 NS c̄ 20meq KCl @ 40cc/hr CL drsg CDI, ⊖ edema or redness @ site. Pt consumed 25% dinner. Will monitor [redacted]

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b(6)-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
23 Oct 03	Received pt from Cpt [redacted] Pt sleeping in bed, easily arousable. Pt has pervative @ 100cc/hr running through dobbhoff tube, and D5NS c 20K running through LSC Triple lumen @ 40cc/hr. pt has no c/o pain at this time. — Sgt [redacted] LAN
	0715 - Dr [redacted] at bedside. Pt dressings changed. Abd wound very purulent. Thigh (R) wound beefy red. Colostomy emptied. — Sgt [redacted] LPN
23 Oct	S-
	O- afeb VSS
	wound - sorry, slightly necrotic central mid line incision otherwise granulating, good vac on dressing
	A - stable
	P - OR 24 Oct, ↑ ant [redacted] ← b(6)-2
	0850 - CBC drawn, Foley changed. Pt being transferred to ICW1. Pt VSS. Pt colostomy bag emptied for 2nd time today. No c/o pain Sgt [redacted] LPN
25 Oct	Op note
	Changed out vac drain, wound (2) big smaller, + ant portion closed c 3 2-0 nylon. JP replaced in deep tract going laterally to pt's (R) & curled in rectal wound area →

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
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[redacted] b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	+ packed c̄ NS soaked gauze + betadine utility applied
	fluid 600 LBC min [redacted] b(6)-2
	note 1st 30 min spent d'g colostomy bag, (R) thigh dressing + old wound dressing. Bag leaking all over pt's flank + into wound, + midline dressing soaked in green. Ostomy of cecum [redacted] is separated from skin @ 270°, otherwise OK [redacted] b(6)-2

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b(6)-2 (011)

LAST NAME | NAME | INITIAL ID NUMBER

DATE	NOTES
26OCT03	(cont) old bag. Drsg to RLE c̄d WTD. Pt OOB to chair independently. Amb in room - c/o dizziness - returned to bed. Drsg to buttock wound c̄ vac device to high cont. suction, leaking sm amount serosang drainage. MD aware. @ SC triple lumen infusing IVFs s̄ S/Sx infection/infiltration. @ point restraints in place s̄ S/Sx complications. Tol. 50% reg diet well. Foley draining quantity sufficient clear yellow urine. Will continue to monitor. [redacted]
27OCT03 0200	Assumed care of Pt @ 1800 hrs. Pt A&O Speaking Arabic. Pain controlled c̄ percocet ~~[illegible]~~ MS04. Pt completed self colostomy care. NPO @ this time. cont Antibiotics Midline Abd Drsg Δ q 4°. LR infusing @ ~~[illegible]~~ 150 cc/h via LSC Triple lumen. 2 point restraint inplace. Will continue to monitor. [redacted]
27Oct03 1443	Assume care of PT @ 0600. LSD, A&OX3 2x restraints present without any signs of skin irritation. Colostomy bag intact. Hasn't eaten waiting for surgery, c/o being hungry. Med drsg to midline and (R) leg ∅ bleeding or infection. Will continue to monitor. [redacted]

2NOV QR

Wound washout - very clean - foley Δ'd

retention removed

[redacted] b(6)-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES b(6)-2
25OCT (0530)	UOP this shift 1100cc mod. yellow urine, input this shift 700cc. [redacted] 91WM6
25OCT03	(1710) Assumed care of pt @ 0000. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs. Vac device to buttock wound intact to high cont. suction. Drsg to open midline incision Δd q4°. Colostomy bag intact c̄ sm. amount dark brown stool. Pt doing own colostomy care. IVFs infusing into triple lumen in ⊙sc s̄ s/sx infiltration. OOB to chair independently. Tol well. 2-point restraints in place s̄ s/sx complications. Tol reg diet well. Foley to gravity draining quantity sufficient clear yellow urine w/ monitor. b(6)-2 [redacted] 91Am
25 OCT 03 0145	Assumed care of Pt @ 1800. A&O VSS. Pain controlled c̄ percocet and MSO4. Vac Device to Buttocks wound. Drsg to Open midline incision Δ. 94°. Colostomy Bag CDI. Foley To Gravity Draining CYU. Will continue to monitor. b(6)-2 [redacted] Spc 91WM6
26OCT03	(1610) Assumed care of pt @ 0000 p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs. Abd drsg Δd q4° WD. Colostomy bag Δd d/t leakage from

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
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[redacted] b(6)-4

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MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
27 Oct 2000	
	Q note
	Pulse large wound good granulation, exposed bone is being covered, packed c̄ JS soaked Kerlix + will do at home for few days + ↑ act & pt → ambulate [redacted]
	b(6)-2

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

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MEDICAL RECORD | **PROGRESS**

DATE	NOTES
27OCT03	Pt returned from ICU3 via litter. Pt able to self from litter to bed. ~~Drsg~~ ~~Anal~~ ~~B~~ Rectal wound draining yellow/Green fluid. Wound ~~[illegible]~~ is malodorous. NS c̄ 20meqKCL running @ 40 cch. colostomy bag has thick Black stool. FTG Draining CYU. Pain [redacted] ontrolled c̄ Ibuprofin. Will continue to monitor. — [redacted] Spc 91WM6
28OCT03 1135	VSS. AO. Dsg to abdomen and (R) ~~inner~~ outer thigh. Seen by MD this AM and instructed to Δ hip Dsg in afternoon. Provided ray bath to patient while seated in chair. Ambulated c̄ walker for 35 min c̄ assistance. Winced c/o dizziness @ first trial of ambulation and stated ϕ c/o dizziness after resting. Noted stage II decubitis sacral ulcer 1.5 cm in diameter c̄ eschar to 70% of surface and open stage II-III ulcer @ base of sacral region, on (R) inner buttock. Used ~~[illegible]~~ interpreter to explain status of wounds and need for ambulation, OBTC and turning for healing of ulcers. Pt. verbalized understanding.
29oct03@0300	Assumed care @1800; All VSS, pt A&O speaking arabic; MD gave 1 time order for 10mg Ambien c̄ pt stated he hadn't slept in 4 days'; ML dsg

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

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[redacted] b(6)-4

LAST NAME	ME	MI	T	IBER 6(6)-2

DATE	NOTES
	(cont) dsg Δd, ⊖ s/sx infection, ⊖ drainage, ⊕ hip dsg Δd ⊖ s/sx infection, ⊖ drainage; FTCa during QS, c/o; colostomy intact, pt performed own colostomy care; Restraints in place, ⊕ circ, ⊖ skin break ↓, cont to monitor. [redacted]
29 OCT 03 1150	VSS. AO. DSG Δd to ⊕ Hip & buttock. ⊕ odor and bloody/purulent drainage. Restarted on IV ABx, etc AM. Colostomy intact and draining, soft formed, dark brown stool. ⊕ pulses. A bilomial wound c̄ ⊖ s/s infection and performed VSS Δ. Voiding light yellow urine, quantity sufficient to FTC. 5 stage I and stage III ulcers to sacral and perianal region remain and MD aware. Cont to monitor. [redacted]
29 OCT 03 2300	Assumed Pt care @ 1800. Pt c/o pain. Moaning for epigastric pain. Pt refuses percocet. Motrin 400 mg ~~Δ~~ is not effective. Abd. Drsg [redacted] Δd WTD. Pt completed colostomy care. Will co[redacted]ve to Monitor. [redacted] Spc 9/WMb
30 OCT 03	(1440) Assumed care @ 0800. Pt alert, speaking Arabic VSS. Pain controlled c̄ Percs. Drsg to midline abd incision, ⊕ thigh, and ⊕ buttock Δd WTD. MD @ bedside during drsg Δs. Pt medicated c̄ 10mg MSO4 prior to drsg Δ and 5mg p̄ Δ. Pt tol. well. ⊖ S/Sx infection @ wound sites. Colostomy bag Δd d/t leakage from old bag. Pt OOB to chair, amb in hallway holding onto IV pole. Gait steady. Pt tol. well. Foley d/cd this am. Pt DTV by 1530. Tol 50% lunch. IVFs infusing into ⊕ SC CL s̄ S/Sx infiltration/infection, 2 point restraints in place s̄

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
30OCT03 (1440)	(cont) S/Sx complications. Will cont. to monitor [redacted]
30 OCT 03 2200	Assumed care of Pt @ 1800hrs. A&O. Pt had Foley removed earlier shift. @ 1900hrs pt c/o Abd pain. Palpated abd and found Bladder distended. Inserted Foley catheter and Drained 975 cc of c/y urine. Midline Dressing Ad. Pt c/o epigastric pain. Maalox Administered [redacted] Will cont to monitor. [redacted] 91WM6
31 Oct	S- O- afeb wound clean, dry ambulate fly reinsert [redacted] A- stable P- ↑ act [redacted]

b(6)-2 (all

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[redacted] b(6)-4

b(6)-2 (all)

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
31 OCT Ø3 (113Ø)	Pt a/o, VSS, c/o pain often. Premedicated c̄ 10mg MSO4 IV for (R) hip drsg change. packed loosely c̄ NS soaked Kerlix. drsg to mid-abd incision Δ'd. colostomy bag c̄ Ø leakage. emptied by pt x 2. Pt ambulated in hallway x 15 minutes using walker. foley to gravity draining cyu Q5. DSC CL ≅ s/sx infection/infiltration. ⊕ adm [redacted] Pt tolerated 50% of lunch, encouraging ↑ PO fluids. Turning often encouraged to prevent any further skin breakdown. 2 pt restraints on ≅ compromise to skin or circulation. will monitor [redacted] 91WM6.
31 OCT Ø3 2Ø3Ø	Pt A+Ox3, VSS, pain controlled c̄ percs, adm 30cc Maalox, Δ'd midline abd incision dsg, skin granulated beefy red, Ø s/sx of infex, dsg on (R) hip Δ'd, wound healing well, W→D dsg applied, IVF patent D5½NS 20KCL, Ø s/sx of infex or infiltration, NPO p̄ MN, foley → gravity draining cyu, self care of colostomy bag, 2 point restraint ≅ s/sx of complications, LS CTA (B), ⊕BS x4 [redacted] 9WJ

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME		SPONSOR'S ID NUMBER
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#[redacted] b(6)-4

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b(6)-2 (all)

LAST NAME	NAME	MI	ID NUMBER

DATE	NOTES
Nov 03 @ 1900	Assumed care @ 0600; AAO VSS, pt AAO speaking arabic; pt refused percocet for pain; pt premedicated c̄ 10mg MS04 prior to (L) hip dsg Δ w→D; skin beefy red, ⊖ s/sx infection; dsg to ML Δd w→D; Colostomy bag Δd, d/t pt pulling it off; pt OOB to amb in hall c̄ walker assistance; FTG patent draining Q s, clear, yellow urine; pt TOL Regular, NPO f̄ MN for OR tomorrow. Restraints in place, ⊕ cir, ⊖ skin break ↓, cont to monitor [redacted]
1 NOV. 03 1915	Pt AAOx3, VSS, OOB → chair, tol well, medicated c̄ ii percs for pain, pt requested Maalox to prevent an upset stomach, foley draining blood tinged urine, dsg to ML abd Δd c̄ w→D dsg, dsg on hip Δd, skin appears beefy s̄ s/sx of infex, colostomy bag intact, peripheral pulses equal (B), 2 point restraint s̄ s/sx of complications, LS CTA (B), ⊕ BS x4 [redacted] 9mm
2 nov. (1215)	Pt back from OR, received via gurney from PACU. Pt AAO, VSS, c/o mild pain. LR @ 125cc/h to (R) SC CL. Dsg intact to buttock c̄ minimal drainage noted. midline abd dsg Δ'd, ⊘ leakage from colostomy noted. bag emptied by pt. ⊕ peripheral pulses equal bil. Pt medicated c̄ ii Percocet for pain & given Maalox for gastric pain. 2 pt restraints on s̄ compromise to skin or circulation. Will monitor. [redacted] 91MM16

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
2 NOV. 03 1900	Pt resting in bed, A+Ox3, VSS, midline abd dsg Δ'd, wound beefy red, Ø s/sx of infection, w→D dsg, dsg ® hip Δ'd, wound beefy red, serosang drainage on old dsg, dsg to buttock Δ'd, moderate amount of drainage on old dsg, foley to gravity draining cyu, medicated for pain ē ii percs, followed by 30cc of Maalox, colostomy bag intact, loose brown stool, 2 point restraint in place, Ø s/sx of complications. b(6)-2 [redacted] 9IV
	I concur with above allegations [redacted]
3 Nov 03 @	Assumed care @ 0600; A:1 VSS, pt A&O speaking arabic; dsg to ® upper thigh Δd, ⊖ drainage; ML dsg Δd, ⊖ drainage; dsg to (L) buttock Δd ē NS soaked Kerlix roll, lightly packed; moderate amt of drng to bld dsg; all dsgs CDI ⊖ s/sx infections; Colostomy bag intact, pt perform own Colostomy care FTG patent, draining QS, clear, yellow urine; pt premedicated ē 10mg MSO4 prior to dsg Δ for pain; Restraints in place, ⊕ circ, ⊖ skin breakdown, Count to monitor [redacted]
3 Nov 03 1050	Transfered to [redacted] b(6)-2 [redacted] b(6)-2

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

b(2)-2

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b(2)-2

IRAQI [redacted]

Name_____ SSN _____ Unit_____ Location_____

INITIAL ASSESSMENT

Airway

☒ Patent ☐ Nasal ☐ Oral
☐ Intubated ☐ Crich
☐ ETT #___ ☐ Trach

C-Spine

☐ CC ☐ BB ☐ Secured ☐ Clear

NORM MS, COMPETENT, Ø MS Δ's, GCS 15, Ø ML TENDER, Ø DISTRACTING. INJ's.

Breathing

☒ Spont Rate 16
Rhythm
☒ Reg ☐ Tachy ☐ Brady
☐ Sporad ☐ Even ☐ Abnl ___
Quality
☒ Reg ☐ Deep ☐ Labored
☐ Shall ☐ Sonorous ☐ Weak
☐ Assisted ☐ O_2 __ L/min
☐ Ambu ☐ Vent
BBS R ☒ CLR ☐ RLS ☐ WHZ ☐ ABS
L ☒ CLR ☐ RLS ☐ WHZ ☐ ABS

Circulation

☒ Spont ☐ CPR
Rhythm ☐ REG ☐ TACH ☐ BRDY
Pulse _____ ☐ Strong ☐ Weak ☐ Thread
B/P ☐ RAD >80 ☐ FEM >70 ☐ CTD >60
PASG ☐ Legs ☐ ABD ☐ Both
IV's #1 18 ga RAC
#2 18 ga LAC
#3__ ga_____
☐ Tourniquet Where When What Why
☐ Other _____

CNS

EYES		VERBAL		MOTOR	
SPONT	4	ALRT	5	ALRT	6
CMND	3	CONFD	4	LCL P	5
PAIN	2	INAPR	3	WDR P	4
UNRSP	1	INCMP	2	FLX	3
		UNRSP	1	EXT	2
				UNRSP	1

☐ PERLA ☐ ABNL_____
☐DIA ☐PIN ☐UNI ☐FIX ☐SLOW

MOI/DESCRIPTION

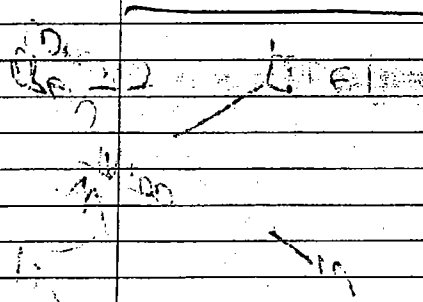
☐ Blunt ☒ Penetrating ☐ Burn
☐ Blast ☒ GSW ☐ Heat
☐ MVC ☒ Shrapnel ☐ Chem
☐ Fall ☐ Stabbed ☐ Elect
☐ Assault WITH _____ SEE 9's ↓
☐ Other _____ EST %_____

EQUIPMENT

☐ Weapon _____
☐ Sens Items _____
☐ Other _____

Vitals: HR 60 B/P 116/51 RR 16 POX 97% RA TEMP 96.0 °F °C

DATE/TIME	NOTES
10/10/09 0200	~20 yrs ā GSW TO BUTTOCKS. GROSS BLOOD IN RECTUM. PT AGITATED C STABLE VS PLAN XLAP IN OR. PT A+O X3 NON ENGLISH SPEAKING. FOLLOWS SIMPLE COMMANDS.
	[redacted]
	b(6)-2

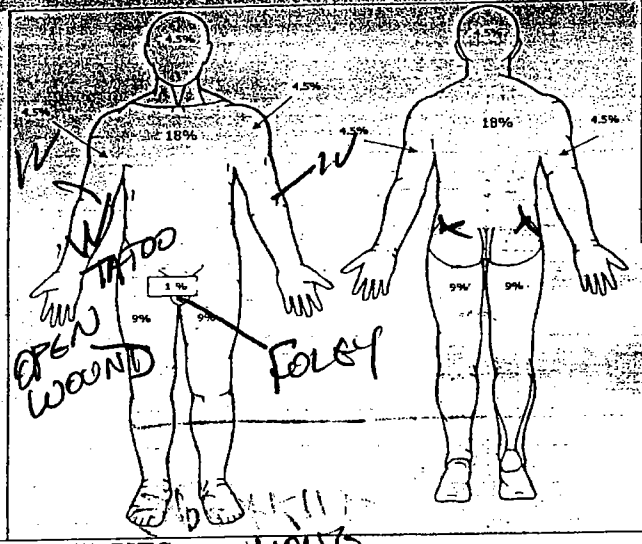


b(2)-2

[redacted]

Name SSN Unit Location

Head-2-Toe/Burn Chart



INTERVENTIONS

Airway

☐ Suction ☐ Position ☐ Oral ☐ Nasal

☐ Intubated/Trach ☐ Crich By Whom

Breathing

☐ Assisted ☐ O_2 L/min ☐ Ambu ☐ Vent

☐ Chest tube R #1 #2

L #1 #2

Time By Whom

☐ Needle decomp R Time L Time

Circulation Bag # and time

Fluid ☐ NS ☐ 1L bags ☐1 ☐2 ☐3

Blood ☐ PRBC ☐ Whole ☐1 ☐2 ☐3

PASG ☐ Legs ☐ ABD ☐ Both

☒ Foley 0148 ☐ NGT

Other

ALLERGIES NONE

MEDICATIONS NONE

PREVIOUS HX UNK

LAST MEAL UNK

EVENTS (see MOI)

Description of Illness

MEDICATIONS

TIME	MEDICATION	DOSE	RTE	BY

[redacted]

Name_____ SSN _____ Unit_____ Location_____

b(2)-2

PRE-OP/POST-OP

INTAKE

Time	Solution	Amount
FIELD	START 1L NS	

OUTPUT

Time	Source	Amount

VITALS

Time	HR	B/P	RR	SaO_2	Temp	Notes
0155	89	96/43	23	100%		AWAIT OR
0200	87	110/42	20	100		
0210	100	93/50	30	93		TO OR

CNS

EYES		VERBAL		MOTOR	
SPONT	4	ALRT	5	ALRT	6
CMND	3	CONFD	4	LCL P	5
PAIN	2	INAPR	3	WDR P	4
UNRSP	1	INCMP	2	FLX	3
		UNRSP	1	EXT	2
				UNRSP	1

☐ PERLA ☐ ABNL_____

☐DIA ☐PIN ☐UNI ☐FIX ☐SLOW

Time	Site	ROM	P	Cap Refill	T	Color

ROM
+ or -
Temp
C=cool
W=warm
Pulse
+ or –
Color
C = cyan
P = pale
Pk= pink

b(6)-4 [redacted] b(2)-2 Trauma Fl[illegible]et

Name (2) [redacted] SSN _____ Unit _____

Blood Type

Date and time of injury: 11 Oct 03 **Time of Arrival** _____

MOI:

HPI:

PMHX:
PSHX:
Meds:
Allergies:

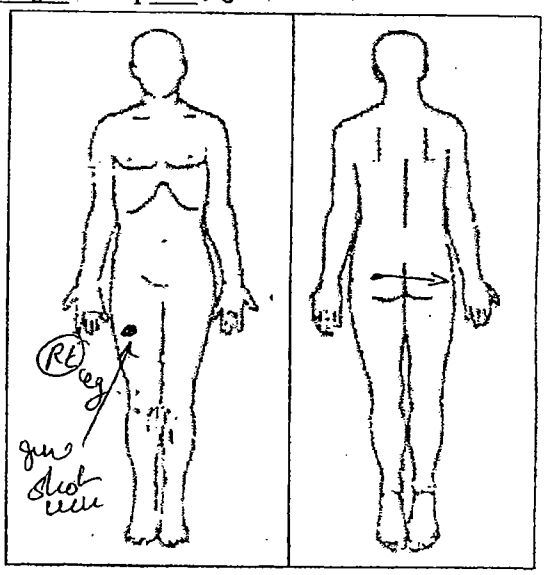
Primary Survey

Airway: Patent Mechanically maintained by _____
Breathing: Spontaneous Assisted by _____
Circulation:
Pulse: Present Absent CPR
Color: Normal Abnormal
Cap refill: Normal Delayed

Secondary Survey

Intial Vital Signs: b/p 110/64 pulse 88 Resp ____ Pulse Ox 95 Temp 98.8

GEN: in pain
HEAD: normocephalic
NECK: supple
HEART: RRR no m
LUNGS: CTA
CHEST: NC
ABD: tender all over (-) masses
PELVIS: NC
EXT: Quart shaped wound Mid Rt upper thigh
RECTAL: (+) Blood
~~BARO~~: ~~oriented time place & person.~~
Buttocks - Rt → left entrance & exit of the bullet.



Neuro
CN II - XII grossly intact
moves extremities
Spontaneously

GLASCOW COMA		
EYES OPEN	Spontaneously	4
	To Speech	3
	To Pain	2
	None	1
BEST VERBAL RESPONSE	Oriented	5
	Confused	4
	Inappropriate sounds	3
	Incomprehensible sounds	2
	None	1
BEST MOTOR REPONSE	Obeys Commands	6
	Localizes Pain	5
	Withdraws to Pain	4
	Flexes to Pain	3
	Extends to Pain	2
	None	1

Revised Trauma Score		
GLASCOW COMA TOTAL	13-15	4
	9-12	3
	6-8	2
	4-5	1
	3	0
SYSTOLIC BLOOD PRESSURE	>89 mmHg	4
	76-89 mmHg	3
	50-75 mmHg	2
	01-49 mmHg	1
	No pulse	0
RESPIRATORY RATE	10-29 / min	4
	>29 / min	3
	6-9 / min	2
	1-5 / min	1
	None	0
	TOTAL	

Interventions

Airway: FACE mask NON RE BREATH

Breathing:

Circulation: IV NS (R) BRANCH
(L) AC

Other: Foley 200ml intake out ⊖ Blood

MEDICATIONS

Time	Drug	Dose	Route	Initials
1:30	10mg morphine		IV	[redacted]
1:30	Penicillin	3g	IV	[redacted]

b(6)-2

Blood Components

Unit #	Type	Time	Response

Vital Signs

Time	B/P	Pulse	Resp	Pulse Ox	Temp	GCS
1045	116 / 51	91				
0150	96/43	91	17	98%		
	/					
	/					
	/					
	/					

Transfer Instructions:

NOTES:

(A) @ Maversing GSW (R) to (L) Buttocks
Suspect pelvic injury

(2) GSW (R) ~~Femur~~ Thigh.

(P) To Surg Fem Suprapubic Caploeath
Amp O/Peton.

~~Prepared By:~~
[redacted]
1LT PA-C

LABS
0200 13/39

b(6)-2

PLAN OF CARE FOR SKIN BREAKDOWN AND WOUND MANAGEMENT

MEDICAL RECORD **PROGRESS NOTES**

Admission Date: 10 OCT 03 **Diagnosis:** GSW Ankle/rt **HD:** Day **POD:** 003

Date: 100ct 03 Time: 1500 RN Signature: [redacted]

Skin breakdown as evidenced by immobility, friction, shear, m[redacted]rasions, surgical wound, skin tear.

Wound type: Surgical wound (s) Location: R Ankle/rt Size: 9 quarter Drainage: bloody
Diabetic ulcer Tubes: none Pins: 8 Appearance: _____
Venous stasis ulcer Dressing change: TID
Other____ Describe _____

Burn wound (s): % BSA_____ Partial_____ Full_____
Location:_____ Size_____
Appearance:_____
Dressing change:_____

Pressure Ulcer (s):
Stage I, II, III, IV (Circle the one that applies and describe below)

Location:_____ Size:_____
Wound character: Pink____ Moist____ Dry____ Granulation tissue____ Yellow slough _____
Tunneling____ Undermining____ Odor____ Purulent discharge_____ Eschar_____ Exudates _____

Refer to SOP for Dressing Change Instrucitons.

Please check the appropriate dressing Change:

- [x] Wet to Dry Dressing
- [ ] Carrasyn-V GelDressing
- [ ] Alginate Dressing
- [ ] Comfeel Dressing
- [ ] Pin Site Care
- [ ] J-Tube Care
- [ ] Colostomy Care
- [ ] Chest Tube Care
- [ ] Burn Care

NOTE: Document daily wound and dressing change on Progress Note or Nursing Note.

Select the appropriate products used:

- [x] Sterile 4x4 gauze dressing
- [ ] Sterile 2x2 gauze dressing
- [ ] Sterile gloves
- [x] Kerlix (super sponge)
- [x] Gauze bandage
- [x] Sterile Normal Saline
- [ ] Sterile Water
- [ ] 8 x 4 Sponge gauze
- [ ] Op-site
- [ ] Tegaderm clear dressing
- [ ] Alkare skin prep
- [ ] Comfeel clear
- [ ] Comfeel pressure ulcer drsg
- [ ] Carrasyn-V Gel
- [ ] Alginate
- [ ] Bacitracin
- [ ] Silvadene Cream

- [ ] Petrolatum gauze
- [ ] Hibicleanse
- [ ] Non-adhesive dressing
- [ ] Telpha Pad
- [ ] Carra-smart film
- [ ] Sterile Q-tip applicator
- [ ] Xeroform 5 x 9.
- [ ] Moisture barrier cream
- [ ] 0.125% Dakins sol
- [ ] Betadine Swab sticks
- [ ] ½ Hydrogen Peroxide & ½ Sterile Normal Saline

Select the frequency of dressing change:

- [ ] b.i.d.
- [x] t.i.d

b(6)-2

MD Signature and Date:

CNS Sig[redacted]outer

Patient's Identification (For typed or written entries give: Name-last, first, middle: Grade; rank; hospital or medical facility)

Medical Record, SF 509

EPW # [redacted] b(6)-4

SKIN AND WOUND ASSESSMENT

MEDICAL RECORD **PROGRESS NOTES**

Admission Date: 10 04 03 **Diagnosis:** GSW Leg **HD:** AUA **POD:** DOS

Skin assessment must be done initially and every 7 days.

Braden Scale Evaluation (See Braden Evaluation Table for Details)

Sensory Perception	No impairment	4	**Mobility**	No limitations	4
	Slightly limited	3		Slightly limited	3
	Very limited	(2)		Very limited	(2)
2				Completely immobile	1
	Completed	1			
1					
Moisture	Rarely moist	4	**Nutrition**	Excellent	4
4				Adequate (Eats >50%)	3
	Occasionally moist	(3)		Adequate (Rarely eats)	2
	Moist	2		Very poor	(1)
2			1		
	Constantly moist	1			
Activity	Walks frequently	4	**Friction and Shear**	No apparent problem	(3)
4				Potential problems	2
	Walks occasionally	3		Problems	1
3			1		
	Chairfast	2			
2					
	Bedfast	(1)			
1					

Add the total score ***Total Score:*** 10

Above 20 Low Risk
Between 16 and 20 Medium Risk
Between 11 and 15 High Risk
Below 10 Very High Risk

Note: A Braden Scale Score of less than 15 indicates **HIGH RISK**-requires immediate Ulcer Prevention program.

Surgical wound (s): Yes X No__ Location: rectum Size:_____ Drainage: _____
Tubes: penrose Pins:_____ Appearance:_____
Dressing change: TID

Burn wound (s): Yes__ No__ % BSA_____ Partial_____ Full_____
Location:_____ Size_____
Appearance:_____
Dressing change:_____

Pressure Ulcer (s): Yes___ No___
Stage I, II, III, IV (Circle the one that applies and describe below)
Location:_____ Size:_____
Wound character: Pink____Moist____Dry____ Granulation tissue_____ Yellow slough _____ Tunneling_____
Undermining_____Odor_____ Purulent discharge_____ Eschar_____ Exudates _____
Type of dressing change: Wet-to-dry_____ Comfeel dressing_____Carrasyn-V Gel_____ Alginate_____

Physician notified/consulted for wound debridement: Yes___No____ Date/time MD notified _____
CNS notified/consulted for Stage II and greater: Yes____No_____
Nutrition Referral: Yes_____ No_____
Physical Therapy Referral: Yes_____ No_____
Action taken:_____ Date & Time_____

REGISTER NO. | WARD NO.

b(6)-2 (all)

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
10 Oct 03	0815	HR 124, 20/35, Given 100 fent / 2.5 mg hero @ 730, [redacted] @ 97.4, Given 30 cc 1 Solus. Call inform Dr [redacted]
		[redacted]
		[redacted]
10 Oct 03	0830	Pt to OR [redacted]
	1030	Returned from OR VS: 119, 93/52, 14, 100, @ 98.0 Pt ⊕ 140 vasoactive, IV ⊕ leg, [redacted]
		[redacted]
		[redacted]
	1100	Assessment by Fellows - HOSP, [redacted] Sedation from anesthesia, ⊘ sedated ⊓, CNS CAS, [illegible], [illegible] [illegible], [illegible], CV: ST 110-120, BP 90-100/50s, ⊕ pulse [illegible], ⊕ Urine, 98.0 [illegible] fluid to stay, [illegible], [illegible] [illegible], [illegible] ⊕ [illegible], [illegible], GI: [illegible], [illegible] [illegible], [illegible] [illegible], [illegible] [illegible], ⊕ [illegible], [illegible] [illegible], [illegible] [illegible], [redacted]
		[redacted]
	1120	Bolus x2, gain ⊕ leg patient intubated, still in 70s/80s, will get CBC, [redacted]
	1175	Sent for CBC / ABG, spot 90s / 40s, Received [illegible] / ⊘ fent, on 10 mg / hr and fating [illegible] (PAN) leg intubated, ↑ BP - [redacted]

DATE

MEDICAL RECORD

STANDARD FORM 510 (REV. 7-91) BACI

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

510-112 NSN 7540-00-634-4123

MEDICAL RECORD — NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
	0400		Initial VS: 96.3, 103, 107/67, 14, 100%.
			Assessed as follows (0400): GCS paralyzed
			and remainder of sedation from surgery
			is still on board. Pupils @ 2mm. Ø seal/MS
			medication on board. Ø response to painful stimuli.
			GCS 4T4E6M, 25cm @ teeth, 4Pro, SIMV TV, TV 600,
			PEEP 5; CVA (R) (R>L); sats 100% on
			above setting. Pupils 2 to 2.0; CVS S, S2
			RSR-ST, BPs 100s/70s; cold - cool to touch bedclothes;
			+2 pulses to LLE, +2 pulse to URE (L>R); dusky
			[illegible] (R) LE; +1 pulse (thready) to LLE; Ø chest
			tubes, neck [illegible]; cuirass [illegible] @ 100; Rectal tray
			[illegible]; GI: BS; FLAT, NT, NDD; [illegible] (L) [illegible]
			to [illegible]; colostomy to (L) side; incisional abd incs
			with staples CDI; GU foley to [illegible]; (R) [illegible]
			[illegible] (Skin) (R) thigh [illegible]; (R) [illegible] drainage.
			(R) [illegible]; [illegible] (L) SC with [illegible] (no
			ordered for placement); PIV to (R) UE; PIV to (L) UE;
			(PMD) 4 to p.; [illegible] for further [illegible]
	0600		Will [illegible] — [redacted]
			[redacted] b(6)-2
	0700		Last VS: 103, 105/77, 24, 100%; [illegible]
			(T) [illegible]

(Continue on reverse side)

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

DATE [redacted] b(6)-4

NURSING NOTES — Medical Record

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

b(6)-2

510-112 NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
100CT03	1330		Last 30 min report: Pt ↓ BP in spt 90s-80s; (-) verbal response. (+) urine UO; Ø seizures; Notified Dr. [redacted] of ↓'n BP (NIDDM Adt); started NS 1000cc bolus x2; Dr [redacted] arrived, received order to start DOPamine @ 5ug/kg/min, Anesthesia service start 1000cc of Neosynephrine; Started Heparin 500cc/hr; Dr [redacted] started (2) IV cooling blankets; Current VS 5-9, Sys 100s/60s, RR 16; heart rate 16, 650, 40s, 5, CBC drawn @ 1230 9.3/30.3 WBC is 1.3 (Plan) ↑ SBP, started first @ 5ug/kg/hr; HR in 120s [redacted]
	1500		↑ DOPamine to 7ug/kg/min for ↓'n SBP, [redacted]
	1550		SBP remain (cuff) 75-85, (art) 85-95, MAPs for both are 60+; CVP is 5, Peak resp pressure remain in low 20s (25-27) [redacted]
100CT03 (1950)		Received report from LT [redacted] and assumed care of pt @ 1815. See DA Form 4700 OP 375 for assessment parameters. Dopamine ↑ to 8 mcg/kg/min d/t MAPS ↓ 60s, Pt given IV NS bolus d/t ↓ BP's. Pt more stable. [redacted]

(Continue on reverse side)

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

DATE [redacted] b(6)-4

NURSING NOTES
Medical Record

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

b(6)-2 (all)

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
100ct03 (2200)			Dr [redacted] came into see pt. Talked to Dr about parameters. Talked to Dr about Temperatures [redacted] tried to put Dobhoff in pts (R) nares. Met resistance. Pt. got bloody nose, stopped p minute. Put dobhoff down mouth. Got Abd. X-ray awaiting results. [redacted] Refer to other SF 509 for blood [redacted]
100ct03 (0400)			Dr [redacted] came in to see pt around 2300 d/t low BP's. Rewrote orders. Rest [redacted] started #2 unit of PRBC. Also started levophed around 2400. got ABG and labs. Dr [redacted] comfortable c̄ ABG. Redrew CBC p̄ blood done. Pt. more stable p̄ levophed started. Continue to monitor. [redacted]
			(0520) Pt's Fentanyl turned up to 100 mcg prior to dressing Δ. Redressed (R) lateral thigh wound. Packed c̄ wet (NS) kerlex 4x4 over top DK red blood. Deep wound. Turned pt and packed (L) buttocks c̄ (NS) wet kerlex 4x4's over top. Linen Δ'd. Pt tolerate it OK. BP stable, HR stable 130's. back down to 110's. Levophed turned off @ 0515 to see how pt's BP's tolerate it. BP now 93/47 MAP 67. [redacted]

b(6)-2 (all)

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
15 OCT 03	0800		T-102.5 Tylenol 650mg Pogium. O2 SAT 96. O2 @ 4 L/min NC. MSO4 4mg IVP given for c/o pain. Resting quietly @ present. — SGT [redacted]
15 OCT 03	0740		Received report from previous shift. Pt lying in bed c̄ ↑ temp. Dressing to Abd intact. Dressing to buttocks intact. Triple lumen cath to (L) subclavian intact. ⊖ s/s of infx. VSS. ⊖ c/o @ this time. Pt remains NPO for surgery today. — [redacted]
15 OCT 03	0930		Pt continues to have ↑ temp. Medicated c̄ 650mg Tylenol. — [redacted]
15 OCT 03	1130		Pt c/o pain. Medicated c̄ 4mg MSO4. Will continue to assess. — [redacted]
15 OCT 03		1455	Pt to OR — [redacted]
15 OCT 03		1625	Pt from OR s/p washout rectal wound. Abd dressing to Abd intact. Dressing to (L) thigh intact, minimal drainage noted.
	0700		Rectal dressing to continuous suction, intact to rectal area intact. Colostomy bag intact. Stoma very red. Triple lumen cath intact. All ports flushed. Foley to gravity drainage concentrated yellow urine. [redacted] P-101-⊖ ⊖3 SPO2 96%. Will continue to monitor & assess. — [redacted]
15 OCT 03	0800	1615	Pt c/o pain. Medicated c̄ 4mg MSO4 — [redacted]
DATE			
MEDICAL RECORD			

b(6)-2 (011)

510-112 NSN 7540-00-63

MEDICAL RECORD — NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
14Oct03	0600		Pt received from Sgt [redacted] VSS. Pt getting 1500 DS ~ c 75K, lemcy Fentanyl. Pt assessment done. Dressings changed. R leg wound and abd wound erythy red. Left flank wound purulent. — Sgt [redacted] LPN
	0850		Dr [redacted] at bedside. DC'd Sent, S'd maintenance to DS½NS c 40KCl 100cc/hr. Removed R central line. Pulled out middle retention suture. — Sgt [redacted]
	1300		Pt temp 102.0. Gave 2 Tylenol. Will continue to monitor — Sgt [redacted]
14OCT03 1800		1800	VSS - Alert X3. O2 @ 2L/m via NC SATS 100%. IV of ~~LR~~ D5½NS c 40mg of K+ into (L) subclavian line. all ports patent flush easily. Foley to gravity drainage clear yellow urine 100-120ml/hr. T-101.5 Tylenol 650mg given PO. Ø c/o @ present time. — Sgt [redacted]
14 Oct03		1900	T-101.5 Tylenol 650mg PO given. MSO4 6mg given for c/o pain IVP. O2 @ 2L/m via NC 100%. — Sgt [redacted]
14Oct03		2200	Drsgs to mid-line Abd incision, (R) thigh and (L) buttocks D/I; (L) buttock wound had lg amts of light red serous drainage foul smelling - wound to (R) thigh medial and serous drainage & foul smell noted; mid line incision small amt of bloody light red drainage. All wound repacked c NS soaked gauze and covered c Abd pad. — Sgt [redacted]

(Continue on reverse side)

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

DATE [redacted] b(6)-4

NURSING NOTES

Medical Record

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

510-112 NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
	0650		Recieved patient from off going shift. Assessment as follows; [A] follows commands, moves all 4 extremities, appropriate interaction; Pain relieved with moderate IVP c Percocet; [R] SpO2 96% ≤ on RA; CCU (2), ⊖ cough; ⊖ sob; cyanosis [CV] NSR-ST, BPs 100-110/50-60s, S1, S2 ⊖ JVD; ⊖ carotid + pulses (3+) x4; (5+) Midline abdomen clean c/d/i; coloring to ⊕ side — ⊖ [redacted] yellow area immediately around colostomy site - pt complain of burning ⊖ stool from colostomy. [GI] [redacted] skin intact to ⊕ lip, but split noted to midline scalp [LWS] L SC ⊖ [redacted]
			[redacted]
			Continue to assessment [PLAN] [redacted]
			[redacted]
			b(6)-2

(Continue on reverse side)

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

REGISTER NO. —

WARD NO. ICU 3

[redacted] b(6)-4

NURSING NOTES

Medical Record

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

b(6)-2 (all)

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
2 2002	1900		VSS, Placed patient OOB to chair, O2 sat; PT/OT ambulate to chair on O2. Muller Abd clsg D/C [redacted]
	2000		assessment completed, new orders per MD Bruns; pt reports improved pain control c Percocet po; (see interpretr); pt to transfer to ward in AM; repositioned for comfort [redacted]
	2100		stoma bag N/I; area pink, stool semi-posteriori; ∅ areas of breakdown noted [redacted]
	2400		drainage to dbum / RLE dry; green tinged drainage remains; W&D dry; area pink/red; ∅ foul odor noted; minimal drainage [redacted]
	0400		medicine in 5 pts; resting, NAD [redacted]
DATE			
MEDICAL RECORD			

MEDICAL RECORD	PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT For use of this form, see AR 40-66; the proponent agency is The Office of the Surgeon General.
1. AGE: 30 HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): NKA 3. PREVIOUS SURGERY [ ] NO [✓] YES (type): see chart @ PST team

4. PROPOSED SURGICAL PROCEDURE:
presacral drainage, rectal washout, arteriogram

5. ADDITIONAL INFORMATION: Last PO: before midnight Medical Hx: see SF513 Implants: Ø Medications: see chart
Jewelry removed: yes no Family waiting: yes no
ring removed and taped to chart PACU aware

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	✓ Pt. verbalizes any specific anxiety. ✓ Pt. exhibits relaxed body posture. pt intubated	✓ 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 ✓ 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 ✓ 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

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

10. [redacted] MPLETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted] CPT/AN 10OCT 03 DATE

[redacted] STO[redacted]TIVE EVALUATION:

Dressings CDI
Bone pad site CDI
pt remains intubated, b(6)-2

12. [redacted] PREOPERATIVE EVALUATION PREPARED BY

[redacted] CPT/AN
[redacted] 0800
10OCT03

13. [redacted] POSTOPERATIVE EVALUATION PREPARED BY

[redacted] Signature [redacted] CPT/AN
[redacted] DATE: [redacted] 1035 TIME: [redacted] 1035
10OCT03

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MEDICAL RECORD

INTRAOPERATIV[illegible] UMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA BY

2. PATIENT IDENTIFIED, R[redacted]D PROCEDURE
VERIFIED BY [redacted]

3. DATE TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM
TIME NUMBER b(6)-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]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* (feet to front, arms sbd LSDP to paddles)

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

COMMENTS: armboards kept straight, bed padded.

8. SKIN PREPARATION

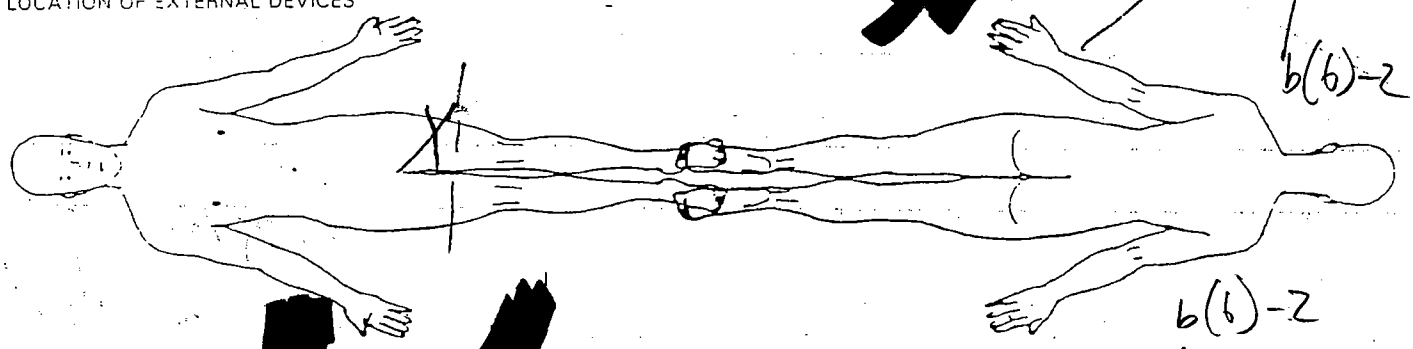
HAIR REMOVAL ☐ YES ☒ NO
DONE BY ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR
☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine
SITE: Abd BY WHOM: [redacted]
SITE: BY WHOM:

COMMENTS: [redacted] b(6)-2

9. LOCATION OF EXTERNAL DEVICES



b(6)-2

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

C = Correct I = Incorrect

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

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

IRAQ NATIONAL

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

☐ ESU NO: A
GROUND PAD: BRAND 3M
LOT NO: 1999-11Cu

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

MEDCOM - 21439

DA FORM 5179-1, OCT 87 REPLACES DA FORM [illegible] WHICH IS OBSOLETE. USAPA V1.01

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S): NSS

OTHER ORDERS	TIME	CARRIED OUT BY
[redacted] b(6)-2		

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

16. LABORATORY SPECIMENS

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

17. TUBES DRAINS PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE SIZE	16 Fr. Foley		
SITE	Bladder		

18. DRESSING/IMMOBILIZATION (Specify)

4X8

19. ADDITIONAL INFORMATION

WC 111

Surgeon: [redacted] b(6)-2

Asst

20. OPERATION(S) PERFORMED

Ex lap b(6)-2

21. PATIENT TRANSFERRED TO	TIME	METHOD
PACU		Litter

22. REGISTERED NURSE SIGNATURE [redacted] CPT

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