ADMISSION AND CODING INFORMATION

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

REPORTING MTF	REGISTER NUMBER
(b)(3)-1	(b)(6)-4

56. TOTAL SICK DAYS *(All Facilities)*	57. BED DAYS THIS MTF	58. BED DAYS OTHER FED MTFS	59. BED DAYS- CIV. HOSPITALS	60. BASSINET DAYS *(Neonatal)*
273 274 275 276 277	278 279 280 281	282 283 284 285	286 287 288 289	290 291 292 293
	0 0 0 2			

61. QUARTERS DAYS	62. MEDICAL HOLDING DAYS	63. COOPERATIVE CARE DAYS	64. CONVALESCENT LEAVE DAYS	65. SUPPLEMENTAL CARE DAYS
294 295 296 297	298 299 300 301	302 303 304 305	306 307 308 309	310 311 312 313

66. OTHER DAYS	67. TOTAL SICK DAYS - THIS MTF	68. BED DAYS - ICU	69. BED DAYS - ADMITTING CLINIC SERVICE	70. CLINIC SERVICE *(Second)*
314 315 316 317	318 319 320 321 322	323 324 325 326	327 328 329 330	331 332 333 334

71. BED DAYS SECOND CLINIC SERVICE	72. CLINIC SERVICE *(Third)*	73. BED DAYS THIRD CLINIC SERVICE	74. CLINIC SERVICE DISPOSITION	75. BED DAYS DISPOSITION CLINIC SERVICE
335 336 337 338	339 340 341 342	343 344 345 346	347 348 349 350	351 352 353 354

76. CONVALESCENT LEAVE RECOMMENDED	77. PATIENT ACUITY - DAYS I	78. PATIENT ACUITY - DAYS II	79. PATIENT ACUITY - DAYS III	80. PATIENT ACUITY - DAYS IV
355 356 357	358 359 360 361	362 363 364 365	366 367 368 369	370 371 372 373

81. PATIENT ACUITY - DAYS V	82. PATIENT ACUITY - DAYS VI	83. *DO NOT USE THIS SPACE*	84. TYPE RECORD
374 375 376 377	378 379 380 381	382 383 384 385 386 387	388 389 390 391 392 393

FOR LOCAL USE

MEDCOM - 2860

INPATIENT TREATMENT RECORD COVER SHEET

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

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

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	66		Mus			NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
20		EPW	ICU3

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

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
	1030	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
		030405

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
(b)(6)-4		030405	Maj (b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1	030405	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW to bilateral arms

CODING iNFORMATION: E970

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

ADMISSION AND CODING INFORMATION

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

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

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19 20 21 22 23 24 25 26: 1 9 3 8 0 1 0 1	27 28 29: 6 6 4	30	31	MUS

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36: 2 0	37 38 39 40 41 42 43 44 45 (b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
EPW	46	1030	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52: 1C 7 8	53 54 55 56 57 58 59 60 61

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: ERA	ICU3	

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) (b)(6)-4

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO (b)(3)-1	23. DATE OF DISPOSITION (Y Y M M D D)
73 74: XFR	75 76 77 78 79 80	81 82 83 84 85 86: 0 3 0 4 0 5 ROD

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110	111 112 113 114 115 116: 0 3 0 4 0 5

FOR LOCAL USE

DX: GSW to Bilateral Arms

Dx: 2800 [illegible] 12 [illegible]

ADM (b)(6)-2

SIGNATURE OF ADMITTING CLERK

SPC (b)(6)-2

DA FORM 2985, MAR 89 EDITION OF MAY 79 IS OBSOLETE

MEDCOM - 2862

INPATIENT TREATMENT RECORD COVER SHEET

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

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

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	20		MUS			NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
			ICU3

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

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
ERA	1030z	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
(b)(6)-4	XFR	030405

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
(b)(6)-4		030405	Maj (b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1	030405	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: 1. Shrapnel injury to R mid/upper back s/o cheat tube

2. L Buttocks shrapnel injury

CODING INFORMATION: E992

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAO OR MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79

EDITION OF 1 AUG 78 IS OBSOLETE

USAPPC V1.10

1. NAME (Last, First, Middle Initial) (b)(6)-4

2. SSN

3a. STATUS

3b. SERVICE

4. PRECEDENCE U | P | R X

5. GRADE

6. AGE 20

7. SEX | MALE X | FEMALE

8. WEIGHT

9. BLOOD TYPE

10. CLASSIFICATION (1A TO 5F) – AMBUL | X LITTER

11. ACCEPTING MD

12. CITE/AUTH # (b)(6)-4

13. APPT/SURG DATE (b)(6)-4

14a. ORIGINATING FACILITY (b)(3)-1

14b. ORIGINATING FACILITY PHONE NUMBER ICU #3

15a. DESTINATION FACILITY

15B. DESTINATION FACILITY PHONE NUMBER

16. # OF ATTENDANTS

16a. MED ∅ 16b. NON-MED ∅

17. DIAGNOSIS

Shrapnel @ upper chest
chest tube
shrapnel @ buttock

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	
a.		✓	Hypertension	i.		✓	Bowel Problem
b.			Cardiac Hx	j.		✓	Self-care
c.			Diabetes	k.	✓		Ambulatory
d.			Respiratory	l.		✓	Ambulatory Aid
e.			Ears/Sinus	m.		✓	Self-meds
f.			Motion Sick	n.		✓	Adequate Supply of Meds
g.		✓	Vision Impaired	o.			Other:
h.		✓	Voiding Prob.				

20. PHYSICIANS ORDERS

20a. DATE 5APR03

20b. TIME 1230

20c. ALLERGIES NKA

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

RENAL Gm Prot Gm Na MagK mg PO4

TUBE TYPE cc/hr, 1/2, 3/4, FULL STRENGTH

PEDIATRIC: AGE OTHER (Specify)

TPN: Change to D10 at cc/hr for max of days

TUBE FEEDING: at strength at cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

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

OXYGEN: PERCENT or LITERS ROUTE:

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No feet

20h. RECORDS TO ACCOMPANY PATIENT

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

20i. MEDICATIONS / TREATMENTS

Ancef 1 gm IV Q8°
IVF LR @ 125 ml/h.
MSO4 2-3 mg IV Q1° PRN pain

21. PRE-FLIGHT VITALS

21a. DATE / TIME

21b. TEMP:

21c. PULSE

21e. BP

21d. RESP:

22. BRIEF NARRATIVE

s/p MVA Frag 3rd c multiple
Shrapnel WNDS @ back/shoulder
& buttocks. S/P tube
thoracostomy

23. ASSESSMENT / PROGRESS

DATE / TIME NOTES

(b)(6)-2

24. S

AF F

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF: (b)(3)-1
2. MTF LOCATION (State or Country Code):
3. REGISTER NUMBER: (b)(6)-4
NAME (Last, First, Middle Initial): (b)(6)-4
4. PAY GRADE:
5. SEX: M
6. DATE OF BIRTH (Y Y Y Y M M D D): 19830101
7. AGE AT ADMISSION: 20Y
8. RACE:
9. ETHNIC BACKGROUND:
RELIGION: MOS
10. LENGTH OF SERVICE:
ETS:
11. FMP:
12. SOCIAL SECURITY NUMBER: (b)(6)-4
ORGANIZATION (Active Duty Only):
13. MARITAL STATUS:
HOUR OF ADMISSION: 1030Z
BRANCH / CORPS: EBN
14. FLYING STATUS:
15. BENEFICIARY CATEGORY: K 7 8
16. ZIP CODE OF RESIDENCE:
17. UNIT LOCATION (State or Country Code):
18. MOS:
19. TRAUMA:
PREV. ADMISSION: YEAR
[X] NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: ER
WARD: ICU 3
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: (b)(6)-4
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): (b)(6)-4
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE:
21. TYPE OF DISPOSITION: XPR
22. MTF TRANSFERRED TO: (b)(6)-2
23. DATE OF DISPOSITION (Y Y M M D D): 030405 1830
24. CLINIC SVC - ADMITTING:
25. MTF TRANSFERRED FROM:
26. DATE THIS ADMISSION (Y Y M M D D):
27. LOCATION OF OCCURRENCE (Battle Casualty Only):
28. MTF OF INITIAL ADMISSION:
29. DATE INITIAL ADMISSION (Y Y M M D D): 030405

FOR LOCAL USE

Dx 1. Shrapnel Injury to @ mid/upper back s/p chest tube
2. @ buttocks shrapnel injury

Dx: 8760
8771
E9919

Inj Trauma
4/3 1

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

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

EDITION OF MAY 79 IS OBSOLETE

MEDCOM - 2865

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4			3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE 42	6. RACE	7. RELIGION MUS	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION NO	
11. FMP		12. SSN		13. ORGANIZATION EPW		14. WARD ICU3	
15. FLYING STATUS NO	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE INJ	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION ERA				22. HOURS OF ADMISSION 1050z	23. CLINIC SERVICE		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE Wife/ (b)(6)-4				25. TYPE DISPOSITION XFR	26. DATE OF DISPOSITION 030407		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) (b)(6)-4				27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION 030407		ADMITTING OFFICER Col (b)(3)-1
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1					30. DATE OF INTIAL ADMISSION 030407		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: L Open elbow FX
L Thigh GSW
R Shoulder GSW

CODING INFORMATION: E 991.9, ~~E 812.59, E 820.13~~

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79 EDITION OF 1 AUG 76 IS OBSOLETE USAPPC V1.10

1. NAME (Last, First, Middle) (b)(6)-4

2. SSN

3a. STATUS CIV

3b. SERVICE

4. PRECEDENCE U P R

5. GRADE

6. AGE 20

7. SEX MALE FEMALE

8. WEIGHT

9. BLOOD TYPE

10. CLASSIFICATION (1A TO 5F)– AMBUL | X | LITTER

11. ACCEPTING MD

12. CITF/ALITH # (b)(6)-4

13. APPT/SURG DATE

14a. ORIGINATING FACILITY (b)(3)-1

14b. ORIGINATING FACILITY PHONE NUMBER 558-(b)(3)-

15a. DESTINATION FACILITY

15B. DESTINATION FACILITY PHONE NUMBER

16. # OF ATTENDANTS

16a. MED

16b. NON-MED

17. DIAGNOSIS

(L) Shoulder shrapnel

(L) Side chest wound

(L) forearm

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	
a.		X	Hypertension	i.		X	Bowel Problem
b.			Cardiac Hx	j.	X		Self-care
c.			Diabetes	k.		X	Ambulatory
d.			Respiratory	l.		X	Ambulatory Aid
e.			Ears/Sinus	m.		X	Self-meds
f.			Motion Sick	n.		X	Adequate Supply of Meds
g.			Vision Impaired	o.		X	Other:
h.		X	Voiding Prob.				

20. PHYSICIANS ORDERS

20a. DATE

20b. TIME

20c. ALLERGIES

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

RENAL Gm Prot Gm Na MagK mg PO4

TUBE TYPE cc/hr, 1/2, 3/4, FULL STRENGTH

PEDIATRIC: AGE OTHER (Specify)

TPN: Change to D10 at cc/hr for max of days

TUBE FEEDING: at strength at cc/hr

20e. IV / BLOOD 18g (L) wrist LR

20f. SPECIAL EQUIPMENT

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

OXYGEN: PERCENT or LITERS ROUTE:

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No feet

20h. RECORDS TO ACCOMPANY PATIENT

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

20i. MEDICATIONS / TREATMENTS

MS04 @ 0514Z DS Aper

Ancef 1gm 1st dose @ 0513002 APR05

Phenergan 12.5mg IVP

21. PRE-FLIGHT VITALS

21a. DATE / TIME

21b. TEMP:

21c. PULSE

21e. BP

21d. RESP:

22. BRIEF NARRATIVE

SIP GSW (shrapnel) to (L) shoulder

Chest tube to 25 centro & cont & drg side

Drainage (L) forearm

23. ASSESSMENT / PROGRESS

DATE / TIME

NOTES

Wrong pt=

(b)(6)-4

this chart

(b)(6)-4

24. STAMP AND SIGNATURE OF ATTENDING PHYSICIAN

(b)(6)-2

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

F Form 3899 (433 AES Ex

ADMISSION AND CODING INFORMATION

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

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

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19 20 21 22 23 24 25 26: 1 9 6 1 0 1 0 1	27 28 29: 4 2 Y	30	31	Mus

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36: 2 0	37 38 39 40 41 42 43 44 45: (b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
EPW	46	1050Z	

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: ER/A	ICU3	(b)(6)-4

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): (b)(6)-4

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
73 74: XPR	75 76 77 78 79 80: (b)(3)-1	81 82 83 84 85 86: 0 3 0 4 0 7 1030

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110	111 112 113 114 115 116: 0 3 0 4 0 5

FOR LOCAL USE

Dx (L) Open Elbow Fx
(L) Thigh GSW
(R) Shoulder GSW

Dx 81250
8900
8200
[illegible]2

Inj 450

Trauma 1

PR: 3404

ADMITTI (b)(6)-4

SIGNATURE OF ADMITTING CLERK: Soc (b)(6)-4

DA FORM 2985, MAR 89 EDITION OF MAY 79 IS OBSOLETE

INPATIENT TREATMENT RECORD COVER SHEET

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

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

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	1920		MUS			NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
		EPW	

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
NO					INJ

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
ERA	1050z	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	XFR	030406

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		030405	Maj (b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1	030405	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW R leg

CODING INFORMATION: E970

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

U60630APR03
D60430APR03

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

6. AGE	7. SEX	8.WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F)	11.ACCEPTING MD	12.CITE/ALUTIUM
20	X MALE / FEMALE			AMBUL / X LITTER		(b)(6)-4

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

17. DIAGNOSIS

GSW (b) knee
(b) forearm fracture
GSW (b) thigh
2° Burn (b) chest

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	
a.		X	Hypertension	i.		/	Bowel Problem
b.			Cardiac Hx	j.		/	Self-care
c.			(b)(6)-4 Diabetes	k.	X		Ambulatory
d.			Respiratory	l.		/	Ambulatory Aid
e.			Ears/Sinus	m.		/	Self-meds
f.			Motion Sick	n.		/	Adequate Supply of Meds
g.			Vision Impaired	o.		/	Other:
h.			Voiding Prob.				

20. PHYSICIANS ORDERS

20a. DATE	20b. TIME	20c. ALLERGIES
5APR03	2015	NKA

20d. DIET X REG | 3GM NA | CARDIAC | DIABETIC ___ CALS
RENAL ___ Gm Prot ___ Gm Na ___ MagK ___ mg PO4
TUBE ___ TYPE ___ cc/hr, 1/2, 3/4, FULL STRENGTH
PEDIATRIC: AGE ___ OTHER (Specify) ___
TPN: Change to D10 at ___ cc/hr for max of ___ days
TUBE FEEDING: ___ at ___ strength at ___ cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

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

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

20g. ALTITUDE RESTRICTION: Yes / No ___ feet

20h. RECORDS TO ACCOMPANY PATIENT

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

20i. MEDICATIONS / TREATMENTS

Ancef 1gm IVQ8°
MSO4 2-4mg IVQ1° PRN pain

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE

~20yr.o. Iraqi ♂ S/P multi GSW's, S/P washout, stable for X-spart.

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

(b)(6)-2

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

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

ADMISSION AND CODING INFORMATION

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

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

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
9 10 11 12 13 14 15 (b)(6)-4	(b)(6)-4	16 17	18 M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19 20 21 22 23 24 25 26: 1 9 8 3 0 1 0 1	27 28 29: 2 0 4	30	31	

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36: 2 0	37 38 39 40 41 42 43 44 45 (b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
EPW	46	1050z	

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72 ERA		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
N (b)(3)-1		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
73 74: XPR	75 76 77 78 (b)(3)-1	81 82 83 84 85 86: 0 3 0 4 0 10 1830

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYMMDD)
103 104	105 106 107 108 109 110	111 112 113 114 115 116: 0 3 0 4 0 5

FOR LOCAL USE

GSW (R) leg
Inj Trauma
450 1

Lx 8910
81380
8900
94525
E9972 + E9248

Proc 9659

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

DA FORM 298 EDITION OF MAY 79 IS OBSOLETE USAPPC V1.00

INPATIENT TREATMENT RECORD COVER SHE

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

1. REGISTER NUMBER (b)(6)-4	2. NAME (Last, First, MI) (b)(6)-4			3. GRADE	ADMISSION REMARKS
4. SEX m	5. AGE 13 Y	6. RACE	7.	9. ETS	10. PREVIOUS ADMISSION
11. FMP	12. SSN (b)(6)-4		13. ORGANIZATION		14. WARD
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN EPW K-78	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION				22. HOURS OF ADMISSION	23. CLINIC SERVICE
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION		26. DATE OF DISPOSITION
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)			27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY					30. DATE OF INTIAL ADMISSION
					32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW (L) eye
Head Injury GC 5 - 3
mangled (R) foot

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF (1–6): (b)(3)-1
2. MTF LOCATION (7–8) *(State or Country Code.)*
3. REGISTER NUMBER (9–15): (b)(6)-4
NAME: (b)(6)-4
4. PAY GRADE (16–17):
5. SEX (18): M
6. DATE OF BIRTH *(YYYYMMDD)* (19–26): 19901013
7. AGE AT ADMISSION (27–29): 34
8. RACE (30):
9. ETHNIC BACKGROUND (31):
RELIGION: N.Jh
10. LENGTH OF SERVICE (32–34):
ETS:
11. FMP (35–36): 20
(b)(6)-4
ORGANIZATION *(Active Duty Only)*:
13. MARITAL STATUS (46):
HOUR OF ADMISSION: 1020
BRANCH / CORPS:
14. FLYING STATUS (47–49):
15. BENEFICIARY CATEGORY (50–52): K 7 8 EPW
16. ZIP CODE OF RESIDENCE (53–61):
17. UNIT LOCATION *(State or Country Code)* (62–63):
18. MOS (64–70):
19. TRAUMA (71):
PREV. ADMISSION: YEAR: ☒ NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72):
WARD: ICU3
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): XFR
22. MTF TRANSFERRED TO (75–80): (b)(3)-1
23. DATE OF DISPOSITION *(YYMMDD)* (81–86): 030406 1800
24. CLINIC SVC - ADMITTING (87–90):
25. MTF TRANSFERRED FROM (91–96):
26. DATE THIS ADMISSION *(YYMMDD)* (97–102):
27. LOCATION OF OCCURRENCE *(Battle Casualty Only)* (103–104):
28. MTF OF INITIAL ADMISSION (105–110):
29. DATE INITIAL ADMISSION *(YYMMDD)* (111–116): 030406

FOR LOCAL USE

(1) GSW (L) eye
(2) Head injury GCS (3)
(3) manglet (R) foot

DX: 8715
8739
9597
E9912
NSD

ADMITTING OFFICER *(Signature, as re...)*: (b)(6)-2
SIGNATURE OF ADMITTING CLERK: (b)(6)-2

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

INPATIENT TREATMENT RECORD COVER SI

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

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4				3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS		10. PREVIOUS ADMISSION	
11. FMP 20	(b)(6)-4			13. ORGANIZATION			14. WARD	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN K78		18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION					22. HOURS OF ADMISSION	23. CLINIC SERVICE		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE				25. TYPE DISPOSITION		26. DATE OF DISPOSITION 03-04-10		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)				27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY						30. DATE OF INITIAL ADMISSION 03-04-06		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79 EDITION OF 1 AUG 76 IS OBSOLETE USAPPC V1.10

1. NAME (Last, First, Middle Initial): (b)(6)-4

2. SSN

3a. STATUS | 3b. SERVICE

4. PRECEDENCE: U | P | R X

5. GRADE

6. AGE: 25

7. SEX: X MALE | FEMALE

8. WEIGHT

9. BLOOD TYPE

10. CLASSIFICATION (1A TO 5F) – AMBUL | X LITTER

11. ACCEPTING MD

12. CITE/AUTH #: (b)(6)-4

13. ATT/SURG DATE

14a. ORIGINATING FACILITY: (b)(3)-1

14b. ORIGINATING FACILITY PHONE NUMBER: (b)(3)-1 ICU #3

15a. DESTINATION FACILITY

15B. DESTINATION FACILITY PHONE NUMBER

16. # OF ATTENDANTS: 16a. MED: Ø | 16b. NON-MED: Ø

17. DIAGNOSIS: S/P GSW (L) foot / (R) thigh

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	
a.		X	Hypertension	i.			Bowel Problem
b.			Cardiac Hx	j.			Self-care
c.			Diabetes	k.	X		Ambulatory
d.			Respiratory	l.			Ambulatory Aid
e.			Ears/Sinus	m.			Self-meds
f.			Motion Sick	n.			Adequate Supply of Meds
g.			Vision Impaired	o.			Other:
h.			Bleeding Prob.				

20. PHYSICIANS ORDERS

20a. DATE: 6 APR 03

20b. TIME: 1730

20c. ALLERGIES: NKDA

20d. DIET: X REG | BGM DIA | CARDIAC | DIABETIC CALS

RENAL Gm Pro Gm Na MagK mg PO4

TUBE TYPE cc/hr, 1/2, 3/4, FULL STRENGTH

PEDIATRIC: AGE OTHER (Specify)

TPN: Change to D10 at cc/hr for max of days

TUBE FEEDING: at strength at cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

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

OXYGEN: PERCENT or LITERS ROUTE:

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No feet

20h. RECORDS TO ACCOMPANY PATIENT

	OUTPATIENT RECORDS	X	XRAYS
X	INPATIENT RECORDS		OB
	NARRATIVE SUMMARY		DENTAL
	FINANCIAL		

OTHER:

20i. MEDICATIONS / TREATMENTS

Tylenol 650mg p.o. Q6O

Keflex 500mg p.o. BID

21. PRE-FLIGHT VITALS

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

21d. RESP:

22. BRIEF NARRATIVE

a 25 y.o. Iraqi ♂ S/P GSW (L) foot / (R) thigh S/P debridement EST 5 APR 03 Pt. stable for transport.

23. ASSESSMENT / PROGRESS

DATE / TIME | NOTES

24. (b)(6)-2

SIGNATURE

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

ADMISSION AND CODING INFORMATION

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

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

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
9 10 11 12 13 14 15 (b)(6)-4	(b)(6)-4 (b)(6)-4	16 17	18 M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19 20 21 22 23 24 25 26 1 9 7 8 0 1 0 1	27 28 29 25	30	31	MUS

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36 2 0	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	1020	

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72 EMT	ICU3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
(b)(3)-1	

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
73 74 XFR	75 76 77 78 79 80 (b)(3)-1	81 82 83 84 85 86 0 3 0 4 1 0 0500

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYMMDD)
103 104	105 106 107 108 109 110	111 112 113 114 115 116 0 3 0 4 0 6

FOR LOCAL USE GSW (L) FOOT + (R) T-high

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

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

MEDCOM - 2876

INPATIENT TREATMENT RECORD COVER SI

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

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4			3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION	
11. FMP 20	12. SSN (b)(6)-4		13. ORGANIZATION			14. WARD	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN 278	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION				22. HOURS OF ADMISSION	23. CLINIC SERVICE		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION		26. DATE OF DISPOSITION 03-04-07		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)			27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY					30. DATE OF INTIAL ADMISSION 03-04-06		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79 EDITION OF 1 AUG 78 IS OBSOLETE USAPPC V1.10

(b)(6)-4

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

6. AGE	7. SEX	8. WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F)	11. ACCEPTING MD	12. CITE/AUTH #
32	X MALE / FEMALE			AMBUL / X LITTER		(b)(6)-4

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

17. DIAGNOSIS

GSW (L) shoulder, (L) thigh
SI wound (R) forearm, (R) leg

18. X BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

20. PHYSICIANS ORDERS

20a. DATE	20b. TIME	20c. ALLERGIES
6 APR 03	1600	NKDA

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

RENAL ___ Gm Prot ___ Gm Na ___ MagK ___ mg PO4

TUBE TYPE ___ cc/hr, 1/2, 3/4, FULL STRENGTH

PEDIATRIC: AGE ___ OTHER (Specify) ___

TPN: Change to D10 at ___ cc/hr for max of ___ days

TUBE FEEDING: ___ at ___ strength at ___ cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

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

OXYGEN: ___ PERCENT or ___ LITERS ROUTE: ___

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No ___ feet

20h. RECORDS TO ACCOMPANY PATIENT

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

20i. MEDICATIONS / TREATMENTS

Keflex 500 po, QID
IVF LR @ 125 ml/hr.

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

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

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE

32 y.o. ♂ s/p multiple GSW's
to shoulder, s/p washout,
stable for X-port.

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

24. S (b)(6)-2 NG PHYSICIAN

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF Form 3899 (433 AES Excel version)

ADMISSION AND CODING INFORMATION

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

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

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19 20 21 22 23 24 25 26: 1 9 7 1 0 1 0 1	27 28 29: 3 2 4	30	31: 9	M-3

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36: 2 0	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	1020	

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: 0 ENT	ICU3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
(b)(3)-1	

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
73 74: KFR	(b)(3)-1: 75 76 77 78 79 80	81 82 83 84 85 86: 0 3 0 4 0 7 0830

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYMMDD)
103 104	105 106 107 108 109 110	111 112 113 114 115 116: 0 3 0 4 0 4

FOR LOCAL USE

GSW to ⓛ shoulder ⓛ thigh
Shrapnel to ⓛ forearm, ⓛ leg

450 1

(b)(6)-2

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

DA FOR

EDITION OF MAY 79 IS OBSOLETE

USAPPC V1.00

INPATIENT TREATMENT RECORD COVER SHE

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

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4 (b)(6)-4			3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE 35	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION	
11. FMP 20		12. SSN (b)(6)-4		13. ORGANIZATION		14. WARD	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT/ BEN EPW KAG		18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION					22. HOURS OF ADMISSION	23. CLINIC SERVICE	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE				25. TYPE DISPOSITION		26. DATE OF DISPOSITION	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)				27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY						30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAO OR MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79 EDITION OF 1 AUG 76 IS OBSOLETE USAPPC V1.10

(b)(6)-4

1. NAME (Last First Middle Initial) (b)(6)-4 | 2. SSN | 3a. STATUS EP(W) | 3b. SERVICE USMC | 4. PRECEDENCE U P (R) | 5. GRADE

6. AGE 20 | 7. SEX [X] MALE [ ] FEMALE | 8. WEIGHT | 9. BLOOD TYPE | 10. CLASSIFICATION (1A TO 5R) AMBUL [X] LITTER | 11. ACCEPTING MD | 12. CITE/AUTH # (b)(6)-4

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

17. DIAGNOSIS

(R) open tib/fib fx

18. [ ] BATTLE CASUALTY [ ] DISEASE [ ] NON BATTLE INJURY

20. PHYSICIANS ORDERS

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

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

RENAL ___ Gm Prot ___ Gm Na ___ MagK ___ mg PO4

TUBE ___ TYPE ___ cc/hr, 1/2, 3/4, FULL STRENGTH

PEDIATRIC: AGE ___ [ ] OTHER (Specify) ___

TPN: Change to D10 at ___ cc/hr for max of ___ days

TUBE FEEDING: ___ at ___ strength at ___ cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

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

OXYGEN: ___ PERCENT or ___ LITERS | ROUTE:

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No ___ feet

20h. RECORDS TO ACCOMPANY PATIENT

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

20i. MEDICATIONS / TREATMENTS

D-D & FJT

pathway opened

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

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

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE

(R) open tib/fib fx

23. ASSESSMENT / PROGRESS

DATE / TIME | NOTES

24. STAMP AND SIGNATURE

(b)(6)-2

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF Form 3899 (433 AES E[illegible]ion)

ADMISSION AND CODING INFORMATION

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

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

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
9 10 11 12 13 14 15	(b)(6)-4	16 17	18 M
(b)(6)-4			

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19 20 21 22 23 24 25 26: 1 9 6 8 0 1 0 1	27 28 29: 3 5 Y	30	31: 9	Mus.

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36: 2 0	37 38 39 40 41 42 43 44 45 (b)(6)-4

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

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: EmT	ICU3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO (b)(3)-1	23. DATE OF DISPOSITION (YYMMDD)
73 74: XFR	75 76 77 78 79 80	81 82 83 84 85 86: 0 3 0 4 1 0 0580

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYMMDD)
103 104	105 106 107 108 109 110	111 112 113 114 115 116: 0 3 0 4 0 6

FOR LOCAL USE

GSW (R) Lower Leg Dx: 82392 E9912

Trauma Dx: 8622

Injury 450

(b)(6)-2

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

DA FORM 2985, MAR 89 EDITION OF MAY 7 USAPPC V1.00

INPATIENT TREATMENT RECORD COVER SHE

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

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4		(b)(6)-4	3. GRADE	ADMISSION REMARKS
4. SEX m	5. AGE 30	6. RACE	7. RELIGION	8. [illegible]	9. ETS	10. PREVIOUS ADMISSION	
11. FMP 20		12. SSN		13. ORGANIZATION		14. WARD	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN EPW K-78		18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION					22. HOURS OF ADMISSION	23. CLINIC SERVICE	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE				25. TYPE DISPOSITION		26. DATE OF DISPOSITION	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)				27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY						30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW (L) S. Houlden

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

1. NAME (Last, First, Middle Initial) [redacted] 2. SSN

3a. STATUS: EDW | 3b. SERVICE | 4. PRECEDENCE: U P R X | 5. GRADE

6. AGE: 30 | X MALE | FEMALE | BLOOD TYPE | 10. CLASSIFICATION (1A TO 5F): AMBUL | X LITTER | 11. ACCEPTING MD | 12. CITIZENSHIP: (b)(6)-4 #

13. APPT/SURG DATE: 6 April 08 | 14a. ORIGINATING FACILITY: [redacted] | 15a. DESTINATION FACILITY | 16. # OF ATTENDANTS: 16a. MED: 0 | 16b. NON-MED

14b. ORIGINATING FACILITY PHONE NUMBER: ICU #3 | 15B. DESTINATION FACILITY PHONE NUMBER

17. DIAGNOSIS
6 Sep - (1) Shoulder / Chest
(2) LOC

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	
a.			Hypertension	i.			Bowel Problem
b.			Cardiac Hx	j.			Self-care
c.			Diabetes	k.			Ambulatory
d.			Respiratory	l.			Ambulatory Aid
e.			Ears/Sinus	m.			Self-meds
f.			Motion Sick	n.			Adequate Supply of Meds
g.			Vision Impaired	o.			Other:
h.			Voiding Prob.				

20. PHYSICIANS ORDERS

20a. DATE: 6 APRIL | 20b. TIME: 1500 Z | 20c. ALLERGIES: NONE

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

RENAL ___ Gm Prot ___ Gm Na ___ MagK ___ mg PO4

TUBE ___ TYPE ___ cc/hr, 1/2, 3/4, FULL STRENGTH

PEDIATRIC: AGE ___ OTHER (Specify) ___

TPN: Change to D10 at ___ cc/hr for max of ___ days

TUBE FEEDING: ___ at ___ strength at ___ cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

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

OXYGEN: PERCENT or ___ LITERS | ROUTE:

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No feet

20h. RECORDS TO ACCOMPANY PATIENT

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

20i. MEDICATIONS / TREATMENTS
IVF LR @ 100/hr.
S/P EX LAP TODAY
Rocephin 1gm IV Q24° x 3 days
(starting 6 APRIL)

21. PRE-FLIGHT VITALS

21a. DATE / TIME: 6 APRIL 08 | 21b. TEMP: | 21c. PULSE | 21e. BP: 128/73
21d. RESP: 20

22. BRIEF NARRATIVE
S/P 6 Sep (1) Chest / Shoulder
S/P EX LAP
S/P Splenectomy

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES
6 April	EX LAP Done
	NO DOCUMENTATION
	A/E

24. STAMP

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

F Form

110

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF (1–6): (b)(3)-1
2. MTF LOCATION (7–8) (State or Country Code)
3. REGISTER NUMBER (9–15): (b)(6)-4
4. PAY GRADE (16–17)
5. SEX (18): M
6. DATE OF BIRTH (Y Y Y Y M M D D): 19730101
7. AGE AT ADMISSION (27–29): 304
8. RACE (30)
9. ETHNIC BACKGROUND (31)
RELIGION: Mus Mus
10. LENGTH OF SERVICE (32–34)
ETS
11. FMP (35–36): 20
12. SOCIAL SECURITY NUMBER (37–45): (b)(6)-4
ORGANIZATION (Active Duty Only)
13. MARITAL STATUS (46)
HOUR OF ADMISSION: 1905
BRANCH / CORPS
14. FLYING STATUS (47–49)
15. BENEFICIARY CATEGORY (50–52): K78 EPW
16. ZIP CODE OF RESIDENCE (53–61)
17. UNIT LOCATION (State or Country Code) (62–63): 12
18. MOS (64–70)
19. TRAUMA (71): B
PREV. ADMISSION: YEAR; [X] NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72): 0
WARD: ICU3
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
21. TYPE OF DISPOSITION (73–74): XFR
22. MTF TRANSFERRED T (75–80): (b)(3)-1
23. DATE OF DISPOSITION (Y Y M M D D): 030410 0500
24. CLINIC SVC - ADMITTING (87–90)
25. MTF TRANSFERRED FROM (91–96)
26. DATE THIS ADMISSION (Y Y M M D D) (97–102)
27. LOCATION OF OCCURRENCE (Battle Casualty Only) (103–104): 12
28. MTF OF INITIAL ADMISSION (105–110)
29. DATE INITIAL ADMISSION (Y Y M M D D) (111–116): 030406

FOR LOCAL USE

GSW (L) Shoulder
Trauma
Dx: 88010
8911
E9910
Rx: 8081
8202
~~Ortho~~ 450

AD (b)(6)-2

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

DA FORM 2885, MAR 89

MEDCOM - 2885

INPATIENT TREATMENT RECORD COVER SHE

For use of this form, see AR 40-400; the proponent agency is O1.

1. REGISTER NUMBER (b)(6)-4			(b)(6)-4				3. GRADE	ADMISSION REMARKS
4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS		10. PREVIOUS ADMISSION	
11. FMP 20		(b)(6)-4		13. ORGANIZATION			14. WARD	
15. FLYING STATUS	16. RATING/ DSG		17. DEPT./ BEN K78	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION					22. HOURS OF ADMISSION	23. CLINIC SERVICE		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE				25. TYPE DISPOSITION		26. DATE OF DISPOSITION		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)				27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY						30. DATE OF INTIAL ADMISSION		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GWW (R) Leg

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

(b)(6)-4

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

6. AGE	7. SEX	8. WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F)–	11. ACCEPTING MD	12. CITE/AUTH #
32	MALE / FEMALE			AMBUL / LITTER		(b)(6)-4

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

17. DIAGNOSIS

(L) FEMUR FRACTURE

18. BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

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

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

20. PHYSICIANS ORDERS

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

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

RENAL Gm Prot Gm Na MagK mg PO4

TUBE TYPE cc/hr, 1/2, 3/4, FULL STRENGTH

PEDIATRIC: AGE OTHER (Specify)

TPN: Change to D10 at cc/hr for max of days

TUBE FEEDING: at strength at cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

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

OXYGEN: PERCENT or LITERS ROUTE:

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No feet

20h. RECORDS TO ACCOMPANY PATIENT

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

20i. MEDICATIONS / TREATMENTS

(L) femur external fixator
& I & D

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE

(L) distal femur fx

23. ASSESSMENT / PROGRESS

DATE / TIME NOTES

24. STAMP AND SIGNATURE OF ATTENDING PHYSICIAN

(b)(6)-2

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

Form 3899 (433 A el version)

ADMISSION AND CODING INFORMATION

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

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

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
9 10 11 12 13 14 15 (b)(6)-4	(b)(6)-4	16 17	18 M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19 20 21 22 23 24 25 26: 1 9 7 0 1 0 1	27 28 29: 3 1 4	30	31: 9	MUS

10. LENGTH OF SERVICE	ETS	11. FMP	(b)(6)-4
32 33 34		35 36: 2 0	

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	1356 Z	EPW

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52: K 3 8	53 54 55 56 57 58 59 60 61

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: D	ICU3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO (b)(3)-1	23. DATE OF DISPOSITION (Y Y M M D D)
73 74: XFR	75 76 77 78	81 82 83 84 85 86: 0 3 0 4 1 0 0500

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110	111 112 113 114 115 116: 0 3 0 4 0 6

FOR LOCAL USE

GSW left leg

Dx: [illegible]

[illegible]

[illegible]

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

DA FORM 2985, MAR 89 EDITION OF MAY 79 IS

MEDCOM - 2888

.NPATIENT TREATMENT RECORD COVER SHE

For use of this form, see AR 40-400; the proponent agency is 01.

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4				3. GRADE	ADMISSION REMARKS
4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS		10. PREVIOUS ADMISSION	
11. FMP 20		12. SSN		13. ORGANIZATION			14. WARD	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN K-78 EPW		18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION					22. HOURS OF ADMISSION	23. CLINIC SERVICE		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE				25. TYPE DISPOSITION		26. DATE OF DISPOSITION		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)				27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY						30. DATE OF INTIAL ADMISSION		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

(b)(6)-4

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

6. AGE	7. SEX MALE / FEMALE	8. WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F) -- AMBUL / LITTER	11. ACCEPTING MD	12. CITE/AUTH # (b)(6)-4

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

17. DIAGNOSIS

(L) AK AMPUTATION FMR

GSW

18. BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

20. PHYSICIANS ORDERS

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

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

RENAL ___ Gm Prot ___ Gm Na ___ MagK ___ mg PO4

TUBE ___ TYPE ___ cc/hr, 1/2, 3/4, FULL STRENGTH

PEDIATRIC: AGE ___ OTHER (Specify) ___

TPN: Change to D10 at ___ cc/hr for max of ___ days

TUBE FEEDING: ___ at ___ strength at ___ cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

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

OXYGEN: ___ PERCENT or ___ LITERS ROUTE: ___

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No ___ feet

20h. RECORDS TO ACCOMPANY PATIENT

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

20i. MEDICATIONS / TREATMENTS

(L) AKA

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

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

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE

(L) MANGLED LEG

Sp (L) AKA

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

24. STAMP AND SIGNATURE OF ATTENDING PHYSICIAN

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF Form 3899 (433 AES Excel version)

ADMISSION AND CODING INFORMATION

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

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

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19 20 21 22 23 24 25 26	27 28 29	30	31	
1985	17Y			MUS

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36	37 38 39 40 41 42 43 44 45
		20	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	1905	
	1		

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72	FCU3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
2		
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO (b)(3)-1	23. DATE OF DISPOSITION (Y Y M M D D)
73 74	75 76 77 78 79 80	81 82 83 84 85 86
XFR		0 3 0 4 0 7 0800

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110	111 112 113 114 115 116
		0 3 0 4 0 6

FOR LOCAL USE

(L) Lower Extremity Traumatic Amputation

Dx: 8973

V7912

Trauma

Surg

1450

ADMITTING OFFICER (Sig (b)(6)-2

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

DA FORM 2985, M ITION OF MAY 79 APPC V1.00

INPATIENT TREATMENT RECORD COVER SHEET

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

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

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M			MUS			NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
			ICU3

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

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
EMT	1500	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	XFR	030410

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		030406	MAJ (b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(6)-2	0330406	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW TO SCROTUM

CODING INFOMATION: 991.2

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

1. NAME (Last, First, Middle, Initial) (b)(6)-4	2. SSN (b)(6)-4	3a. STATUS: Iraqi	3b. SERVICE	4. PRECEDENCE: U / P / R X	5. GRADE

6. AGE	7. SEX	8. WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F)	11. ACCEPTING MD	12. CITE/AUTH #
32	X MALE / FEMALE			AMBUL / X LITTER		(b)(6)-4

13. APPT/SURG DATE	14a. ORIGINATING FACILITY (b)(3)-1	15a. DESTINATION FACILITY	16. # OF ATTENDANTS	
(b)(6)-4			16a. MED	16b. NON-MED
	14b. ORIGINATING FACILITY PHONE NUMBER: FCU #3	15B. DESTINATION FACILITY PHONE NUMBER	Ø	Ø

17. DIAGNOSIS

GSW to scrotum and (2) medial thigh c̄ cellulitis

18. X BATTLE CASUALTY / DISEASE / NON BATTLE INJURY

20. PHYSICIANS ORDERS

20a. DATE	20b. TIME	20c. ALLERGIES
06Apr03	1528 (Z)	NKDA

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

RENAL ___ Gm Prot ___ Gm Na ___ MagK ___ mg PO4

TUBE ___ TYPE ___ cc/hr, 1/2, 3/4, FULL STRENGTH

PEDIATRIC: AGE ___ / OTHER (Specify) ___

TPN: Change to D10 at ___ cc/hr for max of ___ days

TUBE FEEDING: ___ at ___ strength at ___ cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

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

OXYGEN: ___ PERCENT or ___ LITERS ROUTE:

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No ___ feet

20h. RECORDS TO ACCOMPANY PATIENT

	OUTPATIENT RECORDS		XRAYS
X	INPATIENT RECORDS		OB
	NARRATIVE SUMMARY		DENTAL
	FINANCIAL		

OTHER:

20i. MEDICATIONS / TREATMENTS

Ancef 1 gm IV Q8°

Percocet 1-2 p.o. Q6° PRN pain

Motrin 800mg p.o. TID PRN pain

(b)(6)-4

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

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

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE

S/p GSW x II on 3Apr03; tx to MASH from FST 06Apr03 c̄ noted cellulitis around medial thigh wound. Given IV Ancef.

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

(b)(6)-4

ADMISSION AND CODING INFORMATION

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

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

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
9 10 11 12 13 14 15 (b)(6)-4	(b)(6)-4	16 17	18 M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19 20 21 22 23 24 25 26: 1 9 7 1 0 1 0 1	27 28 29: 3 2 4	30	31	Muslim

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36: 2 0 EPW	37 38 39 40 41 42 43 44 45 (b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	1500Z	

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: 0 EMT	ICU3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO (b)(3)-1	23. DATE OF DISPOSITION (Y Y M M D D)
73 74: XPR	75 76 77 78	81 82 83 84 85 86: 0 3 0 4 1 0 0500

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110	111 112 113 114 115 116: 0 3 0 4 0 6

FOR LOCAL USE

GSW To Scrotum

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

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

ADMISSION AND CODING INFORMATION

30. AGE AT DISP			31. AUTOPSY Y / N	32. UNDERLYING CAUSE OF DEATH / SEP	33. RESIDUAL DISABILITY			34. DO NOT USE - DATA FILLER #1									35. CAUSE OF INJURY		
123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142

36. FIRST DIAGNOSIS *(Principal Diagnosis)*								37. SECOND DIAGNOSIS								38. THIRD DIAGNOSIS							
143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166
	E	9	9	1		2																	

39. FOURTH DIAGNOSIS								40. FIFTH DIAGNOSIS								41. SIXTH DIAGNOSIS							
167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190

42. SEVENTH DIAGNOSIS								43. EIGHTH DIAGNOSIS							
191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206

44. FIRST PROCEDURE *(Principal Diagnosis)*								45. SECOND PROCEDURE								46. THIRD PROCEDURE							
207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230

47. FOURTH PROCEDURE								48. FIFTH PROCEDURE								49. SIXTH PROCEDURE							
231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254

50. SEVENTH PROCEDURE								51. EIGHTH PROCEDURE							
255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270

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

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4			3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE 23	6. RACE	7. RELIGION MUS	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION NO	
11. FMP		12. SSN		13. ORGANIZATION		14. WARD ICU3	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN		18. BRANCH/CORPS EPW	19. UIC/ZIP	20. TYPE CASE INJ	

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION EMT	22. HOURS OF ADMISSION 0505	23. CLINIC SERVICE	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION XFR	26. DATE OF DISPOSITION 030409	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION 030407	ADMITTING OFFICER (b)(6)-2
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1		30. DATE OF INTIAL ADMISSION 030407	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW BUTTOCK, THIGH, AND BACK

CODING INFORMATION: 991.9

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

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

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

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

17. DIAGNOSIS

GSW Buttocks, thigh, Back

18. ✓ BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

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

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

20. PHYSICIANS ORDERS

20a. DATE	20b. TIME	20c. ALLERGIES
07 April 03	0600 2nd	Penicillin

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

RENAL ___ Gm Prot ___ Gm Na ___ MagK ___ mg PO4

TUBE TYPE ___ cc/hr, 1/2, 3/4, FULL STRENGTH

PEDIATRIC: AGE ___ OTHER (Specify) ___

TPN: Change to D10 at ___ cc/hr for max of ___ days

TUBE FEEDING: ___ at ___ strength at ___ cc/hr

20e. IV / BLOOD LR

20f. SPECIAL EQUIPMENT

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

OXYGEN: ___ PERCENT or ___ LITERS ROUTE:

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No ___ feet

20h. RECORDS TO ACCOMPANY PATIENT

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

20i. MEDICATIONS / TREATMENTS

Clindamycin 900 mg IVPB
q 8°

Morphine 2-4 mg IV
q 2° PRN

21. PRE-FLIGHT VITALS

21a. DATE / TIME	21b. TEMP:	21c. PULSE	21e. BP
07 April 03	21d. RESP:		

22. BRIEF NARRATIVE

Pt shot in Buttocks, thigh and Back EPW at detasin Camp. Pt stable now SEEN at Fast team wound packed. Will advise

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

24. STAMP AND SIGNATURE OF ATTENDING PHYSICIAN

(b)(6)-2

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

F Form 3899 (433 AES Excel version)

(b)(6)-4

ADMISSION AND CODING INFORMATION

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

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

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19 20 21 22 23 24 25 26: 1 9 8 0 0 1 0 1	27 28 29: 2 3 Y	30	31: 9	MUS

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36: 2 0	37 38 39 40 41 42 43 44 45: (b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46: S	0505 Z	

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: EMT	ICW3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
73 74: XPR	75 76 77 78 79 80: Najaf	81 82 83 84 85 86: 0 3 0 4 0 9 0800

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYMMDD)
103 104	105 106 107 108 109 110	111 112 113 114 115 116: 0 3 0 4 0 7

FOR LOCAL USE

GSW Buttock, thigh, and Back

TRAUMA

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

450

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

MEDCOM - 2898

ADMISSION AND CODING INFORMATION

30. AGE AT DISP			31. AUTOPSY Y / N	32. UNDERLYING CAUSE OF DEATH / SEP	33. RESIDUAL DISABILITY			34. DO NOT USE - DATA FILLER #1									35. CAUSE OF INJURY		
123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142
2	3	P																	

36. FIRST DIAGNOSIS *(Principal Diagnosis)*								37. SECOND DIAGNOSIS								38. THIRD DIAGNOSIS							
143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166
	E	9	9	1		9																	

39. FOURTH DIAGNOSIS								40. FIFTH DIAGNOSIS								41. SIXTH DIAGNOSIS							
167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190

42. SEVENTH DIAGNOSIS								43. EIGHTH DIAGNOSIS							
191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206

44. FIRST PROCEDURE *(Principal Diagnosis)*								45. SECOND PROCEDURE								46. THIRD PROCEDURE							
207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230

47. FOURTH PROCEDURE								48. FIFTH PROCEDURE								49. SIXTH PROCEDURE							
231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254

50. SEVENTH PROCEDURE								51. EIGHTH PROCEDURE							
255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270

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

INPATIENT TREATMENT RECORD COVER SHEET

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

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

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	41		MUS			NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
		EPW	ICU3

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
NO			EPW		INJ

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
EMT	0750	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	XFR	030409

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		030409	MAJ (b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1	030409	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW TO L LOWER EXTREMITY

CODING INFORMATION: E991.2

Dx 8910 E9912 Trauma Dmg 1 450

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

(b)(6)-4

ADMISSION AND CODING INFORMATION

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

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

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
9 10 11 12 13 14 15	(b)(6)-4	16 17	18
(b)(6)-4			M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19 20 21 22 23 24 25 26	27 28 29	30	31	
1 9 6 2 0 1 0 1	4 1			Muslim

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36	37 38 39 40 41 42 43 44 45
		2 0	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
EPW	46	0750z	EPW

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72 EMT	ICU3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO (b)(3)-1	23. DATE OF DISPOSITION (Y Y M M D D)
73 74	75 76 77 78 79 80	81 82 83 84 85 86
XFR		0 3 0 4 0 9 0500

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION (b)(3)-1	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110	111 112 113 114 115 116
	(b)(3)-1	0 3 0 4 0 9

FOR LOCAL USE

GSW to Left Lower Extremity

ADMITTING OFFICER (Printed)	SIGNATURE OF ADMITTING CLERK
(b)(6)-2	(b)(6)-2

DA FORM EDITION OF MAY 79 USAPPC V1.00

MEDCOM - 2901

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4				3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE 44	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS		10. PREVIOUS ADMISSION NO	
11. FMP		12. SSN (b)(6)-4		13. ORGANIZATION			14. WARD ICU3	
15. FLYING STATUS NO	16. RATING/ DSG	17. DEPT./ BEN		18. BRANCH/CORPS EPW	19. UIC/ZIP		20. TYPE CASE INJ	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION EMT					22. HOURS OF ADMISSION 0745	23. CLINIC SERVICE		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE				25. TYPE DISPOSITION XFR		26. DATE OF DISPOSITION 030409		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)				27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION 030409	ADMITTING OFFICER MAJ (b)(6)-2	
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1						30. DATE OF INTIAL ADMISSION 030409	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW TO BOTH LEGS/CALFS

CODING INFORMATION: 991.2

Dx 8910 E9912

Inj Trauma 450 1

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAO OR MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79 EDITION OF 1 AUG 76 IS OBSOLETE USAPPC V1.10

(b)(6)-4

ADMISSION AND CODING INFORMATION

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

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

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
9 10 11 12 13 14 15 (b)(6)-4	(b)(6)-4	16 17	18 M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19 20 21 22 23 24 25 26: 1 9 6 [illegible] 0 1 0 1	27 28 29: 4 2 Y	30	31	Muslim

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36: 2 0	37 38 39 40 41 42 43 44 45 (b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
GPW	46 M	0745Z	EPW

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: EMT	ICU3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO (b)(3)-1	23. DATE OF DISPOSITION (Y Y M M D D)
73 74: XFR	75 76 77 78 79 80	81 82 83 84 85 86: 0 3 0 4 0 9

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION (b)(3)-1	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110 (b)(3)-1	111 112 113 114 115 116: 0 3 0 4 0 9

FOR LOCAL USE

GSW to both legs / (b)(6)-2

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

INPATIENT TREATMENT RECORD COVER SI

For use of this form, see AR 40-400; the proponent agency is D[illegible]

(b)(6)-4			(b)(6)-4			3. GRADE	ADMISSION REMARKS
4. SEX: M	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION	
11. FMP: 20		12. SSN: (b)(6)-4		13. ORGANIZATION		14. WARD	
15. FLYING STATUS	16. RATING/DSG	17. DEPT/BEN: 178		18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE	

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION: 03-04-10	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY		30. DATE OF INTIAL ADMISSION: 03-04-09	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check If Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79 EDITION OF 1 AUG 76 IS OBSOLETE USAPPC V1.10

(b)(6)-4

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

6. AGE	7. SEX	8.WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F)–	11.ACCEPTING MD	12.CITE/AUTH #
	MALE / FEMALE			AMBUL ☒ LITTER		(b)(6)-4

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

17. DIAGNOSIS

17yrs old Iraqi male
s/p GSW (R) Arm

18. ☑ BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

20. PHYSICIANS ORDERS

20a. DATE	20b. TIME	20c. ALLERGIES
09 April 03	1545 Zulu	NKDA

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

RENAL ___ Gm Prot ___ Gm Na ___ MagK ___ mg PO4

TUBE ___ TYPE ___ cc/hr, 1/2, 3/4, FULL STRENGTH

PEDIATRIC: AGE ___ OTHER (Specify) ___

TPN: Change to D10 at ___ cc/hr for max of ___ days

TUBE FEEDING: ___ at ___ strength at ___ cc/hr

20e. IV / BLOOD IV & LR to with

20f. SPECIAL EQUIPMENT

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

OXYGEN: ___ PERCENT or ___ LITERS ROUTE:

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No ___ feet

20h. RECORDS TO ACCOMPANY PATIENT

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

20i. MEDICATIONS / TREATMENTS

Ancef 1 gram IVPB
q 8°

Morphine 2-4mg IV
q 2° PRN

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

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

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE

Pt shot Rt Arm S/P Surgery at fast Rm Tuday. Paramedic Pt would appear to be recently post op. S/P TAD bush out of Rt radius fx plan Evac

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

24. STAMP AND SIGNATURE OF ATTENDING PHYSICIAN

(b)(6)-2

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

F Form 3890 (432 AE Excel version)

(b)(3)-1

ADMISSION AND CODING INFORMATION

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

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

REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
9 10 11 12 13 14 15	(b)(6)-4 (b)(6)-4	16 17	18 M
(b)(6)-4			

DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19 20 21 22 23 24 25 26: 1 9 8 6 0 1 0 1	27 28 29: 1 7 4	30	31	

LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36: 2 0	37 38 39 40 41 42 43 44 45: (b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	1530Z	EPW

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

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

SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72 O ERA		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
73 74: XSR	75 76 77 78 79 80 (b)(3)-1	81 82 83 84 85 86: 0 3 0 4 1 0 0500

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

LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYMMDD)
103 104	105 106 107 108 109 110	111 112 113 114 115 116: 0 3 0 4 0 9 0735

FOR LOCAL USE

DX: GSW R/ARM

DX 8840 E9412

Ins Tech 450 1

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

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

INPATIENT TREATMENT RECORD COVER SI

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

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4				3. GRADE	ADMISSION REMARKS
4. SEX m	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS		10. PREVIOUS ADMISSION	
11. FMP 20		12. SSN (b)(6)-4		13. ORGANIZATION			14. WARD	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN LT8		18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION					22. HOURS OF ADMISSION	23. CLINIC SERVICE		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE				25. TYPE DISPOSITION		26. DATE OF DISPOSITION 03-04-10		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)				27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY						30. DATE OF INTIAL ADMISSION 03-04-07		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check If Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79 EDITION OF 1 AUG 78 IS OBSOLETE USAPPC V1.10

(b)(6)-4

(b)(3)-1

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

6. AGE | 7. SEX ☑ MALE FEMALE | 8. WEIGHT | 9. BLOOD TYPE | 10. CLASSIFICATION (1A TO 5F) AMBUL LITTER | 11. ACCEPTING MD | 12. CITE/AUTH # (b)(6)-4

13. APPT/SURG DATE | 14a. ORIGINATING FACILITY (b)(3)-1 | 15a. DESTINATION FACILITY | 16. # OF ATTENDANTS

14b. ORIGINATING FACILITY PHONE NUMBER | 15B. DESTINATION FACILITY PHONE NUMBER | 16a. MED | 16b. NON-MED

17. DIAGNOSIS

OSW (L) ankle sprained

18. BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

20. PHYSICIANS ORDERS

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

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

RENAL Gm Prot Gm Na MagK mg PO4

TUBE TYPE cc/hr, 1/2, 3/4, FULL STRENGTH

PEDIATRIC: AGE OTHER *(Specify)*

TPN: Change to D10 at cc/hr for max of days

TUBE FEEDING: at strength at cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

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

OXYGEN: PERCENT or LITERS ROUTE:

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No feet

20h. RECORDS TO ACCOMPANY PATIENT

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

20i. MEDICATIONS / TREATMENTS

Cefoxitin 1 gm IVPB q8h

morphine 1-4 mg IV/IM q 3-4h PRN pain

Phenergan 25 mg IV q 4-6h PRN

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

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

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE

yo. ♂ w/ sprained injury to (L) ankle ? chronic age

Pt. referred ok for further care

Pt. will require surgery for his (L) ankle.

23. ASSESSMENT / PROGRESS

DATE / TIME | NOTES

. STAMP AND SIGNATURE OF ATTENDING PHYSICIAN

(b)(6)-2

MD

ORTHOPEDIC SURGERY

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

Form 3899 (433 AES Excel version)

(b)(3)-1

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF (1–6)	2. MTF LOCATION (7–8) (State or Country Code.)
(b)(3)-1	

REGISTER NUMBER (9–15)	NAME (Last, First, Middle Initial)	4. PAY GRADE (16–17)	5. SEX (18)
(b)(6)-4	(b)(6)-4 (b)(6)-4		M

DATE OF BIRTH (Y Y Y M M D D) (19–26)	7. AGE AT ADMISSION (27–29)	8. RACE (30)	9. ETHNIC BACKGROUND (31)	RELIGION
1 9 5 6 0 7 0 1	4 6 Y			MUS

LENGTH OF SERVICE (32–34)	ETS	11. FMP (35–36)	12. SOCIAL SECURITY NUMBER (37–45)
		2 0	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS (46)	HOUR OF ADMISSION	BRANCH / CORPS
		1745	EPW

14. FLYING STATUS (47–49)	15. BENEFICIARY CATEGORY (50–52)	16. ZIP CODE OF RESIDENCE (53–61)
	K 7 8 EPW	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72)	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
ERA	ICU3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
(b)(3)-1 IRAQ	

21. TYPE OF DISPOSITION (73–74)	22. MTF TRANSFERRED TO (75–80)	23. DATE OF DISPOSITION (Y Y M M D D) (81–86)
XFR	(b)(3)-1	0 3 0 4 1 0 0500

24. CLINIC SVC - ADMITTING (87–90)	25. MTF TRANSFERRED FROM (91–96)	26. DATE THIS ADMISSION (Y Y M M D D) (97–102)

27. LOCATION OF OCCURRENCE (Battle Casualty Only) (103–104)	28. MTF OF INITIAL ADMISSION (105–110)	29. DATE INITIAL ADMISSION (Y Y M M D D) (111–116)
		0 3 0 4 0 7

FOR LOCAL USE

Shrapnel Injury
(L) Ankle ? Intra articular
fragment

Dx 3911 Inj Trauma
4/4/3 1

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

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

INPATIENT TREATMENT RECORD COVER SI

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

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4			3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION	
11. FMP 20	12. SSN (b)(6)-4			13. ORGANIZATION		14. WARD	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN LTR		18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION					22. HOURS OF ADMISSION	23. CLINIC SERVICE	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE				25. TYPE DISPOSITION		26. DATE OF DISPOSITION 0304-10	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)				27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY						30. DATE OF INTIAL ADMISSION 03-04-07	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check If Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79 EDITION OF 1 AUG 78 IS OBSOLETE USAPPC V1.10

(b)(6)-4

(b)(6)-4

1. NAME (Last, First, Middle Initial) (b)(6)-4	2. SSN	3a. STATUS	3b. SERVICE	4. PRECEDENCE U / P / R	5. GRADE
6. AGE 33 / 7. SEX ☒ MALE ☐ FEMALE	8. WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F) ☑ AMBUL ☐ LITTER	11. ACCEPTING MD	12. CITE/AUTH # (b)(6)-4
13. APPT/SURG DATE	14a. ORIGINATING FACILITY (b)(3)-1	15a. DESTINATION FACILITY		16. # OF ATTENDANTS	
	14b. ORIGINATING FACILITY PHONE NUMBER 558-(b)(3)-	15B. DESTINATION FACILITY PHONE NUMBER		16a. MED	16b. NON-MED

17. DIAGNOSIS

O-SEN (L) Right Fracture/ Dislocation Simple Fracture

18. ☒ BATTLE CASUALTY ☐ DISEASE ☐ NON BATTLE INJURY

20. PHYSICIANS ORDERS

20a. DATE 09 MAR 03 | 20b. TIME 21 06 Z | 20c. ALLERGIES

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

NPO

RENAL ___ Gm Prot ___ Gm Na ___ MagK ___ mg PO4

TUBE ___ TYPE ___ cc/hr, 1/2, 3/4, FULL STRENGTH

PEDIATRIC: AGE ___ ☐ OTHER (Specify) ___

TPN: Change to D10 at ___ cc/hr for max of ___ days

TUBE FEEDING: ___ at ___ strength at ___ cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

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

OXYGEN: ___ PERCENT or ___ LITERS ROUTE:

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No ___ feet

20h. RECORDS TO ACCOMPANY PATIENT

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

20i. MEDICATIONS / TREATMENTS

Ceftriaxone 1 gm IVPB q24h

Morphine 1-4 mg IV/IM q4-6h PRN

Promethazine 25 mg IM q4-6h PRN

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

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

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE

[illegible] to [illegible] Land.

Pt. referred to [illegible] for further treatment.

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

24. STAMP AND SIGNATURE OF ATTENDING PHYSICIAN, M.D.

(b)(6)-2

[illegible] ORTHOPAEDIC SURGERY

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF Form 3899 (433 AES Excel version)

(b)(3)-1

ADMISSION AND CODING INFORMATION

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

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

6. DATE OF BIRTH (YYYYMMDD) (19–26)	7. AGE AT ADMISSION (27–29)	8. RACE (30)	9. ETHNIC BACKGROUND (31)	RELIGION
19701013	33Y			MOS

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS (46)	HOUR OF ADMISSION	BRANCH / CORPS
		1745 Z	EPW

14. FLYING STATUS (47–49)	15. BENEFICIARY CATEGORY (50–52)	16. ZIP CODE OF RESIDENCE (53–61)
	K 7 8 EPW	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72)	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
ERA	ICU3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION (73–74)	22. MTF TRANSFERRED TO (75–78)	23. DATE OF DISPOSITION (YYMMDD) (81–86)
XFR	(b)(3)-1	030410 0500

24. CLINIC SVC - ADMITTING (87–90)	25. MTF TRANSFERRED FROM (91–96)	26. DATE THIS ADMISSION (YYMMDD) (97–102)

27. LOCATION OF OCCURRENCE (Battle Casualty Only) (103–104)	28. MTF OF INITIAL ADMISSION (105–110)	29. DATE INITIAL ADMISSION (YYMMDD) (111–116)
		030407

FOR LOCAL USE

GSW (D) Index finger
Infection with

D 8831
Z4912

Pt: 9921

(b)(6)-4

450 1

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

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

DA FORM 2935, MAR 89 EDITION OF MAY 79 IS OBSOLETE CV1.00

MEDCOM - 2912

INPATIENT TREATMENT RECORD COVER SI

For use of this form, see AR 40-400; the proponent agency is D1 5d

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4				3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS		10. PREVIOUS ADMISSION	
11. FMP 20		12. SSN (b)(6)-4		13. ORGANIZATION			14. WARD	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP			20. TYPE CASE	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION				22. HOURS OF ADMISSION	23. CLINIC SERVICE			
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE				25. TYPE DISPOSITION	26. DATE OF DISPOSITION 03-04-10			
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)				27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION			ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY					30. DATE OF INTIAL ADMISSION 03-04-07			32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check If Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79 EDITION OF 1 AUG 78 IS OBSOLETE USAPPC V1.10

(b)(6)-4

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

6. AGE	7. SEX	8. WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F)	11. ACCEPTING MD	12. CITE/AUTH #
33	✓ MALE / FEMALE			AMBUL / ✓ LITTER		(b)(6)-4

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

17. DIAGNOSIS

GSW Right Humerus OPEN

(1) Hemothorax

18. ✓ BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

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

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

20. PHYSICIANS ORDERS

20a. DATE	20b. TIME	20c. ALLERGIES
09 APR 03.	2117 Z.	

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

NPO

RENAL ___ Gm Prot ___ Gm Na ___ MagK ___ mg PO4

TUBE ___ TYPE ___ cc/hr, 1/2, 3/4, FULL STRENGTH

PEDIATRIC: AGE ___ OTHER (*Specify*) ___

TPN: Change to D10 at ___ cc/hr for max of ___ days

TUBE FEEDING: ___ at ___ strength at ___ cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

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

OXYGEN: ___ PERCENT or ___ LITERS ROUTE: ___

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No ___ feet

20h. RECORDS TO ACCOMPANY PATIENT

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

20i. MEDICATIONS / TREATMENTS

(1) Posterolateral thoracotomy & decortication

Ofloxacin 7gm PVD q 8h.

morphine 1-4mg IV/IM q 4-6h PRN pain.

Phenergan 25mg IV q 4-6h PRN

(2) I&D (R) humerus & external fixator

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE

33 yo [illegible].

Sip after to. (12) thoracotomy and (1) ortho.

Stable ever.

Pt. has chest tube.

Pt. is referred to Ramstein for further care.

(work up of (R) arm, PO. + Eye Rpo)

Pt will require surgery for (R) arm.

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

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

ORTHOPAEDIC SURGERY

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

F Form 3899 (433 AES Excel version)

(b)(3)-1

ADMISSION AND CODING INFORMATION

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

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

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19 20 21 22 23 24 25 26: 6 9 7 0 0 1 0 1	27 28 29: 3 3 Y	30	31	MUS

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36: 2 0	37 38 39 40 41 42 43 44 45 (b)(6)-4

13. ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	1745Z	EPW

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: O	ICU 3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
(b)(3)-1	

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
73 74: XFR	(b)(3)-1 75 76 77 78 79 80	81 82 83 84 85 86: 0 3 0 4 1 0 0500

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYMMDD)
103 104	105 106 107 108 109 110	111 112 113 114 115 116: 0 3 0 4 0 7

FOR LOCAL USE

Opn GSW Rt human

Inj Trauma

450 1

Dx: 81230 Pr: 2961
8602 3489
E9912 3404

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

INPATIENT TREATMENT RECORD COVER SI

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

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4			3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION	
11. FMP 20	12. SSN (b)(6)-4			13. ORGANIZATION		14. WARD	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN		18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION					22. HOURS OF ADMISSION	23. CLINIC SERVICE	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE				25. TYPE DISPOSITION		26. DATE OF DISPOSITION 03-04-10	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)				27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY						30. DATE OF INTIAL ADMISSION 03-04-05	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79

EDITION OF 1 AUG 78 IS OBSOLETE

USAPPC V1.10

1. NAME (Last, First, Middle Initial) (b)(6)-4

2. SSN

3a. STATUS | 3b. SERVICE

4. PRECEDENCE: U | P | R X

5. GRADE

6. AGE: 37

7. SEX: X MALE | FEMALE

8. WEIGHT

9. BLOOD TYPE

10. CLASSIFICATION (1A TO 5F)--

11. ACCEPTING MD

12. CITE/AUTH # (b)(6)-4

13. APPT/SURG DATE: (b)(6)-4

14a. ORIGINATING FACILITY (b)(3)-1

14b. ORIGINATING FACILITY PHONE NUMBER: ICU #3 558 (b)(3)-1

15a. DESTINATION FACILITY

15B. DESTINATION FACILITY PHONE NUMBER

16. # OF ATTENDANTS | 16a. MED | 16b. NON-MED

17. DIAGNOSIS

GSW @ flank s/p ex lap

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	
a.			Hypertension	i.			
b.			Cardiac Hx	j.		/	Bowel Problem
c.			Diabetes	k.	X		Self-care
d.			Respiratory	l.			Ambulatory
e.			Ears/Sinus	m.			Ambulatory Aid
f.			Motion Sick	n.			Self-meds
g.			Vision Impaired	o.			Adequate Supply of Meds
h.			Voiding Prob.				Other:

20. PHYSICIANS ORDERS

20a. DATE: 10 APR 03

20b. TIME: 0410

20c. ALLERGIES: NKA

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

RENAL ___ Gm Prot ___ Gm Na ___ MagK ___ mg PO4

TUBE ___ TYPE ___ cc/hr, 1/2, 3/4, FULL STRENGTH

PEDIATRIC: AGE ___ OTHER (Specify) ___

TPN: Change to D10 at ___ cc/hr for max of ___ days

TUBE FEEDING: ___ at ___ strength at ___ cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

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

OXYGEN: ___ PERCENT or ___ LITERS | ROUTE:

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No ___ feet

20h. RECORDS TO ACCOMPANY PATIENT

	OUTPATIENT RECORDS	X	XRAYS	OTHER:
X	INPATIENT RECORDS		OS	
	NARRATIVE SUMMARY		DENTAL	
	FINANCIAL			

20i. MEDICATIONS / TREATMENTS

Cefoxitin 2gm IV Q8°

MSO4 2-4mg IV Q2° PRN pain

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE

37 y.o. Iraqi from GPW camp c h/o abd GSW. Pt. taken for ex lap, found to have small liver lac. Pt. stable for E-5 port

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

24. S (b)(6)-2

F F

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

(b)(3)-1

ADMISSION AND CODING INFORMATION

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

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

DATE OF BIRTH (YYYYMMDD) (19–26)	7. AGE AT ADMISSION (27–29)	8. RACE (30)	9. ETHNIC BACKGROUND (31)	RELIGION
19660701	37Y			MUS

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS (46)	HOUR OF ADMISSION	BRANCH / CORPS
	I	1745	EPW

FLYING STATUS (47–49)	15. BENEFICIARY CATEGORY (50–52)	16. ZIP CODE OF RESIDENCE (53–61)
	K78 CPW	

UNIT LOCATION (State or Country Code) (62–63)	18. MOS (64–70)	19. TRAUMA (71)	PREV. ADMISSION YEAR	
		B INJ		☒ NO

SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72)	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
ERA	ICU3	

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
(b)(3)-1	

TYPE OF DISPOSITION (73–74)	22. MTF TRANSFERRED TO (75–80)	23. DATE OF DISPOSITION (YYMMDD) (81–86)	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
XFR	(b)(3)-1	030401 0500	

CLINIC SVC - ADMITTING (87–90)	25. MTF TRANSFERRED FROM (91–96)	26. DATE THIS ADMISSION (YYMMDD) (97–102)

LOCATION OF OCCURRENCE (Battle Casualty Only) (103–104)	28. MTF OF INITIAL ADMISSION (105–110)	29. DATE INITIAL ADMISSION (YYMMDD) (111–116)
		030405

FOR LOCAL USE

Dx GSW to RLQ ABD

Inj Trauma

450 1

DA 3641D

Pr 5411

ADMITTING OFFICE	SIGNATURE OF ADMITTING CLERK
(b)(6)-2	Spc (b)(6)-2

DA FORM 2981

EDITION OF MAY 79 IS OBSOLETE

USAPPC V1.00

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4			3. GRADE	ADMISSION REMARKS
4. SEX	5. AGE	6. RACE	7. RELIGION MUS	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION Ø	
11. FMP		12. SSN		13. ORGANIZATION		14. WARD	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE INJ	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION ERA				22. HOURS OF ADMISSION 1ØØØZ	23. CLINIC SERVICE		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE				25. TYPE DISPOSITION	26. DATE OF DISPOSITION Ø3 Ø4 1Ø		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)				27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION Ø3 Ø4 1Ø		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1					30. DATE OF INTIAL ADMISSION Ø3 Ø4 1Ø		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79

EDITION OF 1 AUG 78 IS OBSOLETE

USAPPC V1.10

(b)(6)-4

(b)(6)-4

1. NAME (Last, First, Middle Initial) (b)(6)-4 | 2. SS | 3a. STATUS | PRECEDENCE | 5. GRADE

6. AGE 35 | 7. SEX X MALE FEMALE | 8. WEIGHT | 9. BLOOD TYPE | 10. CLASSIFICATION AMBUL | P X R | ACCEPTING MD | 12. CITE/AUTH # (b)(6)-4

13. APPT/ORG LAUNCH | 14. ORIGINATING FACILITY (b)(3)-1 | 15a. DESTINATION (b)(3)-1 | 16. # OF ATTENDANTS | 16a. MED | 16b. NON-MED

14b. ORIGINATING FACILITY PHONE NUMBER | 15b. DESTINATION FACILITY PHONE NUMBER

Iraq #3 558-(b)(3)-1 GMC

17. DIAGNOSIS

(R) Eye (R) Face Injury
(R) eye orbital blow out fracture,
(R) maxillary open fracture

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

19. CLINICAL STATUS (Please indicate Yes or No on clinical issues. Explain on 23)

	YES	NO	
i.			Bowel Problem
j.			Self-care
k.	X		Ambulatory
l.			Ambulatory Aid
m.			Self-meds
n.			Adequate Supply of Meds
o.			Other:

20. PHYSICIAN'S ORDERS

20a. DATE 10 APR 03 | TIME 0630 | 20c. ALLERGIES NKDA

20d. DIET | ENTERAL | TUBE | PARENTERAL | TPN | TUBE FEEDING

Prot Mag mg
cc/hr, 1/2, ULL SGT
10 at cc/hr max
at strength

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT | PRIORITY CARE | FOLLOW BY | TRACTION | CAST/HEAT | TRAIN | MONITOR | ROUTINE

OXYGEN: | or LITERS | ROUTINE

20g. ALTITUDE: Yes / No

20h. RECORDS: ANY PATIENT RECORDS | XRAY | OTHER | RDS | OB | MARY | DENT

X

20i. MEDICATIONS / TREATMENTS

Cefoxitin 2 gm IV Q8°
MSO4 2-4 IV Q2° PRN

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE

35 y o penetrating wound to (R) face + (R) eye.
Pt is awake + breathing
Transfer to Rear ASAP.
Pt. needs ENT + oral-maxillofacial surgery

23. DATE | ASSESSMENT / PROGRESS NOTES

10 Apr 03 | Transferred for FST

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

24. (b)(6)-2

25. NAME | SURGEON

(b)(6)-2

(b)(6)-4 [redacted]

(b)(3)-1 [redacted]

ADMISSION AND CODING INFORMATION

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

1. ...NG MTF (1–8)	2. MTF LOCATION (State or Country Code.)
(b)(3)-1 [redacted]	

3. REGISTER NUMBER (9–15)	NAME (Last, First, Middle Initial)	4. PAY GRADE (16–17)	5. SEX (18)
(b)(6)-4 [redacted]	(b)(6)-4 [redacted]		M

6. DATE OF BIRTH (YYYYMMDD) (19–26)	7. AGE AT ADMISSION (27–29)	8. RACE (30)	9. ETHNIC BACKGROUND (31)	RELIGION
19680101	35Y			Muslim

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS (46)	HOUR OF ADMISSION	BRANCH / CORPS
		1000Z	

14. FLYING STATUS (47–49)	15. BENEFICIARY CATEGORY (50–52)	16. ZIP CODE OF RESIDENCE (53–61)
	K78 EPW	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72)	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0 EMT	ICW3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1 [redacted]		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION (73–74)	22. MTF TRANSFERRED TO (75–80) (b)(3)-1 [redacted]	DATE OF DISPOSITION (YYMMDD) (81–86)
21		030410 1253

24. CLINIC SVC - ADMITTING (87–90)	25. MTF TRANSFERRED FROM (91–96)	26. DATE THIS ADMISSION (YYMMDD) (97–102)

27. LOCATION OF OCCURRENCE (Battle Casualty Only) (103–104)	28. MTF OF INITIAL ADMISSION (105–110)	29. DATE INITIAL ADMISSION (YYMMDD) (111–116)
		030410

FOR LOCAL USE

(R) eye + (R) face injury (D) hand injury Dx: 8026 Pr: 9921
8025
E 9919

1 Inj 449 Trauma 1

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

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4				3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE	6. RACE	7. RELIGION MUS	8. LENGTH OF SVC	9. ETS		10. PREVIOUS ADMISSION	
11. FMP		12. SSN		13. ORGANIZATION			14. WARD ICU 3	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN		18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE INJ	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION					22. HOURS OF ADMISSION 1040	23. CLINIC SERVICE		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE				25. TYPE DISPOSITION		26. DATE OF DISPOSITION 03 04 10		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)				27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION 03 04 10		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1						30. DATE OF INTIAL ADMISSION 03 04 10		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79

EDITION OF 1 AUG 78 IS OBSOLETE

USAPPC V1.10

(b)(6)-4

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

6. AGE	7. SEX	8. WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F)	11. ACCEPTING MD	12. CITE/AUTH #
35	X MALE / FEMALE			AMBUL / X LITTER		(b)(6)-4

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

17. DIAGNOSIS

GSW (L) buttocks

18. BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

20. PHYSICIANS ORDERS

20a. DATE	20b. TIME	20c. ALLERGIES
10 APR 03	1000	NKDA

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

RENAL ___ Gm Prot ___ Gm Na ___ MagK ___ mg PO4

TUBE ___ TYPE ___ cc/hr, 1/2, 3/4, FULL STRENGTH

PEDIATRIC: AGE ___ OTHER (Specify) ___

TPN: Change to D10 at ___ cc/hr for max of ___ days

TUBE FEEDING: ___ at ___ strength at ___ cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

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

OXYGEN: ___ PERCENT or ___ LITERS ROUTE:

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No ___ feet

20h. RECORDS TO ACCOMPANY PATIENT

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

20i. MEDICATIONS / TREATMENTS

Ancef 1gm IV Q8°

Percocet 1-2 p.o. Q6°

PRN Ambien

MSO4 2-4 mg IV Q2° PRN

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

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

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE

35 y.o. ♂ c GSW (L) buttocks. Proctoscopy reveals ↓ rectal involvement. Pt. stable for X-port

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

(b)(6)-2

G PHYSICIAN

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

Form 3899 (433 AES Excel version)

(b)(6)-4

(b)(3)-1

ADMISSION AND CODING INFORMATION

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

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

6. DATE OF BIRTH (YYYYMMDD) (19–26)	7. AGE AT ADMISSION (27–29)	8. RACE (30)	9. ETHNIC BACKGROUND (31)	RELIGION
19680101	354			

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS (46)	HOUR OF ADMISSION	BRANCH / CORPS
		1040	

14. FLYING STATUS (47–49)	15. BENEFICIARY CATEGORY (50–52)	16. ZIP CODE OF RESIDENCE (53–61)
	K 7 8	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72)	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0	3ICU	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION (73–74)	22. MTF TRANSFERRED TO (75–80)	23. DATE OF DISPOSITION (YYMMDD) (81–86)
XFR	(b)(3)-1	030410 1253

24. CLINIC SVC - ADMITTING (87–90)	25. MTF TRANSFERRED FROM (91–96)	26. DATE THIS ADMISSION (YYMMDD) (97–102)

27. LOCATION OF OCCURRENCE (Battle Casualty Only) (103–104)	28. MTF OF INITIAL ADMISSION (105–110)	29. DATE INITIAL ADMISSION (YYMMDD) (111–116)
		030410

FOR LOCAL USE

Dx GSW to buttock (Dx 8720 Pr 1623

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

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

DA FORM 2985, 1 EDITION OF MAY 79 IS OBSOL USAPPC V1.00

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4			3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION	
11. FMP		12. SSN		13. ORGANIZATION		14. WARD ICU 3	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE INJ	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION				22. HOURS OF ADMISSION 1040	23. CLINIC SERVICE		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION		26. DATE OF DISPOSITION 03 04 10		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)			27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION 03 04 10		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1					30. DATE OF INTIAL ADMISSION 03 04 10		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79

EDITION OF 1 AUG 76 IS OBSOLETE

USAPPC V1.10

1. NAME (L (b)(6)-4 [redacted] ...itial) | 2. SSI | 3a. STATU... EPW | 4. PRECEDENCE U P (R) | 5. GRADE

6. AGE ~28 | 7. SEX X MALE | 8. WEIGHT MALE | 9. BLO... TYPE | ...ASSIFICAT... AMBULAT... X | 11. ACCEPTING MD | 12. CITE/AUTH # (b)(6)-4

13. APPT/SURG DAT... | ...ORIGINATING FACILITY (b)(3)-1 | 15a. DEST (b)(3)-1 | 16. # OF ATTENDANTS

...ORIGINATING FACILITY ... Fac #58 (b)(3)-1 | 15b. DEST ...ITY PHONE NUMBER | 16a. MED Ø | 16b. NON-MED Ø

17. ...OSIS
GSW (R) shoulder
(L) thigh wound

19. CLINIC ...ES co... ...MESI N... | ...ase indicate Yes or No on clinical issues. Explain (on 23)

		YES	NO	
a.			X	
b.			X	
c.			X	
d.			X	
e.			X	
f.			X	
g.			X	
h.			X	
...on	i.		X	Bowel Problem
	j.		X	Self-care
	k.		X	Ambulatory
	l.		X	Ambulatory Aid
	m.		X	Self-meds
	n.		X	Adequate Supply of Meds
...ired	o.		X	Other:
...b.				

18. X BATTLE ...DISEASE | NO ...TTLE ...URY

20. ...NS ORDERS

20a. DATE 10 April 03 | ...TIME 0700Z | 20c. ...RGIE...

20d. DIET ...GM NA ...CARE ...ETIC ...ALS
RENAL ...rot ... G... N... Mag... mg
TUBE ... cc/hr, ... FULL S... ...NGTH
PEDIATR... ...R (Spec...
TPN: Ch... 10 at ... for max c... da...
TUBE FE... at ... strength ...

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT ...Y CA...
SUCTION ...TRACTION ...O BF...
IGT TUBE ...IV PUMP ...ST/HE...
CHEST TUBE ...TRACH ...RAIN...
INCUBATOR ...MONITOR ...ER (U...

OXYGEN: ... or ... LITERS ROUT...
VENTS ...

20g. ALTITUDE PRE... ...TION: Yes / N...

20h. RECORDS TO ...ANY PATI...
COMPAT... ...CORDS X XRAY ...OTH
X ...RDS OB
...MARY DENT
...

20i. ...ATIONS / TREATMENTS

MSO4 2-4mg IV Q4h PRN
Ancef 1g IV Q8h

21. PRE-FLIGHT VITALS
21a. DATE | 21b. TEMP: | 21c. PULSE | 21e. BP
21d. RESP:

22. BRIEF NARRATIVE

EPW s/p GSW to (R) shoulder and (L) thigh wound, s/p I&D.

23. ...DATE | SESSMENT / PROGRESS NOTES

24. STAMP ...(b)(6)-2 | 25. ...AME | ...RE OF FLIGHT SURGEON

AF Form 3...9 (4...

(b)(6)-4

(b)(3)-1

ADMISSION AND CODING INFORMATION

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

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

(b)(3)-1

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

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

DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19 20 21 22 23 24 25 26: 1 9 7 5 0 1 0 1	27 28 29: 2 8 Y	30	31	

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36: 2 0	37 38 39 40 41 42 43 44 45 (b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	1060	

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

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

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

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO (b)(3)-1	23. DATE OF DISPOSITION (YYMMDD)
73 74: XFR	75 76 77 78 79 80	81 82 83 84 85 86: 0 3 0 4 1 0 1253

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYMMDD)
103 104	105 106 107 108 109 110	111 112 113 114 115 116: 0 3 0 4 1 0

FOR LOCAL USE

Dx GSW to Abdomen and (L) thigh

Dx 8000 8400 E9912

Proc: 8800

USO 1

ADMITTING OFFICER (Signature, (b)(6)-2

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

DA FORM 2985, MAR 8 EDITION OF MAY 79 IS OBS USAPPC V1.00

MEDCOM - 2927

INPATIENT TREATMENT RECORD COVER SI

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

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4					3. GRADE	ADMISSION REMARKS
4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS			10. PREVIOUS ADMISSION	
11. FMP		12. SSN (b)(6)-4		13. ORGANIZATION				14. WARD	
15. FLYING STATUS	16. RATING/ DSG		17. DEPT./ BEN K78	18. BRANCH/CORPS	19. UIC/ZIP			20. TYPE CASE	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION					22. HOURS OF ADMISSION	23. CLINIC SERVICE			
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE				25. TYPE DISPOSITION		26. DATE OF DISPOSITION 03-04-11			
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)				27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION			ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY						30. DATE OF INTIAL ADMISSION 03-04-10			32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79 EDITION OF 1 AUG 78 IS OBSOLETE USAPPC V1.10

(b)(6)-4

(b)(6)-4

1. NAME (Last, First, Middle Initial)	2. SS	3a. STA	3b. SERVICE	4. PRECEDENCE			5. GRADE
		GRW		U	P	R	
6. AGE	7. SEX	8.WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F)--		11.ACCEPTING MD	12.CITE/AUTH #
	MALE / FEMALE			AMBUL / LITTER			(b)(6)-4
13.APPT/SURG DATE	14a. ORIGINATING FACILITY 212TH MAS			15a. DESTINATION FACILITY (b)(3)-1			16. # OF ATTENDANTS
	14b.ORIGINATING FACILITY PHONE NUMBER 558-4987			15B. DESTINATION FACILITY PHONE NUMBER			16a. MED / 16b.NON-MED

17. DIAGNOSIS

(1) GJW chest

(V) GJW femur

18. BATTLE CASUALTY / DISEASE / NON-BATTLE INJURY

19. PHYSICIANS ORDERS

19a. DATE / 19b. TIME / 20c. ALLERGIES

20a. DIET	20b. REG	3GM NA	CARDIAC	DIABETIC	CALS	
RENAL	Gm Prot	Gm Na	Mag	mg PO4		
TUBE	TYPE	cc/hr, 1/2, 3/4, FULL STRENGTH				
PEDIATRIC: AGE		OTHER (Specify)				
TPN: Change to D10 at		cc/hr for max of		days		
TUBE FEEDING		at	strength	cc/hr		

20f. IV / BLOOD

20g. SPECIAL EQUIPMENT

SUCTION	TRACTION	FOLEY CATH	
NEBULIZER	IV PUMP	ORTHO BRACES	
STRYKER	TRACH	CPR/HEIMLICH	
INCUBATOR	MONITOR	RESTRAINTS	
		OTHER (USE 23)	

20h. OXYGEN: VENTURI or LITERS ROUTE

20i. SETTINGS:

20j. ALTITUDE RESTRICTION: Yes / No

20k. RECORDS TO ACCOMPANY PATIENT

CURRENT RECORDS		XRAY	OTHER:
INPAT RECORDS		CB	
NURSING SUMMARY		DENT	
FINAL			

20l. MEDICATIONS / TREATMENTS

(1) Ex fixator

(L) femur and I-D

(V) Re-I-D

(R) chest

(3) Initial debridement

(R) chest - (FST)

(b)(6)-2

24. STAMP AND SIGNATURE

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE

GJW chest & (L) femur

prior treatment (chest)

c FST

23. ASSESSMENT / PROGRESS NOTES

DATE / TIME

a.	Hypertension	i.			Bowel Problem
b.	Cardiac Hx	j.			Self-care
c.	Diabetes	k.			Ambulatory
d.	Resp. Hx	l.			Ambulatory Aid
e.	Ears/Sinus	m.			Self-meds
f.	Motion Sick	n.			Adequate Supply of Meds
g.	Vision Impaired	o.			Other:
h.	Voice Prob.				

(YES / NO / Comments in Section 23)

Form 389 ... ES Ex

(b)(3)-1

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF: (b)(3)-1
2. MTF LOCATION (State or Country Code.)

REGISTER NUMBER: (b)(6)-4

NAME (Last, First, Middle Initial): (b)(6)-4

(b)(6)-4

4. PAY GRADE:
5. SEX: M

DATE OF BIRTH (YYYYMMDD): 19 19 74 08 01 01

7. AGE AT ADMISSION: 33 Y
8. RACE:
9. ETHNIC BACKGROUND:

RELIGION: MOS

LENGTH OF SERVICE:

ETS:

11. FMP: 2 0

12. SOCIAL SECURITY NUMBER: (b)(6)-4

ORGANIZATION (Active Duty Only):

13. MARITAL STATUS:

HOUR OF ADMISSION: 1900Z

BRANCH / CORPS: Epw

FLYING STATUS:

15. BENEFICIARY CATEGORY: K 7 8

16. ZIP CODE OF RESIDENCE:

UNIT LOCATION (State or Country Code):

18. MOS:

19. TRAUMA:

PREV. ADMISSION: YEAR: ☒ NO

SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION:

WARD: ICU3

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE:

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code):

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE:

TYPE OF DISPOSITION: XFR

22. MTF TRANSFERRED TO: (b)(3)-1

23. DATE OF DISPOSITION (YYMMDD): 0 3 0 4 1 1 0630

CLINIC SVC - ADMITTING:

25. MTF TRANSFERRED FROM:

26. DATE THIS ADMISSION (YYMMDD):

LOCATION OF OCCURRENCE (Battle Casualty Only):

28. MTF OF INITIAL ADMISSION:

29. DATE INITIAL ADMISSION (YYMMDD): 0 3 0 4 1 0

FOR LOCAL USE

DGSW Rt Chest

(2) Femur fracture

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

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

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

INPATIENT TREATMENT RECORD COVER SI

For use of this form, see AR 40-400; the proponent agency is O1 SG

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4				3. GRADE	ADMISSION REMARKS
4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS		10. PREVIOUS ADMISSION	
11. FMP 80		12. SSN (b)(6)-4		13. ORGANIZATION			14. WARD	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN K78		18. BRANCH/CORPS	19. LRC/ZIP		20. TYPE CASE	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION					22. HOURS OF ADMISSION	23. CLINIC SERVICE		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE				25. TYPE DISPOSITION		26. DATE OF DISPOSITION 03-04-11		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)				27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY						30. DATE OF INTIAL ADMISSION 03-04-10		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79 EDITION OF 1 AUG 76 IS OBSOLETE USAPPC V1.10

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

6. AGE	7. SEX	8. WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F)	11. ACCEPTING MD	12. CITE/AUTH #
25	X MALE / FEMALE	75 kg		AMBUL / X LITTER		(b)(6)-4

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

17. DIAGNOSIS

1) DM
2) R fibular fracture
3) L closed malleolar fracture (medial, displaced)
4) R closed shoulder injury

18. X BATTLE CASUALTY / DISEASE / NON BATTLE INJURY

20. PHYSICIANS ORDERS

20a. DATE	20b. TIME	20c. ALLERGIES
10 Apr 03	2040	NKDA

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

RENAL ___ Gm Prot ___ Gm Na ___ MagK ___ mg PO4

TUBE ___ TYPE ___ cc/hr, 1/2, 3/4, FULL STRENGTH

PEDIATRIC: AGE ___ / OTHER (Specify) ___

TPN: Change to D10 at ___ cc/hr for max of ___ days

TUBE FEEDING: ___ at ___ strength at ___ cc/hr

20e. IV/BLOOD LR @ 125 cc/hr

20f. SPECIAL EQUIPMENT

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

OXYGEN: ___ PERCENT or ___ LITERS ROUTE: ___

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / (No) ___ feet

20h. RECORDS TO ACCOMPANY PATIENT

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

20i. MEDICATIONS / TREATMENTS

Percocet 1-2 PO q4-6 PRN pain
Motrin 800 mg 1 PO q8 PRN pain
Regular insulin (sliding scale)

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

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

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE

S/p MVA c̄ possible ADW 6 Apr 03; Seen by FST + R LE cast placed for R fib fracture. Transferred to MASH → ortho test L malleolar fx → cast placed. DM controlled. Pt c̄ tetanus booster, IV fluids (Sliding scale Reg I)

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

24. STAMP AND SIGNATURE OF PHYSICIAN

(b)(6)-2
MAJ, USA, MC
DEPT OF OB/GYN

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

DD Form 3899 (432 AES Exceptions)

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

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF (b)(3)-1 (redacted)

2. MTF LOCATION (State or Country Code.)

REGISTER NUMBER: (b)(6)-4 (redacted)

NAME (Last, First, Middle Initial): (b)(6)-4 (redacted)

4. PAY GRADE: 16 17

5. SEX: M

DATE OF BIRTH (YYYYMMDD): 19780101

7. AGE AT ADMISSION: 25 Y

8. RACE: Z

9. ETHNIC BACKGROUND: Z

RELIGION: Muslim

LENGTH OF SERVICE:

ETS:

11. FMP: 20

12. SOCIAL SECURITY NUMBER: (b)(6)-4 (redacted)

ORGANIZATION (Active Duty Only):

13. MARITAL STATUS: Z

HOUR OF ADMISSION: 1900Z

BRANCH / CORPS:

FLYING STATUS:

15. BENEFICIARY CATEGORY: K 7 8 EPW

16. ZIP CODE OF RESIDENCE: 0930200 0

UNIT LOCATION (State or Country Code):

18. MOS:

19. TRAUMA:

PREV. ADMISSION: YEAR: NO ☒

SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 0 EMT

WARD: ICU 3

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE:

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code):

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1 (redacted)

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE:

TYPE OF DISPOSITION: 21 XFR

22. MTF TRANSFERRED TO: (b)(3)-1 (redacted) (b)(3)-1 (redacted)

23. DATE OF DISPOSITION (YYMMDD): 030411 0030

CLINIC SVC - ADMITTING: ABAA

25. MTF TRANSFERRED FROM:

26. DATE THIS ADMISSION (YYMMDD):

LOCATION OF OCCURRENCE (Battle Casualty Only): IZ

28. MTF OF INITIAL ADMISSION:

29. DATE INITIAL ADMISSION (YYMMDD): 030410

FOR LOCAL USE

Dx: 1) DM - no DKA
2) (R) LE fracture
3) Multiple (L) LE scraped wounds

Px: 8248
25000
8911
E8199

Pr 9353
9921

Ins Tx
102 9

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

SIGNAT: (b)(6)-2 (redacted)

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

INPATIENT TREATMENT RECORD COVER SI

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

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4			3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION	
11. FMP 20	(b)(6)-4			13. ORGANIZATION		14. WARD	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN K78	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION				22. HOURS OF ADMISSION	23. CLINIC SERVICE		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION		26. DATE OF DISPOSITION 03-04-11		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)			27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY					30. DATE OF INTIAL ADMISSION 03-04-10		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check If Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79 EDITION OF 1 AUG 76 IS OBSOLETE USAPPC V1.10

(b)(3)-1

1. NAME (Last ... Middle Initial) (b)(6)-4

2. S...

3a. STATUS

3b. SERVICE

4. PRECEDENCE: U | P X | R

5. GRADE

6. AGE: 21

7. S... M | FEMALE

8. WEIGHT

9. E... TY...

10. CLASSIFICATION (A TO 5F) – AMBUL | X | ...TER

11. ACCEPTING MD

12. CITE/AUTH # (b)(6)-4

13. APPT/SURG ... E

... ORIGINATING FACILIT... (b)(3)-1

... ORIGINATING FACILIT... ...NE... ...ER

Icu #3 558-(b)(3)-

15a. DESTINA... N FACILITY (b)(3)-1

15B. DESTINA... N FACILITY PHONE NUMBER

16. # OF ATTENDANTS

16a. MED: Ø

16b. NON-MED: Ø

17. ...NOSIS

GSW face
(R) mandible fracture
open fracture (R) fibula

9. CLINICAL ... UES (Please indicate Yes or No on clinical issues. Explain YES comm... in Section 23)

	YES	NO	...SUE		YES	NO	
a.			...pertension	i.			Bowel Problem
b.			...rdiac Hx	j.			Self-care
c.			...abetes	k.	X		Ambulatory
d.			...spira...ory	l.			Ambulatory Aid
e.			...rs/Sinus	m.			Self-meds
f.			...tion ...ick	n.			Adequate Supply of Meds
g.			...ion ...paired	o.			Other:
h.			...di... Prob.				

18. ...BATTLE ... U... | DISEASE | ...ATT... ...JURY

20. ...NS OF ...DERS

20a. DATE: 11APR03

...TIME: 0135

20c. ...RG

20d. DIET ...

	REG	GM NA	CARDIAC
	TUL	Prot	Gm Na
	PED		cc/hr, 1/2, 3/4, FULL
	TPN		OTHER (S...
	TUB	010 at	cc/hr for ma...
		at	stren...

...ETI... ...ALS

20e. IV / BLOOD

20f. SPECIAL ...

SUC...		TRACTION	
NG		IV PUMP	
STR...		TRACH	
INC...		MONITOR	

OXYGEN: ...ER ... or ... LITERS ... RC...

VEN... ...T

20g. ALTITUDE ...T ...N: ...s / No

20h. RECORD... ...C ...PAN... PATIENT

	OUT...	...E	CO...DS	X	XR...
X	INP...	...T	...ORDS		OR...
	NAT...	...VI	...IMA...Y		DE...
	FIN...	...AL			

20i. ...E ...IONS / TREATMENTS

Ancef 1gm IV Q8°
MS04 1-2 mg IV Q1° PRN pain

22. PRE-FLIGHT VITALS

22a. DATE / ...

21b. TEMP:	21c. PULSE	21e. BP
21d. RESP:		

23. BRIEF NARRATIVE

24yo. Tag ō GSW (R) face & (R) LE's
Pt. ō (R) mandible fx ē retained
shrapnel. Comminuted fx (L) fibula.
S/P LLE fasciotomy. Stable for evac.

24. ASSESSMENT / PROGRESS NOTES

DATE / T...

24. STAMP AND ... OF ATTENDING PHYSICI... (b)(6)-2

25. STAMP A... IGN... TURE OF FLIGHT SURGEON

...F Form 3899 ... E ... el version)

[redacted]

(b)(3)-1

ADMISSION AND CODING INFORMATION

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

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

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

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36: 2 0	37 38 39 40 41 42 43 44 45 (b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
EPW	46	1900Z	EPW

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: O ERA	ICU3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1 — TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO (b)(3)-1	23. DATE OF DISPOSITION (Y Y M M D D)
73 74: XFR	75 76 77 78 79 80	81 82 83 84 85 86: 0 3 0 4 1 1 0630

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110	111 112 113 114 115 116: 0 3 0 4 0 0

FOR LOCAL USE

(R) Complex ~~Mandible~~ Mandibular Fx
(E) Abulsa A
Inj Trauma
450 1

Dx 80230 Pr 8314
82391 9921
E9912
E9919

ADMITTING OFFICER (b)(6)-2 — SIGNATURE OF ADMITTING CLERK (b)(6)-2

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

MEDCOM - 2936

INPATIENT TREATMENT RECORD COVER SI

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

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4				3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE	6. RACE	7. RELIGION MUS	8. LENGTH OF SVC	9. ETS		10. PREVIOUS ADMISSION	
11. FMP 20		12. SSN (b)(6)-4		13. ORGANIZATION			14. WARD	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN K78	18. BRANCH/CORPS	19. UIC/ZIP			20. TYPE CASE	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION				22. HOURS OF ADMISSION	23. CLINIC SERVICE			
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE				25. TYPE DISPOSITION	26. DATE OF DISPOSITION 03-04-11			
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)				27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION			ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY					30. DATE OF INTIAL ADMISSION 03-04-10			32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAO OR MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79 EDITION OF 1 AUG 78 IS OBSOLETE USAPPC V1.10

1. (b)(6)-4

2. SSN

3a. STATUS

3b. SER

4. PRECEDENCE: U | P ✓ | R

5. GRADE

6. AGE: 31

7. SEX: ✓MALE | FEMALE

9. BLOOD TYPE

10. CLASSIFICATION (1A TO 5): AMBUL ✓ | LITTER

11. ACCEPTING MD

12. CITE/AUTH #: (b)(6)-4

13. APPT/SURG DATE: 10 APR 03

ORIGINATING FACILITY: (b)(3)-1

ORIGINATING FACILITY PHONE NUMBER: (b)(3)-1 FCU # 3

15a. DESTINATION FACILITY: (b)(3)-1

15B. DESTINATION FACILITY PHONE NUMBER

16. # OF ATTENDANTS: 16a. MED: 0 | 16b. NON-MED: 0

17. DIAGNOSIS: GSW CHEST

18. | BATTLE CASUALTY | SEVERE | NON BATTLE INJURY

20. PHYSICIAN ORDERS

20a. DATE: 10 APR 03

20c. ALLERGIES

20d. DIET: NPO

DIABETIC CALS

MagK ___ mg PO4

FULL STRENGTH

(Specify)

max of ___ days

length at ___ cc/hr

20e. IV / BLOOD: Ringer Lactate

20f. SPECIAL EQUIPMENT: SUCTION | CHEST TUBE | STRETCHER | WALKER OR CRUTCHES

✓ FOLEY CATH | ORTHO BRACES | ✓ CHESTHEIMLICH | RESTRAINTS | OTHER (USE 23)

OXYGEN: PERC | VENTILATOR

ROUTE:

20g. ALTITUDE RESTRICTIONS: Yes | feet

20h. RECORDS TO ACCOMPANY: ✓ OUTPATIENT | ✓ PATIENT | MEDICAL | DENTAL | X-RAYS | LAB | OTHER:

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

	YES	NO	ISSUE
a.			Hyperten
b.			Cardiac
c.			Diabetes
d.			Respirat
e.			Ears/Sin
f.			Motion S
g.			Vision I
h.			Voiding

	YES	NO	
i.			Bowel Problem
j.			Self-care
k.	X		Ambulatory
l.			Ambulatory Aid
m.			Self-meds
n.			Adequate Supply of Meds
o.			Other:

21. PRE-FLIGHT VITALS

21a. DATE / TIME

21b. TEMP:

21c. PULSE

21e. BP

21d. RESP:

22. BRIEF NARRATIVE

GSW Chest

S/p ex lap / thoracotomy

CT / Foley / central line

23. ASSESSMENT / PROGRESS NOTES

DATE / TIME

Ancef 1gm IV Q8°

O_2

Foley (b)(6)-2

MSO4 2-4mg Q1° PRN pain

24. STAMP AND SIGNATURE

(b)(6)-2

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

SF Form 3899 (43

(b)(3)-1

ADMISSION AND CODING INFORMATION

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

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

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
9 10 11 12 13 14 15	(b)(6)-4	16 17	18
(b)(6)-4			M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19 20 21 22 23 24 25 26	27 28 29	30	31	MOS
1 9 7 2 0 1 0 1	3 1 Y			

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36	37 38 39 40 41 42 43 44 45
		Z O	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	1900Z	EPW

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72	ICU3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
O		

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
(b)(3)-1	

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
73 74	75 76 77 78 79 80	81 82 83 84 85 86
XPR		0 3 0 4 1 1

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110	111 112 113 114 115 116
		0 3 0 4 1 0

FOR LOCAL USE

65W CLES7

(b)(6)-2

SIGNATURE OF ADMITTING CLERK

(b)(6)-2

EDITION OF MAY 79 IS O

USAPPC V1.00

MEDCOM - 2939

INPATIENT TREATMENT RECORD COVER SHEET

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

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

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M		O	Muslim			No

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
K78			ICU3

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

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
EMT	1900z	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	XFR	11 Apr 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		10 Apr 03	LTC (b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1	10 Apr 03	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX. Soft Tissue Injury Left/ Case 4

CODING INFOMATION: 729.6

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
				2	2

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

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

6. AGE	7. SEX	8. WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F)--	11. ACCEPTING MD	12. CITE/AUTH #
27	X MALE / FEMALE			AMBUL / X LITTER		(b)(6)-4

13. APPT/SURG DATE	14a. ORIGINATING FACILITY	15a. DESTINATION FACILITY	16. # OF ATTENDANTS	
	(b)(3)-1	(b)(3)-1	16a. MED	16b. NON-MED
	14b. ORIGINATING FACILITY PHONE NUMBER 358- (b)(3)-1	15B. DESTINATION FACILITY PHONE NUMBER		

17. DIAGNOSIS

1) SOFT TISSUE INJURY (L) CHEST & FLANK

18. BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

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

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

20. PHYSICIANS ORDERS

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

20d. DIET | REG | 2GM NA | CARDIAC | DIABETIC ___ CALS

RENAL ___ Gm Prot ___ Gm Na ___ MagK ___ mg PO4

TUBE ___ TYPE ___ cc/hr, 1/2, 3/4, FULL STRENGTH

PEDIATRIC: AGE ___ OTHER *(Specify)*

TPN: Change to D10 at ___ cc/hr for max of ___ days

TUBE FEEDING: ___ at ___ strength at ___ cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

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

OXYGEN: ___ PERCENT or ___ LITERS ROUTE:

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No ___ feet

20h. RECORDS TO ACCOMPANY PATIENT

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

20i. MEDICATIONS / TREATMENTS

FST (IJD)

2mg IV (RE IVD)

s/p (R) BKA (FST)

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE

2 days STEN & FST UNEVENTFUL

WCC DEBRIDEMENT (L) FLANK &

(R) BKA.

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

24. STAMP AND SIGNATURE OF ATTENDING PHYSICIAN

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

Form 3899 (433 AES Excel version)

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

ADMISSION AND CODING INFORMATION

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

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

REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
9 10 11 12 13 14 15 (b)(6)-4	(b)(6)-4	16 17	18 M

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

LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36 2 0	37 38 39 40 41 42 43 44 45 (b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	1900Z	

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

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

SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72 O EMT		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1 — TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

TYPE OF DISPOSITION	22. MTF TRANSFERRED TO (b)(3)-1	23. DATE OF DISPOSITION (YYMMDD)
73 74 XFR	75 76 77 78 79 80	81 82 83 84 85 86 0 3 0 4 1 1 0030

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

LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYMMDD)
103 104	105 106 107 108 109 110	111 112 113 114 115 116 0 3 0 4 1 0

LOCAL USE

SOFT TISSUE INJURY
LEFT FUNK/CASEA

DX: 9971 95911 89289

(b)(6)-2

ADMITTING OFFICER (Signature, as (b)(6)-2 — SIGNATURE OF (b)(6)-2

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

INPATIENT TREATMENT RECORD COVER SHEET

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

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

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M		O	MUS			NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
K78			ICU3

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
No					

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
EMT	1035z	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	XFR	14 APR 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		11 APR 03	MAJ (b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1 IRAQ	11 APR 03	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW TO L SIDE OF HEAD, WRIST

CODING INFORMATION: 991.2

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

1. NAME [b(6)-4]

SSN

3a. STATUS | 3b. SERVICE

4. PRECEDENCE: U | P X | R

5. GRADE

6. SEX: X MALE | FEMALE

7. WEIGHT | 9. BLOOD TYPE | 10. CLASSIFICATION (1A TO 5F)– AMBUL X | LITTER

11. ACCEPTING MD

12. CITE/AUTH # (b)(6)-4

13. APPT/SURG DATE

14a. ORIGINATING FACILITY [b(3)-1]

14b. ORIGINATING FACILITY PHONE NUMBER 558-[b(3)-1] ICU #3

15a. DESTINATION FACILITY

15B. DESTINATION FACILITY PHONE NUMBER

16. # OF ATTENDANTS: 16a. MED Ø | 16b. NON-MED Ø

17. DIAGNOSIS

(L) maxillary/orbital open fracture c̄ partial vision loss

(R) wrist/hand open fracture

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	
a.			Hypertension	i.			Bowel Problem
b.			Cardiac Hx	j.			Self-care
c.			Diabetes	k.	X		Ambulatory
d.			Respiratory	l.			Ambulatory Aid
e.			Ears/Sinus	m.			Self-meds
f.			Motion Sick	n.			Adequate Supply of Meds
g.	X		Vision Impaired	o.			Other:
h.			Voiding Prob.				

20. PHYSICIANS ORDERS

20a. DATE: 11 APR 03 | 20b. TIME: 1250 | 20c. ALLERGIES: NKOA

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

RENAL ___ Gm Prot ___ Gm Na ___ MagK ___ mg PO4

TUBE ___ TYPE ___ cc/hr, 1/2, 3/4, FULL STRENGTH

PEDIATRIC: AGE ___ OTHER (Specify) ___

TPN: Change to D10 at ___ cc/hr for max of ___ days

TUBE FEEDING: ___ at ___ strength at ___ cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

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

OXYGEN: ___ PERCENT or ___ LITERS | ROUTE:

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No ___ feet

20h. RECORDS TO ACCOMPANY PATIENT

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

20i. MEDICATIONS / TREATMENTS

Heparin 5000 units SQ BID

Ancef 1 gm IV Q8

MSO4 2-4 mg IV Q1Q PRN pain

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE

33 y.o. Iraqi ♂ c̄ stabbed to (L) face c̄ maxillary sinus/orbital fx & (R) wrist/hand open fx. Pt. will need orbital maxillofacial reconstructive surgery.

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

[b(6)-2]

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

PCL XL error

Subsystem: IMAGE

Error: MissingData

Operator: ReadImage

Position: 33

(b)(3)-1

ADMISSION AND CODING INFORMATION

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

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

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
9 10 11 12 13 14 15	(b)(6)-4	16 17	18
(b)(6)-4			M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19 20 21 22 23 24 25 26	27 28 29	30	31	
1 9 7 0 0 1 0 1	3 3 4	0	9	Mus

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36	37 38 39 40 41 42 43 44 45
		2 0	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	1035z	

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72		
0 ENT	1C43	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
(b)(3)-1	

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
73 74	75 76 77 78 79 80	81 82 83 84 85 86
XFR	(b)(3)-1	0 3 0 4 1 4 0430

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYMMDD)
103 104	105 106 107 108 109 110	111 112 113 114 115 116
		0 3 0 4 1 1

FOR LOCAL USE

GSW to ① side of head ② wrist

Dx: 8025
8029
81410
81510
E9202

Trauma
1

Surgery
450

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

INPATIENT TREATMENT RECORD COVER SHE

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

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

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

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
20			

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
		EPW K-78			

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

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

103

1. NAME (Last, First, Middle Initial) (b)(6)-4	2. SSN	3a. STATUS / SERVICE	4. PRECEDENCE U P R X	5. GRADE
6. AGE 23	7. SEX MALE / FEMALE	8. WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (ICD 5F) AMBUL / TEP X	11. ACCEPTING MD	12. CITE/AUTH # (b)(6)-4
13. APPT/SURG DATE	14a. ORIGINATING FACILITY (b)(3)-1	15a. DESTINATION FACILITY	16. # OF ATTENDANTS 16a. MED 0	16b. NON-MED 0
	14b. ORIGINATING FACILITY PHONE NUMBER ICU#3 558-(b)(3)-1	15B. DESTINATION FACILITY PHONE NUMBER		

17. DIAGNOSIS
(L) femur fracture
(R) tib-fib fracture
(R) foot fracture

18. [X] BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

20. PHYSICIANS ORDERS

20a. DATE 11 APR 03 | 20b. TIME 1040 | 20c. ALLERGIES NKDA

20d. DIET [X] REGULAR | GM NA | CARDIAC | DIABETIC | LIQUIDS
RENAL Gm Prot Gm Na MagK mg P
TUBE FEEDING cc/hr, 1/2, 3/4, FULL STRENGTH
PEDIATRIC AGE | OTHER (Specify)
TPN: Change to 2010 at cc/hr for max of days
TUBE FEEDING: at strength cc

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT | FOLLEY CATH
SUCTION | TRACTION | CHEST/HEIMLICH
NG TUBE | IV PUMP | CHEST STRAINT
STRETCHER | TRACH | RESTRAINT
INCUBATOR | MONITOR | OTHER (US)

OXYGEN: FLOW or LITERS | ROUTE
VENTILATOR

20g. ALTITUDE ENTRY OK: Yes / No et

20h. RECORDS CARRIED BY PATIENT

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

20i. MEDICATIONS / TREATMENTS
Ancef 1 gm IV Q8
MSO4 2-4 mg IV Q 1° PRN pain
Toradol 30 mg IV Q8° PRN pain
(b)(6)-2

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

	YES	NO	ISSUE		YES	NO	
a.			Hypertension	i.			Bowel Problem
b.			Cardiac Hx	j.			Self-care
c.			Diabetes	k.	X		Ambulatory
d.			Respiratory	l.			Ambulatory Aid
e.			Psychiatrous	m.			Self-meds
f.			Sickle	n.			Adequate Supply of Meds
g.			Impaired	o.			Other:
h.			Medical Prob.				

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE
25 y.o. ♂ c̄ (B) GSW's ~6 APR 03
Stable for x-ports.
LC

23. ASSESSMENT / PROGRESS NOTES
DATE / TIME

24. (b)(6)-2

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF Form 3899 (Aug 93, Medical version)

(b)(6)-4

Code # (b)(3)-1

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF (1–6): (b)(3)-1
2. MTF LOCATION (7–8) (State or Country Code.)
3. REGISTER NUMBER (9–15): (b)(6)-4
NAME (Last, First, Middle Initial): (b)(6)-4 (b)(6)-4
4. PAY GRADE (16–17)
5. SEX (18): M
6. DATE OF BIRTH (YYYYMMDD) (19–26): 19780101
7. AGE AT ADMISSION (27–29): 25Y
8. RACE (30): 0
9. ETHNIC BACKGROUND (31): 9
RELIGION: MJ3
10. LENGTH OF SERVICE (32–34)
ETS
11. FMP (35–36): 20
12. SOCIAL SECURITY NUMBER (37–45): (b)(6)-4
ORGANIZATION (Active Duty Only)
13. MARITAL STATUS (46)
HOUR OF ADMISSION: 10367
BRANCH / CORPS
14. FLYING STATUS (47–49)
15. BENEFICIARY CATEGORY (50–52): KTB
EPW
16. ZIP CODE OF RESIDENCE (53–61)
17. UNIT LOCATION (State or Country Code) (62–63)
18. MOS (64–70)
19. TRAUMA (71): ✗
PREV. ADMISSION: YEAR ✗ NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72): 0 EMT
WARD: IW3
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
21. TYPE OF (73–74): XFR
22. MTF TRANSFERRED (75–80): (b)(3)-1
23. DATE OF DISPOSITION (YYMMDD) 0630 (81–86): 030414
24. CLINIC SVC - ADMITTING (87–90)
25. MTF TRANSFERRED FROM (91–96)
26. DATE THIS ADMISSION (YYMMDD) (97–102)
27. LOCATION OF OCCURRENCE (Battle Casualty Only) (103–104)
28. MTF OF INITIAL ADMISSION (105–110)
29. DATE INITIAL ADMISSION (YYMMDD) (111–116): 030411
FOR LOCAL USE

@ femur /@ tib/fib open fx

Dx: 8210 [illegible] 82130 [illegible]

(b)(6)-4

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

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

A FORM 2985, MAR 89 EDITION OF MAY 79 IS O USAPPC V1.00

INPATIENT TREATMENT RECORD COVER SHEET

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

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

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M			MUS			NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
20		EPW	IUC3

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

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
EMT	1037z	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	XFR	030414

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		030411	Maj (b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
	030411	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: R femur, L headwound

CODING INFORMATION: 829.1

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

(b)(6)-4 [redacted]

1. NAME (Last, First, Middle Initial)	SSN	3a. STATUS	3b. SERVICE	4. PRECEDENCE U / P / R X	5. GRADE

6. AGE	7. SEX	8. WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F)--	11. ACCEPTING MD	12. CITE/AUTH #
	X MALE / FEMALE			AMBUL / X LITTER		(b)(6)-4

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

17. DIAGNOSIS
(1) (R) Femur fracture
(2) (L) Foot soft tissue injury

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	
a.			Hypertension	i.			Bowel Problem
b.			Cardiac Hx	j.			Self-care
c.			Diabetes	k.	X		Ambulatory
d.			Respiratory	l.			Ambulatory Aid
e.			Ears/Sinus	m.			Self-meds
f.			Motion Sick	n.			Adequate Supply of Meds
g.			Vision Impaired	o.			Other:
h.			Voiding Prob.				

20. PHYSICIANS ORDERS

20a. DATE	20b. TIME	20c. ALLERGIES
4 APR 03	1500	NKA

20d. DIET: X REG | 3GM NA | CARDIAC | DIABETIC ___ CALS
RENAL ___ Gm Prot ___ Gm Na ___ MagK ___ mg PO4
TUBE ___ TYPE ___ cc/hr, 1/2, 3/4, FULL STRENGTH
PEDIATRIC: AGE ___ OTHER (Specify) ___
TPN: Change to D10 at ___ cc/hr for max of ___ days
TUBE FEEDING: ___ at ___ strength at ___ cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

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

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

20g. ALTITUDE RESTRICTION: Yes / No ___ feet

20h. RECORDS TO ACCOMPANY PATIENT

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

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE
(1) (R) Femur fx
(2) (L) foot soft tissue inj

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

24. MEDICATIONS / TREATMENTS
(1) (R) Femur IDD & ex. fixation
(2) (L) foot IDD

24. STAMP AND SIGNATURE OF [redacted]

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF Form 3899 (433 AES Exce

(b)(6)-2

(b)(3)-1

ADMISSION AND CODING INFORMATION

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

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

REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
9 10 11 12 13 14 15	(b)(6)-4	16 17	18
(b)(6)-4			M

DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19 20 21 22 23 24 25 26	27 28 29	30	31	
		0	9	Mus

LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36	37 38 39 40 41 42 43 44 45
		2 0	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	10372	

FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52	53 54 55 56 57 58 59 60 61
	5 7 8 EPW	

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

SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72 73 3 EMT	ICU3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

TYPE OF DISPOSITION	22. MTF TRANSFERRED TO (b)(3)-1	23. DATE OF DISPOSITION (YYMMDD)
73 74 XPR	75 76 77 78 79 80	81 82 83 84 85 86
		0 3 0 4 1 4 0630

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

LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYMMDD)
103 104	105 106 107 108 109 110	111 112 113 114 115 116
		0 3 0 4 1 1

FOR LOCAL USE

(R) femur fx, (L) head wound

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

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4				3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE	6. RACE	7. RELIGION MUS	8. LENGTH OF SVC	9. ETS		10. PREVIOUS ADMISSION NO	
11. FMP 20		12. SSN		13. ORGANIZATION EPW			14. WARD IUC3	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN K-78		18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE INJ	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION EMT					22. HOURS OF ADMISSION 1015z	23. CLINIC SERVICE		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE				25. TYPE DISPOSITION XFR		26. DATE OF DISPOSITION 030414		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)				27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION 030411		ADMITTING OFFICER Maj (b)(6)-2
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY						30. DATE OF INTIAL ADMISSION 030411		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW to R knee,

CODING INFORMATION: 991.2

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

(b)(6)-4

1. NAME (Last, First, Middle Initial)	2. N	3a. STATUS EAW	3b. SERVICE	4. PRECEDENCE U P (R)	5. GRADE

6. AGE	7. SEX	8.WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F)–	11.ACCEPTING MD	12.CITE/AUTH #
	X MALE / FEMALE			AMBUL / X LITTER 2A		(b)(6)-4

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

17. DIAGNOSIS

(R) OPEN PATELLAR FX

18. X BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

20. PHYSICIANS ORDERS

20a. DATE	20b. TIME	20c. ALLERGIES
11 APR 03	K 8-8	NKA

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

RENAL ___ Gm Prot ___ Gm Na ___ MagK ___ mg PO4

TUBE ___ TYPE ___ cc/hr, 1/2, 3/4, FULL STRENGTH

PEDIATRIC: AGE ___ OTHER (Specify) ___

TPN: Change to D10 at ___ cc/hr for max of ___ days

TUBE FEEDING: ___ at ___ strength at ___ cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT | FOLEY CATH

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

OXYGEN: ___ PERCENT or ___ LITERS | ROUTE: ___

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No ___ feet

20h. RECORDS TO ACCOMPANY PATIENT

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

20i. MEDICATIONS / TREATMENTS

LTD OPEN PATELLA FX

(4/8)

RE LTD " (4/11)

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

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

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE

(R) OPEN PATELLAR FX

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

24. STAMP AND SIGNATURE OF ATTENDING PHYSICIAN

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF Form 3899 (433 A ... ersion)

(b)(6)-2

(b)(6)-4

(b)(3)-1

ADMISSION AND CODING INFORMATION

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

REPORTING MTF (1–6) | MTF LOCATION (7–8) (State or Country Code.)

(b)(3)-1

REGISTER NUMBER (9–15)

(b)(6)-4

NAME (Last, First, Middle Initial)

(b)(6)-4

(b)(6)-4

4. PAY GRADE (16–17)

5. SEX (18) M

DATE OF BIRTH (YYYYMMDD) (19–26)

7. AGE AT ADMISSION (27–29)

8. RACE (30) O

9. ETHNIC BACKGROUND (31) 9

RELIGION: Mus

LENGTH OF SERVICE (32–34)

ETS

11. FMP (35–36) Z O

12. SOCIAL SECURITY NUMBER (37–45)

(b)(6)-4

ORGANIZATION (Active Duty Only)

13. MARITAL STATUS (46)

HOUR OF ADMISSION: 10152 ~~10382~~

BRANCH / CORPS

FLYING STATUS (47–49)

15. BENEFICIARY CATEGORY (50–52) K 7 8 EPW

16. ZIP CODE OF RESIDENCE (53–61)

UNIT LOCATION (State or Country Code) (62–63)

18. MOS (64–70)

19. TRAUMA (71) I

PREV. ADMISSION: YEAR | NO 4

SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72–73) 0 E/MT

WARD: ICU3

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY

(b)(3)-1

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

TYPE OF DISPOSITION (74) XFR

22. MTF TRANSFERRED TO (75–80) (b)(3)-1

23. DATE OF DISPOSITION (YYMMDD) 0630 (81–86) 0 3 0 4 1 4

CLINIC SVC - ADMITTING (87–90)

25. MTF TRANSFERRED FROM (91–96)

26. DATE THIS ADMISSION (YYMMDD) (97–102)

LOCATION OF OCCURRENCE (Battle Casualty Only) (103–104)

28. MTF OF INITIAL ADMISSION (105–110)

29. DATE INITIAL ADMISSION (YYMMDD) (111–116) 0 3 0 4 1 1

FOR LOCAL USE

@ Knee GSW

Dx: 8221
E9912

Trauma
1

Injury
GSD

ADMITTING OFFICER (Signature, as required)

(b)(6)-2

SIGNATURE OF ADMITTING CLERK

(b)(6)-2

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

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4				3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE	6. RACE	7. RELIGION MUS	8. LENGTH OF SVC	9. ETS		10. PREVIOUS ADMISSION NO	
11. FMP 20		12. SSN		13. ORGANIZATION EPW			14. WARD IUC3	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP			20. TYPE CASE INJ	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION					22. HOURS OF ADMISSION 1039z	23. CLINIC SERVICE		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE				25. TYPE DISPOSITION XFR		26. DATE OF DISPOSITION 030414		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)				27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION 030411		ADMITTING OFFICER Maj (b)(6)-2
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY						30. DATE OF INTIAL ADMISSION 030411		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW to L knee, open patella Fx

CODING INFORMATION: 991.2

Dx 8221 E9912

Pr 7816 9927 9659

Trauma Unit 450 1

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

1. NAME (b)(6)-4	SSN	3a. STATUS	3b. SERV	4. PRECEDENCE U / P ✓ / R	5. GRADE
6. AGE 1	7. SEX ✓ MALE / FEMALE	8. WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A TO S	11. ACCEPTING MD
				AMBUL / ✓ LITTER	(b)(6)-4

13. APPT/SURG DATE	14a. ORIGINATING FACILITY	15a. DESTINATION FAC	16. # OF ATTENDANTS	
11 APR 03	[redacted] (b)(3)-1		16a. MED	16b. NON-MED
	14b. ORIGINATING FACILITY PHONE NUMBER [redacted] DSN #3 (b)(3)-1	15B. DESTINATION FAC Y PHONE NUMBER	Ø	Ø

17. DIAGNOSIS

GSW (L) femur

18. ✓ BATTLE CASUALTY / DISEASE / NON BATTLE INJURY

20. PHYSICIAN ORDERS

20a. DATE 11 APR 03 — 20b. TIME — 20c. ALLERGIES

20d. DIET ✓ REG / ASM NA / CARDIAC / DIABETIC CALS

RENAL — MagK ___ mg PO4

TUBE — TYPE — FULL STRENGTH

PEDIATRIC — (Specify)

TPN: Change — max of ___ days

TUBE FEED — rength at ___ cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPME

SUCTION	IRRIG	FOLEY CATH	
NG TUBE	CPAP	✓ ORTHO BRACES	
STRYKER	TRACH	CHEST HEIMLICH	
INCUBATOR	ICP	RESTRAINTS	
		OTHER (USE 23)	

OXYGEN: ___ PERC — LITER — ROUTE: ___

VENT SETTI

20g. ALTITUDE RESTRI Yes No ___ feet

20h. RECORDS TO ACC PATIENT

✓ OUTPATIENT		XRAYS	OTHER:
INPATIENT		OB	
NARRATIVE		DENTAL	
FINANCIAL			

20i. MEDI ERT/TREA TS

Ancef 1 gm IV q8h
12/16 Med / GSW
ORT Cix (L) femur

19. CLINICAL ISSUES (Pl e indicate Yes or No on clinical issues. Explain YES comments in Sec 23)

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

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE

GSW (L) femur
ex fix application

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

(b)(6)-2

AN

25. STAMP AND SIGNA E OF FLIGHT SURGEON

(b)(6)-4

(b)(3)-1

ADMISSION AND CODING INFORMATION

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

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

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

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36	37 38 39 40 41 42 43 44 45
		2 0	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
EPW	46	10392 ~~12117Z~~	EPW

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
III	ICU3	

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
(b)(3)-1	

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO (b)(3)-1	DATE OF DISPOSITION (Y Y Y Y M M D D) 0630
73 74	75 76 77 78	81 82 83 84 85 86 87 88
XFR		2 0 0 3 0 4 1 4

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y Y Y M M D D)
107 108	109 110 111 112 113 114	115 116 117 118 119 120 121 122
		2 0 0 3 0 4 1 1

FOR LOCAL USE

GSW to ⓛ knee, open patella fx

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

DA FORM 2985, MAR 2000 EDITION OF MAR 8 USAPA V1.00

MEDCOM - 2958

INPATIENT TREATMENT RECORD COVER SHE

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

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4				3. GRADE	ADMISSION REMARKS
4. SEX m	5. AGE 30y	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS		10. PREVIOUS ADMISSION	
11. FMP 20		12. SSN (b)(6)-4		13. ORGANIZATION			14. WARD	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN K-78		18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION					22. HOURS OF ADMISSION	23. CLINIC SERVICE		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE				25. TYPE DISPOSITION		26. DATE OF DISPOSITION		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)				27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY						30. DATE OF INTIAL ADMISSION		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

(b)(6)-4

1. NAME (Last, First, Middle Initial)	SN	3a. STATUS	3b. SERVICE	4. PRECEDENCE	5. GRADE
# (b)(6)-4				U P R X	EPW

6. AGE	7. SEX	8. WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F)--	11. ACCEPTING MD	12. CITE/AUTH #
30	X MALE / FEMALE			AMBUL / X LITTER		(b)(6)-4

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

17. DIAGNOSIS

~~GSW~~ shrapnel wounds (B) legs / (R) butt

18. X BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

20. PHYSICIANS ORDERS

20a. DATE	20b. TIME	20c. ALLERGIES
11APR03	1725	NKDA

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

RENAL ___ Gm Prot ___ Gm Na ___ MagK ___ mg PO4

TUBE ___ TYPE ___ cc/hr 1/2, 3/4, FULL STRENGTH

PEDIATRIC: AGE ___ OTHER (Specify) ___

TPN: Change to D10 at ___ cc/hr for max of ___ days

TUBE FEEDING: ___ at ___ strength at ___ cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

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

OXYGEN: ___ PERCENT or ___ LITERS ROUTE: ___

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No ___ feet

20h. RECORDS TO ACCOMPANY PATIENT

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

20i. MEDICATIONS / TREATMENTS

Ancef 1 gm IV Q8°

Tylenol #3 1-2 p.o. Q6° PRN

(b)(6)-2

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

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

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE

30 y.o. Iraqi ♂ c̄

extensive (B) LG shrapnel wounds

s/p I&D

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

(b)(6)-2

24. (b)(6)-2

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF [illegible] 3899 (435 AES Excel version)

(b)(6)-4

c?de#

(b)(3)-1

ADMISSION AND CODING INFORMATION

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

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

2. MTF LOCATION (State or Country Code.)

REGISTER NUMBER (b)(6)-4

NAME (Last, First, Middle Initial) (b)(6)-4

4. PAY GRADE: 16 17

5. SEX: 18 M

DATE OF BIRTH (YYYYMMDD): 19 20 21 22 23 24 25 26 — 1 9 7 3 0 1 0 1

7. AGE AT ADMISSION: 27 28 29 — 3 0 4

8. RACE: 30 — 0

9. ETHNIC BACK-GROUND: 31 — 9

RELIGION: Mus

LENGTH OF SERVICE: 32 33 34

ETS

11. FMP: 35 36 — 2 0

12. SOCIAL SECURITY NUMBER: 37 38 39 40 41 42 43 44 45 (b)(6)-4

ORGANIZATION (Active Duty Only): EPW

13. MARITAL STATUS: 46

HOUR OF ADMISSION: 10472

BRANCH / CORPS: EPW

FLYING STATUS: 47 48 49

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

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

UNIT LOCATION (State or Country Code): 62 63

18. MOS: 64 65 66 67 68 69 70

19. TRAUMA: 71

PREV. ADMISSION: YEAR ☑ NO

SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 73 — O

WARD: ICU3

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

TYPE OF DISPOSITION: 73 74 — XFR

22. MTF TRANSFERRED TO (b)(3)-1: 75 76 77 78 79 80

23. DATE OF DISPOSITION (YYMMDD): 81 82 83 84 85 86 — 0 3 0 4 1 4 0630

CLINIC SVC - ADMITTING: 87 88 89 90

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

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

LOCATION OF OCCURRENCE (Battle Casualty Only): 103 104

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

29. DATE INITIAL ADMISSION (YYMMDD): 111 112 113 114 115 116 — 0 3 0 4 1 1

LOCAL USE

Shrapnel wounds to buttock

Dx: 8911
8771
E9912
Trauma
Injury

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

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

(b)(6)-4

DA FORM 2985, MAR 89 EDITION OF MAY 79 IS OBSOLETE

USAPPC V1.00

INPATIENT TREATMENT RECORD COVER SHE

For use of this form, see AR 40-400; the proponent agency is O'I...

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4				3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS		10. PREVIOUS ADMISSION	
11. FMP 20		12. SSN		13. ORGANIZATION			14. WARD	
15. FLYING STATUS	16. RATING/ DSG		17. DEPT./ BEN EPW K-78	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION					22. HOURS OF ADMISSION	23. CLINIC SERVICE		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE				25. TYPE DISPOSITION		26. DATE OF DISPOSITION		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)				27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY						30. DATE OF INTIAL ADMISSION		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAO OR MEDICAL RECORDS OFFICER

1. NAME (Last, First, Middle Initial) (b)(6)-4

2. STATUS | 3. SERVICE | 4. PRECEDENCE: U P R X | 5. GRADE

6. AGE: SS | 7. SEX: MALE / FEMALE | 8. HEIGHT | 9. BLOOD TYPE | 10. CLASSIFICATION: X | 11. ACCEPTING MD | 12. CITE/AUTH # (b)(6)-4

13. APPROX SURG DATE | 14a. ORIGINAL FACILITY: MAS | 14b. ORIGINAL FACILITY PHONE NUMBER: [redacted] Ical #3 (b)(2)-1 | 15. DESTINATION FACILITY | DESTINATION FACILITY PHONE NUMBER | 16. # OF ATTENDANTS: 16a. MED | 16b. NON-MED

17. DIAGNOSIS
GSW (R) leg
Burn (L) foot

18. CLINICAL ISSUES (Please indicate Yes or No on clinical issues. Explain YES answers in Section 23)

	YES	NO	
Hypertension			Bowel Problem
Cardiac Risk			Self-care
Diabetic	X		Ambulatory
Respiratory			Ambulatory Aid
Cancer/Chemo			Self-meds
Pollen Sick			Adequate Supply of Meds
Vision Impaired			Other:
Bleeding Prob.			

19. BATTLE CASUALTY | 20. INJURY

21. PHYSICIAN ORDERS
a. DATE: 11APR03 | b. TIME: 1930 | c. ALLERGIES: NKDA

d. PRE-OP: | SIGNS: NA | LABORATORY RESULTS: CALS
RENAL: Gm Pr | PO4
TUBE: TYPE cc | H
PEDIATRIC: AGE
TPN: CONTENTS | max | days
TUBE FEEDING | cong | cc/hr

e. BLOOD

f. SPECIAL EQUIPMENT
SUCTION | ON | TIME | LENGTH
NG TUBE | P | RACES
STRETCHER | EIMICH
INCUBATOR | NTS
(USE 23)

g. OXYGEN: VENTILATOR
h. ALTITUDE RESTRICTION: Yes
i. DRUGS TO CONTINUE: YES
OUTPATIENT RECORDS | OTHER:
INPATIENT | Y
NARCOTICS
FINANCIAL

j. MEDICATIONS

22. PRE-FLIGHT VITALS
21a. DATE | 21b. TEMP: | 21c. PULSE | 21e. BP
21d. RESP:

23. BRIEF NARRATIVE
SS y.o. Injury: 0 c
GSW (R) leg / Burn (L) foot
S/P I&D @ FST

24. ASSESSMENT / PROGRESS NOTES
Ancef 1gm IV Q8°
Sitvadene BID to (L) foot
Tylenol #3 1-2 p.o. Q6°
MSO4 2-4mg IV Q 2° PRN pain

(b)(6)-2

25. SIGNATURE OF FLIGHT SURGEON

(b)(6)-4 [redacted]

(b)(3)-1 [redacted]

ADMISSION AND CODING INFORMATION

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

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

(b)(3)-1 [redacted]

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
9 10 11 12 13 14 15	(b)(6)-4 [redacted]	16 17	18 M

(b)(6)-4 [redacted]

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19 20 21 22 23 24 25 26: 1 9 4 8 0 1 0 1	27 28 29: 5 5 4	30: 0	31: 9	Mus

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36: 2 0	37 38 39 40 41 42 43 44 45 (b)(6)-4 [redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
EPW	46	1847z	EPW

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: D EMT	ICU3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(6)-2 [redacted]

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYYYMMDD) 0630
73 74: KPR	75 76 77 78 (b)(3)-1 [redacted]	81 82 83 84 85 86 87 88: 2 0 0 3 0 4 1 4

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
89 90 91 92	93 94 95 96 97 98	99 100 101 102 103 104 105 106

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYYYMMDD)
107 108	109 110 111 112 113 114	115 116 117 118 119 120 121 122: 2 0 0 3 0 4 0 3

FOR LOCAL USE

Dx: GSW (R) leg
(L) foot burn
Scrapnel (R) chest wall

Dr [illegible]
[illegible]
Trauma
(b)(6)-4 [redacted]

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

SIGNATURE OF ADMITTING CLERK (b)(6)-2 [redacted]

DA FORM 2985, MAR 2000 EDITION OF MAR 89 IS OBS [redacted] USAPA V1.00

MEDCOM - 2964

..PATIENT TREATMENT RECORD COVER SHEET

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

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

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	50					

11. FMP	12. SSN	13. ORGANIZATION	14. WARD

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
		K-78			

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

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

1. NAME (Last First Mid o Initial) (b)(6)-4

3a. STATUS | 3b. SERVICE | 4. PRECEDENCE: U P R X | 5. GRADE

6. AGE: 50 | 7. SEX: X MALE | FEMALE | 9. BLOOD TYPE | 10. CLASSIFICATION (A TO S): AMBUL X LITTER | 11. ACCEPTING MD | 12. CITIZENSHIP (b)(6)-4

13. APPROX DATE | 14a. ORIGINATING FACILITY [redacted] (b)(3)-1 | 15a. DESTINATION FACILITY | 16. # OF ATTENDANTS: 16a. MED | 16b. NON-MED

14b. ORIGINATING FACILITY PHONE NUMBER: Icu #3 [redacted] (b)(3)-1 | 15b. DESTINATION FACILITY PHONE NUMBER | 16a. MED: P | 16b. NON-MED: P

17. DIAGNOSIS:
GSW @ leg / @ foot
DM
HTN

18. X BATTLE CASUALTY | INJURY | BATTLE INJURY

19. MEDICAL HISTORY

20a. DATE: 11 APR 03 | 20b. TIME: 1245 | 20c. ALLERGIES: NKDA

20d. X PRESENT | ELIGIBLE | CLINICAL | DIAGNOSTIC | THERAPEUTIC | CALS
RENAL | Foley | Mark | mg PO4
TUBE | TUBE | ULL | ATH
PEDIATRIC | TUBE | (Sp
TPN: Dextrose | Dextrose | mex
TUBE FEEDING | engl | cc/hr

20e. BLOOD

20f. SPECIAL EQUIPMENT | X | ATH
SUCTION | RACES
NG TUBE | EIMUCH
STRYKER | NTS
INCUBATOR | (USE 23)
OXYGEN | or | ROM
VENTILATOR SETTINGS:

20g. ANTIBIOTIC THERAPY:

20h. RECORDS TRACE ANALYSIS
OUTPATIENT RECORD | X | TER:
INPATIENT RECORD | OF
NARRATIVE | MA | OL
FINAL

20i. MEDICATIONS
Heparin 5000 a SQ BID
Ancef 1gm IV Q8°
MSO4 2 6mg IV Q1° PRN pain

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

YES	NO	ISSUE		YES	NO	
X		Hypertension	i.		/	Bowel Problem
	X	Cardiac risk	j.		/	Self-care
X		Diabetes	k.	X		Ambulatory
		Respiratory	l.		/	Ambulatory Aid
		Fears/Sickness	m.		/	Self-meds
		Motion Sick	n.		/	Adequate Supply of Meds
		Vision Impaired	o.		/	Other:
		Bleeding Prob.				

21a. PRE-FLIGHT VITALS | 21b. TEMP: | 21c. PULSE | 21e. BP | 21d. RESP:

22. BRIEF NARRATIVE
~50y o. ♂ c̄ multi shrapnel WNDS to @ LE / @ foot, initial I&D 9 Apl. Pt. stable for K-Spark.

23. ASSESSMENT / PROGRESS NOTES | DATE | TIME

24. (b)(6)-2

25. STAMP OF SIGNATURE OF FLIGHT SURGEON

FORMER COMMANDERS

CPT	(b)(6)-2	January 1985 to July 1985
CPT		July 1985 to September 1986
CPT		September 1986 to May 1987
CPT		May 1987 to July 1988
CPT		July 1988 to March 1989
MAJ		March 1989 to July 1990
LTC		July 1990 to December 1990
COL		December 1990 to April 1991
MAJ		April 1991 to December 1991
LTC		December 1991 to July 1992
LTC		July 1992 to November 1992
LTC		November 1992 to July 1993
LTC		July 1993 to July 1995
LTC		July 1995 to July 1997
LTC		July 1997 to June 1999
LTC		June 1999 to June 2001

(b)(6)-4

Code # 991.2

ADMISSION AND CODING INFORMATION

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

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

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19530101	50Y	0	9	Mus.

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
		20	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
EPW		1947z	EPW

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	R7 EPW	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0 EMT	ICU3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED (b)(3)-1	23. DATE OF DISPOSITION (YYYYMMDD) 0630
XFR		20030414

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYYYMMDD)
		20030411

FOR LOCAL USE

Dx: 1) (B) LE GSW 5
2) Abdominal Scrotal wound
3) DM
4) HTN

E9911
E9912
Trauma
450

ADMITTING (b)(6)-2 (b)(6)-2 MAJ, USA, MC DEPT OF OB/GYN

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

DA FORM [illegible] 2000 EDITION OF MAR 89 IS O[illegible] USAPA V1.00

MEDCOM - 2968

INPATIENT TREATMENT RECORD COVER SHE

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

1. REGISTER NUMBER (b)(6)-4			2. (b)(6)-4				3. GRADE	ADMISSION REMARKS
4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS		10. PREVIOUS ADMISSION	
11. FMP 20		12. SSN (b)(6)-4		13. ORGANIZATION			14. WARD	
15. FLYING STATUS	16. RATING/ DSG		17. DEPT./ BEN EPU K-78	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION					22. HOURS OF ADMISSION	23. CLINIC SERVICE		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE				25. TYPE DISPOSITION		26. DATE OF DISPOSITION		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)				27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY						30. DATE OF INTIAL ADMISSION		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79 EDITION OF 1 AUG 78 IS OBSOLETE USAPPC V1.10

(b)(6)-4

RU #3.

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

6. AGE	7. SEX	8. WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F)	11. ACCEPTING MD	12. CITE/AUTH #
22	MALE / FEMALE			AMBUL / LITTER		(b)(6)-4

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

17. DIAGNOSIS

(R) open TIB-FIB fracture
2° GSW

18. BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

20. PHYSICIANS ORDERS

20a. DATE	20b. TIME	20c. ALLERGIES
11 Apr 03	1700 Z	NKDA

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

RENAL ___ Gm Prot ___ Gm Na ___ MagK ___ mg PO4

TUBE ___ TYPE ___ cc/hr, 1/2, 3/4, FULL STRENGTH

PEDIATRIC: AGE ___ OTHER (Specify) ___

TPN: Change to D10 at ___ cc/hr for max of ___ days

TUBE FEEDING: ___ at ___ strength at ___ cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

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

OXYGEN: ___ PERCENT or ___ LITERS ROUTE: ___

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No ___ feet

20h. RECORDS TO ACCOMPANY PATIENT

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

20i. MEDICATIONS / TREATMENTS

Morphine 1-4 mg IV/IM q 4-6 hr PRN pain

Phenergan 25 mg IV q 4-6 hr PRN

Ancef 1 gm IVB q 8 hr.

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

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

21. PRE-FLIGHT VITALS

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

22. BRIEF NARRATIVE

22 y.o. Iraqi male GSW
sustained GSW to (R) lg. open tib-fib fx
Pt s/p ORIF, ex-fix w/ [illegible]
Pt referred to Nam for further care.

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

24. STAMP AND SIGNATURE OF FLIGHT SURGEON

(b)(6)-2

UTC, MC, USA
ORTHOPAEDIC SURGERY

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF Form 3899 (433 AES Excel version)

(b)(6)-4

code# 823.40

ADMISSION AND CODING INFORMATION

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

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

REGISTER NUMBER	NAME (Last, First, Middle Initial)		4. PAY GRADE	5. SEX
9 10 11 12 13 14 15	(b)(6)-4	(b)(6)-4	16 17	18
(b)(6)-4				M

DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19 20 21 22 23 24 25 26	27 28 29	30	31	
1 9 8 1 0 1 0 1	2 2 Y	0	9	Mos

LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36	37 38 39 40 41 42 43 44 45
		2 0	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	1247z	

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

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

SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
0 EMT	ICU3	

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
(b)(3)-1	

TYPE OF DISPOSITION	22. MTF TRANSFERRED TO (b)(3)-1	23. DATE OF DISPOSITION (YYMMDD)
73 74	75 76 77 78 79 80	81 82 83 84 85 86
XFR		0 3 0 4 1 4 0630

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

LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYMMDD)
103 104	105 106 107 108 109 110	111 112 113 114 115 116
		0 3 0 4 1 1

FOR LOCAL USE

Dx: (R) open tib-fib fx

Lx: 823.40
Trauma
1
450

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

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

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

MEDCOM - 2971

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4				3. GRADE	ADMISSION REMARKS
4. SEX m	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS		10. PREVIOUS ADMISSION	
11. FMP		12. SSN		13. ORGANIZATION			14. WARD	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN EPW K-78		18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION					22. HOURS OF ADMISSION	23. CLINIC SERVICE		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE				25. TYPE DISPOSITION		26. DATE OF DISPOSITION		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)				27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY						30. DATE OF INTIAL ADMISSION		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79 EDITION OF 1 AUG 76 IS OBSOLETE USAPPC V1.10

1. NAME (Last, First, Middle Init) (b)(6)-4 (b)(6)-4

3a. STATUS | 3b. SERVICE | 4. PRECEDENCE: U | P | R ✓ | 5. GRADE

6. AGE ~24 | 7. SEX: MALE | FEMALE | WEIGHT | BLOOD TYPE | 10. CLASSIFICATION (1A TO 5F)-- AMBUL | ✓ LITTER | 11. ACCEPTING MD | 12. CITE/AUTH # (b)(6)-4

13. APPT/SURG DATE | 14a. ORIGINATING FACILITY [redacted] (b)(3)-1 | 15a. DESTINATION FACILITY | 16. # OF ATTENDANTS: 16a. MED Ø | 16b. NON-MED Ø

14b. ORIGINATING FACILITY PHONE NUMBER ICU #3 [redacted] (b)(3)-1 | 15B. DESTINATION FACILITY PHONE NUMBER

17. DIAGNOSIS
s/P (R) BKA

18. ✓ BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

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

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

20. PHYSICIANS ORDERS
20a. DATE 11 APR 03 | 20b. TIME 1255 | 20c. ALLERGIES NICOTINE
20d. DIET: ✓ REG | 3GM NA | CARDIAC | DIABETIC | CALS
RENAL Gm Prot Gm Na MagK mg PO4
TUBE TYPE cc/hr 1/2, 3/4, FULL STRENGTH
PEDIATRIC: AGE OTHER (Specify)
TPN: Change to D10 at cc/hr for max of days
TUBE FEEDING: at strength at cc/hr
20e. IV BLOOD
20f. SPECIAL EQUIPMENT
SUCTION | EXTRACTION | ✓ FOLEY CATH
NG TUBE | IV PUMP | ORTHO BRACES
STRYKER | TRACH | CHEST/HEMLICH
INCUBATOR | MONITOR | RESTRAINTS
OXYGEN: PERCENT or LITERS | OTHER (LINE 23)
VENT SETTINGS: ROUTE:
20g. ALTITUDE RESTRICTION: Yes / No feet
20h. RECORDS TO ACCOMPANY PATIENT
OUTPATIENT RECORDS | ✓ | XRAYS | OTHER:
✓ INPATIENT RECORDS | OB
NARRATIVE SUMMARY | DENTAL
FINANCIAL

21. PRE-FLIGHT VITALS
21a. DATE / TIME | 21b. TEMP: | 21c. PULSE | 21e. BP | 21d. RESP:

22. BRIEF NARRATIVE
27 y.o. Iraqi POW s/P traumatic (R) BKA, stable for transport

20i. MEDICATIONS / TREATMENTS
Cefotaxim 2gm IV Q8°
Heparin 5000 units SQ BID
MSO4 2-4mg IV Q2° PRN pain

23. ASSESSMENT / PROGRESS NOTES
DATE / TIME

24. PHYSICIAN (b)(6)-2

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

(b)(6)-4

Code # 991.02

ADMISSION AND CODING INFORMATION

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

REPORTING MTF (2–6)	2. MTF LOCATION (7–8) (State or Country Code.)	NAME (Last First Middle Initial)	4. PAY GRADE (16–17)	5. SEX (18)
(b)(3)-1	I Z	(b)(6)-4 (b)(6)-4		M

REGISTER NUMBER (9–15)	DATE OF BIRTH (YYYYMMDD) (19–26)	7. AGE AT ADMISSION (27–29)	8. RACE (30)	9. ETHNIC BACKGROUND (31)	RELIGION
(b)(6)-4	19760101	274	0	9	MUS

LENGTH OF SERVICE (32–34)	ETS	11. FMP (35–36)	12. SOCIAL SECURITY NUMBER (37–45)
		20	002020 16

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS (46)	HOUR OF ADMISSION	BRANCH / CORPS
EPW		1052	EPW

FLYING STATUS (47–49)	15. BENEFICIARY CATEGORY (50–52)	16. ZIP CODE OF RESIDENCE (53–61)
	K 78 EPW	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72)	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0 EMT	ICU3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION (73–74)	22. MTF TRANSFERRED TO (75–80)	23. DATE OF DISPOSITION (YYMMDD) (81–86)
XFR	(b)(3)-1	030414 0630

24. CLINIC SVC - ADMITTING (87–90)	25. MTF TRANSFERRED FROM (91–96)	26. DATE THIS ADMISSION (YYMMDD) (97–102)

27. LOCATION OF OCCURRENCE (Battle Casualty Only) (103–104)	28. MTF OF INITIAL ADMISSION (105–110)	29. DATE INITIAL ADMISSION (YYMMDD) (111–116)
		030411

FOR LOCAL USE

65W to Ⓟ leg 5/p BICB

Dr [illegible] EOD

[illegible]

450

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

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

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

MEDCOM - 2974

INPATIENT TREATMENT RECORD COVER SHEET

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

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

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

11. FMP	12. SSN	13. ORGANIZATION	14. WARD

15. FLYING STATUS	16. RATING/ OSG	17. DEPT./ REN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
		(b)(6)-4 (b)(6)-4			

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

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79 EDITION OF 1 AUG 78 IS OBSOLETE USAPPC V1.10

(b)(6)-4

(b)(3)-1

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF: 1 2 3 4 5 6

2. MTF LOCATION: 7 8 (State or Country Code.)

(b)(3)-1

3. REGISTER NUMBER: 9 10 11 12 13 14 15

(b)(6)-4

NAME (Last First Middle Initial)

(b)(6)-4

(b)(6)-4

4. PAY GRADE: 16 17

5. SEX: 18 M

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

7. AGE AT ADMISSION: 27 28 29

8. RACE: 30 O

9. ETHNIC BACK-GROUND: 31 9

RELIGION: MUS

10. LENGTH OF SERVICE: 32 33 34

ETS

11. FMP: 35 36 20

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

(b)(6)-4

ORGANIZATION (Active Duty Only)

13. MARITAL STATUS: 46

HOUR OF ADMISSION: 1252

BRANCH / CORPS

14. FLYING STATUS: 47 48 49

15. BENEFICIARY CATEGORY: 50 51 52

(b)(6)-4

(b)(6)-2

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 I

PREV. ADMISSION YEAR

[X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 72 O EMT

WARD: IC13

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY

(b)(6)-4

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION: 73 74 XFR

22. MTF TRANSFERRED TO: 75 76 77 78

(b)(3)-1

23. DATE OF DISPOSITION (Y Y Y Y M M D D) 0830: 81 82 83 84 85 86 87 88 0 8 0 3 0 4 1 4

24. CLINIC SVC - ADMITTING: 89 90 91 92

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

26. DATE THIS ADMISSION (Y Y Y Y M M D D): 99 100 101 102 103 104 105 106

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

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

29. DATE INITIAL ADMISSION (Y Y Y Y M M D D): 115 116 117 118 119 120 121 122 2 0 0 3 0 4 1 1

FOR LOCAL USE

R foot 2/3/4TH MT FRACTURE
DX: 82535 OPEN
EXT Trauma

(b)(6)-2

ADMITTING OFFICER

(b)(6)-2

Signature

DA FORM 2985 N OF MAR 8

USAPA V1.00

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