MEDICAL RECORD	PROGRESS NOTES
DATE	
7/12/03 0530	Received Report, Assessment complete see DA form 4700, chest xray done Ø pain @ this time, will ask to switch ~~pt~~ to toradol + percocet stop MS04, add colace 100mg BID. Will continue to monitor — (b)(6)-2 CPT/ON
7/12/03 0830	Up to chair x1 hour Am care + linen Δ done. At 30% breakfast + 1 carnation Instant Breakfast Shake. IV HL. Changed to Tylox PO, colace given. Will continue to monitor — (b)(6)-2
7/12/03 0930	New pleurovac container — (b)(6)-2 CPT/ON
7/12/03 1330	Up to chair x1° for lunch, ate 50% tolerated well, medicated c tylox — (b)(6)-2 CPT/ON
7/12/03 1600	Patient ambulated to ER and back tolerated well, up to chair now. — (b)(6)-2 CPT/ON
7/12/03 1645	end of shift note. Ø change. Report given to oncoming shift — (b)(6)-2 CPT/ON
1715	Report received From — CPT (b)(6)-2 Assist IG running to (R) AC @ this time pt. up to bedside chair, Ø c/o pain @ this time, pt. seems to be having some epistaxis to (R) nostril, will continue to monitor — JPC (b)(6)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

(b)(6)-4

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

PROGRESS NOTES

DATE	
12 July 1850	Pt. ambulated up and down ward w/, while ambulating pt. developed a cough c̄ bloody secretions. ⊖ SS of pain noted, ⊖ % pain either @ this time. Pt. returned to bed and asked for pain meds. USS. SPC (b)(6)-2
1900	2 cc's output from (L) CT for a total of 40 in container, 38 marked on container for 1600, 28 marked in DA 4700, ii Tylox given for pain @ this time SPC (b)(6)-2
2330	Pt. resting quietly in bed c̄ eyes closed, easily aroused. USS SPC (b)(6)-2
0210	Pt. % pain. 30 mg Toradol given SPC (b)(6)-2
0500	110 cc's total Drainage to CT container. SPC (b)(6)-2
13 July 03 0530	Reports received from SPC (b)(6)-2 Patient lying in Supine position. X Resumption and posted. Patient remains on SR & ectopy via monitor. Drowsy when asked questions due to language barrier. Denies pain at present time. O_2 at 97% room air. Chest tube to 20 cm suction total output at this time 115. Heplock 18G to (L) Arm site & redness or drainage, dressing changed. Further assessments as per DA Form 4700 ICU flowsheet. Plan: (1) Encourage pulmonary toilet and assist as to ambulate three times this shift. (2) Medicate as needed for pain (3) Change dressings to chest tube site and entry and exit wounds. (b)(6)-2 SPC
0630	Patient given complete am hygiene, dressings changed to entry wound c̄ vaseline gauze applied. Exit wound c̄ vaseline gauze applied. Protrude diameter is approx 1 inch c̄ serous bloodstain drainage at site. Chest tube dressing changed c̄ vaseline gauze reinforced. Assisted WS to chair c̄ breakfast tray set up. (b)(6)-2 SPC

STA (b)(6)-2 REV. 7-91 BACK USAPPC V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

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

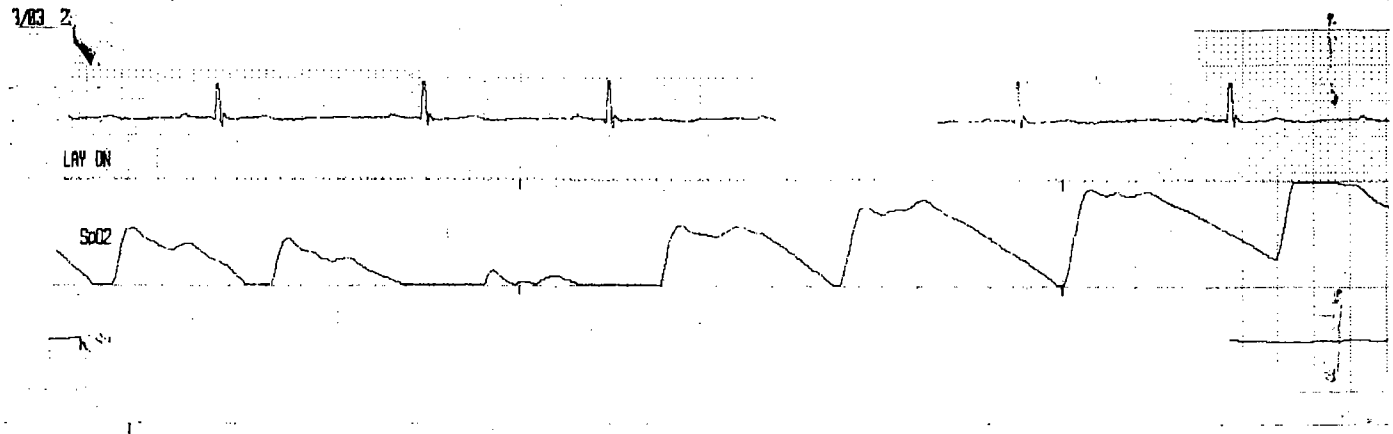
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13 July 03 0730	Chest tube placed to water seal as per Dr (b)(6)-2 (b)(6)-2
	06:00:21 HR=62 P1=OFF P2=OFF RR=19 SpO2=95% NIBP=OFF T1=OFF T2=OFF ΔT=OFF NSR PR .20 QRS .10 DISPLAY ON SpO2 RESP
13 July 03 0800	Patient ambulated 100 feet and assisted back to bed. c/o pain given Tylox 2 caps as ordered prn. (b)(6)-2 mogul
13 July 03 1000	Patient c/o (L) shoulder pain. Passive ROM performed to patient tolerance - well managed for further assessment (b)(6)-2 mogul
1200	Patient still c/o pain, given Toradol 30mg IV. assisted OUT to chair for lunch. Ate 3/4 of contents
1230	CXray completed. (b)(6)-2 mogul
1400	Patient lying quiet. No change in assessment (b)(6)-2 mogul
1600	Physician rounding at bedside. CXray shows Pneumothorax. CT placed to suction O2 sat 93% on Room air Will continue to monitor. (b)(6)-2 mogul
1700	Report given to SGT Doe. CT remains on suction 20cm. Patient walking up 5 corridors. O2 sat 93% on RA. (b)(6)-2 mogul

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

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

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	13 July 03



1700	Report recieved: Pt sitting up in bed, NAD Vital Signs Stable 112/68 P-66 R-14 99% RA T-97 ⊕ CT to LCS (20 cm) CT line patent not kinked - Dsg to CT, wnl, CDI - Heplock 18G IV cath (L) arm patent and flushed - will continue to monitor (b)(6)-2 SGT Wm
1730	Pt assessment: Pt A+O - Perrl - Lungs clear Productive upper resp cough + BS x 4 quadrants abdomen soft - nondistended - Pt states will attempt BM soon - + peripheral pulses - no edematous extremities - no skin breakdown noted (b)(6)-2 SGT Wm.
1800	Pt up to bedside commode - ⊕ BM large, soft and formed - Pt ambulating and maintaining easily steady gait (b)(6)-2 SGT

STANDARD FORM 600 (REV. 6-97) BACK
*U.S. GPO: 2002 - 491-600/50618

MEDICAL RECORD	PROGRESS NOTES
DATE	
14 Jul 03 0700	Report received from SGT (b)(6)-2 pt resting c̄ head covered c̄ blanket. Given ∴ Tylox for pain discomfort. ⓛ CT to 20 cm H2O suction. Draining minimal bloody pink chest drainage. VIS stable. HR 60, Ø ectopy. RR 15. SaO2 97%. BP. 98/38. Ø respiratory distress noted. pt condition stable. Will continue to monitor — (b)(6)-2 MAJ MC
0715	awakened for assessment. Lungs Ⓑ CTA. ⓛ diminished and unable to auscultate lung sound. % ⓛ chest pain when asked to take deep breath. able to sit up c̄ assistance. Tender to palpate on ⓛ chest area. Chest tube drsg dry & intact poor inspiratory effort noted. no dyspnea noted. RR 18. SaO2 96% on room air. offered breakfast, but denied eating @ this time. Will let pt rest for now. no other changes from initial assessment — (b)(6)-2 MAJ MC
0720	ⓡ antecubital IV site. grey signs of infection. checked for patency. unable to draw any blood but flushes c̄ any resistance. Anced. 1 bag NS IVPB infusing slowly. will infuse over 30'. —
0800	IVPB completed. AM care done per sch.
0900	pt sleeping. VIS stable. (b)(6)-2 MAJ MC

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

PROGRESS NOTES

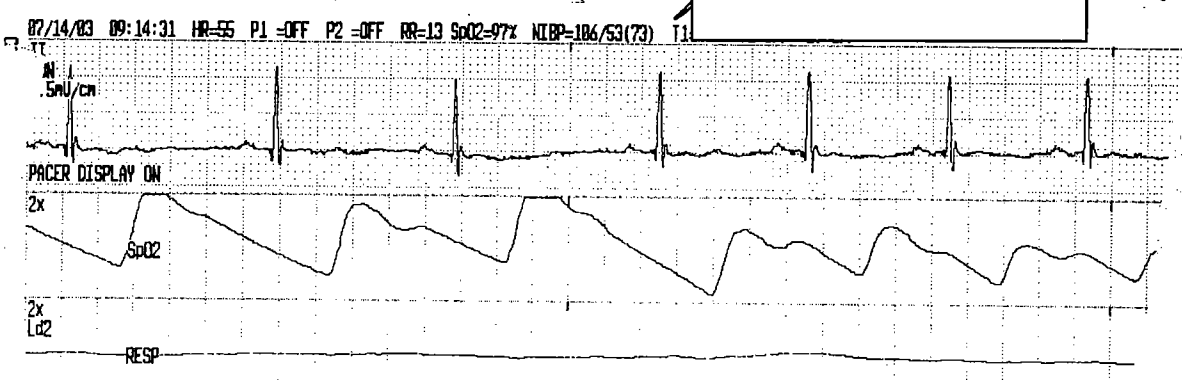
DATE	
1900	Pt requesting pain medication. 2 Tylox administered for pain - CT still to LCS minimal output VSS Pulse ox 99% RA
2100	Pt consumed 200 cc H2O & resting in bed talking c interpreter about medical condition possible allergy to perfume/cologne/fragrance. Pt states through interpreter that seems "itchy" takes a pill back home "cortisone"? "steroid"? Pt Lungs clear, VSS Pulse ox 99% RA will continue to monitor (b)(6)-2
2300	Pt sleeping VSS will continue to monitor (b)(6)-2
0200	Pt requesting pain medication for pain @ CT insertion site - Pulse ox 99% RA Vital Signs stable - Tylox PO for pain (b)(6)-2
0300	Pt sleeping Chest tube drainage <30 cc x 7 hours - VSS (b)(6)-2

14Jul03@0600 Pt ↑ OOB, amb to new bed assignment c steady, even gait & c/o SOB or weakness. Lying in bed @ present, VSS. 98.1 P 63 R 16 BP 110/57 SpO2 97% on RA. CT (L) to 20cm cont' suction. Insertion site dsg CDI. Lungs ~~clear~~ CTA, productive cough, (-) use of IS. (+) bowel sounds. last BM 13Jul p.m. Voids per urinal. Cap Refills <3 secs. SR @ 63 bpm. (+) pulses. skin w/o, intact. CXR done this a.m. HL in (L) arm c s/sx of infx. Receives Ancef. T. 101.8 P 8° Will cont to monitor (b)(6)-2

MEDICAL RECORD	PROGRESS NOTES

DATE

14 Jul 03 0900 pain med effective. States pain is gone. (b)(6)-2 MAJ [illegible]



Voided 500 cc's clear yellow urine per urinal

1100. pt still asleep. VS stable. SaO2 96%. CT to 20cm H2O suction < 20 cc's within past 3°. HR 55, Ø ectopy, 94/42 RR 16 SaO2 98%. Encouraged to use IS. able to move all three balls and hold for sec. x 12. Small amount of bright blood (epistaxis from (R) nare) with manifor. Temp 96.6 (b)(6)-2 MAJ [illegible]

1130 Drsg's done. (L) post near scapula drsg dry. old drsg removed. Wound approx. 2½ cm irregular wound edge c̄ erythema, exudate, or odor. site cleaned c̄ betadine swab and rinsed c̄ saline. Wound bed clean and dry. wet to dry-

(continue on reverse side)

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

REGISTER NO. (b)(6)-2

(b)(6)-4

PROGRESS NOTES MAJ [illegible]
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

PROGRESS NOTES

DATE	
14 July 1240	drsg. applied and secured it c̄ dry 4x4 and occlusive tape. old chest tube drsg. removed. Dry. dry. tube site c̄ gel & drainage, erythema or order. Tender to palpate. small amt of subcutaneous emphysema noted near the tube site. Suture still intact holding the tube. Site cleaned c̄ betadine swab. occlusive petrolium drsg applied around tube. Secured it c̄ dry 4x4. occlusive tape secured. (E) anterior chest drsg Ad. wound approx less than .28 cm and almost all heard & closed. cleaned site c̄ betadine / sterile c̄ saline. Small petrolium gauze drsg applied. Secured it c̄ 4x4 & tape. Chest tube still remaining @ 20cm H_2O suction c̄ minimal ct drainage. Lungs CTA bilaterally (R) > than (L). ↓ breath sound to (L)
1200	lower bases. pt requesting pain med for (2) chest tube pain. pt able to point to pain site. Tylox 2 capsual given P.O for pain. Will evaluate for pain effectiveness. (b)(6)-2
	HR 91 115/57 RR 57. SaO2 95% — MRS RN
1230	ate one orange. Refuse to eat regular food.
	(b)(6)-2
	(b)(6)-2 MRS RN

PROGRESS NOTES

DATE	
14 Jul 03 1915	Report given to on coming shift. (b)(6)-2
1730	Pt alert and oriented, NAD, Vital Signs Stable 106/44 P-66 R-16 Temp 98 @ Lungs clear diminished in the left base + BS x 4 quadrants + UO on day shift - Pt sitting in chair reading magazine Chest tube to low cont. suction, minimal output reported from day shift tube patent 20cm suction Dsg's Clean, Dry and intact — (b)(6)-2
1800	Pt consumed 1/2 of dinner chicken stuffing, and cake oral intake 150cc H_2O — (b)(6)-2
1830	Pt requested pain medication. Ct insertion site? 17 ox x 00/11 — (b)(6)-2
2000	Toradol 30 mg IVP for breakthru pain Settled
2100	Pain ↓ - Pt would like something to make him sleepy - I believe client is requesting pain med for IVP, most effect most IV ordered has been d/c'd - will ask Dr (b)(6)-2 for sleep aid for client (b)(6)-2
2130	10mg ambien ordered for sleep (b)(6)-2
2300	Pt sleeping with signs stable 106/55 P-66 Pulse ox 96% RA — (b)(6)-2
0200	Pt sleeping, VSS, Chest tube to LCS drainage minimal amt of discharge tubing patent no kinks noted Suction machine on — (b)(6)-2

STANDARD FORM 509 (REV. 7-91) BACK
USAPPC V1.00

MEDICAL RECORD	PROGRESS NOTES
DATE	
1300	Resting in bed ∅ discomfort. pain med effective. Denies ⓛ chest tube pain. HR 82 114/52 RR 18 SaO2 97%
1400	CT drainage 30 cc's since 11:00. 111/55 HR 72 RR 20. SaO2 97% (b)(6)-2
1500	20 cc's CT drainage. HR 60, 113/53, RR 12 SaO2 98%. pt sleeping @ this time -
1525	Checked ⓛ antecubital IV site. unable to draw blood but flushes ∅ resistance. Hung 1 gm cancef in 100 ml NS to be infused over 30'. pt attempting to communicate by non-verbal means. Requesting IV pain med. offered p.o. p.o. med but refused @ this time. (b)(6)-2
1600	Resting in bed. HR 75, 124/63, RR 25, 99% on RA. MD's made rounds @ bedside. plan is to transfer pt in 48 to 72°. Waiting for
1620	chest to seal. OOB. ambulated to one end of 10 section temper and back X2 ∅ any difficulty. Denies SOB or ⓛ chest tube pain. Sitting in a chair for now. Chest tube to 20 cm H2O seal. pt stable. (b)(6)-2

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

REGISTER NO.

WARD NO.

(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

MEDICAL RECORD	PROGRESS NOTES
DATE	
15 Jul 03 @ 1746	NN: Assumed care of Patient A+O. Sitting up in bed. Pt tolerated regular diet. Ate about 30% of meal. Ø C/O Pain at this time. Abd Soft non tender pt voids spontaneously IV & L flushes well Ø S/S of infection at IV site PO Abb to move all extremities without obstruction or complication. Chest Tube intact Ø drainage at entrance to chest wall will continue to monitor Pt's status (b)(6)-2 LST/AN
1855	Pt C/O Pain Tylenol 650 mg PO given will continue to monitor Pain status (b)(6)-2 LC
160600 July 03	ABDOMINAL ASSESSMENT: Assumed care of pt. Airway intact, breathing even and unlabored, LS to (R) lung clear in apex, diminished in bases. LS to (L) lung clear in apex and absent in bases. Abd soft, nontender, ↑ distention. Voids spontaneously. BS x 4. BM x 1 this AM. FLOM and neurovascularly intact to all extremities. IV to (L) AC flushes well and ↓ ↑ S/S of infection/infiltration. (b)(6)-2 LST, AN
160730 July 03	NURSING NOTE: Pt would not eat breakfast. Appears that pt just didn't like the food. (b)(6)-2 LST, AN
161530 July 03	NURSING: CT DC'd by MD. Ø C/O SOB or pain ↑ removal (b)(6)-2 LST, AN

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

PROGRESS NOTES

DATE	
0400	Pt OOB to chair - 300cc dark yellow urine - Tylox x 2 for pain - Pt with signs stable 114/58 P-83 R-12 Pulse ox 99% RA - Chest tube to LCS - tubing patent - 200cc soda - (b)(6)-2
15 July 03 0600	NN: assumed care of patient, assesment complete see DA 4700. Patient resting comfortably in bed ⊼ receiving 2 tylox @ 0500 ∅ c/o pain. CT to 20 cm Sv. Will continue to monitor — (b)(6)-2 CPT/AN
15 July 03 0800	NN: Patient up to chair this am. Am care done. Dressing Δ'ed, small amount of drainage to posterior chest wound, other dsg clean. CT to water seal, will do cxray @ 1200. Will continue to monitor — (b)(6)-2 CPT/AN
15 July 03 1200	NN: Cxray done, patient up to chair for whole am. now back in bed, using IS well. Will continue to monitor — (b)(6)-2 CPT AN
15 July 03 1300	Tranfered to ICW. Patient stable, pain controlled ⊼ Tylox. CT to water seal, CXray in AM then plan to pull tube. Report given to ICW staff — (b)(6)-2 CPT MN
15 Jul 03 1325	Nursing: Tra —

(b)(6)-4

STANDARD FORM 509 (REV. 7-91) BACK
USAPPC V1.00

MEDICAL RECORD — PROGRESS NOTES

DATE

17 JUL - A&O x3, PERRLA, LUNGS CTA BILAT, S1-S2 STRONG AND REGULAR, (+) BS x4. PT COMPLAINED Ø PAIN. TOLERATED REG DIET. CONTINUED ANTIBIOTIC THERAPY - ANCEF 1g. RESTING COMFORTABLY WILL CONTINUE TO MONITOR — (b)(6)-2 SGT, USA

18 JUL 03 Nursing Assessment: Pt sleeping, easily aroused. Lungs CTA bilat, HR reg, (+) BS x4. Ø c/o pain @ present. Drsg to (L) flank X2. Anterior drsg CDI, posterior drsg c̄ lrg area dried drainage — (b)(6)-2 LCpl, USA

18 JUL 03 2200 ASSESSMENT - A&O x3, PERRLA, LUNGS CTA BILAT, S1-S2 STRONG AND REGULAR, (+) BS x4, Ø c/o PAIN. DRSG A'd @ 1800, C, D, I to (L) FLANK. TOLERATED REG DIET. ANCEF 1gm @ 2200 TO BE GIVEN WILL CONTINUE TO MONITOR — (b)(6)-2 SGT USA

19 0600 JULY 03 NURSING ASSESSMENT: Assumed care of pt. Pt awake, alert, O x 3. Airway intact, breathing even and unlabored, LS clear to all fields (B) c̄ a cough. Old CT site has sutures c̄ healing the wound completely. Wound to posterior chest has granular bed c̄ minimal purulent drng to wound bed. Wound is approx 1 inch diameter. IV to (R) FA flushes well and is c̄ site of infection or infiltration. — (b)(6)-2 LCpl USA

20 July 03 @ 0315 NSG shift assessment: Pt has appeared to sleep throughout the shift. Denied any pain. Dressing change completed — (b)(6)-2

21 July 03 @ 0230 NSG shift assessment: Dressing change done (pink granulation tissue seen as well as some areas, small, of white material). — (b)(6)-2

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries, give: Name - last, first, middle, grade, rank, hospital or medical facility) — REGISTER NO.

(b)(6)-4

PROGRESS NOTES — Medical Record

STANDARD FORM 509 (REV. 7-91) PRESCRIBED BY GSA ICMR, FIRMR (41 CFR) — GSAPPC V1.00

21Jul03 Nursing Assessment: Pt sleeping, easily aroused. Ø C/O pain.
0720 Lungs CTA, HR reg, (+) BS x4, abd soft, nondistended. Pt is voiding well, BM x1 of loose stool. +2 pulses x 4 extremities. Pt ↑ OOB, amb w/ assist. Wound to (R) chest w/ stitches intact Ø drainage noted. Drsg to (L) flank Δ'd. O/d drsg w/ serous dried drainage. Wound is red w/ white striation, Ø active drainage noted. Reapplied W → D drsg. — LT (b)(6)-2

21 Jul 2003 Nursing: Wound: MD in to remove pt drsg to (L) flank,
1615 Steri-Strips placed & covered w/ opsite — LT (b)(6)-2

21 July 03 Nursing Notes: Assumed care of pt ATO. Pt
@ 1752 tolerated regular diet at about 45%. Ø C/O pain or discomfort at this time. Breathing intact Ø SOB or labored breathing. IVSL flushes well. Pt able to move all extremities without pain or complication. Ø drainage or bleeding noted on dressing to (L) flank. Will continue to monitor pt status — (b)(6)-2 (b)(6)-2 LT/AN

1906 Pt Ambulated to BR, loose stool noted. Ø C/O pain in abd. Will continue to monitor pt's status — (b)(6)-2 LT/AN

2155 Pt Asleep — (b)(6)-2 LT/AN

2320 Dressing changed completed. Wound weeping serous drainage Ø odor noted. — (b)(6)-2 LT/AN

2348. Pt C/O pain 30 mg Toradol IV given. Will continue to monitor pain status — (b)(6)-2

2419 Pt Asleep — (b)(6)-2 LT/AN

MEDICAL RECORD | PROGRESS NOTES

DATE

22 Jul 03 0835 Nursing Assessment: Pt sleeping, Ø c/o pain. Lungs CTA, HR 72, reg; Ⓟ BSX4, abd soft, flat. Sutures to Ⓡ chest intact. Drsg to Ⓡ flank, steri-strips intact, small amt. serous drainage under opsite. Pt ↑ in bed for breakfast. — LCT (b)(6)-2 ANC

0940 Nursing: ADL: Pt ↑ in bed for am care. A'd pt linen on bed & pajamas. Pt ↑ OOB, amb on ward s assist x2. — LCT (b)(6)-2 ANC

23 Jul 03 @ 0300 NSG Shift assessment: Pt had a good appetite this shift eating approx 95% of dinner. Denied any pain when assessed. Resps are even + unlabored. Slept throughout shift, will continue to monitor — (b)(6)-2 CMA

24 Jul 03 @ 0015 NSG Shift assessment: Pt has spent a good deal of the shift either resting quietly in bed, or smiling/talking w/ another EPW. Denied any complaints this shift — (b)(6)-2

24 Jul 03 1630 Nursing: Shift note Pt. sleeping most of shift. Drug change per physician request, heart drug left open. Ø major changes this shift — (b)(6)-2 CPR

(Continue on reverse side)

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

(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

PROGRESS NOTES

DATE	
24Jul03 1724	Nurses Note: Assumed care of pt Alert and Oriented sitting up in bed. Breathing intact Ø SOB or labored breathing Ø c/o pain at this time. Pt tolerated Regular diet. Abd soft and non tender pt able to move all extremities without complaint. Will continue to monitor (b)(6)-2 (b)(6)-2
2200	Dressing change completed. Pt had Ø c/o pain. Voids spontaneously. Will continue to monitor (b)(6)-2 12AM
25Jul03 0715	Nursing Assessment. Pt sleeping, easily aroused. Breakfast at bedside, pt not ready to eat at this time. VSS, Lung CTA; HR w/ reg; (+)BS x4, abd soft, Pt has wound to (L) chest, stitches intact, Ø drainage noted. Drsg to (L) flank c̄ small amt. serous drainage to 2x2. Replaced c̄ new drsg. Ø active drainage noted (b)(6)-2
25Jul03 @ 1747	Nursing Note: Assumed care of Pt A+O. tolerated Regular diet well. Pt sitting up in bed. Breathing intact Ø SOB or labored breathing. Ø IV Access Ø c/o pain or discomfort at this time. Abd soft and non tender pt able to move all extremities without complication. Will continue to monitor status (b)(6)-2
2204	Dressing change complete Ø drainage noted on changed dressing. Will continue to monitor (b)(6)-2
26Jul03 1425	Nursing Discharge Pt cleared for d/c. Medical staff aware of need to provide cont care c̄ Dates, Labs, Medications (b)(6)-2

STANDARD FORM 509 (REV. 7-91) BACK
USAPPC V1.00

558-103 See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY *(Stamp)* (b)(3)-1

LOG NUMBER

ARRIVAL DATE DAY	MONTH	YR.	TIME
09	JUL	03	0850

TRANSPORTATION TO HOSPITAL *(Attach care enroute sheet)*: ☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER *(Specify)*

CURRENT MEDS. *(tetanus immunization and other data)*: ?

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER *(Specify)*

ALLERGIES: ?

PATIENT'S HOME ADDRESS OR DUTY STATION *(City, State and ZIP Code)*: Iraq

HOME TELE. NO. *(Inc. area code)*

CHIEF COMPLAINT(S) *(Include symptom(s), duration)*: GUNSHOT wound

SEX: M AGE:

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 0830

PO298 VITAL SIGNS			100
TIME	0835	0840	0850
BP	113/65	108/53	108/53
PULSE	96	94	98
RESP.	28	26	28
TEMP.			
WT. *(Child)*			

CATEGORY *(See reverse)*: ☐ EMERGENT ☐ URGENT ☐ NON-URGENT

ORDERS	INITS.	TIME

ASSESSMENT/DIAGNOSIS: GSW To Chest

DISPOSITION *(Check all that apply)*: ☐ HOME ☐ FULL DUTY

QUARTERS: ☐ 24 Hrs. ☐ 48 Hrs. ☐ 72 Hrs.

MODIFIED DUTY UNTIL: DAY MONTH YEAR

REFERRED TO *(Indicate clinic)*: Gen Surg

☒ EMERGENCY ☐ TODAY ☐ 72 HOURS ☐ ROUTINE

ADMIT. TO HOSP. UNIT/SERVICE: ICU.

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

TIME OF RELEASE:

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

TOI 0520

S: Pt is ~30yo Iraqi o/ S/p GSW to (L) Chest by US Forces
Pt had a (L) Chest Tube placed @ BAS + b.b Helo.
Pt had attempted to overrun a sniper OP and was shot in chest.

O: Was in severe distress 2° to GSW to Chest; mod Respiratory
HEENT: nm.
Chest Small 1/2 cm GSW to ant Chest wall ~4Th Rib mid Clavicle
Lg 1" GSW to (L) 7Th Rib area, post Ax line.
Lungs: ↓ BS on (L), wet Sounding BS.
Cor RRR (-) (M): (-) pericardial effusion by U/S.
Abd: (-) BS. Tense, Distended + gen Tender
FAST (-) (+) Fluid around (R) Kidney/Liver area
(-) Bld @ (L) Kidney/Spleen.
Ext: Atraumatic N/V intact.

PMH?

24 14 42 353
Yel, Clr 1.030
Tr Bld, Sm Leu
139 107 7 1.2
4.2 22 168
CK 663.
LFT's WNL
7.28/49/79/41/94

PATIENT'S IDENTIFICATION *(Mechanical imprint)*
FOR WRITTEN ENTRIES GIVE: *Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).*

(b)(6)-4

(b)(6)-2

(b)(6)-2

SIG ... SF 507, IF NEEDED) ... ND ID STAMP

... ns ordered, any limitations and follow-up

To ICU.

MEDCOM - 6829 ... ATMENT
Medical Record Copy

STANDARD FORM 558 (Rev. 6-82)
Prescribed by GSA and ICMR

510-112

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
16 July 03		1800	NN: Assumed care of Pt Alert and Oriented. IV SL flushes well. Breathing intact ∅ SOB or Labored breathing ∅ C/O pain or discomfort at the time. dressing to chest wall intact ∅ drainage or bleeding noted. Chest tubes removed today. Pt able to move extremities without complication. Abd soft and non tender. Pt voids spontaneously clear yellow urine noted in bedside urinal. Will continue to monitor Pt's status — (b)(6)-2
		2100	Pt Asleep ∅ complain. Stable at this time — (b)(6)-2
17 Jul 03		1700	Nursing: Shift Assessment Pt. c̄ slight cough this shift. Upper airway c̄ slight wheezes, tolerating ambulating w/o SOB. CXR complete. Drg. D&T. Continue to assess for ↓ pat, SOB, P/S inspection which are all ⊖ at present — (b)(6)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

NURSING NOTES

Medical Record

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

MEDCOM - 6830

(b)(6)-4

NSN 7540-00-634-4124

EDICAL RECORD — VITAL SIGNS REC

HOSPITAL DAY																							
July	DAY	15		16		17			18		18			19		20	21						
NTH-YEAR 2003	DAY	Tuesday		Wed																			
19	HOUR	1400	2200		1400	0000	0600	1400	2200	0600	1000	2100	0420	0400	1445	1845	2200	0000	0400	0800	1200	0000	0200	0000	
PULSE (O)	TEMP. F (•)																							TEMP. C
	105°																							40.6°
180	104°																							40.0°
170	103°																							39.4°
160	102°																							38.9°
150	101°																							38.3°
140	100°																							37.8°
130	99°																							37.2°
	98.6°																							37.0°
120	98°																							36.7°
110	97°																							36.1°
100	96°																							35.6°
90	95°																							35.0°
80																								
70																								
60																								
50																								
40																								
RESPIRATION RECORD		20	9		20	12					1	16	8	0			18	8						
BLOOD PRESSURE		114/55	104/53		119/66	113/56	113/59	117/59	101/58	101/58		132/71	107/61	107/59			110/58	106/74	114/70	115/80				
HEIGHT:	WEIGHT →																							
	O^2	97%	95%		95%	96%	95%	95%	96%	96%	97	96%	97%		96		97%	96%	97%					

(Centigrade Equivalents, for Reference only)

Record special data only when so ordered

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

(b)(6)-4

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.2

MEDICAL RECORD — VITAL SIGNS REC

HOSPITAL DAY: 14 15 16 17

POST- DAY

MONTH-YEAR: 19 | DAY: 20th 21 22 23 24 25 26

HOUR

PULSE (O) | TEMP. F (•)

TEMP. C (Centigrade Equivalents, for Reference only)

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

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER (b)(6)-4

WARD NO.

STANDARD FORM 511 (REV. 7–95) BACK

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

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
EPW (b)(6)-4	09JUL03	0830	(b)(6)-4

Hematology

TEST	RESULT	REF. RANGE
WBC	24.2	4.8-10.8 x 10^3
RBC	4.85	4.7-6.1 x 10^9
Hgb	13.8	14-18 g/dl (M) 12-16 g/dl (F)
Hct	42.2	42-52% (M) 37-47% (F)
MCV	87.0	80-94 fl (M) 81-99 fl (F)
Plt	353	130-500 x 10^3 verified
Lymph %	5.7	20.5-51.1%

Differential (manual)

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

TEST	RESULT	REF. RANGE
Color	Yellow	N/A
App	Clear	N/A
Glu	NEG	Negative
Bili	NEG	Negative
Ket	NEG	Negative
SG	1.030	N/A
Bld	TRACE	Negative
pH	5.0	N/A
Prot	NEG	Negative
Urob	0.2	0.2-1.0
Nit	NEG	Negative
Leuk	NEG	Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microbiology Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

UNIT	TYPE	CROSSMATCH

REMARKS: TYPE & SCREEN

REPORTED BY:	DATE:	LAB ID NO.:

Chem 12

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

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

TEST	RESULT	REF. RANGE
ALB	3.5	3.5-5.5 g/dl
ALP	54	26-84 u/l
ALT	22	10-47 u/l
AMY	18	14-97 u/l
AST	39 *	11-38 u/l
TBIL	0.4	0.2-1.6 mg/dl
BUN	6 *	7-22 mg/dl
CA++	8.4	8.0-10.3mg/dl
CHOL	115	100-200 mg/dl
CRE	1.0	0.6-1.2 mg/dl
GLU	169 *	73-118 mg/dl
TP	6.1 *	6.4-8.1 g/dl

TEST	RESULT Met 8	REF. RANGE
GLU	168 *	73-118 mg/dl
BUN	7	7-22 mg/dl
CRE	1.2	0.6-1.2 mg/dl
CK	663	39-380 u/l (M) 30-190 u/l (F)
NA+	139	128-145 mmol/l
K+	4.2	3.3-4.7 mmol/l
CL-	107	98-108 mmol/l
tCO2	22	18-33 mmol/l

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

TEST	RESULT Liver Panel	REF. RANGE
ALB	3.5 g/dl	3.3-5.5 g/dl
ALP	54	26-84 u/l
ALT	22	10-47 u/l
AMY	18	14-97 u/l
AST	39	11-38 u/l
TBIL	0.4	0.2-1.6 mg/dl
~~GGT~~		5-65 u/l
TP	6.1	6.4-8.1 g/dl

TEST	RESULT	REF. RANGE
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO2		18-33 mmol/l

REMARKS:

REPORTED BY: | DATE: | LAB ID NO.:

Ward/Section:	REQUESTING PHYSICIAN: (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. (b)(6)-4	DATE	TIME	SSN/PSEUDO SSN: (b)(6)-4

Hematology CBC

TEST	RESULT	REF. RANGE
WBC	12.5	4.8-10.8 x 10^3
RBC	4.40	4.7-6.1 x 10^9
Hgb	12.4	14-18 g/dl (M) 12-16 g/dl (F)
Hct	38.3	42-52% (M) 37-47% (F)
MCV	86.9	80-94 fl (M) 81-99 fl (F)
Plt	263	130-500 x 10^3 verified
Lymph %	12.6	20.5-51.1%

Hematology Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

ICSF

Cell Count		
Directigen		Negative

Misc Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: (b)(6)-2	DATE: 09 Jul 03	LAB ID NO.:

Ward/Section: ICU	REQUESTING PHYSICIAN: Dr. (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. (b)(6)-4	DATE 8/26/03	TIME 1150	SSN/PSEUDO SSN: (b)(6)-4

Hematology/CBC

TEST	RESULT	REF. RANGE
WBC	18.7	4.8-10.8 x 10^3
RBC	4.47	4.7-6.1 x 10^9
Hgb	12.7	14-18 g/dl (M) 12-16 g/dl (F)
Hct	38.8	42-52% (M) 37-47% (F)
MCV	86.9	80-94 fl (M) 81-99 fl (F)
Plt	267	130-500 x 10^3 verified
Lymph %	6.7	20.5-51.1%

Hematology/Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

ICSF

Cell Count		
Directigen		Negative

Misc Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICU	REQUESTING PHYSICIAN: (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST FIRST MI: (b)(6)-4	DATE: 10 Jan 1	TIME: 0850	SSN/PSEUDO SSN: (b)(6)-4

Hematology/RBC

TEST	RESULT	REF. RANGE
WBC	7.4	4.8-10.8 x 10^3
RBC	3.74	4.7-6.1 x 10^9
Hgb	10.8	14-18 g/dl (M) 12-16 g/dl (F)
Hct	32.0	42-52% (M) 37-47% (F)
MCV	85.6	80-94 fl (M) 81-99 fl (F)
Plt	210	130-500 x 10^3 verified
Lymph %	24.7	20.5-51.1%

Hematology/Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

TOSF

Cell Count		
Directigen		Negative

Misc Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

NSN 7540-01-165-7294

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

519-301

EXAMINATION(S) REQUESTED

PCXR

AGE	SEX	SSN (Re...	WARD/CLINIC	REGISTER NO.
	M	(b)(6)-4	ICU	

FILM NO.

REQUES... (b)(6)-2

PREGNANT ☐ YES ☐ NO

TELEPHONE/PAGE NO.

SIG... (b)(6)-2

DATE REQUESTED

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

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

RADIOLOGIC REPORT

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

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

MEDCOM - 6838

RADIOLOGIC CONSULT...

NSN 7540-01-185-7294

519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN *(Sponsor)*	WARD/CLINIC	REGISTER NO.
CXR		M	(b)(6)-4	ZCW	
	FILM NO.				PREGNANT ☐ YES ☒ NO
	REQUESTED BY *(Print)*		(b)(6)-2		TELEPHONE/PAGE NO.
	(b)(6)-2		TOR	LCDR	DATE REQUESTED 16 July 03

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

CT

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

RADIOLOGIC REPORT

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*	LOCATION OF MEDICAL RECORDS
(b)(6)-4	LOCATION OF RADIOLOGIC FACILITY
	SIGNATURE

MEDCOM - 6839

ATION REQUEST/REPORT

STANDARD FORM 519-B (8-83)
Prescribed by GSA/ICMR

NSN 7540-01-165-7294

519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
Chest x-ray			(b)(6)-4		
	FILM NO.				PREGNANT ☐ YES ☐ NO
	REQUESTED BY (Print) (b)(6)-2				TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR				DATE REQUESTED 17JU403

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

PT had chest tube

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

RADIOLOGIC REPORT

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

(b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION

MEDCOM - 6840 T

RD

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

NSN 7540-01-185-7294

519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN *(Sponsor)*	WARD/CLINIC	REGISTER NO.
CXR		M	(b)(6)-4	ICW	
	FILM NO.				PREGNANT ☐ YES ☒ NO
	REQUESTED BY *(Print)* Dr. (b)(6)-2				TELEPHONE/PAGE NO.
SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*	(b)(6)-2			TOR	DATE REQUESTED 19 J-1, 03

S/P CT removal

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

RADIOLOGIC REPORT

ed or written entries give: y)	LOCATION OF MEDICAL RECORDS
	LOCATION OF RADIOLOGIC FACILITY
	SIGNATURE

MEDCOM - 6841

RADIOLOGIC CONSULTATION

STANDARD FORM 519

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 7/8 TIME OF ORDER HOURS | LIST TIME ORDER NOTED AND SIGN

1. Admit ICU
2. Sp GSW chest
3. Chest tube to -20
4. Foley to gravity
5. CXR qAM
6. Labs: CBC q 4° x 24° starting at 12 Noon
7. NPO

CPT/MN 1030 7/9/03

(b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

8. IVF LR @ 150 cc/hr
9. Incentive spirometer
10. Ancef 1g ivp q8
11. Morphine 2-4 mg ivp q1° prn pain

NURSING UNIT	ROOM NO.	BED NO.

(b)(6)-2

(b)(6)-2 MA-USMC

noted

PATIENT IDENTIFICATION

DATE OF ORDER 7/8 TIME OF ORDER 1400 HOURS

1. D IVF 50/hr
2. Clear diet. Advance as tolerated to regular

1400 (b)(6)-2 MA

(b)(6)-2

MA-USMC

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 7/9/03 TIME OF ORDER 1700 HOURS

D/C Q4° CBC

Obtain CBC in am 7/9/03

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

1200

NURSING UNIT	ROOM NO.	BED NO.
24°	(b)(6)-2	

(b)(6)-2 CPT MN 7/9/03

FORM 425 1 APR 79 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER: 10 Jul 03 TIME OF ORDER: 1530 HOURS

LIST TIME ORDER NOTED AND SIGN

① Toradol 30mg IV now + q6° prn pain. 1530 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER: 10 July 03 TIME OF ORDER: 2130 HOURS

① 1 Liter Ringers x 1 now

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

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

PATIENT IDENTIFICATION

Transcribed 0830 hrs 10 July 03 (b)(6)-2

DATE OF ORDER: 10 July 03 TIME OF ORDER: 2245 HOURS

① Neb Tx x 1 (.5 albuterol / 5cc NS)

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

(b)(6)-2

NURSING UNIT: Jip chart | ROOM NO. | BED NO.: None

(b)(6)-2

0330 11 July

PATIENT IDENTIFICATION

DATE OF ORDER: 12 July 03 TIME OF ORDER: 0800 HOURS

X ① Heplock 1UF noted

X ② Colace PO 100mg BID (b)(6)-2

X ③ Tylox 1-2 caps PO Q 4-6° prn pain. 0820

X ④ DIC MSO4 CPT/AN / Dr (b)(6)-2 12 July 03

VO: J (b)(6)-2 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

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

☆ U.S. GPO: 1983-363-710

MEDCOM - 6843

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 14 Jul 03 TIME OF ORDER: 2030 HOURS

LIST TIME ORDER NOTED AND SIGNED

(1) Ambien 10 mg ~~T~~ po q HS prn insomnia (b)(6)-2

(b)(6)-2

(b)(6)-2

NURSING UNIT: ICU ROOM NO. BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 15 July 03 TIME OF ORDER: 1230 HOURS

(1) Change VS to Q4° ~~c~~ HO

(2) Transfer to ICU (b)(6)-2

(3) CT to waterseal 7/15/03

VO: Dr (b)(6)-2 / J (b)(6)-2 1230

NURSING UNIT ROOM NO. BED NO.

24° chart ✓ 15 July @ 2241 (b)(6)-2 15/AW

PATIENT IDENTIFICATION

DATE OF ORDER: 7/16 TIME OF ORDER: 0700 HOURS (b)(6)-2

(1) CTA now and qAM (b)(6)-2 AW

(b)(6)-2 NATHAN D 16 July 03 0800

NURSING UNIT ROOM NO. BED NO.

24° chart ✓ 17 July 03 @ 0105 (b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER: 18 July 03 TIME OF ORDER: 1146 HOURS

noted 1100 18 July (b)(6)-2

D5W-D drsg Δ bid ~~T~~ NS

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

19 July 03 0730 (b)(6)-2 AW

20 July 03 24° chart ✓ (b)(6)-2

NURSING UNIT ROOM NO. BED NO.

23 July 24° chart ✓ (b)(6)-2

24 July 24° sheet used (b)(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
7/9	730 HOURS	
① D/C Foley		0730 (b)(6)-2
	(b)(6)-2	

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
7/11	0700 HOURS
① D/C Ancef	
② D/C Xray	
(b)(6)-2	(b)(6)-2
	MAT (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
7/22	2000 HOURS
① Ambien 10mg po tonight and qhs	
(b)(6)-2	

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
7/25	0700 HOURS
① D/C today to EPW cup	

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD

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

Mo. 07 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 09	10	11	12	13	14	15	16	17	18	19	20	21	22
7/9/03	(b)(6)-2	Chest tube to 20cm	05	(b)(6)-2													
		suction	17	(b)(6)-2													
7/9/03		Foley to gravity	05	(b)(6)-2													
			17	(b)(6)-2													
7/9/03		Cxray Q AM	04														
7/9/03		Labs; CBC Q4°	04														
		x24° starting @	08														
		1200hrs	12	(b)(6)-2													
			16														
			20														
			24														
7/9/03	(b)(6)-2	diet: NPO	05	(b)(6)-2													
			17														
7/9/03		Incentive Spirom	05	(b)(6)-2													
			17														
9 July 03		Clear liquid diet	05														
		Advance as tolerated to	17														
		Regular															
7/15/03	(b)(6)-2	CT to water seal	05														
			17														
15 July		VS Q4° c I+O	05														
			17														
16	(b)(6)-2	CXR q AM	06														
18 July		W-D drsg Δ BID	06														
		TNS	18														

ALLERGIES: ☐ YES ☐ NO
unknown

PRIMARY DIAGNOSIS:
S/p GSW (L) chest

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

PATIENT IDENTIFICATION:
(b)(6)-4

(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*				Mo 07 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
07 July 2003	(b)(6)-2	CBC in am	10 July	0400	0340	(b)(6)-2
		DC CXR	2003		0800	

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

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CLINICAL RECORD

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

Mo. 07 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 20	21	22	23	24	25	26	27	28	29	30
20 Jul 03	(b)(6)-2	VS Q Shift	6	/	/	(b)(6)-2								
			14	/	/									
			22	(b)(6)-2										
24 Jul 03	(b)(6)-2	VS BID	5	/	/	/	/	(b)(6)-2						
			22	/	/	/	/							
24 Jul 03	(b)(6)-2	Regular Diet	6	/	/	/	/	(b)(6)-2						
			12	/	/	/	/							
			17	/	/	/	/							
24 Jul 03	(b)(6)-2	Act. OOB ambulate	5	/	/	/	/	(b)(6)-2						
		EPW Prot	17	/	/	/	/							

ALLERGIES: ☐ YES ☐ NO

unknown

PRIMARY DIAGNOSIS:

S/P GSW (L) chest

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

CLINICAL RECORD

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

Mo. 07 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 09	10	11	12	13	14	15	16	17	18	19	20	21	22
7/9/03	(b)(6)-2	LR @ 150 cc/°	05	(b)(6)-2								Order	Δd				
			17										age 03				
7/9/03		Ancef 1gm IVPB	08	(b)(6)-2											(b)(6)-2		DC
		Q 8°	16														
			24												(b)(6)-2		
age 07		IVF: LR @ 50 cc/hr	05	(b)(6)-2					DC		7/12/03						
			17														
7/12/03		HL IVF - flush	08				(b)(6)-2										
		TID	16														
			24														
7/12/03		Colace 100mg PO	10														
		BID	22														

ALLERGIES: ☐ YES ☐ NO
unknown

PRIMARY DIAGNOSIS:
S/p GSW (R) chest

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

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. 07 Yr. 03			
Order Date / Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
10 July (b)(6)-2	Toradol 30mg IVP now	10 July 03	1530	1530	(b)(6)-2
10 JM	1 Liter Bolus x1 now	Dore	2230		
10 JM	neb Tx x1 now .5cc albuterol 5cc NS	Dore	2300		
2400	D/C ANCLF			0800	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
9 July	(b)(6)-2	MSO4 2-4mg	7/9 1015	7/9 1600	7/9 2115	7/10 0190	7/10 0350	7/10 0720	7/10 0850	10 Jul 1030	10 July 1400	10 July 1800	10 July 2000	11 July 0100	11 July 0300	11 July 0930
		IVP Q 1° prn	4mg	2mg	4mg	4mg	3mg	2mg	4mg	4mg IVP	4mg IVP	4mg IVP	4mg	4mg	4mg IVP	2mg IVP
		pain	(b)(6)-2													
	(b)(6)-2	Toradol 30mg IV Q6°	D	7/11 0600	7/11 1200	7/11 1850	7/12 0415	7/13 0210	7/13 1030	7/13 1445	7/21 2000	7/21 2248				
		prn	T	30mg IVP	30mg IVP	30	30	30	30	30	30mg					
			F	(b)(6)-2												
			E													
11 July	(b)(6)-2	Tylenol 650mg	7/11 1500	7/11 1700	7/15	7/15 1855										
		PO Q 4° prn	2PO													
9 July	(b)(6)-2	MSO4 2-4mg	10 July 1030	11 July 1730	11 July 2330	11 July 2200	12 July 0315									
		IVP Q1° prn	2mg IVP	2	2	3	4									
		pain														
9 July	(b)(6)-2	Tylox 1-2caps PO Q 4-6° prn pain	7/12 0830	7/12 1330	7/12 1900	7/13 0145	7/13 0500		13 1900	13 0220	14 July 0700	14 July 1200	14 July 1820	15 July 0500	7/15 0900	7/15 1300
			2PO	2PO	2 PO	2 PO										

MEDCOM - 6850

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

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

Mo. ____ Yr. ____

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED													
				23	24	25											
23 Jul 03	(b)(6)-2	Colace 100mg po bid	10	(b)(6)-2													
			22														

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/P GSW Chest

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED													
July	(b)(6)-2	Ambien 10mg	July 2100	July 2230	July 2300											
- - - -	- - - - -	i po QHS prn	(b)(6)-2		(b)(6)-2			(b)(6)-2								
15 July	(b)(6)-2	Tylox 1-2caps PO	7/15	7/16				2235 (b)(6)-2								
- - - -		Q4-6° prn pain	2347	1510												
- - - -	- - - - -		(b)(6)-2													
- - - -	- - - - -															
- - - -	- - - - -															
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MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)* QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0930	INITIALS (b)(6)-2	1730	INITIALS (b)(6)-2		INITIALS
NEURO	PUPILS	Pupils 3mm equal		Pupils = @ 3mm			
	SENSORIUM	and reactive to light c/o		pt. A + O x 3			
		(L) side pain. MOS x4		language barrier,			
		Head gauze removed,		interpreter present			
RESPIRATORY	RESPIRATORY PATTERN	Clear + ~~[illegible]~~ labored		Unlabored + even			
	BREATH SOUNDS	C pain. Deep ~~[illegible]~~		↓ to (R) ~~[illegible]~~ bases			
	SECRETIONS	(L) side c diminished breath		(R) side CTA			
		sounds. CT no auscultation		CT to (L) side on CS			
		to (L) lung. No evidence		O2 @ 2LPM via NC			
		of rales + rhonchi. VMS [illegible]		CT rub heard			
SKIN	COLOR	Normal for race		Normal for race		Exit wound to (L)	
	INTEGRITY	Entrance Wound Closed		Entrance wound to		posterior chest. CDI	
		Covered 4x4. Exit Wound		(L) upper chest - 4x4 CDI		DRSG	
IV SITE	LOCATION	[illegible]		(R) wrist [illegible]			
	CONDITION	opening. Cleaned [illegible] ABD		50cc/HR @ SS infiltration			
		Pad applied.		(L) AC 18G,			
		IVS: (L) AC Replaced		saline locked. @			
		(L) Wrist to LR @		SS infiltration,			
		150 cc/hr		good flash			
GASTRO	ABDOMEN	DS x 4, Abdomen		Soft, non-distended			
	BOWEL SOUNDS	soft, no pain upon		BS x4 (+), active			
		palpation. Bowel sounds					
		hyperactive					
GU	URINE:	Foley to gravity		Foley to gravity			
	COLOR/CLARITY	Clear yellow urine.		clear yellow			
				urine			
CARDIOVASCULAR	CARDIAC RHYTHM	Sinus Rhythm to		SR - tachy @ 99			
		Sinus to Sinus Tach		BPM			
		PR .16, QRS .08, no PVCs		(+) pulses x4			
		noted. Pulses [illegible] to		extremities, c-p			
		all extremities		refill <3 secs.			

LEGEND
Cr - Creatinine
F_IO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY *(Signature & Title)* (b)(6)-2 [illegible]

DEPARTMENT/SERVICE/CLINIC: ICU Quest

DATE: 9 July 2003

PATIENT'S IDENTIFIC[illegible] *middle; grade; d[illegible]* [illegible]ries give: *Name—last, first, [illegible]ty)*

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

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

☐ DIAGNOSTIC STUDIES

☐ TRE[illegible]T

DATE	DX													HOSPITAL DAY				
VITAL SIGNS — TIME	~~05~~	~~06~~	~~07~~	~~08~~	~~09~~	~~10~~	~~11~~	~~12~~		~~13~~	~~14~~	~~15~~	~~16~~	~~17~~	~~18~~	~~19~~		
BP Arterial Line																		
BP Cuff					123/54	115/55	107/48	107/54		107/54	118/60	111/53	105/57	112/50	120/72	106/50	102/48	
Temperature					98.9						98.8		98.8				98.7	
Pulse					107	85	85	75		93	96	85	90	90	109	79	78	
Respiratory Rate					34	22	21	25		24	29	20	20	20	24	17	20	
q15					136/63	110/56												
HR					107	92												
q30					134/68	107/48												
HR					96	89												
q45					136/68	89/48												
HR					104	83												
SaO2					100%	100%	100%			100%	100%	100%	100%	100%	100	100	97	
O2					100%	35%	35%			35%	4LNC	4L/NC	4LNC	4L	2LNC	2LNC	RA	
intervention																		
INTAKE — TIME	~~05~~	~~06~~	~~07~~	~~08~~	~~09~~	~~10~~	~~11~~	~~12~~	8°T	~~13~~	~~14~~	~~15~~	~~16~~	~~17~~	~~18~~	~~19~~		8°T
IV						150	150	150	450	150	50	50	50	50	50	50	50	
LR																		
TOTALS																		
OUTPUT — URINE HOUR/TOTAL					150/150	150/300	150/450			200/650	200/850	100/950	50/100	50/1050	60	100	80	1290
URINE sp gr																		
URINE S/A																		
NG OUTPUT																		
NG pH																		
NG GUIAC																		
EMESIS																		
~~STOOL~~ CT output							60	28		20	40	15	0	15				
DRAINS CT Total						128	182	210		280	270	285	285	300				
DRAINS																		
DRAINS																		
TOTALS																		

POST-OP DAY	21	22	23	24	01	02	03	04	
VITAL SIGNS	16	17	18	19	20	21	22	23	
	102/48	110/49	116/52	104/54	103/48	105/53	103/46		
				98.2			98.1		
	87	85	81	85	82	83	68		
	29	24	20	23	18	99	18		
	96	96	98	95	97	99	100		
	RA	RA	RA	RA	2L NC	2L NC	2L NC		
	21	22	23	24	01	02	03	04	
INTAKE	16	17	18	19	20	21	22	23	8° T
	50	50	50	100	50	50	50	50	1400
OUTPUT	70	90	100	60	70	70	80	50	1700
								100	400
								400	400

ACUITY LEVEL CLASSIFICATION

RESPIRATORY											
TIME		0830									
MODE		105h									
F_IO_2		NSB									
TV		~~[illegible]~~									
RATE											
PEEP											
ARTERIAL BLOOD GAS	A	pH	7.28								
		PCO_2	49								
		pO_2	79								
	B	HCO_3									
		SAT	94%								
	G	BASE	-4								

LABORATORY DATA											
TIME		0848	1150	1600							
GLUCOSE		168									
Na/K		139/4.2									
Cl/CO_2		102/35									
BUN/Cr		7/.2									
WBC/PLATELET		34.8/333	15.7/267	12.0/263							
Hct/Hgb		42.8/13.8	38.4/12.7	38.3/12.4							

ACTIVITIES OF DAILY LIVING											
TIME					TURN	TIME					
MOUTH CARE											
BATH											
SKIN CARE											
FOLEY CARE					SUCTION						
TRACH CARE											
ROM EXERCISES											

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE _____

NURSE'S SIGNATURE	INITIALS
(b)(6)-2	(b)(6)-2

NEUROLOGICAL ASSESSMENT

		HOURS	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20
COMA SCALE	EYES OPEN	SPONTANEOUSLY 4																
		TO SPEECH 3																
		TO PAIN 2																
		NO EYE OPENING 1																
	BEST VERBAL RESPONSE	ORIENTED 5							✓									
		CONFUSED 4																
		VERBALIZES 3																
		VOCALIZES 2																
		NO VOCALIZATION 1																
	BEST MOTOR RESPONSE	OBEYS COMMANDS 6							✓									
		LOCALIZES PAIN 5																
		FLEXION WITHDRAWAL 4																
		ABNORMAL FLEXION 3																
		EXTENSION TO PAIN 2																
		NO MOTOR RESPONSE 1																
LIMB MOVEMENT	ARMS	NORMAL POWER							4L									
		MILD WEAKNESS																
		SEVERE WEAKNESS																
		ABNORMAL FLEXION																
		ABNORMAL EXTENSION																
		NO RESPONSE																
	LEGS	NORMAL POWER																
		MILD WEAKNESS																
		SEVERE WEAKNESS																
		ABNORMAL FLEXION																
		ABNORMAL EXTENSION																
		NO RESPONSE																
PUPILS	RIGHT	SIZE							3L									
		REACTION							+									
	LEFT	SIZE							3									
		REACTION							+									
PUPIL SCALE			● 2		● 3		● 4		● 5		● 6		● 7 mm					
ICP																		
CEREBRAL PERFUSION PRESSURE																		

LEGEND

C Closed by swelling

T Trach/Endo
S Slurring
D Dysphasia
R Receptive
E Expressive

R Right
L Left

Record separately if there is a difference between the two sides.

++ Brisk
+ Slow
- No Response

+ Intact
- Abnormal

VASCULAR ASSESSMENT

		HOURS	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20
Radial	R L																	
Dorsalis Pedis	R L																	
	R L																	
	R L																	
	R L																	

LEGEND

++ Normal
+ Weak
- Absent
D Doppler
R Right
L Left

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0500	INITIALS (b)(6)-2	INITIALS	INITIALS
NEURO	PUPILS	Pupils 3mm Brisk. Equal		Pupil Equal reactive	
	SENSORIUM	+ Round. Alert + oriented		to light 3mm	Same as
		x3. Follows commands		A&O attempts to	prior note
		appropriately. Given 3mg		communicate	
		Morphine IVP for c/o pain		language barrier	
RESPIRATORY	RESPIRATORY PATTERN	Even + Unlabored. ~~deep~~		shallow breaths	CT output 35 cc 55
	BREATH SOUNDS	Lungs Diminished bases		Lungs CTA - diminished	x12 hours
	SECRETIONS	Sounds throughout all		bilat - Leg to	
		fields. CT Insert to		(L) side, ∅ drainage	
		(L) side. Serous sanguinous		at this time.	
		Drg stained. CT Psg D+I			
SKIN	COLOR	Normal for race. No		normal for race	
	INTEGRITY	evidence of skin breakdown			
		Extreme wound to cheek D+I			
IV SITE	LOCATION	18G to (R) wrist I		18G IV cath (R) wrist	1L bolus
	CONDITION	LR running @ 50 cc/hr.		infusing LR @ 50 cc/hr	
		(L) AC Hep locked. Pended		18G IV cath (L) AC	
		+ patent		HL ∅ S&S of infl	
				both sites patent	
				and flushed	
GASTRO	ABDOMEN	BS X4 Quadrants.		BS hyperactive x	
	BOWEL SOUNDS	abdomen ↓ distention		4 quad - ∅ ate nuts	
		↑ tenderness upon		and H2O for dinner	
		palpation			
GU	URINE:	Foley to Gravity		Foley d/c'd no	950 void ∅
	COLOR/CLARITY	Clear Yellow Urine		void at this time 1800	Foley d/c
				will monitor	
CARDIOVASCULAR	CARDIAC RHYTHM	S1 + S2 Auscultated.		NSR @ 80's	
		PR - 16 bmp. 12. Cap		Thrombolast	
		Refill less than 3 seconds			
		Rhythm on NSR 5			
		ectopy. Pulses 2+ to all extremities			

LEGEND: Cr - Creatinine; F_IO_2 - Fraction of Inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; S/A - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title) (b)(6)-2 [redacted] mgr/AN

DEPARTMENT/SERVICE/CLINIC ICU Quest

DATE 10 July 03

PATIENT'S IDENTIFICAT[redacted]ive: Name—last, first, middle; grade; date; hospital or medical facility)

(b)(6)-4 [redacted]

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE | DX | HOSPITAL DAY

VITAL SIGNS																		
TIME	04	05	06	07	08	09	10	11		13	14	15	16	17	18	19	20	
BP Arterial Line	05	06	07	08	09	10	11	12	E	13	14	15	16	17	18	19	20	
BP Cuff	138/60	138/68	120/58	113/56	120/57	101/51	127/59	116/59		118/57	113/49	118/61	103/57	118/68	116/57	110/52	113/55	
Temperature	97.5						97.7				97.4		98.1		98.7	98.7	98.8	
Pulse	83	76	98	89	93	92	76	85		78	94	89	91	98	92	93	90	
Respiratory Rate	28	26	32	27	25	24	19	19		19	22	16	22	15	25	27	30	
SaO2	100%	100%	98%	97%	98%	98%	97%	98%		98%	99%	98%	100%	100%	99%	98%	98%	
O2 Source	2L NC	2L NC	RA	RA	2L NC	2LNC	2L NC	2L NC		2L NC	2L NC	2L NC	[illegible]	4LNC	4L	4L	4L	
													4L NC		NC	NC	NC	
pain																		
intervention																		

INTAKE																			
TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
LR	50	50	50	50	50	50	50	50	400	50	50	50	50	50	50	50	50	800
po					500				500						20		100	1220
IVPB													50					50
TOTALS									900									2300

OUTPUT																			
URINE	HOUR	50	25	100											0	0	0	0	
	TOTAL	50	75	175															175
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS	CT	0		20	—	—	—	—		—	—	30		30	0	—	—	—	
	CT TOT	400		420								450		480	480				480
TOTALS																			

POST-OP DAY

VITAL SIGNS									
	16	17	18	19	20	21	22	23	
	21	22	23	24	01	02	03	04	
	104/46	114/54	126/62	114/55	122/60	110/53	104/51	104/53	
	/	/	/	/					
	78	92	96	95	92	83	71	71	
	22	33	30	20	20	15	17	17	
	98	98	98	98	98	98	98	98	
	UL	UL	UL	UL	UL	UL	UL	UL	
	NC	NC	NC	NC	NC	NC	NC	NC	

INTAKE									
	16	17	18	19	20	21	22	23	8°T
	50	1000	50	50	50	50	50	50	1350
				50					
									370

OUTPUT									
	0	0	0	950	0	0	0	0	950
			Bolus						
	—	30	/	/	/	/	/	5	515
									1465

ACUITY LEVEL CLASSIFICATION

RESPIRATORY THERAPY										
	TIME									
	MODE									
	F_iO_2									
	TV									
	RATE									
	PEEP									
A	pH									
A	PCO_2									
A	pO_2									
B	HCO_3									
B	SAT									
G	BASE									

LABORATORY DATA										
	TIME	0900								
	GLUCOSE									
	Na/K									
	Cl/CO_2									
	BUN/Cr									
	WBC/PLATELET	7.4 / 310								
	Hct/Hgb	22.0 / 10.8								

DAILY ACTIVITIES DOING										
	TIME									
	MOUTH CARE									
	BATH									
	SKIN CARE									
	FOLEY CARE									
	TRACH CARE									
	ROM EXERCISES									

TURN	TIME					

SUCTION						

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE	OUTPUT
~~1750~~ 2300	Urine: 950
~~1220~~ 1220	GT 515
~~3700~~	
TOTAL ~~3520~~ 3520	TOTAL 1465
BALANCE ~~2055~~ 2055	

NURSE'S SIGNATURE	INITIALS
(b)(6)-2	(b)(6)-2
(b)(6)-2	

NEUROLOGICAL ASSESSMENT

COMA SCALE	HOURS	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21
EYES OPEN: SPONTANEOUSLY 4		4																
EYES OPEN: TO SPEECH 3																		
EYES OPEN: TO PAIN 2																		
EYES OPEN: NO EYE OPENING 1																		
BEST VERBAL RESPONSE: ORIENTED 5		5																
BEST VERBAL RESPONSE: CONFUSED 4																		
BEST VERBAL RESPONSE: VERBALIZES 3																		
BEST VERBAL RESPONSE: VOCALIZES 2																		
BEST VERBAL RESPONSE: NO VOCALIZATION 1																		
BEST MOTOR RESPONSE: OBEYS COMMANDS 6		6																
BEST MOTOR RESPONSE: LOCALIZES PAIN 5																		
BEST MOTOR RESPONSE: FLEXION WITHDRAWAL 4																		
BEST MOTOR RESPONSE: ABNORMAL FLEXION 3																		
BEST MOTOR RESPONSE: EXTENSION TO PAIN 2																		
BEST MOTOR RESPONSE: NO MOTOR RESPONSE 1																		
LIMB MOVEMENT: ARMS: NORMAL POWER		AC																
LIMB MOVEMENT: ARMS: MILD WEAKNESS																		
LIMB MOVEMENT: ARMS: SEVERE WEAKNESS																		
LIMB MOVEMENT: ARMS: ABNORMAL FLEXION																		
LIMB MOVEMENT: ARMS: ABNORMAL EXTENSION																		
LIMB MOVEMENT: ARMS: NO RESPONSE																		
LIMB MOVEMENT: LEGS: NORMAL POWER		AC																
LIMB MOVEMENT: LEGS: MILD WEAKNESS																		
LIMB MOVEMENT: LEGS: SEVERE WEAKNESS																		
LIMB MOVEMENT: LEGS: ABNORMAL FLEXION																		
LIMB MOVEMENT: LEGS: ABNORMAL EXTENSION																		
LIMB MOVEMENT: LEGS: NO RESPONSE																		
PUPILS: RIGHT: SIZE		3																
PUPILS: RIGHT: REACTION		++																
PUPILS: LEFT: SIZE		3																
PUPILS: LEFT: REACTION		++																
PUPIL SCALE		● 2		● 3		● 4		● 5		● 6		● 7 mm						
ICP																		
CEREBRAL PERFUSION PRESSURE																		

LEGEND

- C Closed by swelling
- T Trach/Endo
- S Slurring
- D Dysphasia
- R Receptive
- E Expressive
- R Right
- L Left
- Record separately if there is a difference between the two sides.
- ++ Brisk
- + Slow
- - No Response
- + Intact
- - Abnormal

VASCULAR ASSESSMENT

	HOURS	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20
Dorsalis Pedis	R	++															
	L	++															
Posterior Tibial	R	++															
	L	++															
	R																
	L																
	R																
	L																
	R																
	L																

LEGEND

- ++ Normal
- + Weak
- - Absent
- D Doppler
- R Right
- L Left

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0600	INITIAL (b)(6)-2	1730	INITIAL (b)(6)-2		INITIALS
NEUROLOGICAL	PUPILS	Pupils 3mm brisk reaction		Pupils 3 — ⊖			
	SENSORIUM	to light. Moves all ext		A+O, language			
		on command, MS04		barrier, understands			
		for pain, toradol		simple commands			
		started this am					
RESPIRATORY	RESPIRATORY PATTERN	Resp rate 20's.		RR 20's			
	BREATH SOUNDS	even + unlabored,		even + unlabored			
	SECRETIONS	coarse throughout		rub heard L. Ⓐ			
		lung is ⊖ mild		chest, ↓ to Ⓛ base			
		non productive cough		Ⓡ CTA, CT to Ⓛ			
		Sats 99% on 2L		side on CS, Ⓐ cough ⊖ secretion			
SKIN	COLOR	normal for race,		Normal for race			
	INTEGRITY	warm + dry, dog to		DRSG to Ⓡ chest			
		Ⓛ chest intact		CDI, post + ant			
IV SITE	LOCATION	Ⓛ AC patent ÷ Hl		Ⓛ AC, patent - SL 186			
	CONDITION	Ⓡ wrist patent - LR @ 50		Ⓡ wrist, patent, LR @			
	meds:	Ancef Q8°		50cc/HR 186			
	tubes:	Ⓡ CT to 20cm H_2O		Ⓐ SS infiltration			
		Six, bloody output		to either IV site			
		approx 5cc/°					
GASTRO	ABDOMEN	flat, firm, N/T		soft, mm-distended			
	BOWEL SOUNDS	to palpation, BS		Ⓐ BS x4, active			
		hypoactive Ø N/V/D					
		Ø stool					
GU	URINE:	Voiding spont in		No urine yet			
	COLOR/CLARITY	urinal per night					
		shift.					
CARDIOVASCULAR	CARDIAC RHYTHM	NSR rate 80's		SR @ 98, tachy			
		pulses palpable		Ⓐ pulses x4			
		afebrile BP stable					
		⊖ MAPs 70's					
		Ø labs ordered					

(b)(6)-2

LEGEND
Cr - Creatinine
F_IO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title) (b)(6)-2 CPT/AN
DEPARTMENT/SERVICE/CLINIC ICU 2 east
DATE 11 July 03

(Legible; grade; date; hospital or medical facility) (When entries give: Name—last, first,

(b)(6)-4

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

DATE	DX 05	06	07	08	09	10	11	12		13	14	15	16	HOSPITAL DAY 17	18	19	20	
VITAL SIGNS																		
TIME	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
~~BP Arterial Line~~																		
BP Cuff	114/55	109/50	98/50	118/57	102/49	118/63	109/54	109/58	113/51	113/51	109/55	91/64	124/65	103/46	122/62	103/46	107/53	
Temperature	97.1				97.3 T				97.7				97.7	97.1				
Pulse	81	82	73	92	89	84	86	82	81	81	84	96	89	94	105	98	97	
Respiratory Rate	20	21	14	26	25	24	20	27	20	20	20	27	25	20	23	21	23	
O2 sats	100	99	100	95%	97%	100%	100%	100%	99%	99%	100%	94%	97%	95	96	97	98	
source	2L	2L	2L	RA	RA	2L	2L	2L	2L	2L	2L	RA	RA	RA	RA	RA	RA	
INTAKE																		
TIME	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
IUF	50	50	50	50	50	50	50	50		50	50	50	50	50	50	50	50	800
IUPB				50									50					
PO					200						200		~~100~~	100				
TOTALS	50	50	50	100	250	50	50	50		50	250	50	100	150 ~~100~~				
OUTPUT																		
URINE HOUR				200				800										
URINE TOTAL				200				100										
URINE sp gr																		
URINE S/A																		
NG OUTPUT																		
NG pH																		
NG GUIAC																		
EMESIS																		
STOOL																		
DRAINS CT#1	10	10	10	0	35	0	5	0		10	0	0	10					
TOTALS	10	10	10	200	35	0	5	800	✓	10	0	0	10					

POST-OP DAY	21	22	23	24	01	02	03	04	
VITAL SIGNS	16	17	18	19	20	21	22	23	
	116/63	126/61		113/56	117/55	132/71	138/71	112/58	
		98.4				97.8			
	98	94	90	95	87	88	91	96	
	25	19	18	16	16	24	20	19	
	98	99	95	97	95	96	95	97	
	RA	RA	RA	RA	RA	RA	RA	RA	
INTAKE	21	22	23	24	01	02	03	04	
	16	17	18	19	20	21	22	23	8° T
	50	50	50	100	50	50	100	50	1250
		200							700
									1950
OUTPUT		620 / 620							1620
								80	

ACUITY LEVEL CLASSIFICATION

RESPIRATORY										
	TIME									
	MODE									
	F_IO_2									
	TV									
	RATE									
	PEEP									
ABG	pH									
	PCO_2									
	pO_2									
	HCO_3									
	SAT									
	BASE									

LABORATORY										
	TIME									
	GLUCOSE									
	Na/K									
	Cl/CO_2									
	BUN/Cr									
	WBC/PLATELET									
	Hct/Hgb									

ACTIVITIES OF DAILY LIVING										
	TIME				TURN	TIME				
	MOUTH CARE									
	BATH									
	SKIN CARE									
	FOLEY CARE				SUCTION					
	TRACH CARE									
	ROM EXERCISES									

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	_____	Urine:	_____
po	_____		_____
	_____		_____
TOTAL	_____	TOTAL	_____

BALANCE _____

NURSE'S SIGNATURE	INITIALS

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0630	INITIALS (b)(6)-2		INITIALS	1800	INITIALS (b)(6)-2
NEURO	PUPILS	Patient awake, alert				3 — (=)	
	SENSORIUM	follows commands, moves				A+O, language	
		all extremities well, pupils				barrier, responds	
		3mm brisk reaction to light				appropriately to	
		Pain controlled c̄ Tordal/MSO4				commands	
RESPIRATORY	RESPIRATORY PATTERN	Rate 00's even + unlabored				Even + unlabored @20	
	BREATH SOUNDS	Diminished c̄ pleural rub on (+)				pleural rub on (L),	
	SECRETIONS	coarse on right, occasional				coarse to (L) base, (R)	
		productive cough c̄ bloody (old)				CTA. (+) cough @	
		sputum Sats 96% on RA				this time, (-)	
		CT to 20cm suction 0-10cc/hr output				secretions CT to CS (L)	
SKIN	COLOR	warm dry, normal for race				Normal for race	
	INTEGRITY	Dressing to anterior/posterior				DRSG to ant. post.	
		chest and chest tube intact				chest (R) CDI	
IV SITE	LOCATION	18g to (+) AC c̄ LR @ 50cc/hr				18G to (R) AC, sli-	
	CONDITION	patient (-) S/S of infection				tender, (-) S/S infiltration	
	meds →	Ancef 1gm IV Q 8°				Ancef 1G IV Q8°	
	activity	ambulated last pm				pt. @ bedside chair	
		will get OOB today and					
		ambulate BID					
GASTRO	ABDOMEN	Soft N/T, non distended				soft, non-distended	
	BOWEL SOUNDS	Bowel sounds (+), (-) N/V/D				BS (+) x4, (-) N/V/D	
		(-) stool yet, (+) flatus				(+) flatus, 100%	
		Regular diet tolerates well				Reg-Diet consumed	
GU	URINE:	Clear dark yellow urine				(+) urine @ this	
	COLOR/CLARITY	Void 1-2 x per shift				time	
		>10cc/kg c̄ each void					
CARDIOVASCULAR	CARDIAC RHYTHM	NSR rate 80-90's				SR @ 80-100	
		pulses palpable				(+) pulses to extremities	
		cap refill <3 seconds				x4, cap. refill <3 sec.	
		(-) edema noted					
		afebrile.					

LEGEND: Cr - Creatinine; F_IO_2 - Fraction of inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; S/A - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (b)(6)-2 CPT JON

DEPARTMENT/SERVICE/CLINIC ICU 2 east

DATE 12 July 03

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

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line																		
BP Cuff	117/55	128/61	117/56	135/74	121/67	110/57	113/51	121/55		119/63	110/50	94/44	107/44		121/66	112/57	115/55	
Temperature	97.2				97.1					97.0					98.2			
Pulse	89	83	86	93	103	90	85	81		81	88	66	77		84	81	92	
Respiratory Rate	17	16	17	22	24	19	18	22		20	34	14	20		22	19	21	
sats	96	96	96	96	96	97	97	95		95	96	94	98		98	98	96	
Source	RA	RA	RA	RA	RA	RA	RA	RA		RA	RA	RA	RA		RA	RA	RA	
pain																		
sedation																		

INTAKE

TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
IUPB				50									50					
IUF	60	50	50	HL	→												→	
PO				300	240			500					200					
TOTALS	50	50	50	350	240	Ø	Ø	500		Ø	Ø	Ø	250					

OUTPUT

URINE	HOUR				420						650					100			
	TOTAL				420						1020								
	10 gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS	CT#1	Ø	Ø	Ø	40	Ø	Ø	Ø	9		Ø	Ø	Ø	28		2			
TOTALS																			

POST-OP DAY

VITAL SIGNS	21	22	23	24	01	02	03	04	
	105/40	107/50	105/48	103/41	100/45	114/55	107/52	97/40	
	75	71	63	61	71	69	68	5X	
	14	14	14	14	16	22	14	15	
	95	94	94	95	97	97	94	94	
	RA	RA	RA	RA	RA	RA	RA	RA	

INTAKE	21	22	23	24	01	02	03	04	8° T
				50					

OUTPUT									
	/	/	/	/	/	/	/	/	1120
	3		12	8	4	15	17	10	95

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME									
	MODE									
	F_IO_2									
	TV									
	RATE									
	PEEP									
ABG	pH									
	PCO_2									
	pO_2									
	HCO_3									
	SAT									
	BASE									

LABORATORY	TIME									
	GLUCOSE									
	Na/K	/	/	/	/	/	/	/	/	/
	Cl/CO_2	/	/	/	/	/	/	/	/	/
	BUN/Cr	/	/	/	/	/	/	/	/	/
	WBC/PLATELET	/	/	/	/	/	/	/	/	/
	Hct/Hgb	/	/	/	/	/	/	/	/	/

DAILY ACTIVITIES DOF	TIME				TURN	TIME				
	MOUTH CARE									
	BATH									
	SKIN CARE									
	FOLEY CARE				SUCTION					
	TRACH CARE									
	ROM EXERCISES									

24 I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	_____	Urine:	_____
po	_____		_____
	_____		_____
TOTAL	_____	TOTAL	_____

BALANCE _____

NURSE'S SIGNATURE	INITIALS
(b)(6)-2	(b)(6)-2

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0530	INITIALS (b)(6)-2	1700	INITIALS (b)(6)-2	0100	INITIALS (b)(6)-2
NEURO	PUPILS	Pupils 3mm Much. Equal,		Pupils Equal Round			
	SENSORIUM	round reactive to light.		Reactive 3mm			
		Ⓓ pain at chest tube site.		⊕P pulses - scattered			
		MAE x4. Hand grasp		and pain at insertion			
		equal x4.		site			
RESPIRATORY	RESPIRATORY PATTERN	Even & Unlabored. Clear		Even - unlabored			
	BREATH SOUNDS	to auscultation on					
	SECRETIONS	Ⓓ side. Diminished when				productive cough	
		turned to lateral.				lungs clear	
		CT to 20 cm suction.					
SKIN	COLOR	No evidence of skin breakdown		normal for race,			
	INTEGRITY	Normal for race.		no breakdown noted			
		Dressing D+I intact to Ⓓ Posterior Axillary					
IV SITE	LOCATION	18G to Ⓓ AC. Dressing		18G to Ⓓ AC			
	CONDITION	Dry and intact. Flushed		⊕ S/Sx of infiltration			
		to facilitate blood return		IV ancef			
GASTRO	ABDOMEN	Bowel Sounds present x4 -		+BM soft formed			
	BOWEL SOUNDS	Tenderness upon palpation		35 ⊕ x 4 ⊕			
		to Upper Quadrants. No					
		BM x 2 days. Laxative ordered					
GU	URINE:	Voiding per urinal, clear		+UO QS see note		+UO QS clear	
	COLOR/CLARITY	Yellow urine				yellow	
CARDIOVASCULAR	CARDIAC RHYTHM	NSR ECG, PR. 16		NSR		NSR	
		GNS, 08. Heart tones		+pulses		+cap refill	
		rhythm regular c occasional				brisk c 2 seconds	
		PAC. Pulses X 4 extremities				+ radial, dorsalis	
		2+. Cap refill brisk.				pulses	

LEGEND: Cr - Creatinine; F_IO_2 - Fraction of inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; S/A - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title) (b)(6)-2 MAGN

DEPARTMENT/SERVICE/CLINIC ICU Quest

DATE 13 July 03

PATIENT'S ID (b)(6)-2 (When entries give: Name—last, first, middle; grade; organization; facility)

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE		05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
VITAL SIGNS	TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
	BP Arterial Line																		
	BP Cuff	107/40		114/84	118/49	111/53	107/40	98/48	109/49		105/45	109/40	109/40	109/57	114/54	110/62	112/72	116/68	
	Temperature		96.7						98.5				98.5					98.7	
	Pulse	59		80	92	56	60	90	94		80	79	82	69	78	74	72	80	
	Respiratory Rate	23		21	25	18	15	25	26		20	18	12	22	20	20	20	18	
	SaO_2	96%		98%	95%	95	96%	99%	99%		97%	97%	100%	97%	96%	97°	97°	97	
	O_2 Source			RA	RA	RA	RA	RA	RA		RA	RA	RA	RA	RA	RA	RA	RA	
	pain intervention	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
INTAKE	TIME	24	01	02	03	04	05	06	07	8° T	08	09	10	11	12	13	14	15	8° T
	PO			240					240					240		100			820
	IVPB								50					50					100
	TOTALS																		920
OUTPUT	URINE HOUR/TOTAL				500/500				300/800							300/1100			1100
	URINE sp gr																		
	URINE S/A																		
	NG OUTPUT																		
	NG pH																		
	NG GUIAC																		
	EMESIS																		
	STOOL																		
	DRAINS CT						35					10		4	0	0	0	6	
	DRAINS Gastric	115					150					160		164				170	
	TOTALS																		

POST-OP DAY	21	22	23	24	01	02	03	04	
VITAL SIGNS	16	17	18	19	20	21	22	23	
	120/68	130/60	132/66	125/62	124/64	119/56	124/68		
	68	66	68	69	54	62	68		
	18	18	16	20	16	16	13		
	97	97	97	98	98	98	96%		
	RA	RA	RA	RA	RA	RA	RA		
	21	22	23	24	01	02	03	04	
INTAKE	16	17	18	19	20	21	22	23	8° T
	Ø	100	Ø	100	Ø	Ø	Ø		100
		50							50
									150
OUTPUT	150/1250								1250
	0	0	5	0	5	5	11	0	
			175		180	185	196	196	

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME									
	MODE									
	F_IO_2									
	TV									
	RATE									
	PEEP									
ABG	pH									
	PCO_2									
	pO_2									
	HCO_3									
	SAT									
	BASE									

LABORATORY	TIME									
	GLUCOSE									
	Na/K									
	Cl/CO_2									
	BUN/Cr									
	WBC/PLATELET									
	Hct/Hgb									

ACTIVITIES OF DAILY LIVING	TIME				TURN	TIME				
	MOUTH CARE									
	BATH									
	SKIN CARE									
	FOLEY CARE				SUCTION					
	TRACH CARE									
	ROM EXERCISES									

24 HR I&O TOTALS		NURSE'S SIGNATURE	INITIALS
wt Yesterday	wt Today	(b)(6)-2	(b)(6)-2
		(b)(6)-2	(b)(6)-2
INTAKE	OUTPUT		
IV 920	Urine: 1250		
po 300	CT 196		
TOTAL 1220	TOTAL 1446		
BALANCE +226			

NEUROLOGICAL ASSESSMENT

		HOURS	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
COMA SCALE	EYES OPEN	SPONTANEOUSLY 4	4																							
		TO SPEECH 3																								
		TO PAIN 2																								
		NO EYE OPENING 1																								
	BEST VERBAL RESPONSE	ORIENTED 5	5																							
		CONFUSED 4																								
		VERBALIZES 3																								
		VOCALIZES 2																								
		NO VOCALIZATION 1																								
	BEST MOTOR RESPONSE	OBEYS COMMANDS 6	6																							
		LOCALIZES PAIN 5																								
		FLEXION WITHDRAWAL 4																								
		ABNORMAL FLEXION 3																								
		EXTENSION TO PAIN 2																								
		NO MOTOR RESPONSE 1																								
LIMB MOVEMENT	ARMS	NORMAL POWER	R/L																							
		MILD WEAKNESS																								
		SEVERE WEAKNESS																								
		ABNORMAL FLEXION																								
		ABNORMAL EXTENSION																								
		NO RESPONSE																								
	LEGS	NORMAL POWER	R/L																							
		MILD WEAKNESS																								
		SEVERE WEAKNESS																								
		ABNORMAL FLEXION																								
		ABNORMAL EXTENSION																								
		NO RESPONSE																								
PUPILS	RIGHT	SIZE	3																							
		REACTION	++																							
	LEFT	SIZE	3																							
		REACTION	++																							
PUPIL SCALE			2		3		4		5		6		7 mm													
ICP																										
CEREBRAL PERFUSION PRESSURE																										

LEGEND

- C Closed by swelling
- T Trach/Endo
- S Slurring
- D Dysphasia
- R Receptive
- E Expressive
- R Right
- L Left

Record separately if there is a difference between the two sides.

- ++ Brisk
- + Slow
- - No Response
- + Intact
- - Abnormal

VASCULAR ASSESSMENT

	HOURS	05																								
Dorsalis Pedis	R	++																								
	L	++																								
Radial	R	++																								
	L	++																								
	R																									
	L																									
	R																									
	L																									
	R																									
	L																									

LEGEND

- ++ Normal
- + Weak
- - Absent
- D Doppler
- R Right
- L Left

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0600	INITIAL (b)(6)-2		INITIALS		INITIALS
NEURO	PUPILS	Pupils 2-3mm					
	SENSORIUM	brisk reaction to light					
		moves all ext well, full					
		strength Ø c/o pain					
		@ this time.					
RESPIRATORY	RESPIRATORY PATTERN	even + unlabored					
	BREATH SOUNDS	rate 20s, lungs clear					
	SECRETIONS	bilaterally ↓ in LLL					
		Sats 97% on RA.					
		CT to suction,					
		25cc/° last hour					
SKIN	COLOR	normal for race					
	INTEGRITY	warm + dry, dsg					
		CDI, well A @ 1000					
I.V. SITE	LOCATION	⊕ RA 18g HL patent					
	CONDITION	flushes well.					
	medo IV	Ancef 1gm TID					
	PO	Tylox prn					
		Celace BID					
		tylenol/tradol pm					
GASTRO	ABDOMEN	Soft, flat N/T					
	BOWEL SOUNDS	BS⊕, stool yesterday					
		Ø N/V/D, Tolerated					
		regular diet.					
GU	URINE:	Voiding spont					
	COLOR/CLARITY	per urinal,					
		clear amber QS					
CARDIOVASCULAR	CARDIAC RHYTHM	NSR in 70's, BP					
		stable, pulses					
		palpable, skin					
		warm + dry					
		afebrile					

LEGEND: Cr - Creatinine; F_IO_2 - Fraction of Inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; S/A - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title) (b)(6)-2 CPT IAN

DEPARTMENT/SERVICE/CLINIC ICU

DATE 15 July 03

For typed or written entries give: Name—last, first, m

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE | DX | HOSPITAL DAY

VITAL SIGNS	TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
	BP Arterial Line																		
	BP Cuff		92/41				108/53												
	Temperature		97.6				97.9												
	Pulse		78				70												
	Respiratory Rate		16				16												
	sats		97				97												

INTAKE	TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
	1 VPB				50														
	TOTALS																		

OUTPUT																			
URINE	HOUR				400														
	TOTAL				400														
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS	CT#1		25				Ø												
TOTALS																			

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) OA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME		INITIALS		INITIALS		INITIALS
NEURO	PUPILS						
	SENSORIUM						
RESPIRATORY	RESPIRATORY PATTERN						
	BREATH SOUNDS						
	SECRETIONS						
SKIN	COLOR						
	INTEGRITY						
I.V. SITE	LOCATION						
	CONDITION						
GASTRO	ABDOMEN						
	BOWEL SOUNDS						
GU	URINE:						
	COLOR/CLARITY						
CARDIOVASCULAR	CARDIAC RHYTHM						

LEGEND

Cr - Creatinine
F_IO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: [illegible]

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

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

DATE | DX | HOSPITAL DAY

VITAL SIGNS																		
TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line																		
BP Cuff																		
Temperature																		
Pulse																		
Respiratory Rate																		

INTAKE																			
TIME	05	06	07	08	09	10	11	12	8° T	13	14	15	16	17	18	19	20	8° T
															150		150	300
TOTALS																		

OUTPUT																			
URINE	HOUR / TOTAL														200			100 / 200	200
	wt gr																		
	S/A																		
CT	OUTPUT														Ø	Ø	5	Ø	5
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS	21	22	23	24	01	02	03	04

INTAKE	21	22	23	24	01	02	03	04	8° T
	00								400

OUTPUT									
	200	0	0	0	0	0	0	0	500
	00	00	100	100	00				

RESPIRATORY	TIME									
	MODE									
	F_IO_2									
	TV									
	RATE									
	PEEP									
ARTERIAL GAS	A	pH								
		PCO_2								
		pO_2								
	B	HCO_3								
		SAT								
	G	BASE								

LABORATORY	TIME									
	GLUCOSE									
	Na/K									
	Cl/CO_2									
	BUN/Cr									
	WBC/PLATELET									
	Hct/Hgb									

ACTIVITIES OF DAILY LIVING	TIME				TURN	TIME				
	MOUTH CARE									
	BATH									
	SKIN CARE									
	FOLEY CARE				SUCTION					
	TRACH CARE									
	ROM EXERCISES									

24 H I&O TOTALS

NURSE'S SIGNATURE (b)(6)-2 INITIALS

wt Yesterday _____ wt Today _____

	INTAKE		OUTPUT	
IV	50	Urine	500	
po	400		30	
TOTAL	450	TOTAL	530	

BALANCE +80

ADMISSION AND CODING INFORMATION

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

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	0 0 0 (b)(6)-4	(b)(6)-4		M

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

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
	N/A	~~9 9~~ 20	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
N/A	U	0830	N/A

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K 7 8	

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
		9 b(3)-1	YEAR [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72 0	ICW	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 (YYYYMMDD)
2 4		2 0 0 3 0 7 2 6

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
A E A A		2 0 0 3 0 7 0 9

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYYYMMDD)
b(6)-4		

FOR LOCAL USE

DX: ~~SBP~~ GSW TO LEFT CHEST
HEMOPNEUMOTHORAX
PULMONARY CONTUSION

DX-8605
Trauma-1 86131
Injury-450 E9912
PR-3404

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK
(b)(6)-2 COL, MC	(b)(6)-2 PFC, 91G

DA FORM 2985, MAR 2000 EDITION OF MAR 89 IS OBSOLETE USAPA 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)(3)-1	(b)(6)-4	N/A	

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

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99	(b)(6)-4	N/A	ICW

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

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
DIRECT FROM E.R.	1540	ABAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	XFER EPW HOLD	2 AUG 2003

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		24 JUL 2003	DR (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		

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

FRAGMENT WOUNDS
LEFT KNEE/ BACK/ FACE

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
0	0	0	0	9	9

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
		0	0	9	9

SIGNATURE	SIGNATURE OR RANK OF MEDICAL RECORDS OFFICER
(b)(6)-2 COL, MC	(b)(6)-2 (b)(6)-2 SSG, NCOIC, PAD

DA FORM 3647, MAY 75 EDITION OF 1 AUG 76 IS OBSOLETE USAPPC V1.10

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

≈40 yo male c/o fragmentation wound to back, (L) shoulder, (L) knee
Conditions ⇒ fragmentation wound from exploding mortar round.
Pt is army yo. Denies abd pain - has h/o ulcers and abdomen
feels like normal abdominal sx.

PMHx (-)
PMSH (-)
meds, ∅

PHYSICAL EXAMINATION

130/78 P 92 R 20 98°
MAO, cooperative.
HEENT: (+) nonstable small wound on clear
Chest LTA (-) LN tender palp.
Abd s/ND, NT, NP. ∅ pistonal signs
Extr. (-) deformed wound, (-) and knee small wound.
Back: small frag wound (-)

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

A/ Fragment wound,
Stable

P/ Admit IVF
Observe

[redacted]

(b)(6)-2

S		DATE 7/24	IDENTIFICATION NO.	ORGANIZATION
P	(If typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)		REGISTER NO.	WARD NO.

(b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975

539-106

(b)(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

24 JUL 03

OP NOTE

PRE OP DX (L) OPEN KNEE, R/O INTRA PERITONEAL HEMORRHAGE, FACIAL LAC C FB

POST OP DX - NO ABD, EXTRAARTICULAR (L) KNEE WND, FACIAL LAC C FB

PROCEDURE - MINI EXPLORATORY LAPAROTOMY, DEBRIDEMENT, RT. KNEE & FACE WOUNDS

SURGEONS - (b)(6)-2

ANES GEN MONCOM

FLUIDS 1800 CRYS CBC MAN UO 200 TTL 17 @ 275m

ANAMS JP (L) KNEE SPEC CX

INDICATIONS ~~FINDINGS~~ - QUESTIONABLE FAST EXAM C INTRA ABD

FRAG ON XR - SCAN LEAN C BRUSELLENT

(L) KNEE C PERIARTICULAR FRAG ON XR

FINDINGS - NO ABD - EXTRAARTICULAR (L) KNEE FRAG

TO PCU FOR NEUROLY STABLE

(b)(6)-2

LTC, MC
ORTHOPEDIC SERVICE

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

(b)(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1.0)
USAPA V1.00

(b)(6)-4

MEDCOM - 6879

LAST NAME | M... ...D NUMBER

DATE	NOTES
24 Jul 03	Nursing Notes: Received Pt from ICU via Stretcher
2240	foley to gravity. IV to gravity. Pt in stable condition
	& c/o at this time. Breathing intact ∅ SOB
	or Labored breathing. Abd slight distended
	dressing to abd and (L) leg ∅ drainage on dressing
	visible. Will continue to monitor Pt's Status
	[redacted] (b)(6)-2 ICT/AN
7/24/03	Pt c/o pain 2mg IV MSO4 given. Will continue to
2305	monitor [redacted] (b)(6)-2 ICT/AN
2345	Pt c/o pain 2mg IV MSO4 given for pain. Will continue
	to monitor Status [redacted] (b)(6)-2 ICT/AN
0019	Pt c/o pain 2mg IV MSO4 given IV PRN. Will continue
	to monitor [redacted] (b)(6)-2 ICT/AN
0030	Pt [redacted] leg [redacted] (b)(6)-2 ICT/AN
0123	Pt c/o pain 2mg IV MSO4 given IV PRN for pain
	Will continue to monitor [redacted] (b)(6)-2 ICT/AN
0153	Pt c/o pain 650mg Tylenol PO given. Pt also c/o
	nausea. 25mg Phenergan IV given. Will continue
	to monitor [redacted] (b)(6)-2 ICT/AN
0200	Pt vomited liquid ∅ chunks. Pt states OK after
	vomiting. [redacted] (b)(6)-2 ICT/AN
0300	Pt [redacted] leg [redacted] (b)(6)-2 ICT/AN
25 Jul 03	Nursing Assessment: Pt awake, c/o pain. Medicated ō
0730	2mg MSO4. Pt Temp 100.4, gave 625mg Tylenol. Lungs
	CTA; assist pt @ bedside. T 15 ISL. HR 96, reg; abd soft,
	distended, hypoactive, BS x4. Abd drsg intact; covered c
	bloody drainage but has not ~~soak~~ seeped through gauze — LUT [redacted] (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

(b)(6)-4 [redacted]

MEDICAL RECORD	PROGRESS NOTES
DATE 26 Jul 03 1151	Pt able to move all extremities without complication c/o pain in abd. Vitals within normal limits. SpO2 Range from 91-94%. will continue to monitor [redacted] 147
2022	O2 @ 2L administered Pt SpO2 ~~at~~ 90% ↑ 94-96% continued monitoring of Sats [redacted]
2026	Dressing changes to Back and leg completed ∅ obvious bleeding or fluid excess on changed dressing. will continue to monitor. Pt's Sats now range 96-98%. O2 @ 2L via NC intact [redacted] Emmegh 147
26Jul03 1307	Nursing note shift Pt. alert, speech clear in nature tongue, VSS ✗ sat ↓ to 98%; ↑90 on room air. Gave 2L then 96%. ∅ resp. compromise. c/o headache & stomache this shift. (+) BS, ∅ BM this shift. ∅ edema noted able to move all extremities. [redacted] CPMA
26Jul03 2000	Assessment. A&O x3, PERRLA, lungs CTA BILAT, S1-S2 strong + reg. (+) BS x4, Dress D's changed @ 1800. c/o pain to abdomen Given Percocet for pain. Being to prepared for PACU. Tolerated well sent. IV HL to (+) BL. will continue to monitor [redacted] 147 CA
27Jul03 0400	Nursing: shift assessment Pt. bright & alert most of shift. Speech in nature tongue c/o pain to abd. specifically requested Zantac; ordered & given. Physician aware. Foley d/c'd at 1400. Cont. to monitor [redacted] (Continue on reverse side) CPMA

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

REGISTER NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

PROGRESS NOTES

DATE	
2145 125/65	Client from OR via litter and gurney c OR staff nurse and CRNA
2150 125/53	
2155 135/43	Pt drowsy but [illegible] - Face mask 10L SaO_2 99%-100% - Pt c
2200 116/58	IV [illegible] (R) AC NSS TKO - Dsg to (L) ear c, D and intact
2215 115/56	[illegible]
2230 116/58	Dsg to and small c, D and intact Dsg to (R) knee c, D and intact
[illegible]	[illegible]
[illegible]	Pt [illegible] DPL and knee drainage. Meds in OR: 250 mg Ten, 7mg MSO4, 2mg Versed [illegible] LR infused in OR - 200 urine
	out in OR. Foley to Gravity draining cs urine - SaO_2 on RA 95% at time of transfer - ∅ pain medication in ICU recovery - report to RN. (b)(6)-2 (b)(6)-2
24 Jul 03 2300	Nursing Assessment: (cont'd). Dsg to (R) inner thigh
0730	has dime size area scab - slang drainage, applied new 4x4. Dsg to (L) knee CDI. Dsg to (L) ear CDI. Unable to eval pt. back, pt in too much pain to lean forward. Will eval when pain subsides — 1LT (b)(6)-2
25 Jul 03	Nursing: UOP - Pt foley D/C'd @ 0100, pt has not
1005	voided yet, MD want I&O cath if pt not void by 1000. Placed 16 Fr. foley, 775 cc of clr yellow urine out. Will leave foley until consult to MD — 1LT (b)(6)-2
1400	Nursing. Pt c/o difficulty breathing, O_2 sat 88% on RA. Placed pt on 2L O_2 NC, O_2 sat ↑ to 96%. Pt Temp 100.9 Gave 650mg Tylenol — 1LT (b)(6)-2
25 Jul 03	Nursing Notes: Assumed care of pt AFO Foley
1750	to drainage clear yellow urine noted. Breathing intact ∅ SOB or labored breathing noted. IV NS infusing. ∅ C/S of infiltration at site. Pt ate 10% of meal, tolerated it well — (b)(6)-2

DA FORM 3881, 1 Jul 91 (Supersedes DA FORM 3881, 1 Jul 91) BACK
USAPPC V1.00

MEDICAL RECORD — PROGRESS NOTES

DATE

'25 JUL 03 POD 1 - OMCOD

S NO WRITE CLO

O VSSA

NVI HEALTHY

BSG INTACT

A DOING WELL ORTHOPAEDICALLY

P PROPHY ABX & LOCAL WND CARE

(b)(6)-2

LTC, MC
ORTHOPEDIC SERVICE

(Continue on reverse side)

PATIENT IDENTIFICATION (For typed or written entries give: Name - last, first, middle,

(b)(6)-4

REGISTER NO

WARD NO

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
27 Jul 02 @ 1711	Nursing Notes: Assumed care of Pt Sleepy easily aroused - Pt did not eat his dinner c/o stomach discomfort. Encourage Pt to drink more fluids. IV SL flushes well. Pt given Maalox earlier for stomach discomfort. Pt voids spontaneously. Breathing intact Ø SOB or labored breathing. Able to move all extremities without amplification. Will continue to monitor status — (b)(6)-2
1950	Via interpreter Pt c/o impacted stomach. Ø BMX 3 days. Abd distended and tender to touch. New order for Enema obtained per Dr (b)(6)-2 - will administer — (b)(6)-2 Lewis 1C/LPN
2025	Pt Refuses enema. He thought he was getting suppository. New Order obtained Per Dr. (b)(6)-2 for suppository — (b)(6)-2 1C/LPN
2201	Pt took suppository earlier. Attempted for BMX Ø Pt back to bed. Dressing changes to back and leg completed. Will continue to monitor status — (b)(6)-2 1C/LPN

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

(b)(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
29 Jul 03 0045	Nsg Shift assessment: Pt c/o generalized body pain @ 2200 and was given Morphine IM to which he verbalized relief. Resps are even unlabored, VS WNL. Will cont to monitor ——— (b)(6)-2
29 Jul 03	2200 ASSESSMENT: C/O OF PAIN. TOLERATES REG DIET, DRSG C/D/I, MONITORING FLOW. RESTING COMFORTABLY COMPLAINED OF SCAB ON BACK OF HEAD TO BE UNCOMFORTABLE NOTIFIED DR. (b)(6)-2 ——— (b)(6)-2 SATISFACTION
30 Jul 0830	Nursing Assessment: Pt awake, ↑ in bed this am for breakfast. C/O little pain to abd @ around incision site. ML abd incision C̄ staples OTA, ∅ S/S infection. Pt lungs CTA, HR 72, (D)BS x4, abd soft, round, schrapnel wound to back in several placed, replaced drsg x2 to site C̄ small amt old sero-sang. drainage noted. Bil. inner thigh C̄ schrapnel wound, ∅ drainage noted. Drsg to (D)LE ∅ ace wrap over gauze CDI ——— (b)(6)-2 ILT AN
30 Jul	2100 ASSESSMENT: A&Ox3, PERRLA, LUNGS CTA BILAT, S1, S2 STRONG & PUNCTUATE (D)BS x4, C/O PAIN TO ABD OVER PERIODS W̄ TASK. DRSG C/D/I. TOLERATES REG DIET, UP ADLIB. WILL CONTINUE TO MONITOR ——— (b)(6)-2 SAT. CON
31 Jul 03 0830	Nursing Assessment: Pt awake, ↑ in bed. C/O pain to IV site. DLC ∅ HL. A&A, lungs CTA bil; HL SQ rey; hyperactive BS x4, abd soft, round. Pt has multiple schrapnel wounds to back, ∅ drainage noted. Bilateral inner thigh schrapnel wound ∅ drainage. Abd incision C̄ drsg CDI, 2x2 drsg to (L) lateral knee CDI. ——— ILT (b)(6)-2 AN

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
31 Jul 1500	Nursing: Drsg Δ: Perform drsg Δ to abd. Old drsg c̄ 2in. diameter shadowing of gauze & 2x2 packed saturated c̄ sero-sang drainage. Reapplied 2x8 c̄ saline & covered c̄ 4x4 Kerlix gauze. Pt tolerated well ——— UT [redacted]
1Aug03 2000	Nsg shift assessment: Pt c/o pain @ approx 2300 and was given 2 percocets to which he verbalized pain relief. Pt breathsounds are clear, resps even + unlabored, and sats are 95% on RA. A+O x4, speaking some words of english when he needs something. Currently sleeping quietly in bed, will cont to monitor ——— [redacted]
1 Aug03 1530	Nursing: Shift assessment Pt. with no change in resp, cardiac, or g.i. Pt. dressing changed in abd. w/ decant amount of drainage, pt. voiding outside this shift. Pt. reports BM x4. c/o pain in (R) upper back. CXR, UA completed as orders by physician. Percocet x2 this shift. Am care given continue to monitor ——— [redacted] CPT AW
1Aug03 2100	Nsg shift assessment: Dressing Δ done w/

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

[redacted]

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	minimal drainage. Has not asked for pain meds during this shift. Had a good appetite at dinner. VS WNL, resps are clear + unlabored; no complaints at this time, will cont. to monitor — (b)(6)-2
2ANGOB @0009	Nsg: Pt c/o pain (diffuse to head and back) and received 2 percocets PRN. Will cont. to monitor — (b)(6)-2
2 August 03 1749	Nursing Note: Assumed care of A A+O x3 pt tolerated Regular diet OK. Laying in bed. Breathing intact ∅ SOB or Labored breathing. dressing on abd & Steri Strip intact Small amt of drainage noted dressing on (L) leg intact ∅ drainage ∅ odor. Sutures intact. Pt able to move all extremities without complications ∅ IV Access. will continue to monitor status — (b)(6)-2
2000	∅ changes at this time. Pt awake ∅ complaints ∅ pain or discomfort — (b)(6)-2
2200	Dressing change on abd completed — (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
24JUL2003	
1530	pt arrives in E.R. Local national.
1532	BP 130/88 O_2 sat 100 R.A. O_2 sat 98 E O_2 p. 107 Temp. 98.6 R
1535	1000mL Sodium Chloride (R) AC
1540	CBC, TYPE & CROSS, PTPTB was drawn from PT (R) AC
1540	Skull x-ray, AP/Lat, (L) shoulder, (L) hand, (R) & (L) thight
	(L) knee, abdomin, chest ordered
1545	BP 125/91 p 103 O_2 - 99 R 24
~~1545~~	~~1000mL sodium chloride~~ AD
1550	Foley was put in pt
1550	pupils Equal reactive to light, pain is 7 on 1-10 scale, eye
	movement normal, HEENT clear, (L) facial shrapnel wound
	post. scalp shrapnel wound, post. (L) shoulder shrapnel wound
	multiple small back shrapnel wounds, (R) thigh wound, (L) knee
1552	10mg morphine drawn
1553	10mg morphine administered I.V
1554	good Bilateral dorsal pulses
1558	anceph 1g administered I.V
1600	BP 111/68 p 110 O_2 sat 100 R 24
1600	Tetnus (R) shoulder .5g IM
1601	X-ray (L) shoulder arrives
1602	Ultrasound of pt abdomin

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

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

(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1 USAPA V2.00

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
24 July 03	
1610	spine board put underneath pt.
1610	ultra sound taken of pt (L) chest
1611	BP 119/80 p 94 O2sat 100 R-20
1612	ultrasound taken of pt (R) chest
1617	BP 122/84 p. 92 O2 sat 100 (R) 24
1617	lab results in WBC 14.7 Hgb 14.1 Hct 42.8
1618	repeat of skull Ap/Lat x-ray ordered, Ap abdomin
1618	Ap (L) shoulder and chest returned
1619	Lat Abdomin ordered
~~1620~~	~~rectal exam taken~~ AM
1620	Hemaculta taken turned into lab.
1622	Hemacult results (−) blood
1629	chest x-ray taken
1629	1000 mL LR (R) wrist I.V
1630	chem lytes 8 ordered sent to lab
1637	x-rays arrive; (L) shoulder, skull, ~~abd~~ AP
1639	(R) Thigh, (L) Knee x-rays taken
1644	PT wounds cleaned with sodium chloride
1645	BP 121/81 p 93 O2 100 R. 24 T. 99.2
1648	Lat skull x-ray taken, b(b)-2
1650	pt abdomin was palpate by Dr. [redacted], O2 was taken off pt.
1658	X-rays returned to Dr. (b)(6)-2
1705	(L) ear cleaned and steri strip applied
1715 Satent pt	EDW presents in no acute distress – Sat 100 % RA – lungs clear – c/o pain
total IV 2300	especially (L) ear area 8/10 – received 1 10mg MSO4 IVP. (b)(6)-2, AVMSEA
Out foley all to icu	VS stable – see above + SSR, Abd soft, Large round – [illegible]
	feeds NPO – nonspecific – all pulses 2+ – CRT < 2 sec – PERRLA (b)(6)-2 – Alyssa
	oriented + appropriate behavior – MAE – following commands, [illegible]
	common [illegible] – NPO pt bedside 2 [illegible]
	stable – MVI and avoid punctuating – [illegible]
	+ shoulder area [illegible] – [illegible]
	all areas cleaned & sutured
	depart given to ICU – pt stable [illegible]

STANDARD FORM 600 (REV. 6-97) BACK

USAPA V2.00

MEDCOM - 6889

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

558-103 See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL — DATE: DAY 24, MONTH July, YR. 83 — TIME 1530

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): [ ] PRIVATE VEHICLE [X] AMBULANCE [ ] OTHER (Specify)

CURRENT MEDS. (tetanus immunization and other data): Ø

HISTORY OBTAINED FROM: [ ] PATIENT [ ] OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): Mult Back fragments

SEX: M AGE: 40

POSSIBLE THIRD PARTY PAYER? [ ] YES [ ] NO

(b)(6)-2

VITAL SIGNS

TIME	1400	1630	1530
BP	120/90	116/76	120/88
PULSE	64	92	107
RESP.	12	22	20
TEMP.			98
WT. (Child)			

TIME SEEN BY PROVIDER: 1530.

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

Last meal B-fast 1 OI 1400.

♂ EPW c/o shrapnel wounds to back, head (L) ear & (R) Thigh

S: Pt is a 40yo Iraqi EPW who were in a building & fired on by .50 cal, MK19, M4 rounds. Pt sustained mult frags to Back, (L) Scalp/ear, (L) Shoulder + (R) post thigh. C/o some Abd pn ? if Chronic or new.

PMHx ? Colon pain.

PSHx Ø.

⊕ T06.

O: wnw in min dist. 2° to mult frags. Ø Resp dist. Nontoxic. Ø Diaphor. Conversant c̄ Interp. GCS 15

HEENT mult frags to (L) scalp, face, ear.

Lungs: (B) eq CTA.

Cor RRR Ø Ø.

Abd: quiet BS. s. + gen tend. Ø Reb Ø fullity ⊕ FAST

Ext: ⊕ frag to (L) post deltoid. Ø frags (R) mid thighs. M/c N/S

Back: Several deep frag wounds over entire back. Ø frags over both kidneys

15 | 14/43 (24)

CLR: yel, clr 1.030 5.0 All Ø. Ø Bld.

PT/PTT 13/28

146 | 109 | 12 / 3.6 | 26 | 103 LFTs

CXR: wnl. Ø PTX.

Skull:

Ø Shoulder

Abd: ⊕ RUQ frag.

CATEGORY (See reverse): [X] EMERGENT [ ] URGENT [ ] NON-URGENT (b)(6)-2

ORDERS	INITS.	TIME
30 fentanyl	[redacted]	1630
Chest, skull, ab		
(L) shoulder, hand		1640
Knee, (R) thigh		
10mg morphine	[redacted]	1553
1g. ancef	[redacted]	1558

ASSESSMENT/DIAGNOSIS: Mult fragments to Back face, legs, Ø shoulder. Hemoperitoneum.

DISPOSITION (Check all that apply): [ ] HOME [ ] FULL DUTY

QUARTERS: [ ] 24 Hrs. [ ] 48 Hrs. [ ] 72 Hrs.

MODIFIED DUTY UNTIL: DAY / MONTH / YEAR

REFERRED TO (Indicate clinic): Gen Surg

[ ] EMERGENCY [ ] TODAY [ ] 72 HOURS [ ] ROUTINE

ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE: [X] IMPROVED [ ] UNCHANGED [ ] DETERIORATED

TIME OF RELEASE: 1700

PATIENT'S IDENTIFICATION (Mechanical imprint)
FOR WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).

(b)(6)-4

(CO (b)(6)-2

SIGNATURE OF P

MAJ MC

INSTRUCTIONS T any limitations and follow-up plans)

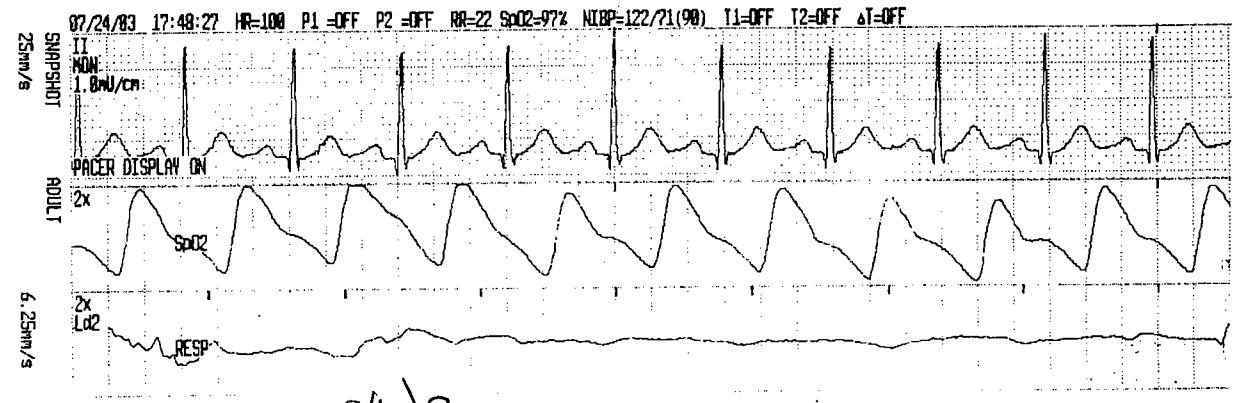
To OR.

EMERGENCY CARE AND TREATMENT
MEDCOM - 6890

STANDARD FORM 558 (Rev. 6-82)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
24 Jul 03		1730	39 yo ♂ admitted to the ICU from BMT via litter c̄ multiple shrapnal wounds. Montior applied. VS 122/71, 102, 14, SAO2 96% on RA. NAD noted. Intial assesement completed
			Neuro: alert, awake, Pupil 2mm Rearl,
			Resp: Reg, non-labored, LS clear ∅ secretions SAO2 96% on RA
			Skin: color normal for Race shrapnal wound to (L) tempal region (L) shoulder & arm (R) thigh, (L) Knee, & Upper Back. Wound are clean. II site. (R) AC 20g saline locked. (R) wrist 18g infusing LR @ 50cc/hr
			Gastro: BS x 4 quads Mod soft nondistended.
			G.U. foley → gravity draining clear yellow urine
			Cardiac: ST, HR 100, NAD skin warm, dry (+) phenoneral pulse x 4 see rthm strip



PROTOCOL SYSTEMS, INC.

Plan: Dr [redacted] B(6)2 to examine at bedside to assess futher Tx. ~~With report~~ to oncoming shift.

(b)(6)-2

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

DARD FORM 510 (REV. 7-91) BACK

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: litter BY Anesthesia

2. PATIENT IDENTITY, RECORD REVIEWED AND PROCEDURE VERIFIED BY (b)(6)-2 UT/AN

3. DATE 24 Jul 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 1915 NUMBER 3

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC (b)(6)-2 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	lt (b)(6)-2 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

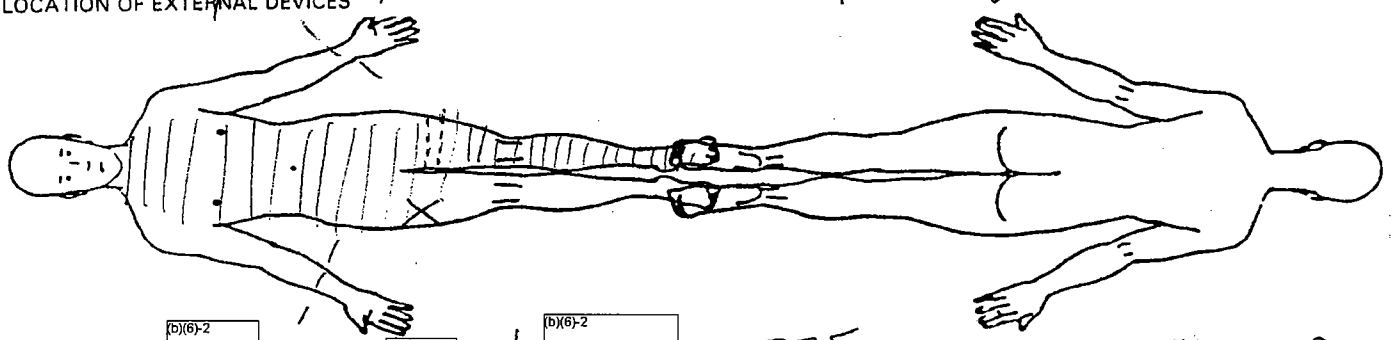
COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☒ OR (b)(6)-2 ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP
COMMENTS: ∅ nicks / cuts

PREP SOLUTION *(Specify)* Beta / Beta (Brandt's Sol on leg)
SITE: ABD - neck to pubis BY WHOM: Chase
SITE: (L) leg - TQ to toes BY WHOM: Chase
COMMENTS: ∅ pooling or irritation

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad (b)(6)-2 -- Safety Strap (b)(6)-2 = = = Tourniquet (b)(6)-2 @ 275 for 17 /// = prep

10. COUNTS

C = Correct I = Incorrect

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

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

(b)(6)-4

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

☐ ESU NO: #1 cut/coag = 50/50
GROUND PAD: BRAND Valley lab
LOT NO: 10527 exp 03-10

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

MEDCOM - 6892

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.01

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
NSS

OTHER ORDERS	TIME	CARRIED OUT BY

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

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 16 fr Foley	2.	3.
SITE	1. Bladder - in place on arrival	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
4x8
xeroform
fluffs
kerlex

19. ADDITIONAL INFORMATION
Dr (b)(6)-2
Dr
Dr

May (b)(6)-2 CRNA

20. OPERATION(S) PERFORMED
1) Ex-Lap
2) (L) knee I+D

21. PATIENT TRANSFERRED TO ICU TIME 21 48 METHOD litter

22. REGISTERED N (b)(6)-2 IA/AN

REVERSE OF DA FO USAPA V1.01

MEDCOM - 6893

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR Jul DAY 31

19 2003 HOUR

PULSE (O) — TEMP. F (°) — TEMP. C

105° — 40.6°

180 — 104° — 40.0°

170 — 103° — 39.4°

160 — 102° — 38.9°

150 — 101° — 38.3°

140 — 100° — 37.8°

130 — 99° — 37.2°

98.6° — 37.0°

120 — 98° — 36.7°

110 — 97° — 36.1°

100 — 96° — 35.6°

90 — 95° — 35.0°

80

70

60

50

40

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: 8'02"

WEIGHT →

Record special data only when so ordered

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

(b)(6)-4

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																	
POST-OPERATIVE DAY			24		25		26		27		28		29	30	31		
MONTH-YEAR	DAY		1						1								
19	HOUR																
PULSE (O)	TEMP. F (•)																TEMP. C
	105°																40.6°
180	104°																40.0°
170	103°																39.4°
160	102°																38.9°
150	101°																38.3°
140	100°																37.8°
130	99°																37.2°
	98.6°																37.0°
120	98°																36.7°
110	97°																36.1°
100	96°																35.6°
90	95°																35.0°
80																	
70																	
60																	
50																	
40																	

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE: 113/64; 122/70, 120/66; 122/70; 118/62; 129/75, 132/81; 126/72; 140/82; 149/72, 120/80; 134/96, 122/70

HEIGHT: WEIGHT →

Spo2: 92; 94/ 94; 92; 91, 92, 90; 94%, 94%; 95%, 95

Record special data only when so ordered

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

(b)(6)-4

REGISTER NO.

WARD NO.

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET	FROM _____ HOURS TO _____ HOURS	TOTAL HOURS COVERED	DATE

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1600	Water	500	500
1800	H_2O	500	1000
2100	H_2O	500	1500

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
2230	1000	NS	0253 1000		1000
0254	1000	NS	~~1000~~ 500	1000 ~~500~~	1500
1630	1000	LR	600	1635	1900

IRRIGATIONS ~~(N/G, Bladder, etc.)~~ UOP

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
1110	Foley (clr, yellow)	775	775
1635	Foley	300	1075

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC v1.00

(b)(6)-4

Ward/Section: ICW	Requesting Physician: (b)(6)-2	Laboratory Result Form (Subject to the Privacy Act of 1974)

LAST FIRST MI (b)(6)-4	DATE 1 AUG 03	TIME 1430	SSN/PSEUDO SSN: (b)(6)-4

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC		4.8-10.8 x 10
RBC		4.7-6.1 x 10
Hgb		14-18g/dl (M) 12-16 g/dl (F)
Hct		45-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10 Verified
Lymph %		20.5-51.1%

(Hematology) Manual Diff

Segs		
Bands		
Lymph		
Atyp		
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Coagulation Studies

Test	Result	Ref. Range
PT		9.8-13.6 secs
APTT		21-34 secs
INR		

Urinalysis

TEST	RESULT	REF. RANGE
Color	Yellow	N/A
App	clear	N/A
Glu	NEG	Negative
Bili	NEG	Negative
Ket	~~NEG~~ MOD	Negative ACETEST: MOD
SG	1.030	N/A
Bld	NEG	Negative
pH	5.0	N/A
Prot	NEG	Negative
Urob	0.2	0.2-1.0
Nit	NEG	Negative
Leuk	NEG	Negative
HCG		Negative

MET 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA*		128-145 mmol/l
K*		3.3-4.7 mmol/l
CL*		98-108 mmol/l
CO2		18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

Chemistry 12

Test	Result	Ref. Range
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA**		8.0-10.3 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

Malaria Smear

Results:

Microscopic UA

Results: WBC - 0-1 Amorph - light
RBC - 5-10 Mucus - Rare
EPT - 0 Bacteria - Few

Remarks:

Reported by: (b)(6)-2	DATE: 01 Aug 03	LAB ID NO:

LAST, FIRST (b)(6)-4 | DATE 24 Jul 04 | TIME | SSN/P (b)(6)-4 | (Subject to the Privacy Act of 1974)

TEST	RESULT	REF. RANGE
WBC	14.7	[illegible]
RBC	4.86	[illegible]
Hgb	14.1	14-16 g/dl (M) 12-16 g/dl (F)
Hct	42.8	42-52% (M) 37-47% (F)
MCV	88.1	80-97 fl
Plt	241	130-[illegible] x10^3/ml
Lymph %	10.6	20.5-51.1%

Diff		
Segs		Mono
Bands		Eos
Lymph		Baso
[illegible]		Imm
RBC morph		

[illegible]		42-52% 37-47%
Sed Rate		
Other		

Urinalysis			Misc Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Color	Yellow	N/A	RPR		Negative
App	Clear	N/A	Mono		Negative
Glu	NEG	Negative	**Microbiology**		
Bili	NEG	Negative	Source		
Ket	NEG	Negative	Gram Stain		
SG	1.030	N/A	Occ Bld		Negative
Bld	NEG	Negative	H. pylori		Negative
pH	5.0	N/A	Micro Parasites		
Prot	NEG	Negative	Malaria		
Urob	~~NEG~~ 0.2	0.2-1.0	O & P		
Nit	NEG	Negative	Other		
Leuk	NEG	Negative	**Microscopic Urinalysis**		
HCG		Negative			

CSF			Blood Bank	
Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED	
Directigen		Negative	ABO/Rh	A POS

Blood Bank Unit Crossmatch
(MUST SUBMIT SF518 WITH EACH UNIT REQUESTED)

TEST	RESULT	REF. RANGE	UNIT	TYPE	CROSSMATCH
[illegible]	12.9	9.8-13.0 [illegible]			
APTT	28.1	21.5-[illegible]			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

SUMMARIES: CBC, TYPE & Screen, PT/PTB, UA

REPORTED BY: (b)(6)-2 | DATE: 24 Jul 04 | LAB ID NO.:

MEDICAL RECORD — ANESTHESIA

DRUG	Dosage	
Versed	(mg)	2
Fent	(mcg)	250
STP	(mg)	350
Sux // Vec	(mg)	100 // 6 4
MSO4	(mg)	4 3
	( )	
VOLAT AGENT: Iso	% del / % e.t.	X-1.5-1.5-1.5-1.5-1.5-X
AIR	L/Min	
N2O	L/Min	
O2	L/Min	X-8-2-2-2-2-2-2

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "|"=CONSTANT INFUSION

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

TOTALS	
Z	
250 mcg	
350 mg	
100 // 10	
7	

TOTAL TIME: min

TOTAL URINE: 200

FLUIDS – SUMMARY
CRYSTALLOID– 1800
COLLOID– ∅
BLOOD– ∅

FLUIDS

LINE site		
NS	☐ Warmed	1000
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES: EST BLOOD LOSS / URINE – 200

PHYS STATUS: 1 (2) 3 4 5 (E)

BODY WEIGHT: 85 (KG) LB

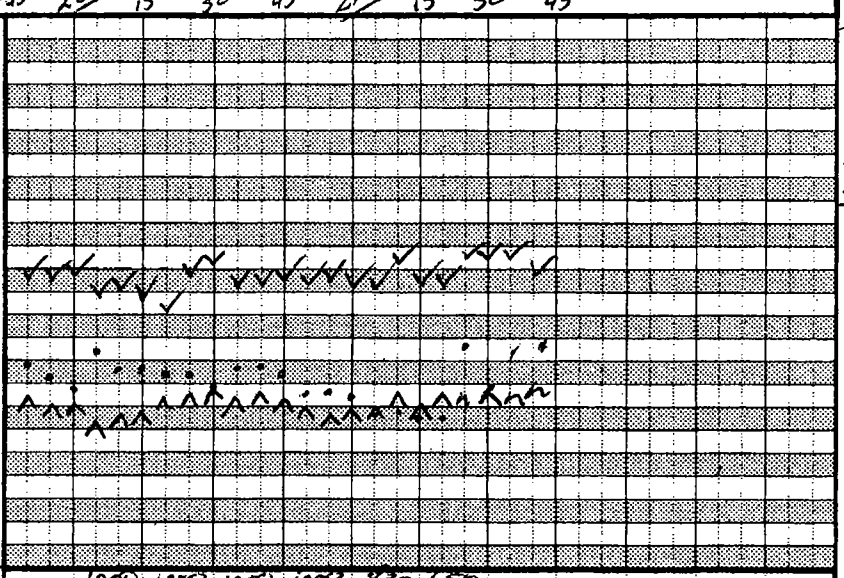
HEMATOCRIT:

INITIAL DATA: BP – 124/80; R-24; HR– 106

COMP CHECK: OK?– (Y) N

PATIENT RECHECK: OK for PROCEDURE? Y; TIME– 1945

SYMBOLS: BP by cuff; Heart rate; Resp rate; BP (transduced); TOURNIQUET T – X; ANES– X-X; PROC– ⊙–∅



VT – ml		1000	1000	1000	1000	850	650	
f – breaths/min		10	10	8	8	8	8	14
Peak inf pres / PEEP		20	20	21	22	21	18	
MODE– S(pon), A(ssist), C(on)		S	C	C	C	C	C	S
BP/Auto Cuff	ET CO2 (torr)	(+)	30	30	29	28	26	30	(+)
BP / oth	FIO2 (Frac or %)	.92	.92	.92	.92	.92	.91	.92	.92
ART line	SpO2 (%)	98	97	97	97	97	97	97	97
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	SR	
Gas analyzer	TEMP- site								
	N-M Block (T/4)	0/4	0/4	1/4	3/4		4/4	EST	
Tourniquet @ 275mm Hg									total time 17 mins
Warming blkt									
Conv warmer									

Mark with letters & symbols, explain under REMARKS — EVENTS — Position → o-1

REMARKS– Code drugs with numbers, events with letters

1945 pt IDd; plan of Care Reviewed & pt
1950 In Rm Monitors O.
1957-1959 Induction & Intubation
2050 Complete DPL
2105 started (L) Knee
2140 pt SVs good TV pt Extubated & pos. pres

RECOVERY AT 2145
(PACU) ICU _____ (Specify)
OTHER _____
CONDITION: Stable
T-96.1
RESP– 14 SpO2– 97
BP– 125/65 HR– 104

ANESTHESIA & PROCEDURE TIME

	Start	Room	End
ANES	1945	1950	2145
PROC	Ready	Begin	End
	2000	2020	2125

PROCEDURES and CPT Codes: DPL / (L) Knee Debridement

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: DL X1 c̄ 4 MAC Visualized Cords; Intubated c̄ 8.0 ETT to 21cm @ lip Bilat BS; ETCO2 X5 waves, Eyes taped

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

SURGEONS: (b)(6)-2

ANESTHETISTS: MAJ V (b)(6)-2 AN, CRNA — Nurse Anesthetist

PROCEDURE LOCATION: Iso 1-1

DATE: 24 July 03

PAGE 1 OF 1

MEDICAL RECORD — ANESTHESIA
WAMC OP 376 REVISED
1 Jan 99

MEDCOM - 6899

*U.S. GPO: 2002-729-180/40137

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age ~40 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

ASA Physical State 1 (2) 3 4 5 E
WT: 82 KG LB HT: 170 cm IN.
ALLERGIES: NKDA

PROPOSED PROCEDURE: Ex Lap / (L) knee
SURGICAL SERVICE: Gen / ortho
NPO SINCE: 1720

HABITS:
TOBACCO: (+) 2-4 cigs/day
ETOH: SOC
DRUGS:

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) Toradol 30 mg 1630
( ) MSO4 10 mg 1553
( ) Ancef 1g 1558
( )
( )
(X) Tylenol Zantac
+ other med for GERD

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

LABORATORY STUDIES:

HB/HCT: ___
U/A: ___
OTHER: ___

146 | 109 | 12 <102
3.6 | 26 | 1.0

14.7 > 14.1 / 42.8 < 241
PT = 13 PTT = 28

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
Hypertension N Y
Angina N Y
MI N Y
CVA N Y
Other N Y

Pulmonary System:
Asthma N Y
Bronchitis/URI N Y
COPD N Y
Other N Y

Renal System:
Acute/Chronic RF N Y

Gastrointestinal:
Hepatitis N Y — Colonic pain / bloating
Hiatal Hernia N Y — diarrhea - periodically
PUD/GERD ~~N~~ Y — Ulcer hx
(+) GERD

Endocrine System:
Diabetes N Y
Steriods N Y
Thyroid N Y

Neurological:
Seizures N Y
Neuropathy N Y
Other N Y

Gynecological :
Pregnancy N Y — N/A

Other Significant Hx:
N Y
N Y
N Y

Familial HX

ASSESSMENT
PAST SURGICAL/ANESTHETIC

Ø

PHYSICAL EXAMINATION 9602 24
BP 124/80 HR 106 R 24 T ___
Pain Scale 0-10 ___
HEENT - Teeth intact
Trachea Midline
TMJ/Neck FROM
Oropharynx MP 2
Nares patent
4PB TMJ+
CHEST: CTA (B)
CARDIAC: S1 S2 RRR
EXTREMITIES:
IV Access: 14g RAC
Ulnar Filling: 18g R wrist
BACK: ___
OTHER: ___

NPO Since 1800 water

Shrapnel wounds back, (+) shoulder + (L) knee from mark 19 grenade.

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

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

The patie[redacted]tand and agrees. Questions answered.
Signed: [redacted] CPT/CRNA Date: 24 JUL 03 Time: 1905 Hrs

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

Signe[redacted] CPT/CRNA Date: 25 JUL 03 Time: 0915 Hrs

Patient Identification: (Ward) ___

[redacted]

SEDATION KEY:

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 9/24 TIME OF ORDER 1700 HOURS

(1) Adm. P ICU
(2) VS q10
(3) Strict I+O
(5) NPO
(6) No pain meds
(7) drains to wounds
(8) LRc 150 cc/hr

LIST TIME ORDER NOTED AND SIGN

1800 MAG

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER CBC at 2000 TIME OF ORDER HOURS

24 JULY 03
ADMIT ICU C/O
DOC FRAGMENT WOUNDS (L) LEG
BACK & FACE
COND SERIOUS
VS ROUTINE
ACT EPW RESTRAINTS - DOB > 60

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER NKA TIME OF ORDER HOURS

NPO ADT
LR TKA 75 cc/HR - HEPLOCK WHEN
PO OK
D/C FOLEY @ MN - STAT CATH Q6° PRN
ANCEF 1 GM IV Q8° x 3 DOSES
MS 2MG IV Q15' PRN UP TO 16MG/4HR
PHENERGAN 1 gm PO Q4° PRN

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

PHENERGAN 25 MG IV Q8° PRN
TYLENOL 650MG PO/PR Q4° PRN
VS Q1° W/A

(b)(6)-2

LTC, MC ORTHOPEDIC SERVICE

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

24° chart ✓ 25 Jul 03 @ 0100

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

U.S. GOV

MEDCOM - 6901

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

DATE OF ORDER: 30 Jul 03 TIME OF ORDER: 1430 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Percocet 1 - 11 tabs po @ 4-6° pm pain (b)(6)-2

VO: Dr. [redacted] / G (b)(6)-2

24° chart ✓ 26 Jul 03 @ 0024 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER: 27 Jul 03 TIME OF ORDER: 1335 HOURS

Give Zantac 150 BID po

(b)(6)-2

COL, MC

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 27 JUL 03 TIME OF ORDER: 1630 HOURS

(1) Maalox or Mylanta 30cc po q4° prn indigestion.

(b)(6)-2

27 JUL 03 1930

(1) Biscodyl p.R. x 1 now.

(b)(6)-2

NURSING UNIT | ROOM NO.

PATIENT IDENTIFICATION

DATE OF ORDER: TIME OF ORDER:

~~24° chart ✓ 00 28 July~~ HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 7/27 TIME OF ORDER: 0730 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) D/c Foley

(b)(6)-2

(b)(6)-2

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 28 Jul 03 @ 0015 TIME OF ORDER: HOURS

(b)(6)-2

(1) 24 chart ✓

(2) 40 chart check 1 Aug 03

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 1 Aug 03 TIME OF ORDER: 0930 HOURS

(b)(6)-2

(1) CXR

(2) UA

(b)(6)-2

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 8/3 TIME OF ORDER: 10 AM HOURS

(1) D/c when released by MPs (to custody)

(b)(6)-2

WATTERSON

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

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. ___ Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 24	25	26	27	28	29	30	31	1	2	3
24	(b)(6)-2	VS - Q10	05											
			17											
24		Strict I&O	05											
			17											
24		NPO	05											
			17											
24		No Pain meds	05											
			17											
24		Dressing to wounds	05	/	(b)(6)-2							(b)(6)-2	(b)(6)-2	
		Change (Nursing)	17	/										
24	(b)(6)-2	Vitals Routine	6	/	(b)(6)-2								(b)(6)-2	
			14	/										
			22	MK									(b)(6)-2	
24	(b)(6)-2	Activities EPW	6	/	(b)(6)-2							(b)(6)-2		
		wrist Restraints	12	/										
		OOB TID	18	MK									(b)(6)-2	
24	(b)(6)-2	Regular Diet	7	/	(b)(6)-2							(b)(6)-2		
			12	/										
			17	MK									(b)(6)-2	
24	(b)(6)-2	15 While Awake	6	/	(b)(6)-2							(b)(6)-2		
			18	/									(b)(6)-2	
24		[illegible]												

ALLERGIES: ☐ YES ☑ NO	PRIMARY DIAGNOSIS:	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
NKA	Dx: Shrapnel Fragment Wounds (2) Knee Back and Face	PAGE NO: ___

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

Verif. by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 7 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
24 July	(b)(6)-2	CSC @ 2000	24 July	2000	2000	(b)(6)-2
24		Admit ICW c/o Granville				
24		Condition Stable				
	-----	D/C Foley @ MN	25 Jul		0100	(b)(6)-2
25	(b)(6)-2	NIO: PTD by 1000	1000	unable		—
27		NIO DTV by 1700	27 Jul		Done	
Aug 03		CXR NW	1 Aug	NW	0950	(b)(6)-2
Aug 03		UA	1 Aug	ASAP		

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
24	(b)(6)-2	D/c Foley e MN														
-----	-----	and Straight Cath														
-----	-----	q 6° PRN														
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															

USAPA V1.00

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 24	25	26	27	28	29	30	31	1	2	3
24	(b)(6)-2	LR @ 50cc/hr 75cc/hr	6	/	(b)(6)-2									
		HL when po OK	14	/							HL			
			22		(b)(6)-2		(b)(6)-2							
27 Jul 03	(b)(6)-2	Zantac 150mg po	10	/	/	/	(b)(6)-2							
		bid	22	/	/	/								

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Dx: Stripped Wound (D) Knee Back Pain

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 7 Yr. 08
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
24	[redacted]	Ancef + Gm IV q 8° x 3 doses	7/24	2300	2315	[redacted]
			7/25	0700	0710	
			7/25	1500	1400	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
24	[redacted]	MSO4 2mg IV 15' PRN up to 16 mg in 4 hours	7/24 2305 2mg	7/24 2345 2mg	7/25 0019 2mg	7/25 0123 2mg	7/27 0700 2mg	25 [redacted]	25 [redacted]	25 0141 2mg	25 1141 2mg	25 1141 2mg	27 2031 2mg	28 2222 2mg	MAC 0000 2mg	
24	[redacted]	Phenergan 25mg IV q8' PRN	7/25 0153 25mg	7/25 2131 25mg	2100 2210 25mg											
24	[redacted]	Tylenol 650mg PO PRN q4°	7/25 0149	7/25 0135	25 [redacted]	25 2012	25 [redacted]	25 [redacted]	30 [redacted] @ 0400							
25	[redacted]	Percocet 5/325 - 1 tab PO Q4-6° PRN pain	7/25	7/26 0900	7/26 2300	7/27	7/30 2000	7/31	2302	30 [redacted]						

USAPA V1.00

Verify by Initialing		TI IC DOCUMENTATION CARE PL (MEDICATIONS)				Mo. 07 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
27	(b)(6)-2	Enema P.R., NT now	27/7	2000	2000	(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED												
27Jul	(b)(6)-2	Maalox or Mylanta	27Jul 1650												
		30cc po Q4O prn	AD 30cc												
		indigestion													

USAPA V1.00

1. LAST NAME, FIRST NAME / NOM ET PRÉNOM: JOHN DOE (b)(6)-4

RANK / GRADE

[X] MALE / HOMME
[ ] FEMALE / FEMME

SSN / NUMÉRO MATRICULE

SPECIALTY CODE / GPM

RELIGION / RELIGION

2. UNIT / UNITÉ

FORCE / ÉLÉMENT: A/T | AF/A | N/M | MC/M

NATIONALITY / NATIONALITÉ: IRAQI CIV / EPW

[X] BC / BC | [ ] NBI / BNC | [ ] DISEASE / MALADIE | [ ] PSYCH / PSYCH

3. INJURY / BLESSURE

FRONT / DEVANT | BACK / ARRIÈRE

Leg

[ ] AIRWAY / TRACHÉE
[ ] HEAD / TÊTE
[X] WOUND / BLESSURE
[ ] NECK/BACK INJURY / BLESSURE AU COU/AU DOS
[ ] BURN / BRÛLURE
[ ] AMPUTATION / AMPUTATION
[ ] STRESS / TENSION
[ ] OTHER (Specify) / AUTRE (Spécifier)

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE

[X] ALERT / ALERTE
[ ] VERBAL RESPONSE / RÉPONSE VERBALE
[ ] PAIN RESPONSE / RÉPONSE À LA DOULEUR
[ ] UNRESPONSIVE / SANS RÉPONSE

5. PULSE / POULS | TIME / HEURE

6. TOURNIQUET / GARROT: [X] NO / NON [ ] YES / OUI | TIME / HEURE

7. MORPHINE / MORPHINE: [X] NO / NON [ ] YES / OUI | DOSE / DOSE | TIME / HEURE

8. IV / IV | TIME / HEURE

9. TREATMENT / OBSERVATIONS / CURRENT MEDICATION / ALLERGIES / NBC (ANTIDOTE)
TRAITEMENT / OBSERVATIONS / PRESENTE MEDICATION / ALLERGIES / ANTIDOTES

BP 120/90
P 64
R 12

LUNGS: CTA B
ABD: NTTP SOFT

10. DISPOSITION / DISPOSITION

[ ] RETURNED TO DUTY / RETOUR À L'UNITÉ
[X] EVACUATED / EVACUÉ
[ ] DECEASED / DÉCÉDÉ

TIME / HEURE

(b)(6)-2 | TÉ (b)(6)-2 | DATE/DATE (YYMMDD) 03 07 2

DD Form 1380, DEC 91 — This form replaces previous editions of DD Form 1380 and DD Form 1380 (TEST), which are obsolete.

U.S. FIELD MEDICAL CARD
FICHE MÉDICALE DE L'AVANT ÉTATS-UNIS

12. REASSESSMENT / RÉASSESSMENT

DATE / DATE (YYMMDD)	TIME OF ARRIVAL / HEURE D'ARRIVÉE

TIME / HEURE	1400	1420		
BP / PS	120/90	116/76		
PULSE / POULS	64	82		
RESP / RESP	12	22		

DATE / TIME
DATE / HEURE

13. CLINICAL COMMENTS / DIAGNOSIS
INFORMATION MÉDICALE / DIAGNOSTIQUES

SHRAPNEL TO BACK,
HEAD (L) EXR : (R)
MIGHT

14. ORDERS / ANTIBIOTICS (Specify) / TETANUS / IV FLUIDS
DIRECTIVES MÉDICALES / ANTIBIOTIQUES (Spécifier) / TÉTANOS / IV FLUIDE

(1) DRESSING
(2) IV NS 14g (R) AC
TKO
(3) TORADOL 30mg IVP

15. (b)(6)-2 , PA. DATE/DATE (YYMMDD) 030724

16. DISPOSITION

	RETOUR À L'UNITÉ
X	EVACUATED / EVACUÉ
	DECEASED / DÉCÉDÉ

TIME / HEURE

17. RELIGIOUS SERVICES / SERVICES RELIGIEUX

	BAPTISM / BAPTISÉ		PRAYER / PRIÈRE
	ANOINTING / ONCTION		COMMUNION / COMMUNION
	CONFESSION / CONFESSION		OTHER / AUTRE

CHAPLAIN / CHAPELAIN

DD Form 1380, DEC 91 (Back)

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. [illegible]ION (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 (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19 20 21 22 23 24 25 26	27 28 29	30	31	
[redacted]	4 0 Y	X	9	UNK

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34	N/A b(6)-4	35 36	37 38 39 40 41 42 43 44 45
		9 9	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
N/A	46	1540	N/A
	U		

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

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
62 63	64 65 66 67 68 69 70	71 b(6)-4	YEAR
[redacted] b(3)-1		Ø 9	[X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72	ICW	
0		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 (YYYYMMDD)
73 74	75 76 77 78 79 80	81 82 83 84 85 86 87 88
2 8		2 0 0 3 0 8 0 2

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
A B A A		2 0 0 3 0 7 2 4

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
[redacted] b(3)-1		

FOR LOCAL USE

DX: FRAGMENT WOUNDS
L KNEE/ BACK/ FACE

DX-87340
8760
8910
E9919
5411
PR-8622
Trauma-1
Injury-449

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

SIGNATURE OF ADMITTING CLERK
(b)(6)-2 PFC, 91G

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

(b)(3)-1

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

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

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

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

11. FMP	12. SSN	13. Organization	14. Ward
20	(b)(6)-4		ICU

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

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	22:00	AEA - ORTHOPEDICS

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	HOME	2003-08-09

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-07-31	DR (b)(6)-2

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
(b)(3)-1	2003-07-31	

31. Selected Administrative Data

Marital Status: DoB:

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

R elbow fx L wrist cellulitis

813.11 682.4

35. Total Days This Facility

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

35. Total Days This Facility

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

Signature of Attending Medical Officer	Signature of PAD or Medical Records Officer
(b)(6)-2 COL, MC	(b)(6)-2 SSG, PAD NCOIC

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)

7/31/03

TIME: 5TJ

BP 130/80

P 100

RESP 14

TEMP 100.

ALLERGIES

MEDS

PMHx

PSHx

(S) Pt, high Value (PV), brought to Clinic after
det a fall which apparently occurred during interrogation
Pt brought in by SF personnel.
Pt in some pain but composed

(O) Pt in no obvious distress
VS
Rt elbow with obvious dt and swelling
crepitus at olecranon
bony fragment possibly palpated

Face: bruise c abrasion L side of nose
eyes dilated
TOPAZ 60 IM given

(A) Apparent Elbow Fx
possible nasal fracture

(P) Rt Elbow post splint w/ simple sling
L Facial nose skin cleaned
Pt sent to (b)(3)-1 (b)(6)-2 (b)(6)-2 (b)(6)-2 MAJ MC 148 44 0997

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

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

REGISTER NO.

WARD NO.

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

USAPPC V1.00

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL — DATE: DAY 31, MONTH Jul, YR 03 — TIME: 1951

TRANSPORTATION TO HOSPITAL (Attach care provided sheet): [X] PRIVATE VEHICLE [ ] AMBULANCE [ ] OTHER (Specify)

CURRENT MEDS. (Tetanus immunization and other data): Providone

HISTORY OBTAINED FROM: [ ] PATIENT [ ] OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): broken R arm TOF ? 1900

SEX: M AGE: 44

POSSIBLE THIRD PARTY PAYER? [ ] YES [ ] NO

TIME SEEN BY PROVIDER: 2000

VITAL SIGNS

TIME	1954		
BP	137/87		
PULSE	112		
RESP.	16		
TEMP.	96.4		
HT. (Child)	98RA	198cm	81kg

CATEGORY (See reverse)
- EMERGENT
- URGENT
- NON-URGENT

ORDERS	INITS.	TIME
X ray R Elbow R wrist		
CBC, Hepatitis		
Metz		
Anect IGM IV		
MS04 5mg IV		
CXR EKG		

ASSESSMENT/DIAGNOSIS: L wrist Cellulitis; R Olecranon fx

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination, include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures, include medication given and follow-up)

S - 44 y/o ♂ c/o broken R arm. Pt fell L wrist is also swollen. Pt has pain in back and shoulders 9/10. Pt also states difficulty breathing. Subjective fever yesterday. In custody x3 d but ⊖ elbow deformity until today. Fall Quest ⊖ fall 2° to flex cuffs. R HD

O: wd/wn in Mild dist. 2° elbow wrist pain. ⊖ resp distress. occas cough

HEENT: WNL

Lungs: B CTA

Cor: RRR

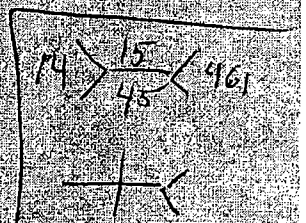
Abd: BS 5 NT no g/r

Ext: R elbow mod dorsal swelling + crepitus. R arm ace tape

Minimal L wrist linear transverse dorsal abrasion

2° to flex cuffs c erythema, mod swelling

PMHx: Diabetes Non Insulin, PSHx: skin graft 93 Motorcycle accident. ⊕ Tob ⊖ ETOH



X Ray: L wrist ⊖ C/F Arthritis. R elbow c 2cm displaced olecranon fx

DISPOSITION (Check all that apply)
- HOME
- FULL DUTY
- QUARTERS: 24 Hrs. / 48 Hrs. / 72 Hrs.
- MODIFIED DUTY UNTIL: DAY / MONTH / YEAR
- REFERRED TO (Indicate clinic): Ortho
- EMERGENCY [X] TODAY
- 32 HOURS [ ] ROUTINE
- ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
- [X] IMPROVED
- UNCHANGED
- DETERIORATED

TIME OF RELEASE: 2200

(CONTINUE ON SF 507, IF NEEDED)

PATIENT'S IDENTIFICATION (Mechanical imprint). FOR WRITTEN ENTRIES GIVE: Name - last, first, middle, SSN, DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).

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

AND ID STAMP

Plans (Include medications and follow-up): To JCW then OR.

MAJ MC

EMERGENCY CARE AND TREATMENT

STANDARD FORM 558 (Rev. 6-82) Prescribed by GSA and ICMR FIRMR (41 CFR) 201-45.505

MEDCOM - 6914

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

MAD 44 y/o ♂ EPW c (R) ELBOW INJ. WHILE IN CUSTODY @ ~ 1900. IN CUSTODY 3d.

PMH: DM ON MED. NKS - FEVER

PSH: SCSG ~~ABDL~~ 2° MVA '93 183 CM

NKA 81 KG

MED - ?

HABITS - ETOH SMK CIGS

PHYSICAL EXAMINATION

MAD

MAXILLARY NOSE ABRASION

CHEST CTA

CVS RRR S(M)

ABD SOFT NT c NABS

EXT (R) ELBOW c OLECRANON ABRASION FEMORS

STS - NO EXT AGAINST RESIST. NVI DIST

(L) WRIST c VOLAR ABRASION c SURROUNDING ECHYMOSIS

PROGRESS (Enter date of discharge and final diagnosis)

XR - DISPLACED (R) OLECRANON FX c MINIMAL COMMINUTION (L) WRIST Ø FX CA++ RADIUS ANT.

A - DISPLACED (R) OLECRANON FX c OVERLYING ABRASION & CONCOMITANT (L) WRIST CONTUSION

P - SPLINT, ADMIT FOR IV ABX, ORIF c INFECTION UNDER CONTROL

(b)(6)-2

DATE 31 DEC 03 | IDENTIFICATION NO.

(b)(6)-2

(b)(6)-4

REGISTER NO.

LOC NO.

ORTHOPEDIC SERVICE

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

9 AUG 03 NARRATIVE SUMMARY
ADMITTED 31 JUL 03
D/C'D 9 AUG 03
DXS - 1 - (R) OLECRANON FX
2 - (L) WRIST CELLULITIS
3 - DM
PROCEDURES - ORIF (R) OLECRANON FX - 2 AUG 03
RESUME: PHD 44 y/o EPW ♂, SADDAM BODYGUARD IN CUSTODY SINCE 28 JUL 03 c/o ELBOW PAIN AT 1900 ON DAY OF ADMISSION.
PE → ABRASION C̄ SURROUNDING ECCHYMOSIS. EDEMA MA (L) WRIST & SUPERFICIAL ABRASION C̄ SWELLING, Ø ACT. EXT., & PALPABLE OLECRANON FX (R) ELBOW. PMH NRADM & GLUCOSE 250 ON ADMISSION.
ADMITTED & RX'D 48° IV UNASYN Ā ORIF WITH GEM ON 2 AUG 03. IV ABX CONT FOR 7D, THEN SWITCHED TO AUGMENTIN. SCANTS ON GLYBURIDE C̄ GOOD RESPONSE. SCAPS REMOVED ON POD 8.
WILL REMAIN IN LAC UNTIL 23 AUG 03.
DISPO - D/C IN MP CUSTODY FU 23 AUG 03
MEDS - AUGMENTIN 500 TID, GLYBURIDE 5MG QD, LORTAB PRN

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

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

(b)(6)-2

(b)(6)-4

LTC MC
ORTHOPEDIC SERVICE

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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

(b)(6)-4

ABBREVIATED MEDICAL RECORD

Standard Form 539

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

539-106

(b)(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
	Nursing Notes
31 July 03 2300	Admitted Pt to ICW from EMT Ambulatory in stable condition a.c. companied by Staff. IV SL flushes well. Breathing [illegible] SOB or laboured breathing. Pt able to move all extremities without complications (R) Elbow dressing intact Pt has fracture. Ø S/S of bleeding noted on dressing. (R) wrist in dressing for cellulitis. Pt c/o pain in (R) Elbow Fortabs II tabs PO given for pain. Abd soft and non tender. will continue to monitor pain status — (b)(6)-2 — 10/[illegible]
2330	Pt Ambulating — (b)(6)-2 — 10/[illegible]
0015	Blood drawn and sent to lab Results pending — (b)(6)-2 — 10/[illegible]
01 Aug 03	Received PT, PT sleeping, will continue to monitor — SGT (b)(6)-2 — EPN
1 Aug 03 -	1800 - ASSESSMENT - A+O x3, PERRLA, LUNGS CTA BILAT, S1-S2 STRONG + REG, (A)BS x4. IV NS @ 150cc/hr to (R) AC. DRSG to BOTH UPPER EXTREMITIES, C, D, I, TOLERATED 2000 KCAL DIET. VNASYN GIVEN @ 1800. EPW. RESTRAINTS. WILL CONTINUE TO MONITOR THROUGHOUT — (b)(6)-2 — SGT. EPN
	TOTAL OUTPUT - 1000cc. TOTAL INTAKE - 3150 cc

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
2 Aug 03 0900	Nursing: Pt glucose level 153 mg/dl, results on chart — LT [(b)(6)-2] AM
0950	Nursing: Pt ↑ OOB to bum-out latrine c̄ NP escort. Ambulate c̄ difficulty — LT [(b)(6)-2] AM
1000	Nursing: Assessment: Pt ↑ in bed, alert. Lung CTA, HR reg; BS x4. Abd soft, distended. Disc (B)LE CDI. (R)LE c̄ brisk cap refill to all fingers, warm, dry. (L)LE c̄ ±2 brachial pulse, brisk cap refill, warm & dry. IV site to (L) fa, NS infusing @ 150cc/hr. Pt scheduled to go to OR today. Pt given bath & gown Δ'd. Glucose results for this am 153 mg/dl - LT [(b)(6)-2]
2 AUG 03	OP NOTE PREOP DX - (R) OLECRANON FX POSTOP DX - SAME PROCEDURE OLLF - TENSION BAND - (L) OLECRANON SURG [redacted] / [redacted] b(6)-2 ANES GEN MONCOM FLUIDS 500 NS EBL MIN TT 76' @ 250MM IMPLANTS 2 x 1.6 MM K WIRES & 3 STRANDS #2 SERVAL WIRE FINDINGS - OSTEOPOROTIC BONE, COMMINUTED OLECRANON FX. TO ICU TOMORROW STABLE [(b)(6)-2] LTC, MC ORTHOPEDIC SERVICE Night shift I+O note Input - 3540cc Output - 975cc

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
7 Aug 03	1900 - ASSESSMENT - A+O x3, PERRLA, LUNGS CTA BILAT, S1-S2 STRONG AND REGULAR. (+) BS x4, CAST TO (R) ARM C,D,T, (L) WRIST SWOLLEN, TENDER TO TOUCH. IV'd TO (R) AC. OOB TO LATRINE. TOLERATED REG DIET. IS q 1°, Ø C/O PAIN. PT RESTRAINED TO BED. WILL CONTINUE TO MONITOR ENVIRONMENT — (b)(6)-2 SGT, USA
8 Aug 2003 1035	Nursing: Assessment: Pt awake, A in bed, c/o little pain. Alert, Lungs CTA, HR 88, reg, (+) BS x4, abd soft. Pt A OOB amb PO BR S assist. (R) UE E cast CDT. (R) fingers to brisk cap refill, warm, dry. — (b)(6)-2 LCT, AN
1440	Nursing VS: Pt temp 100.5. Given Tylenol PO, ~~[illegible]~~ — (b)(6)-2 LCT, AN
8 Aug 03 1800	Nursing Note: Assumed care of Pt sitting up in bed. Vitals stable breathing intact Ø SOB or labored breathing Ø complain. Encourage PO fluids due to down generator and ↑ heat in hospital today Pt able to move all extremities. (R) Arm wrapped Ø drainage or bleeding noted. Will continue to monitor status — (b)(6)-2 [redacted]
2150	Pt C/O pain in Arm. 2 Lortabs PO given for pain. Will continue to monitor — (b)(6)-2 [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO.

(b)(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
9 AUG 03	S NO C/O O VSSA WNL CVR SO & SS, LAC ATROPHY A DONTOCYTE P D/C (b)(6)-2 [redacted] (b)(6)-2 [redacted] LTC, MC ORTHOPEDIC SERVICE
9 Aug 03 17HO	Nursing Notes: Assumed care of Pt A+O sitting up in bed. tolerated ADA diet. Breathing intact & SBS or Labored breathing Restraints in place. Ø IV Access. Pt able to move all extremities. Able to wiggle fingers on affected hand. Abd Soft and nontender will continue to monitor status (b)(6)-2 [redacted] 1267/AN
2130	Pt C/o pain in (R) Arm Percocet II PO given will continue to monitor (b)(6)-2 [redacted]
10 Aug 03 0800	Nursing Discharge Pt dic to MPs, meds + narrative summary given. Ambulated ambulatory (b)(6)-2 [redacted] CPT

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2 AUG 03	- ASSESSMENT - 2315 - A&O x3, PERRLA, LUNGS CTA BILAT, S1 S2 STRONG AND REGULAR. HYPOACTIVE BOWEL SOUNDS. S/P ORIF (R) ELBOW. CAST/DRSG C,D,I, PAIN MANAGED E MSO4 IV 2-4mg. PT RESTING COMFORTABLY. IS @ 1°. UNASYN GIVEN @ 2400. WILL CONTINUE TO MONITOR THE PATIENT THROUGHOUT (b)(6)-2 SGT, USA
4AUG03 @ 0225	NSG SHIFT assessment: Pt c/o pain at approx 2355. 15 minutes after admin, pt appeared to sleep. (R) arm is raised onto a pillow, and cap refill to fingers is WNL. Dressing to elbow/arm is CDI. Encouraged use of incentive spirometer while awake. No complaints at this time. will cont to monitor (b)(6)-2
4AUG03 1400	POD 2 S NO C/O O VSSA RUE NVI WND CLEAN LAC PLACED NVI A DEMO WELL P FINISH 7-10 D IV ABX (b)(6)-2 (b)(6)-2 LTC, MC ORTHOPEDIC SERVICE

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

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

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

USAPA V2.00

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2 AUG-03	Procedure: ORIF (R) elbow
	Preop vital signs 134/80
	Meds in OR 500mg Fent 2 versed 30mg IV Toradol
	EBL - minimal Fluids in OR
	Vital Signs on arrival
	2215 158/91 P.O. 100% 10L 80-HR
	2220 138/85 P.O. 100% 10L 86-HR
	2225 132/82 P.O. 99% 5L 82-HR
	2230 137/89 P.O. 99% 5L 80-HR
	2240 146/85 P.O. 96% RA
	Hx: chronic EDH, Head Injury, Diabetic, Hep C
2220	On arrival to ICW from OR - Pt on litter c̄ litter straps
	O^2 @ 10L P.O. 100% Vital Signs 158/91 P-67 - Pt c̄ cast and
	Dsg to (R) elbow D,D and intact - Pt able to move all extremities
	Pt. follows verbal commands - ∅ pain noted or verbalized
	IV 18G to (L) FA patent inhling NS @ TKO - Cap refill to
	(R) hand brisk < 2 seconds ——— (b)(6)-2 [redacted] signature
2250	Pt. vital signs to ICW 146/85 P-72 - R-12
	P.O. 96% RA ——— (b)(6)-2 [redacted] signature

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

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

(b)(6)-4 [redacted]

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3 AUG 03 0930	POD 1
	S LOCAL PAIN
	O VSSA
	(L) WRIST CONTUSIONS RESOLVING
	(R) ELBOW DSG & SPLINT INTACT
	NVI DISTALLY
	A DOING WELL
	P LAC IN 2D
	FINISH 7-10D COURSE UNASYN
	(b)(6)-2 [redacted]
	LTC, MC (b)(6)-2 [redacted]
	ORTHOPEDIC SERVICE
4 AUG 03	POD 3
	S NO C/O
	O VSSA
	(L) WRIST CONTUSIONS RESOLVED
	(R) LAC INTACT
	A DOING WELL P D 7-10 PO ABX INACTIVE

(b)(6)-2 [redacted]

STANDARD FORM 600 (REV. 6-97) BACK

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

510-112 NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4AUG03		2300	NSG shift assessment: Pt c/o pain to (R) elbow at approx 2200; was given MSO4 for pain, and elbow was placed on a raised blanket for pain relief. Described adequate pain relief approx 10 minutes after above actions were taken. Pt has good cap refill to rt hand, but there is still some swelling to that hand. VS WNL, resp clear & unlabored, will continue to monitor [redacted]
5AUG03		1430	Nursing: Shift note Pt c/o pain X1 this shift c lortab. Able to ambulate w/o assist. >50% for breakfast + lunch. P.O. liquids ↓ 500cc. ↑ alertness. Able to eat w/assist. Continue to assess [redacted]
5Aug03		1800	Nursing Notes: Assumed care of Pt A+O lying in bed. Ø c/o pain. IV out will Replace. Abd soft and Ø tender. Able to move all extremities. Breathing unlabored Ø SOB or labored breathing [redacted]

(Continue on reverse side)

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

NURSING NOTES
Medical Record

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

MEDCOM - 6925

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
5 August 1850			Nursing Notes: New SL in place flushes well. Ø S/S of infiltration IV Antibiotic infusing to patency. Pt denies pain at this time. Able to wiggle fingers on affected arms. Pt comply when demonstrated to pronate and flex feet. Voids spontaneously. Will continue to monitor status. [redacted]
6 Aug 03	0229		Pt c/o pain. 1 mg IV MSO4 given, will continue to monitor status. [redacted]
6 Aug 03			PT sleeping, VSS, will continue to monitor. — SGT [redacted] EPN
6 Aug 03		1757	Nursing Notes: Assumed care of Pt alert and oriented. Pt tolerated Regular diet Ø N/V. Pt sitting up in bed. Able to wiggle fingers under cast. Breathing intact Ø SOB or labored breathing. Abd soft and non tender. Will continue to monitor status. [redacted]
6 Aug		2152	Nursing Notes: pt ambulates for 10 minutes in halls of ward and in PLX corridor. Tolerated it well. Did some stretches and deep breathing exercises. Tolerated it well. Back to bed EPW. Status in place. [redacted]

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

STANDARD FORM 510 (REV. 7-91) BACK

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ____ TO ____ | TOTAL HOURS COVERED | DATE 2 Aug 03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1700	H_2O	150	150
2AUG 0000	NPO		

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
		NS	1000	1742	1000
1742	1000	NS	1000	2258	2000
2258	1000	NS	1000	0300	3000
2AUG 0300	1000	NS	1000	0730	1000
0730	1000	NS	1000	1140	2000
1140	↑1000	NS			
1140	↑100	Unasyn	100		
1800	↑100	UNASYN	100	1900	

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
1830	400	400			
2141	600	1000			
0300	400	400			
0950	300	700			
1410	450				

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT: 1700

REMARKS

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

(b)(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 792, JAN 74

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) JUL 72 WHICH MAY BE USED.

USAPPC V1.00

21 38
10 4

TWENTY-FOUR HOUR PAT[illegible] INTAKE AND OUTPUT WORKSHEET

FROM ________ HOURS
TO ________ HOURS

TOTAL HOURS COVERED

DATE

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
2219	H_2O	150	150
2330	H_2O	150	300
0600	H_2O	150	450
1200	H_2O	150	600

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (*Include Medications*)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
2200	500	NS	500	0600	500
0600	100	Unasyn	100	0630	600
0600	500	NS	500	1100	1100
1100	500	NS			1600
1200	100	Unasyn	100	1300	1700
1800	100	Unasyn			1800
1800	100	Unasyn			1900
2400	1040				2940
					600

3540

IRRIGATIONS (*N/G, Bladder, etc.*)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (*i.e. Bl, Alb, P. cells, etc.*)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
2045	975	975			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL
GRAND TOTAL OUTPUT			

REMARKS

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

(b)(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 792, JAN 74 EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3830(TEMP) 1 JUL 72 WHICH MAY BE USED. USAPPC V1.00

TWENTY-FOUR HOUR P[illegible]T INTAKE AND OUTPUT WORKSHEET	FROM 0001 HOURS TO 2400 HOURS	TOTAL HOURS COVERED	DATE 4 AUG 03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0730	Juice	200	200
0730	milk	250	450
1700	H_2O	150	~~600~~ 600

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0001	1000	NS			
1980	100	Unasyn	100		

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. B1, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

(b)(6)-4

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0730	400	400			
2030	1100	1500			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL
GRAND TOTAL OUTPUT			

REMARKS

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

(b)(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 792, JAN 74

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3830(TEMP) * JUL 72 WHICH MAY BE USED.

USAPPC V1.00

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ____ HOURS TO ____ HOURS	TOTAL HOURS COVERED	DATE

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
2400	2400	Unasyn	100	2400	100
2400	1400	NS	1400	0700	1500
1900	1800	Unasyn	1800		
		Unasyn			

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. B1, A1b, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

TWENTY-FOUR PATIENT INTAKE AND OUTPUT WORKSHEET	FROM ____ HOURS TO ____ HOURS	TOTAL HOURS COVERED	DATE 7 Aug 03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1800	H_2O	150	150
2100	H_2O	100	250
~~2230~~	~~H_2O~~	~~100~~	~~350~~

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
1800	100	UNASYN	100	1900	100
2400	100	UNASYN	100		

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

(b)(6)-4

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM _____ HOURS TO _____ HOURS	TOTAL HOURS COVERED	DATE

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
2400	100	UNASYN	100		

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. B1, A1b, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

(b)(6)-4

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: 44
HEIGHT: 183 cm
WEIGHT: 81 kg

2. KNOWN ALLERGIC SENSITIVITIES (e.g.. Iodine, Tape, Medication)
☒ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD
REACTION:

3. PREVIOUS SURGERY [ ] NO [X] YES (type):
STSG - 93

4. PROPOSED SURGICAL PROCEDURE:
ORIF Rt elbow

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition fresh wound, scrape, Rt sm of nose
Tobacco ½ ppd X many yrs. Body Piercing_____ Diabetes (Y) (N) ROM_____ ASA/Motrin w/72 hrs (Y) (N)
ETOH [bottle/day] Implants_____ Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures_____ Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS: none

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL X Potential for anxiety related to: X 1) Surgical Procedure & Operating Room Environment ___ 2) Separation Anxiety (Child) ___ 3) Surgical Outcomes	o Pt. verbalizes any specific anxiety. SE o Pt. Exhibits relaxed body posture. SE Glucose pill occasional DM - untx'd/undx'd Hepatitis Difficulty c̄ deep breathe pain in right side chest.	o Allow pt. to verbalize freely. o Explain OR environment and answer questions regarding surgery. o Offer comfort measures. (e.g.. warm blanket. touch). o Explain all nursing procedures before they are done. o Remain with pt. whenever possible. o Maintain family interface. Parents to stay with pt.
B. AERATION X Potential for respiratory dysfunction due to: X 1) Positioning X 2) Effects of Anesthesia X 3) Medical Smoking History	o Pt. will be able to breathe without difficulty during immediate intraoperative phase. SE Arabic Speaking	o Offer to elevate head of litter or offer pillow. o Observe pt. while awaiting surgery for signs of distress. o Assist anesthesia during intubation and extubation.
C. INTEGUMENT X Potential impairment of skin integrity due to: X 1) Intraoperative Immobility X 2) ESU Pad Placement X 3) Positional Aids ___ 4) Prosthesis X 5) Pooling of Prep Solutions	o Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas). SE	o Utilize pressure preventing devices on OR table and accessories. o Check for proper positioning and support to maintain good body alignment. o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling.

9. PATIENT'S IDENTIFICATION: (For typed or written entries give: Name- last, first, middle; grade; date; hospital or medical facility)
000-[redacted]
EPW [redacted]
bb-4

VERIFICATIONS AT HOLDING AREA:
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since_____ ! Jewelry Removed
! ~~UHCG/LMP~~ N/A ! Body Pierce Removed
N/A ! Consent/Blood Transfusion Signed/Witnessed/Dated
N/A ! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) (N)
! Family/Friend:_____

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION X Potential for inadequate tissue perfusion due to: ____ 1) Intraoperative Mobility ____ 2) Positioning ____ 3) Existing Disease ____ 4) Safety Devices ____ 5) Hypothermia X T&Rose	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. X Potential impairment of mobility due to: ____ 1) Pain ____ 2) Intraoperative Hazards ____ 3) Prosthesis X 4) Positioning ____ 5) Transfer pt. to/from OR table E.2. X Potential discomfort due to: ____ 1) Length of Surgery X 2) Positioning ____ 3) Arthritis	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ____ Diminished visual perception due to being: ____ 1) Pre-Medicated unknown ____ 2) W/O Glasses F.2. X Potential for decreased communication due to: ____ 1) Diminished Hearing X 2) Language Barrier F.3. ____ Potential injury due to dentures: ____ 1) Upper ____ 4) Caps ____ 2) Lower ____ 5) Crowns ____ 3) Bridges	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from _____ side. o Validate pt.'s understanding of verbal communication. o Verify removal of dentures.
G OTHER PATIENT PROBLEMS/NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

10. OR NURSING INTERVENTIONS COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTIONS NOTED.

b(6) 2 [redacted] 2 AUG 03 DATE

11. POSTOPERATIVE EVALUATION:
LEVEL OF CONSCIOUSNESS: ☐ A&O ☒ Drowsy ☐ Sleepy ☐ Intubated
LEVEL OF ACTIVITY: ☒ Moves All Extremities ☐ Moves Upper Extremities ☐ Transferred to litter with roller due to spinal
SKIN INTEGRITY: Bovie Pad Site: ☒ Clean and Dry ☐ Red ☐ N/A
DRESSING DRY & INTACT (Y) (N)
BREATHING EASY: (Y) (N)

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Ti[redacted] MAT AN
DATE: b(6) 2 AUG 03 TIME: 183[redacted]

13. POSTOPE[redacted]RED BY (Signature an[redacted]
DATE: 2 AUG 03 TIME: 22[redacted] b(6) 2

REVERSE OF FORM 5179, JUN 91 MEDCOM - 6937 USAPA V1.0

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: litter BY: anesthesia

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

3. DATE: 2 AUG 03 TIME PATIENT ARRIVED IN SUITE:

4. PATIENT IN ROOM TIME: 2000 NUMBER: 1-3

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc (b)(6)-2	910	RELIEF SCRUB	
ASSIGNED CIRCULATOR	SP (b)(6)-2	66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS: Bean bag; pt c̄ bean bag to bump up (R) side; (L) arm tucked

8. SKIN PREPARATION

HAIR REMOVAL [ ] YES [X] NO

DONE BY: [ ] OR [ ] NURSING UNIT

METHOD: [ ] DEPILATORY [ ] RAZOR [ ] CLIP

COMMENTS:

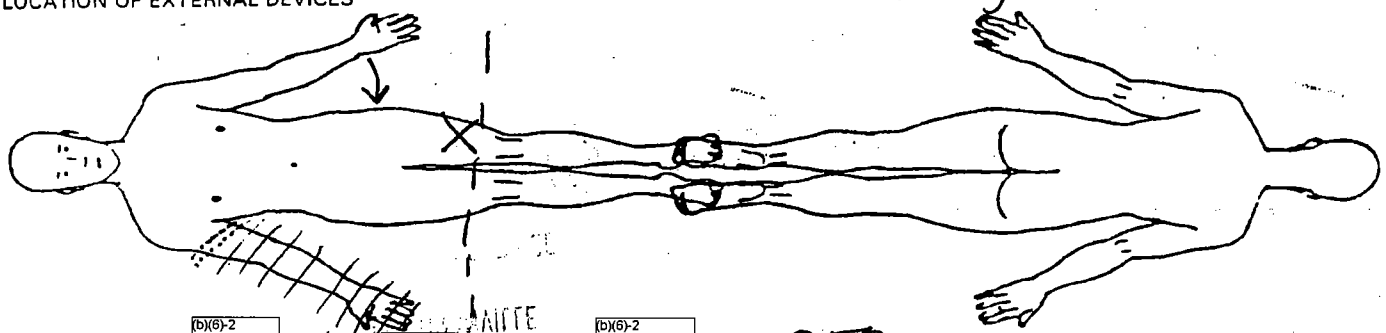
PREP SOLUTION (Specify) Betadine / Brandt's

SITE: (R) arm - hand to TQ BY WHOM: Chase

SITE: BY WHOM:

COMMENTS: ∅ pooling or irritation

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad (b)(6)-2 -- Safety Strap (b)(6)-2 = = = Tourniquet (b)(6)-2 @ 250 for 76 min /// = prep

10. COUNTS

C = Correct I = Incorrect

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

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

(b)(6)-4

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

[ ] ESU NO: #1 cut/coag = 30/30

GROUND PAD: BRAND Valley lab

LOT NO: 65706 2004-11

[ ] ESU NO:

GROUND PAD: BRAND

LOT NO:

[ ] BIPOLAR NO:

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

1.6 k wires x 2 lot # 0221405

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

NSS

OTHER ORDERS	TIME	CARRIED OUT BY
[redacted] b(6)-2		
[redacted] LTC MC		

PHYSICIAN'S SIGNATURE [redacted]

15. X-RAY IN OPERATI[redacted] IF YES, SITE

YES ☒ NO [redacted] (R) elbow

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NA[redacted]	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

	1.	2.	3.
TYPE/SIZE			
SITE			

18. DRESSING/IMMOBILIZATION *(Specify)*

Xeroform
fluffs
wedge
Splint
ace

19. ADDITIONAL INFORMATION

Dr [redacted] b(6)-2
Dr

b(6)-2

~~Dr~~ esl Maj [redacted] CRNA

20. OPERATION(S) PERFORMED

(R) elbow ORIF

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU	22[redacted]15	litter

22. REGISTERED NURSE SIGNATURE b(6)-2 [redacted]

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.01

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY	7	8	9	10	11			
POST- DAY								
MONTH-YEAR / DAY	6	7	8	9	10			
19 / HOUR								

PULSE (0) / TEMP. F (•)

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

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

TEMP. C (Centigrade Equivalents, for Reference only): 40.6°, 40.0°, 39.4°, 38.9°, 38.3°, 37.8°, 37.2°, 37.0°, 36.7°, 36.1°, 35.6°, 35.0°

RESPIRATION RECORD

BLOOD PRESSURE

	130/78	138/88	134/84		116/70	137/88	121/74	
	143/84		136/73		120/70			

HEIGHT: WEIGHT →

		97%	98%			98%	98	
			96				(b)(6)-2	

Record special data only when so ordered

O2 98 94%

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

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 6940

MEDICAL RECORD — VITAL SIGNS RECORD

Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-5.202-1

HOSPITAL DAY		21 Jul 03		1		2		3		4		5						6					
POST- DAY																							
MONTH-YEAR Jul	DAY	2200		01 Aug				02		3		4						5					
10 2003	HOUR		3								1			7					1	7			
PULSE (0)	TEMP. F (•)																						TEMP. C
	105°																						40.6°
180	104°																						40.0°
170	103°																						39.4°
160	102°																						38.9°
150	101°																						38.3°
140	100°																						37.8°
130	99°																						37.2°
	98.6°																						37.0°
120	98°																						36.7°
110	97°																						36.1°
100	96°																						35.6°
90	95°																						35.0°
80																							
70																							
60																							
50																							
40																							

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

(b)(6)-4

REGISTER NO.

WARD NO.

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

[redacted] b(6)-4

ID: [redacted] b(6)-4 31-May-1997 12:27:16 [redacted]

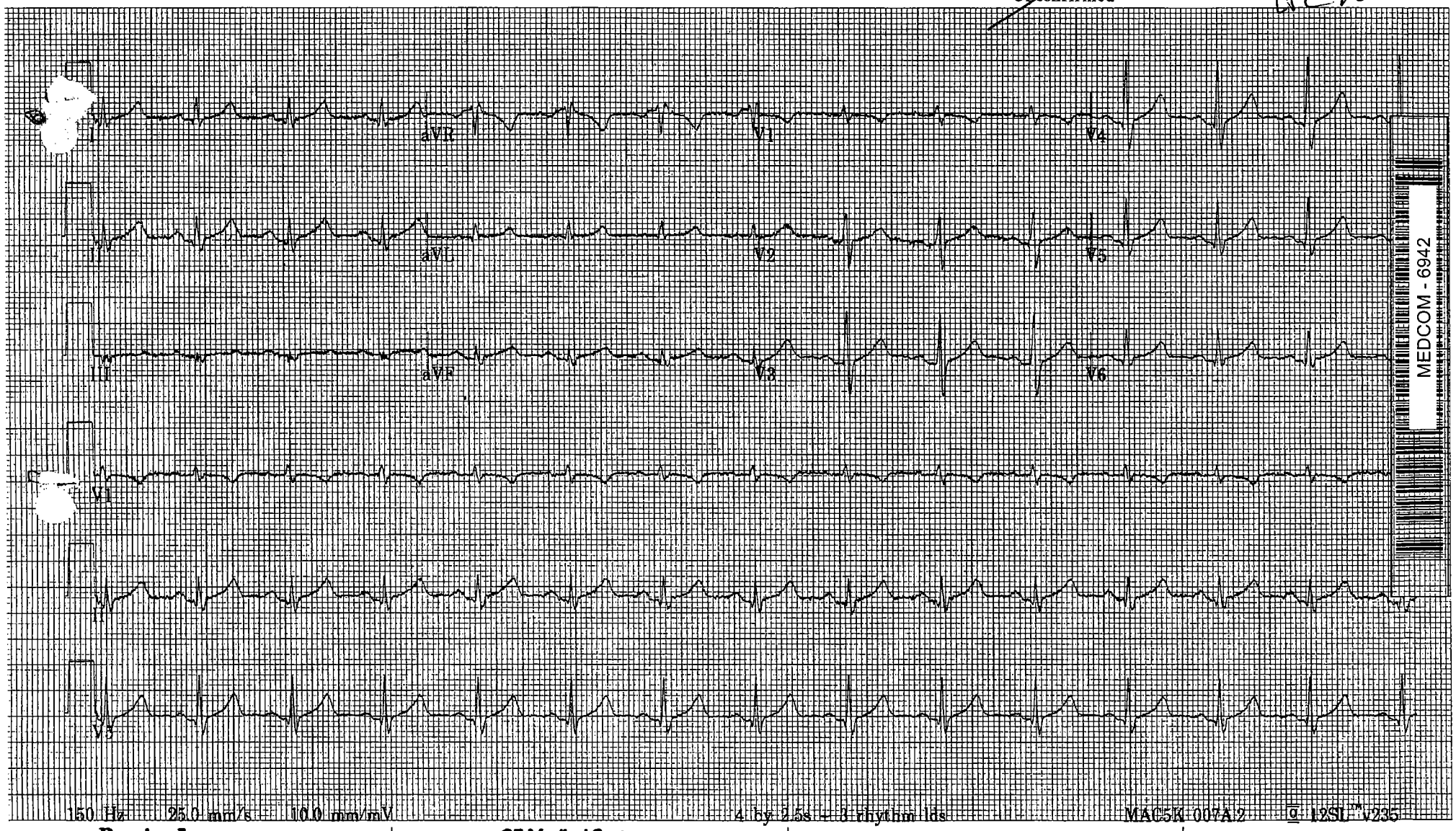
b(3)-1

44years		Vent. rate	85 bpm	Normal sinus rhythm
Male	Asian	PR interval	162 ms	Normal ECG
65in	158lbs	QRS duration	92 ms	
		QT/QTc	388/461 ms	
		P-R-T axes	60 22 44	

Technician:
Test ind:

b(6)-2 b(6)-2 M.C. MC

Unconfirmed



150 Hz 25.0 mm/s 10.0 mm/mV 4 by 2.5s + 3 rhythm lds MAC5K 007A2 12SL™ v235

Premium™ | GE Medical Systems

(b)(6)-4

ICW

MISC

SPECIMEN/LAB RPT. NO.

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

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

SPECIMEN SOURCE (Specify): venous

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE | REPORTED BY (b)(6)-2 | MD | TECH | DATE 02 Aug | LAB ID NO.

REMARKS

TEST(S) SPECIMEN TAKEN	DATE 2 Aug	TIME 0800 A.M. P.M.	REQUESTED Glucose	RESULTS 153 mg/dl

557-107

MISCELLANEOUS

STANDARD FORM 557 (Rev. 3-77) Prescribed by GSA/ICMR FIRMR (41 CFR) 201-45.505

ICW

(b)(6)-4

(b)(6)-2

HEMATOLOGY

SPECIMEN/LAB RPT. NO.

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

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

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

PATIENT'S MED. RECORD (b)(6)-4

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE | REPORTED BY (b)(6)-2 | MD | TECH | DATE | LAB. ID. NO.

REMARKS CBC + Renal Panel Chem 12

TEST(S) SPECIMEN TAKEN	DATE 01 Aug	TIME 0800 A.M. P.M.	REQUESTED (X)	RESULTS
RBC COUNT				4.11
HEMOGLOBIN				13.1
HEMATOCRIT				40.0
MCV				97.7
MCH				31.8
MCHC				32.8
WBC COUNT				10.3
WBC DIFF AND BLOOD CELL MORPH: IMMATURE				
NEUTRO-BANDS				
NEUTROSEGS				24.2
LYMPHS				
EOSINOPHILS				
BASOPHILS				
MONOCYTES				
PLATELETS				
RBC				
SED. RATE				
PLATELET COUNT				376
RETICULOCYTE COUNT				
CLOTTING TIME				
BLEEDING TIME				
PTT CONTROL				
PTT PATIENT				
CONTROL				
PATIENT				
% ACTIVITY				
RATIO				
SICKLING TEST				
LE PREP				

549-107

HEMATOLOGY

STANDARD FORM 549 (Rev. 7-78) PRESCRIBED BY GSA/ICMR FIRMR (41-CFR) 201-45.505

PATIENTS MED. RECORD

SPECIMEN/LAB RPT. NO.

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

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

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

LAB. ID. NO.

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE | MD | CH | DATE | (b)(6)-2

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

CBC, Chem 12

SPECIMEN TAKEN	DATE 3 Aug	TIME A.M. P.M.	REQUESTED (X)	RESULTS
RBC COUNT				3.82
HEMOGLOBIN				12.2
HEMATOCRIT				37.2
MCV				97.3
MCH				
MCHC				
WBC COUNT				6.5
IMMATURE				
NEUTRO-BANDS				
NEUTROSEGS				28.2
LYMPHS				
EOSINOPHILS				
BASOPHILS				
MONOCYTES				
PLATELETS				
RBC				
SED. RATE				
PLATELET COUNT				348
RETICULOCYTE COUNT				
CLOTTING TIME				
BLEEDING TIME				
PTT CONTROL				
PTT PATIENT				
CONTROL				
PATIENT				
% ACTIVITY				
RATIO				
SICKLING TEST				
LE PREP				

549-107

HEMATOLOGY

STANDARD FORM 549 (Rev. 7-78) PRESCRIBED BY GSA/ICMR FIRMR (41-CFR) 201-45.505

MEDCOM - 6943

TEST(S)

SPECIMEN TAKEN

DATE | TIME A.M. P.M.

RESULTS	REQUESTED	(X)
462	RBC COUNT	
14.9	HEMOGLOBIN	
44.7	HEMATOCRIT	
96.7	MCV	
32.3	MCH	
33.4	MCHC	
13.8	WBC COUNT	
	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
	NEUTRO-BANDS	
	NEUTROSEGS	
13.8	LYMPHS	
	EOSINOPHILS	
	BASOPHILS	
	MONOCYTES	
	PLATELETS	
	RBC	
	SED. RATE	
461	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PTT CONTROL	
	PTT PATIENT	
	PT CONTROL	
	PT PATIENT	
	% ACTIVITY	
	RATIO	
	SICKLING TEST	
	LE PREP	

REMARKS

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE

(b)(6)-2

(b)(6)-2

REPORTED BY

TECH MD DATE

(b)(6)-2

HEMATOLOGY

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

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

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

LAB. ID. NO.

SPECIMEN/LAB RPT. NO.

HEMATOLOGY 549-107

STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505

PATIENT'S MED. RECORD

(b)(6)-4

EMT

TEST(S)

SPECIMEN TAKEN

DATE 2 Aug | TIME 1440 A.M. P.M.

REQUESTED

Glucose

RESULTS

125 mg/dl @ 1454

REMARKS

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY

(b)(6)-2

TECH MD DATE 02 Aug 03

MISC

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

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

SPECIMEN SOURCE (Specify): Venous

LAB ID NO.

SPECIMEN/LAB RPT. NO

MISCELLANEOUS 557-107

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

PATIENT'S MED. RECORD

(b)(6)-4

ICW

(b)(6)-4

CHEM I

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

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

SPECIMEN SOURCE: ☐ BLOOD ☐ OTHER (Specify)

SPECIMEN/LAB. RPT. NO.

LAB. ID. NO.

PATIENT'S MED. RECORD

Enter in above space PATIENT IDENTIFICATION—T (b)(6)-2 DATE

REQUESTING PHYSICIAN'S SIGNATURE

Dr. (b)(6)-2

MD DATE

TECH 31 Jul 03

REMARKS

Met 8

546-107

TEST(S)																													
SPECIMEN TAKEN	TIME	A.M. P.M.	(X)																										
			REQUESTED	GLUCOSE	UREA N.	CREATININE	URIC ACID	SODIUM	POTASSIUM	CHLORIDE	CO_2	PHOSPHATE	CALCIUM	TOTAL PROTEIN	ALBUMIN	GLOBULIN	ALKALINE PHOSPHATASE	ACID PHOSPHATASE	SGOT	LDH	CPK	BILIRUBIN (TOTAL)	BILIRUBIN (DIRECT)	CHOLESTEROL	TRIGLYCERIDES	AMYLASE	LIPASE	PROFILE (Specify)		
DATE			RESULTS	230	42	1.2		134	4.3	93	24										97								

CHEMISTRY I

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

MEDICAL RECORD — ANESTHESIA

DRUG	Units	
Versed	mg	2
Fent	mcg	250 250
STP	mcg	300/150
Sux//Vec	mg	100//10 2
Toradol	mg	30
VOLAT AGENT: Iso	% del / % e.t.	X-1.5-1.5-2.5-1.5-1.0-1.0-2.5 X
AIR	L/Min	
N2O	L/Min	
O2	L/Min	X-8-2-2-2-2-2-2-2-8

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "I" = CONSTANT INFUSION

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

TOTALS	
TOTAL FLUID	MIJ
TOTAL URINE	∅

FLUIDS – SUMMARY

CRYSTALLOID– 500

COLLOID– ∅

BLOOD– ∅

LINE site		
NS	☐ Warmed	500
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES: EST BLOOD LOSS / URINE –

PHYS STATUS: 1 2 (3) 4 5 E

BODY WEIGHT: 81 (KG) LB

HEMATOCRIT:

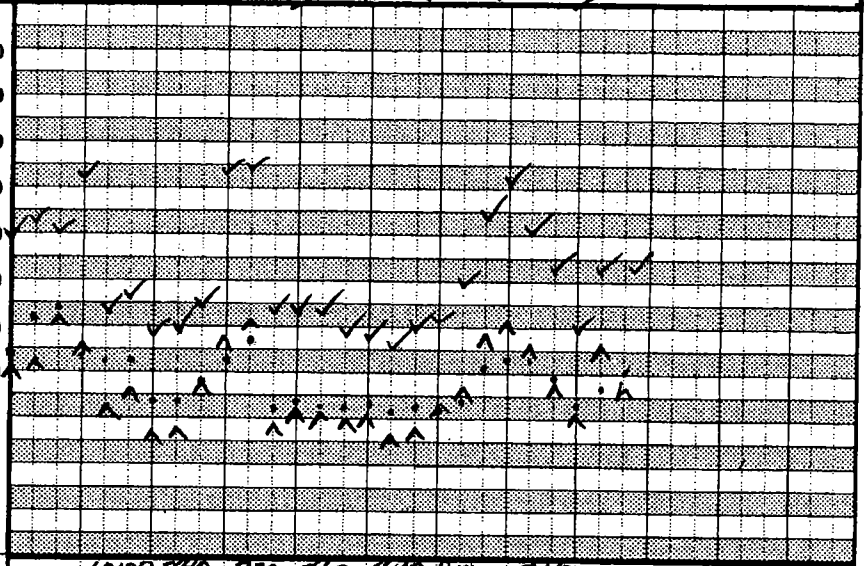
INITIAL DATA: BP – 134/80 T-98.6 R-16 HR– 84

COMP CHECK: OK?– (Y) N

PATIENT PROVIDER: OK for PROCEDURE? Y TIME– 2000

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

TIME → 2000 15 30 45 2100 15 30 45 2200



VT – ml		1000	840	820	860	840	800	840	
f – breaths/min		8	7	8	6	6	6	6	15
Peak inf pres / PEEP		23	19	19	20	19	19	26	
MODE– S(pon), A(ssist), C(on)	S/A	C	C	C	C	C	C	C	S
BP/Auto Cuff	ET CO2 (torr)	+	38	30	28	28	28	28	30	39
BP / oth	FIO2 (Frac or %)	.90	.90	.90	.89	.89	.89	.89	.88	.90
ART line	SpO2 (%)	96	98	98	98	98	99	99	98	98
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP- site									
	N-M Block (T/4)	4/4	4/4					4/4	4/4	
Tourn. pr. ↑ @ 250 mmHg									↓ total time 73 mins	
Warming blkt										
Conv warmer										

Mark with letters & symbols, explain under REMARKS — EVENTS — Position → ∥ on (R) side ≈ 45°

REMARKS – Code drugs with numbers, events with letters

1945 pt ID'd & chart Reviewed
2000 In Rm Monitors
2005-2008 Induction & Intubation
2012 turned to (L) side pres. points ✓ & added
2125 – Forced extubation

RECOVERY AT 2215

PACU (ICU) ____ (Specify)

OTHER ____

CONDITION: stable T–

RESP– 18 SpO2– 99

BP– 158/ HR– 66

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	1945	2000	2215
PROC	Ready 2010	Begin 2035	End 2205

PROCEDURES and CPT Codes

ORIF (R) elbow

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: DLX1 & 4 MAC Visualized cords & intubated w 8.0 ETT to 24 cm @ lip. Bilat BS & ETCO2 X 5 waves, Eyes taped

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

(b)(6)-4

SURGEONS: (b)(6)-2 (b)(6)-2

ANESTHETISTS: MAJ (b)(6)-2 (b)(6)-2 AN CRNA

Nurse Anesthetist

PROCEDURE LOCATION 1-1

DATE 2 Aug 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 6945

*U.S. GPO: 2002-729-180/40137

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 44 DAYS MOS (YRS) Sex (X) MALE ( ) FEMALE

ASA Physical State 1 2 (3) 4 5 E
WT: 81 (KG/LB) HT: 183 (CM/IN)
ALLERGIES: NKDA

PROPOSED PROCEDURE: ORIF
SURGICAL SERVICE: Ortho — (b)(6)-2
NPO SINCE:

HABITS:
TOBACCO: 1/2 PPD x many yrs
ETOH: 1 bottle whiskey/day
DRUGS: Ø

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Ø
( ) Unasyn 3g q6 hr
( ) Glyburide 5mg po qd.
( ) Lortab.
( )
( )

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

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

1 AUG
10.3 / 13.1 / 40.0 / 376
134 / 93 / 18 / 230
4.3 / 25 / 1.2

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
Hypertension (N) Y
Angina (N) Y
MI (N) Y
CVA (N) Y
Other (N) Y

Pulmonary System:
Asthma (N) Y pain c̄ deep
Bronchitis/URI (N) Y inspiration.
COPD (N) Y
Other (N) Y

Renal System:
Acute/Chronic RF (N) Y

Gastrointestinal:
Hepatitis N (Y) → untreated
Hiatal Hernia (N) Y
PUD/GERD (N) Y

Endocrine System:
Diabetes N (Y) ? takes OHA + not reliable
Steriods (N) Y
Thyroid (N) Y

Neurological:
Seizures (N) Y h/o head injc̄ car accident.
Neuropathy (N) Y
Other N (Y)

Gynecological :
Pregnancy N Y NA

Other Significant Hx: (N) (Y) (R) olecranon fx
(N) Y
Familial HX (N) Y

ASSESSMENT
PAST SURGICAL/ANESTHETIC
STSG 2° MCA 93

PHYSICAL EXAMINATION
BP 134/80 HR 84 R 16 T 98.6
Pain Scale 0-10
HEENT - Teeth poor dentition
Trachea midline
(+) Beard TMJ/Neck FROM
Oropharnyx MPII
Nares patent
CHEST: CTA c̄/o pain c̄ deep breathe
CARDIAC: S1 S2
EXTREMITIES: NKTSOCC/UR
IV Access: (D) 20ga 18GLA
Ulnar Filling:
BACK:
OTHER: EKG = NSR

NPO Since

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

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

The patie[redacted]erstand and agrees. Questions answered.
Signed: [redacted] /CRNA Date: 1AUG03 Time: 1830 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
(X) NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER
Signed: (b)(6)-2 CRNA Date: 3AUG03 Time: 1230 Hrs

Patient Identification: (Ward)
(b)(6)-4

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

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

31 JUL 03 2120

ADMIT W/ GRANDMAL SEIZURES ICW

Dx DM, (R) ELBOW FX, (L) WRIST CELLULITIS

COND FAIR

ACT - EPW RESTRAINTS

NPO

2000 KCAL ADA DIET

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

FINGERSTICKS TID AC

CBC, RENAL PANEL QAM X 3D

HEP LOCK

MOSS ~~NAPROXEN 250 MG Q4°~~

~~PENICILLIN~~ CATAPRES 7.5 ½ PO Q4-6° PRN

CONTACT KN [redacted] FOR

FURTHER ORDERS

CEFAZOLIN 3GM IV Q6°

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

(b)(6)-2

LTC, MC
ORTHOPEDIC SERVICE

24° Chart 1 August 03 @ 0311

01 AUG 03 0700

(1) IVF: NS bolus x 2L then 150 cc/hr.

(2) Glipizide or glyburide 5 mg po x 1 now + then qd.

(3) D/C Fingersticks.

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

01 AUG 03 1900

(1) NPO p 12 Midnight

(2) Hold Glyburide in AM.

(3) Fingerstick blood sugar x1 in AM (0800) & notify Anesthesia of results.

(b)(6)-2

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

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

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

2AUG03 2200

ADMIT C/O GRANULE/HANGER

DX - (R) ELBOW FX, (L) WRIST CONTUSION, DM

COND FAIR

VS NORMAL

ACT - DPW SCATS, COB CHAIR & TID

noted

(b)(6)-2

2AUG 03 2210

PATIENT IDENTIFICATION

NUNA

1800 kcal ADA DIET

NS TKA 75cc/HR, HEP LOCK WHEN PO ADQUATE

UNASYN 3GM IV Q8°

MS 2-4MG IV Q 15' PRN UP TO 16 MG/3HR

LORTAB 7.5 ; 1TPO Q4° PRN

PALMAFGAN 12.5-25MG IV PRN NAUSEA

TYLENOL 650MG PO/PR Q4° PRN

IS Q1° W/A

GLIPIZIDE OR GLIBENCLAMIDE 5MG PO QD

(b)(6)-2

LTC, MC ORTHOPEDIC SERVICE

NURSING UNIT | ROOM NO. | BED NO.

24° chest check 4 AUG

PATIENT IDENTIFICATION

5AUG 24° chest check

(b)(6)-2

5AUG 03 0730

D/C UNASYN

D/C HEPLOCK

AUGMENTIN 500MG PO TID

noted

(b)(6)-4

(b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

LTC, MC ORTHOPEDIC SERVICE

24° chest check 7 Aug 03 0200 Ilona

(b)(6)-2

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

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

MEDCOM - 6948

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 9 AUG 03 TIME OF ORDER: 0900 HOURS

LIST TIME ORDER NOTED AND SIGN

D/C IN MP CUSTODY
MEDS - CONTRAB, AUGMENTIN, GLYBURIDE
DIET - 2000 KCAL ADA
FU - 23 AUG 03 ACC
SEND PT C COPY OF NARSUM & X-RAYS

PATIENT IDENTIFICATION

DATE OF ORDER

(b)(6)-2

LTC, MC
ORTHOPEDIC SERVICE

24hr chart ✓ 10 Aug 03 @ 0200

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER _____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER _____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

MEDCOM - 6949

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 07 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 31	01	02	3	4	5	6	7	8	9	10	11	12	13
31	(b)(6)-2	Activities: EPW	6	/	(b)(6)-2												
		Restraints	18	/													
31	(b)(6)-2	Diet: 2000 KCal	7	/	(b)(6)-2												
		ADA diet	12	/													
			17	/													
31	(b)(6)-2	Fingersticks TID															
		AC	6	/													
			14	/	D/C												
			22														
1	(b)(6)-2	N/O VS q SHIFT	06	/	/	(b)(6)-2											
			14	/	/												
			22	/	TJC												
2 Aug	(b)(6)-2	ACT: ERW STATUS OOB	06	/	/	/	(b)(6)-2							10			
		TO CHAIR TID	14	/	/	/											
			22	TJC	/	(b)(6)-2											
2 Aug	(b)(6)-2	IS @ 1° W/A	06	/	/	/	(b)(6)-2										
			17	TJC	/	(b)(6)-2											
2 Aug	(b)(6)-2	DIET: 2000 ADA	06									(b)(6)-2					
			12														
			17														

ALLERGIES: ☐ YES ☑ NO

NKDA

PRIMARY DIAGNOSIS:

DM, (R) Elbow Fx, (L) wrist cellulitis

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 7 Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
31	(b)(6)-2	Admit c/o (b)(6)-2 ICW		Done		(b)(6)-2
31		Condition: Fair				
31		CBC, Renal panel q AM x3 days	1 Aug 03	0600		
			2 Aug 03	0600	0515	(b)(6)-2
			3 Aug 03	0600	0515	
01 Aug	(b)(6)-2	2L NS boluS now	1 Aug 03	Now	0800	(b)(6)-2
01 Aug		Glyburide 5mg PO ÷ now	1 Aug 03	0800	0800	
1 Aug		NPO p MN	1 Aug 03	0000	0000	
1 Aug		Hold Glyburide in AM	2 Aug 03	0600		
1 Aug		Fingerstick x1 blood sugar (AM) + notify	2 Aug 03	0800	0800	(b)(6)-2
		Anesthesia of results				
2 Aug	(b)(6)-2	Admit c/o (b)(6)-2	2 Aug	2200	2200	(b)(6)-2
2 Aug		Dx: (1) Femur fracture (2) Urinary cellulitis	2 Aug			
2 Aug		Cond: Fair	2 Aug			
9 Aug		P/C in MP custody				

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

USAPA V1.00

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

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

Mo. 7 Yr. 8

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 31	1	2	3	4	5	6	7	8	9	10	11	12	13
31	(b)(6)-2	HL	6	/	(b)(6)-2												
			14	/		D/C											
			22	HL													
31	(b)(6)-2	UnaSyn 3gm IV q 6°	6	/	(b)(6)-2												
			12	/													
			18	/													
			24	HL													
01 AUG	(b)(6)-2	NS @ 150cc/hr	06	/	a	PM											
			14	/	a												
			22	/	HL												
01AUG	(b)(6)-2	Glyburide 5mg PO ÷ QD	06	/													
2AUG	(b)(6)-2	NS @ 75cc/hr HL when PO adequate	06	/	/	/	(b)(6)-2										
			14	/	/	/	(b)(6)-2										
			22	/		(b)(6)-2											
2AUG	(b)(6)-2	Glipizide or Glyburide 5 mg PO ÷ QD	06	/	/												
5AUG	(b)(6)-2	Heplock IV	5						(b)(6)-2								
			17														

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: DM, (R) Elbow Fx, (L) wrist cellulitis

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION: (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

MEDCOM - 6952

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 7 Yr. 5

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

ORDER DATE	CLERK/ NURSE	~~RECURRING MEDICATIONS~~, DOSE, FREQUENCY	HR	DATE DISPENSED
31	(b)(6)-2	Lortab 7.5 1-2 tabs PO q 4-6 PRN		7/31 0215 1 14U / 1AM 1630 1 1 / 3AM 1135 1 1 / 4AM 0535 2 tabs / 8AM 2150 1 14U / 9AM 2124 1 14U (b)(6)-2
		MSO4 2-4 mg IV q 15' PRN up to 16mg / 3hr		2AM 4mg 1 / 3AM 4mg @ 3:40 1 14U / 3:40 0815 4mg / 3:40 0830 2mg / 3:40 0845 2mg / 3:45 1135 4mg / 3:45 1150 5mg / 3:45 1205 3mg / 3AM 2:10 4mg / 3AM 3355 4mg / 4AM 0200 4mg (b)(6)-2 (b)(6)-2
		Phenergan 12.5-25mg IV PRN nausea		
		Tylenol 650mg PO PRN q 4° PRN		3AM 2100 1 1 14U
31	(b)(6)-2	MSO4 2-4mg IV q 15' PRN up to 16mg in 3 hrs		6AM 2011 4mg 14U / 8AM 0114 4mg 14U
		Contact Dr (b)(6)-2 for further order		
31	(b)(6)-2			

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION: (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 8	9	10
8Aug	(b)(6)-2	D/C Augmentin 500mg	06	✓	(b)(6)-2	
	......	PO TID	14	✓	(b)(6)-2	
	......		22	(b)(6)-2		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____________

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

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

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

ORDER DATE	CLERK/ NURSE	~~RECURRING MEDICATIONS, DOSE, FREQUENCY~~	HR	DATE DISPENSED													
		Since Admission		Date to Begin	Date to Begin		Time to Take		Initials								
8Aug	(b)(6)-2	D/C Unasyn		8Aug			0800		(b)(6)-2								
8Aug		D/C Heparin		8Aug			0800										
9Aug		D/C Meds (for D/C)															
		Lortab, Augmentin,															
	.....	Glybaride															
9Aug	(b)(6)-2	Diet 2000 ADA															
9Aug		F/U 28 Aug 03 ACC															
9Aug		Send copy of															
		Nurs. Summary															
	.....	& x-ray															
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ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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 FG N	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	27 28 29	30 X	31 9	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
	46	22:00	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52 K 2 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 b(3)-1	64 65 66 67 68 69 70	71 9 b(6)-4 10/5	YEAR / NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72 0		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	23. DATE OF DISPOSITION (YYYYMMDD)
73 74 0 5	75 76 77 78 79 80	81 82 83 84 85 86 87 88 2 0 0 3 0 8 0 9

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
89 90 91 92 A E A A	93 94 95 96 97 98	99 100 101 102 103 104 105 106 2 0 0 3 0 7 3 1

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYYYMMDD)
107 108 b(3)-1	109 110 111 112 113 114	115 116 117 118 119 120 121 122

FOR LOCAL USE

(R) Elbow Fx 813.11

(L) Wrist cellulitis 682.4

25000

DX-81400

Trauma - 9 6824

injury - 989 E9889

PR-7912

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK

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 (b)(3)-1			
3. Register Number (b)(6)-4	Name (Last, First, MI) (b)(6)-4		4. Pay Grade FGN	5. Sex M
6. DoB (YYYYMMDD)	7. Age at Admission	8. Race X	9. Ethnicity 9	Religion MUSLIM
10. Length of Service	ETS	11. FMP 20	12. Social Security Number (b)(6)-4	
Organization (Active Duty Only)		13. Marital Status	Hour of Admission 22:00	Branch / Corps:
14. Flying Status	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES		16. Zip Code of Residence:	
17. Unit Location	18. MOS	19. Trauma DIS	Prev. Admission NO	
20. Source of Admission Direct from ER	Ward: ICU	Name / Relationship of Emergency Addressee		
		Address of Emergency Addressee		
Name and Location of Medical Treatment Facility: (b)(3)-1		Telephone Number of Emergency Addressee		
21. Type of Disposition HOME	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2003-08-09		
24. Clinic Svc - Admitting AEA - ORTHOPEDICS	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-07-31		
27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission 2003-07-31		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: R elbow fx L wrist cellulitis

813.11 682.4

Procedure Narrative(s):

Cause of Injury Narrative:

Admitting Officer (Signature, as required) DR (b)(6)-2	Signature of Admitting Clerk

(b)(3)-1

[illegible]NT TREATMENT RECORD COVER S[illegible]

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		X				NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99	(b)(6)-4		ICU

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
		K65			INJ

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
0	2130	ABMA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	HOME	20030809

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		20030807	DR (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		0

31. SELECTED ADMINISTRATIVE DATA

PATIENT WAS DISCHARGED HOME ON 9 AUG 2003

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: 40% BSA BURNS 2ND DEGREE
BURN RIGHT FOREARM
BURN LEFT SHOULDER
BURN RIGHT ABDOMEN

DX-94321
94127
94223
94840
E9242
PR-8628

Trauma - 989
Injury -

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
0	0	0	0	3	3

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	3	3

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

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER
(b)(6)-2 SSG, NCOIC, PAD

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

23yo civilian Turkish male – splash burn from radiator water and fall from 15'. c/o pain (R) ankle, back to (L) shoulder, forehead, forearm (R)

PMHx ∅
Med ∅
All ∅
PMSx ∅

PHYSICAL EXAMINATION

150/85 94 92 RA
HEENT: ⊖ clear, Bleeding blister; pharynx
Chest CTA CVS RRR
Abd benign
Skin: (L) shoulder / forehead over 1-2° burn c blisters, NT. bleeding
(R) ankle wrapped, ⊖ ⊖.
(R) forearm 1-2 blisters.

WBC 17k
UA 1030 (L)
Cr 1.7

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

A/ Fall, accidental
~ 10% burn; scalding

P/ Admit
Debridement

SIG (b)(6)-2	DATE 8/7	IDENTIFICATION NO.	ORGANIZATION

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

(b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.506
OCTOBER 1975
USAPPC V1.00

MEDICAL RECORD	PROGRESS NOTES
DATE	
10 Aug 03 1630	Nursing: Shift Pt. dressing change this shift. Some bleeding but pt. healing. Premedicated w/ percocet. Ambulating with crutches, VSS, Speech clear, ∅ signs of resp. distress. Slept most of day. Continue to monitor — (b)(6)-2 CPT RN
10 Aug 03	2250 - AAO x3, PERRLA, LUNGS CTA BILAT, S1-S2 STRONG + REG. (+) BS x4. Drsg Aid @ 2230 C, D, I. Pt RECEIVED MORPHINE 8mg for PAIN. OOB & CRUTCH ASSISTANCE VSS, ∅ % PAIN BESIDE WHEN DRSG Δ PERFORMED. TOLERATED REG DIET. WILL CONTINUE TO MONITOR — (b)(6)-2 SGT USA
11 Aug 03 1615	Nursing: Shift Note Pt. w/o change this shift. VSS. Pt. desires release from hospital. Pt. had 2 male visitors to come in w/ hospital escorts. Visit appeared comforting to pt. Dressing change this shift. Site appears to be healing as expected. Continue to monitor — (b)(6)-2 CPT RN
11 Aug 03	ASSESSMENT - 0150 - AAO x3, PERRLA, LUNGS CTA BILAT, S1-S2 STRONG AND REGULAR, (+) BS x4. Drsg Aid @ 2230 C, D, I. ∅ % PAIN BESIDES DURING DRSG Δ. OOB & CRUTCH ASST. TOLERATED REG DIET. WILL CONTINUE TO MONITOR — (b)(6)-2 SGT USA
12 Aug 03 @ 2230	NSG: Pt AAO x3. Spoke w/ interpreter, smiling at times. Gait is improving, and is currently at a physical TX session. VS WNL, no complaints at this time — (b)(6)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

PROGRESS NOTES

DATE	
13 Aug	PT awake, VSS, Ø complaints will continue to monitor. — [redacted] SGT G, USMC
13 Aug 03 - 2200	Assessment - AAO x3, Perrla, lungs CTA bilat, S_1-S_2 strong and regular, (+) BS x4. VSS, Drsg A/d. C,D,I. C/o pain during Drsg A. Percocet x1. Tolerated pt dist [redacted] SGT, USN
14 Aug 03 0415	Nursing Assessment: Pt sleeping, easily aroused. Pt alert, Ø c/o pain @ present. Pt rec. Motrin TID. Lungs CTA, RR 16 bpm O2 sat @ 94% on RA. HR 46, reg. +2 ~~pulse~~ bil. radial pulse, +2 DP pulse to (L) foot. (R) toes c̄ brisk cap refill, +2 popliteal pulse. Abd soft, flat, (+) BS x4. Ø c/o tenderness to abd. Ø n/v. Pt has not voided on this shift yet. Pt has burns to forehead, Ø drainage noted, open to air. Drsg to (R) arm CDI, drsg to (L) shoulder CDI, Cast to (R) LE intact, brisk cap refill, Ø ↑ pain c̄ toe movement. Ø IV access — LUT [redacted] AN
1005	Nursing: ADL - Pt ↑ in chair for am care. Perform bath & wash hair — LCT [redacted] AN
~~14 Aug 03~~	~~[illegible]~~

STANDARD FORM 509 (REV. 7-91) BACK
USAPPC V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7 May 03 2200 -0015.	23 yo Turkish ♂ admitted to ICU c̄ ≤10% BSA burns 1-2°. NS infusing TKO to (R) 18g PIV. O_2 per RA. Pt awake alert oriented x3. Admitted via stretcher accompanied by ER staff x2. Pt non English speaking, awaiting translator to cont. assessment and complete c̄ full admission to ward. (+) Burns - Blisters x2 to forehead, (L) shoulder, (R) arm (R) shoulder. Blisters lined per VO Dr [(b)(6)-2], washed c̄ ~~silvadene~~ hibiclens, coated c̄ silvadene and dressed c̄ super sponges and gauze dressing. MSO4 10mg IV administered, 5mg @ 2215 pre-debridement phase, 5mg @ 2230 during debridement. All burns bright red, partial thickness. Complete bed bath given. (+) ACE wrap to (R) ankle ∅ drainage, CVI, (+) movement (+) swelling to ankle - Ankle elevated, ice. Neurologically: As Above. AOx3 all questions answered, plan of care discussed. Pupils 3mm/3mm PEARLA. Moves all extremities, good sensation x4 ↓ strength c̄ pain/tenderness to (R) ankle. CV: NSR. VSWNP recorded on SF 511. S1S2 green. I: cap refill index bilat U/E <3sec; ∅ pitting edema noted. Resp: BS CTA chest movement symmetrical. GI: (+) BS x4, ∅ abd distention ∅ tenderness GU: (+) foley to gravity, amber, clear urine out. (~~[illegible]~~ enough) PIV to (R) AC Reinforced (-) infiltration noted, placed in EAT upon admission. LATE ENTRY - during debridement forehead washed with Hibiclens, bacitracin applied to forehead —

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

SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR

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

[(b)(6)-4]

REGISTER NO.	WARD NO.

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8 Aug 03 (WS)	left open to air. Comfort measures provided. Pt made comfortable. H_2O, provided s/p oral care. 486 cc's consumed. Pt resting — (b)(6)-2
VS STABLE-0230	Pt sleeping quietly. No audible pain/discomfort [redacted] (b)(6)-2
0415	Pt awake, no complaints, denies pain. IVF's @ 150 cc [redacted] Foley draining amber clear urine. Will cont to monitor — (b)(6)-2
0600	Pt AWAKE. Report given to SGT [redacted]. Care transferred over @ this time. (b)(6)-2 (b)(6)-2
8 AUG 03 0630	Assumed care of pt Rcvd report from off going shift. Pt in bed IV to (R) AC infusing NS @ 150cc/hr, foley → gravity NAD at this time — (b)(6)-2 Grimes SGT USA
0800	Pt in bed refused breakfast. Initial assessment complete. 23 yo ♂ admitted to the ICU last night c̄ 2° burn to shoulder. Neuro: pt alert & oriented. Language barrier for communication. able to move all extremities. Pt c/o pain ⅡⅡ percocet given po. Resp. RR 18 even, non-labored. LS: CTA & SOB, Ø secretions. Color: normal for race. Cardiac: NSR S1 S2 normal Ø murmur noted (+) peripheral pulses x4 (+) color sensation & movement x4. (R) ankle (+) swelling (+) tenderness (+) pain. ankle wrapped c̄ ace and ice applied, elevated. Gastro: abd. flat, non-distended (+) BS x4 quads. Ø BM recorded. GU. D/C'd foley this AM pt given urinal Ø urine output

STANDARD FORM 600 (REV. 6-97) BACK

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8 Aug 03 0800	cont/ at this time. IV site (R) 18g IV infusing LR @ 100cc/hr w/ difficulty. IV site (-) S/S of redness or infiltration. Pt in bed appears comfortable will monitor — (b)(6)-2 [redacted] SGT/USA
8 Aug 03 0840	Burn Care done to (L) upper shoulder and (R) forearm by Sgt Smith. Upper L arm and shoulder c̄ 2nd degree burn, no evidence of eschar or full thickness areas. Pink, yellow tissue. Cleaned c̄ Hibiclens and Silvadene applied. (R) arm c̄ 25% surg area of 2nd Degree burns, cleaned c̄ Hibiclens and Silvadene applied. No areas of necrotic tissue noted. Face cleaned c̄ NSS and Bacitracin applied to done eyed areas along forehead noted 2nd degree burns along forehead and above (R) eye. Will reassess with round with physicians @ 1600. (b)(6)-2 [redacted]
1200	Ortho SGT [redacted] in to look at (R) ankle recommend ice, elevation and physical therapy will be back to re-evaluate for crutches c̄ therapy. Pt denies pain at present time will monitor — (b)(6)-2 [redacted] SGT USA
1400	Q urine output since d/c of foley. Dr [redacted] aware will monitor. Pt able to ambulate c̄ crutches c̄ assist. will monitor — (b)(6)-2 [redacted] SGT USA

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

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

(b)(6)-4 [redacted]

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8/4/03	Pt ambulated c̄ crutches. Generator went
1530	down & AC. Pt voided 800cc amber urine
	Pt sweating c/o dizziness. sat pt. down, bolus
	IV fluid cool cloth c̄ fan. Pt ambulated ~~to~~
	crutches bth. T 100.4. cool cloth apply to head
	c̄ fan. VSS. Complete power failure @ AC
	Pt evacuated outside. 1.5 liter of H_2O given
	encourage to drink. Bolus 1L LR. Will
	monitor — (b)(6)-2 [redacted] quume SGT USA
1700	Pt evac → EMT c/o pain to shoulder
	dressing off will monitor (b)(6)-2 [redacted] quume SGT USA
1710	2mg MSO4 given IVP for pain reinforced drsg
	to (L) shoulder VS 115/53 P 82 SaO2 99% RA
	Pt appears comfortable — (b)(6)-2 [redacted] SGT USA quume
1750	VS T 101.4 107/60 83 14 SaO2 96% RA
	pt appears to be resting will continue to
	monitor — (b)(6)-2 [redacted] quume SGT USA
1800	Pt transfered back to ICU via litter, pt refused
	dinner will report to medical shift. —
	(b)(6)-2 [redacted] SGT USA quume
1800	Assumed care of pt s/p report from SGT [redacted] (b)(6)-2 Pt. supine in
	bed HOB @ 45°. Awake alert oriented appearing hot and tired. IVF's
	LR infusing @ 100cc hr to (R) AC. O_2 per RA. (-) evidence of resp
	difficulties. (+) cont N.S.P in place. — (b)(6)-2
1830:	Pt ooB to WRM commode amb c̄ assistive devices - crutches and
UOP ~500cc	assist of staff. (+) UOP. Pt ooB to chair for R/R. No c/o pain
	@ this time, pt appears tired, (+) calm (+) cooperative. (+) Temp
	101.1 Tympanic. H_2O provided, pt too removed. [illegible]

STANDARD FORM 600 (REV. 6-97) BACK

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9 AUG03	Assumed care of pt. Rec'd report
0700	from off going shift. Pt in bed c̄ HOB↑
	45° angle. 800mg motrin given po c̄ meal
	report given that 800mg motrin given @
	0600. Will inform MD. VS 103/52, 105, 18, SaO2 100% RA
	Pt ↑ ambulated c̄ crutches to commode ī difficulty
	will monitor (b)(6)-2 SGT USA Guyme
0735	MD aware of motrin 800mg extra given to
	Pt. (b)(6)-2 SGT USA Guyme
0800	D/C'd 18g IV to (R) AC (b)(6)-2 SGT USA Guyme
0900	Initial Assessment Complete c̄ am care
	Neuro: pt alert oriented able to communicate
	via translator. Able to move all extremities
	¢ percocets given po at 0915 for pain c̄ gd effect
	Resp: RR 18 SaO2 100% on RA even, unlabored
	LS: CTA. Cardiac: NSR (+) peripheral pulses
	x 4 extremities (+) swelling to (R) ankle pt
	able to ambulate c̄ crutches. (+) color, sensation
	& movement to extremities. Skin: Splash burns
	to (L) shoulder 2° & 3° to (L) shoulder wounds cleans
	c̄ Hibiclens rinse ī sterile H2O & silvadene applied
	cover c̄ gauze & tape 2° burns to (R) arms in splints

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

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

(b)(6)-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9AUG03	cont: Cleanse & Rinse, Betadine applied and wounds
0900	covered c̄ gauze. Gastro: (+) BS x 4 quad Abd
	soft non-distended ∅ BM's this shift. GU: pt
	able to urinate qd amount 200-400cc of clear
	dark yellow urine. Pt ↑ this am and wash
	at sink. Plan: Transfer to ICW
	[(b)(6)-2] USA SGT 91WM
1030	Pt transfered to ICW Report given to Lt [(b)(6)-2] AN
	Pt ambulated c̄ crutches s̄ difficulty
	[(b)(6)-2] SGT USA 91WM
9Aug03	Nursing: Pt received from ICU, ambulatory. ∅ c/o pain
1035	AXO X3. Pt has swelling to (R) foot, warm, dry c̄ brisk
	cap refill. Disc to R/L UE CDI. [(b)(6)-2]
9 Aug 03	Nursing Notes: Assumed care of pt AXO
1800	Sitting up in bed. Pt Returned from ICU
	in stable condition. Ambulated without
	pain or complication. Dressing on arm
	and shoulders intact ∅ Signs & Symptoms
	of infection & odor. ∅ drainage visible.
	∅ IV Access. Abd soft and non tender
	Pt had ∅ complaints of pain at this
	time. Will continue to monitor status
	[(b)(6)-2]
2219	Dressing change complete. wound debrid
	also completed. Morphine 50 mg PO given
	prior to dressing change. Pt tolerated
	it well. ∅ other complaints. will continue
	to monitor [(b)(6)-2]

STANDARD FORM 600 (REV. 6-87) BACK

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8/14	D/C Summary
	Admit date 8/9
	D/C Date 8/14
	Diagnosis: (4) (B) Calcaneus Fx
	(2) Scalp burn (0) shoulder
	Hospital course: Pt admitted s/p fall/scald burn
	To ICU, wound debrided, wound care daily
	wound is 1°, 2°, 3° burns c̄ only small
	3° on shoulder, not amenable to STSG.
	Pt calcaneus fx treated. Pt ready for D/C
	Home Dsg c̄ return
	Disposition: VS Rank
	(b)(6)-2

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

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

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

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

placed near pt. Eval pending. Dr (b)(6)-2 on unit nurse. Assessment as follows:

- NEURO: A&O x3, speech-clear, appropriate. Pupils 2mm/2mm PERRLA. Moves all extremities, purposefully (+) sensation Bilat U/L Ext. ↓ strength to (R) leg r/t ankle injury. ↓ ROM to same extremity. (+) 2+ swelling, warm, tender to touch.
- CV: NSR VS WNP rotated on standard f/S/I. 2+ pulses dorsalis pedis bilat, radial bilat. Capillary refill bilat U/L digits <3 sec. + edema to (R) Ankle, 2+ non pitting. Resp 11-15 BPM, SaO2 97-100%. BS clear throughout ⊖ use of accessory muscle ⊖ cough, chest movement equal/symmetrical. No complaint of SOB/dyspnea on exertion or @ Rest. Q1/64: (+) BS x4q last BM unknown. ⊖ Abd tenderness, pain, distention. Pt tol Po fluids and solids, consumed app 50% every meal i/out N/V. GU: pt voiding per normal c WNL commode. clear yellow urine 750cc/hr. Skin: dressing to R/L Shoulder and arms. Bacitracin to forehead. Dressing S'd pending. ⊖ discoloration to ankle or foot; ⊖ inflammation to (R) Ankle. Ankle elevated 15°. PIV to (R) AC 18g placed ~~2~~ hr in ER. Patent good blood return ⊖ evidence infection, infiltration.

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

SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR

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

(b)(6)-4

REGISTER NO.	WARD NO.

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	Monitory to cont throughout shift. Cont debridement of burns, maintain elevated (R) ankle, Promote H_2O consumption and solid food intake. Maintain good pain control! Monitor Temp. (b)(6)-2
2000:	Pt c/o ankle pain, throbbing — Percocet 2 tabs PO administered and pending. (b)(6)-2
2100:	Debridement of wounds pending effect of MSO4 4mg IV administered @ this time. (b)(6)-2
2115	Pt not tol debridement c/o pain MSO4 2mg IV administered. Will attempt debridement s/p intervention
2140:	Pt c/o pain, (+) facial grimacing MSO4 2mg.
2000 11/7/04 78	administered. (+) 2° burns noted to (R) arm, shoulder
T:100.0 15RR 100%	neck and left upper arm/shoulder. (+) 3° burn patch approx 10 cm in diameter to (R) forehead noted. Dr (b)(6)-2 @ BS. Burns to body washed c̄ hibiclens, rinsed c̄ NS, dried c̄ sterile gauze s/p application of betadine. Burns to forehead washed and dried as above, bacitracin applied, left open to air.
2245:	MSO4 14mg IV administered between 2100° and 2245°. for pain control during debridement. Dressing d'd to IV site. LR infusing @ 100 cc/h.
0015	UOP = 600 cc clear yellow to urinal. Pt resting (b)(6)-2
0220:	Pt awake snacking on potatoe chips and grande bar. 450 cc H_2O consumed. UOP = 300 cc clear yellow. Soft
0400:	Pt sleeping quietly, Ø evidence of discomfort. (b)(6)-2
0425:	Pt awake PO H_2O intake = 440. Returns to sleep
0600:	Report given on pt to Major [redacted] (b)(6)-2. Care of pt transferred at this time. Pt awake, sitting in bed c̄ no complaints. (b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK

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

BED # 3

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2025	23 y/o Turkish civ arrived via 5ton - partial thickness burn to (L) shoulder
	(R) forearm, (R) abdomen (R) forehead post neck - time of injury 1600
	Pt arrived w/(R) arm bandaged - A/O x3 -
2028	NRB
2030	EKG leads on - FST exam
2035	P-79 BP 156/89 PO2 90 R 18
2037	IV establish (R) AC - LR
2037	X-ray (R) ankle
2040	Blood draw - lab - CBC - met 8
2050	morphine 10mg
2050	P 82 PO2 100
2055	Foley
2055	BSA ↓10%
2055	ice on (R) ankle
2100	P-89 BP 168/85 PO2 100 R 18
2105	UA
2115	P 88 BP 145/81 R-18
2110	Surgeon in
2130	P-80 BP 141/71 PO2 95

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
(b)(3)-1	CIVILIAN		
SPONSOR'S NAME	SSN/ID NO. (b)(6)-4	RELATIONSHIP TO SPONSOR	

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

(b)(6)-4

REGISTER NO. (b)(6)-4

WARD NO. ER

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

USAPA V2.00

THORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
07 May 03	PT fell from a refrigerating truck while working on a motor. PT stated it was like 15 feet fall. PT
BP - 118/72	fell from his head, arms. PT also twisted his leg
P - 80	(R) Leg. Probably had radiator unit blow up on him.
T -	O - PT has burns on his (L) shoulder. PT has
R - 20	a huge bump on his head! Laceration on both
	elbows. PT Ø LOC ≈ fall. c/o burns to
Med	both arms, scalp, forehead and post neck. Ø
Allergy unknown	other facial involvement. Ø inhalation injuries.
PMH	Unwitnessed. Non English speaking. Turkish and just
	arrived today.
	G - Awake Alert.
	H - NCAT ≈ scattered burns to scalp and under forehead.
	Ø singed nasal hairs / brows or soot in mouth. Airway
	patent ≈ edema / erythema
	N - supple FAROM Ø c-spine TTP
	S - superficial partial thickness burns to post neck and
	upper back, (L) shoulder and upper arm, (R) elbow and
	forearm
	E - diffuse swelling, TTP (R) ankle
	(over)

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

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

(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-8.202-1

USAPA V2.00

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING OR ACTION (Sign each entry)
	Wounds cleaned and dressed c̄ silvadene cream
	3 tyl #3 and 800 mg motrin given po
	tetanus needed but we don't have
	ACE wrap to (R) ankle
	Assess: (R) ankle sprain
	8-10% BSA superficial partial thickness burns
	plan: to CSH for surg consult, debridement of burns
	and pain control
	x ray (R) ankle if non wt bearing
	(b)(6)-2 (b)(6)-2 see me

STANDARD FORM 600 (REV. 6-97) BACK

USAPA V2.00

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp): (b)(3)-1

LOG NUMBER

ARRIVAL — DATE: DAY 7, MONTH Aug, YR. 03 — TIME: 2023

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): [ ] PRIVATE VEHICLE [ ] AMBULANCE [X] OTHER (Specify) STOW

CURRENT MEDS. (Tetanus immunization and other data): NONE

HISTORY OBTAINED FROM: [X] PATIENT [ ] OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code): [redacted] 8TH TDB

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT (S) (Include symptom(s), duration): 2nd degree burn to (L) shoulder (R) forearm

SEX: M AGE: 23

POSSIBLE THIRD PARTY PAYER? [ ] YES [ ] NO

VITAL SIGNS

TIME	2024		
BP	150/89		
PULSE	94		
RESP.	13		
TEMP.	98.8		
WT. (Child)	97 RA		

O2

CATEGORY (See reverse): EMERGENT / URGENT / NON-URGENT

ORDERS	INITS.	TIME
morphine - 10mg	[redacted]	2050
X-RAY (R) ankle	[redacted]	2045
FOLEY	[redacted]	2054
Lab: CBC, Chem 8, ua	[redacted]	2040
IVLR 440cc/hr x 3hr	[redacted]	2040
then IVLR 110cc/hr x 6hr	[redacted]	

ASSESSMENT/DIAGNOSIS: (R) Ankle Sprain. 10% 2nd Degree BSA Burn

DISPOSITION (Check all that apply): HOME / FULL DUTY / QUARTERS: 24 Hrs. / 48 Hrs. / 72 Hrs.

MODIFIED DUTY UNTIL: DAY / MONTH / YEAR

REFERRED TO (Indicate clinic): Gen Surg

EMERGENCY / TODAY / 72 HOURS / ROUTINE

ADMIT. TO HOSP. UNIT/SERVICE: ICU

CONDITION UPON RELEASE: X IMPROVED / UNCHANGED / DETERIORATED

TIME OF RELEASE: 2130

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

TIME SEEN BY PROVIDER: 0825

(S) 23 y/o Turkish civilian ♂ fell from reefer truck @ 1600
2nd degree burn to (L) shoulder (R) forearm (R) abdomen
also laceration to elbow - injury to (R) ankle and
(R) forehead

(O) A/O x3 - intoxicated present / Blisters (L) shoulder
(R) forearm (R) forehead from (L) ankle

PMH: NONE

PSH: NONE

S: Pt is a 23 y.o. Turkish ♂ Contractor with fall off reefer truck was presumably burned by radiator fluid by Referran. Fell ~15 feet. Sent from BAS 2 hr ago. ∅ IV en route. ∅ LOC. C/o (R) ankle pain + burns to face, scalp, (R) shoulder + back of neck, ~10% BSA by rule of 9. burned by hot water. ∅ Contact spare ∅ Smoke inhalation.

O: normal mir d/ish 2° to burns. A&O x3 GCS 15 ∅ Resp distress
HEENT NC ∅ 2° burns to scalp edge, forehead ∅ Air comparable
Neck 2° burns to post neck above tank-top line. Healed burn/scar on (R) parietal scalp
Chest: (R) eq CTA
Cor RRR ∅ (R)
Abd ∅ BS S NT NDH
GU: WNL
Ext: 2° Burns to (L) deltoid area + (R) distal dorsal forearm
N/V intact.

Orders:
- 5 Tetanus

$4 \times 83K \times 10\% BSA = 3320$ ~~1660~~
2
1/2 = 1660
1660/3hr = 550cc/hr x 3hr
(Severe burns)
1660/6hr = 110cc/hr x 6hr

XRay ∅ Ankle fg
175 / 48 = 247 (16)
130 / 94 = 191 (24)
46 / 24 (10, 13, 100)
CK 278
UA: pk vel, Clr
1.0205 Tr Bld
Q110

(b)(6)-2

PATIENT'S IDENTIFICATION (Mechanical imprint). FOR WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).

(b)(6)-4

SIG: [redacted] MAJ MC

INS: [redacted] ordered, any limitations and follow-up plan

To ICU

EMERGENCY CARE AND TREATMENT — Medical Record Copy

STANDARD FORM 558 (Rev. 6-82) Prescribed by GSA and ICMR FIRMR (41 CFR) 201-45.505

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

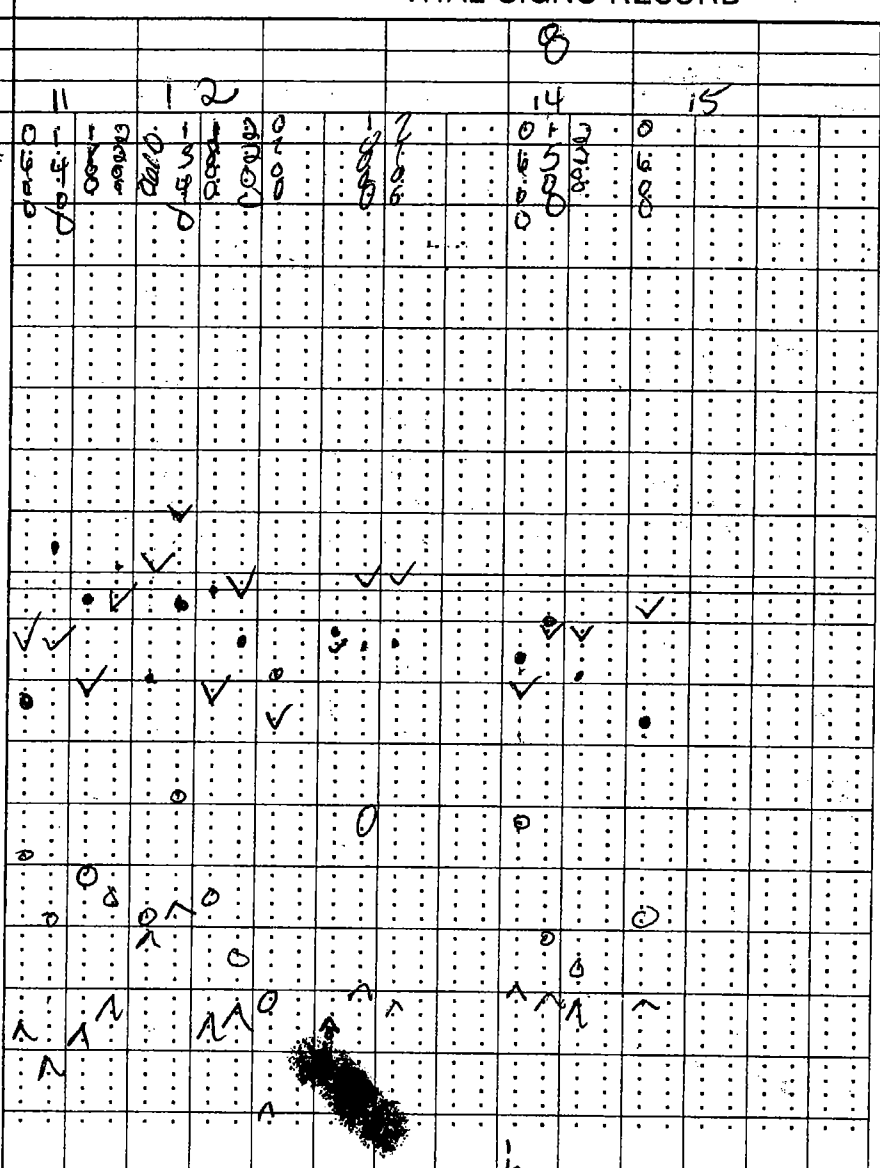
POST- DAY

MONTH-YEAR Aug 2003 DAY 11 12 14 15

HOUR

PULSE (O) | TEMP. F (°)

TEMP. C



(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

(b)(6)-4

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY / POST-DAY: 7 | 8

MONTH-YEAR: August 19 10

HOUR	22	02	06	10	14	18	22	02	06	10	18	0	0	1	2
RESPIRATION RECORD	97.1		97.2	97.4	100.4	100.1	98.7		97.0	96.7					
BLOOD PRESSURE MAP	154/89	112/64	119/65	134/61	127/60	137/70	119/64	101/46	97/53	107/51	107/58	100/45	119/51	101/44	
HR	64	55	54	68	83	83	64	54	55	62	115/48		69		
RR	13	11	15	22	18	14	14	15	14	18					
HEIGHT: WEIGHT ~~SaO2~~	100%	100%	100%	100%	100%	96%	97%	100%	98%	100%			95%	98%	
	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA			RA		
IVFS	150cc/hr	150cc/hr	150cc/hr	200cc/hr	200/2nd 100		100cc/hr	100	(0)		99 97		60/47		
PO ~~IVF~~	→	500cc	240	200cc	240			500							
Foley		550cc	0	0											
		24 cc/hr		~~1000~~ 850cc			400								
UOP			0	0	600		400		600						

Record special data only when so ordered

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

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

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

(Centigrade Equivalents, for Reference only)

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

REGISTER NO.

WARD NO. ICU

(b)(6)-4

7-8 aug
1800 - 0600

INTAKE 1550
OUTPUT 550

Intake ~~[illegible]~~ 3940
out. 850

TOTAL 609
1600 cc clear yellow

1200 hrs / 1500cc bolus

Total Intake
IV 1200
PO 740 1940

STANDARD FORM 511 (REV. 7-95) BACK
*U.S.GPO:1996-404-763/40069

MEDCOM - 6976

BED # 3

Ward/Section: ER	Requesting Physician: (b)(6)-2	Laboratory Result Form (Subject to the Privacy Act of 1974)

LAST, FIRST, MI (b)(6)-4	DATE 07AUG03	TIME 082	SSN/PSEUDO SSN: (b)(6)-4

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC	17.5*	4.8-10.8 x 10
RBC	5.29	4.7-6.1 x 10
Hgb	16.3	14-18g/dl (M) 12-16 g/dl (F)
Hct	48.1	45-52% (M) 37-47% (F)
MCV	91.0	80-94 fl (M) 81-99 fl (F)
Plt	247	130-500 x 10 Verified
Lymph %	7.7%	20.5-51.1%

(Hematology) Manual Diff

Segs		
Bands		
Lymph		
Atyp		
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Coagulation Studies

Test	Result	Ref. Range
PT		9.8-13.6 secs
APTT		21-34 secs
INR		

Urinalysis

TEST	RESULT	REF. RANGE
Color	PK Yellow	N/A
App	CLEAR	N/A
Glu	NEG	Negative
Bili	NEG	Negative
Ket	NEG	Negative
SG	1.030	N/A
Bld	TRACE	Negative
pH	5.0	N/A
Prot	TRACE	Negative SSA: neg
Urob	0.2	0.2-1.0
Nit	NEG	Negative
Leuk	NEG	Negative
HCG		Negative

MET 8

TEST	RESULT	REF. RANGE
GLU	100	73-118 mg/dl
BUN	10	7-22 mg/dl
CRE	1.3	0.6-1.2 mg/dl
CK	278	39-380 u/l (M) 30-190 u/l (F)
NA*	130	128-145 mmol/l
K*	4.6	3.3-4.7 mmol/l
CL*	101	98-108 mmol/l
CO2	24	18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

Chemistry 12

Test	Result	Ref. Range
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA**		8.0-10.3 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

MISC

Results:

Microscopic UA

Results: WBC - 1-3 Amorph Light
RBC - 5-10 Back. Light
EPI - 3-5

Remarks:
UA

Reported by: (b)(6)-2	DATE: 07 Aug	LAB ID NO:

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 8/7 TIME OF ORDER: 2130 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Admit to ICU
(2) Small bowel, scalding injury
(3) Diet Regular
(4) IVF UR @ 150 cc/hr
(5) Cam mx if uop < 30/hr
(6) morphine 2-4mg IV q 1° pm pain
(7) Percocet 1-2 tab q 4-6 pm pain

Orders Transcribed 7 July 23

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

(8) Debride wounds / hair placem
(9) S. lividans for b/a wounds bid
(10) Bacitracin to face wounds

(b)(6)-2

MA Ordered to

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 7 May 03 TIME OF ORDER: 2200 HOURS

VO Dr (b)(6)-2

1.) MSO4 5mg IV x 1 Premed for debridement. Repeat dose @ 15' prn.

Taken by (b)(6)-2 CPT

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.
(b)(6)-2	CPT	8 May 0744

DATE OF ORDER: 8 May 03 TIME OF ORDER: 0700 HOURS

VO DR (b)(6)-2

1) ↓ IVF to 100 cc/hr
2) D/C foley

Taken by (b)(6)-2 CPT

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

240 [illegible] 150 [illegible] 550 49

MEDCOM - 6978

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4 (b)(6)-2 8 Aug 03			8 Aug 03	1622 HOURS	
			Amoxicillin 800mg po TID with food meal		
			V.O. Dr (b)(6)-2		(b)(6)-2 1630
NURSING UNIT	ROOM NO.	BED NO.			

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-2 8 Aug 03			8 Aug	1500 HOURS	
			Bolus LR 1000 cc x 1		
			V.O. Dr (b)(6)-2		(b)(6)-2 1500
NURSING UNIT	ROOM NO.	BED NO.			
Chart ✓	(b)(6)-2		0400 9 August 03		

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
			8/9	0730 HOURS	
			(C) D/C IV		
			(S) TX ward		
			(b)(6)-2		
NURSING UNIT	ROOM NO.	BED NO.			
			24° Chart ✓ 10 Aug 03 @ 0515		(b)(6)-2

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
			9/19	0800 HOURS	
			(1) OK for D/C today		
			(b)(6)-2		
NURSING UNIT	ROOM NO.	BED NO.			

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

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CAPTAIN (NON-MEDICATION)

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

Mo. Aug Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 07	08	9	10	11	12	13	14
7 Aug	(b)(6)-2	Diet: Regular	06	/	(b)(6)-2						
			11	/			(b)(6)-2				
			17	/	(b)(6)-2						
7 Aug	(b)(6)-2	VS q 4° / QS	06	/	QS		(b)(6)-2				
			15	gw	(b)(6)-2						
7 Aug	(b)(6)-2	NHO for UOP <30/hr.	06	/					(b)(6)-2		
			15	SX			(b)(6)-2				
7 Aug	(b)(6)-2	Debridement's PID silvadene to shoulder arms, bacitracin to forehead	10	/	(b)(6)-2						
			22	gw	(b)(6)-2						
8 Aug	(b)(6)-2	foley to gravity	06	/							
			15	MG							

D/C'd

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: <10% BSA 2° Burn shoulders (R) arm forehead.

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D 8 9 10 11 12 13 14 15

E 16 17 18 19 20 21 22 23

N 24 01 02 03 04 05 06 07

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

MEDCOM - 6980

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo Aug Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
7 Aug	(b)(6)-2	Admit to ICU splash burns,	7 Aug	2200	2200	(b)(6)-2
		Scalding burns				
8 Aug		TRANSFER to ICU	8 Aug	—	1025	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
-----	-----															
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USAPA V1.00

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION C[illegible] PLAN *(MEDICATIONS)*

For use of this form, see [illegible]-407; the proponent agency is the Office of The Surgeon General.

Mo. Aug Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 07	08	09	10	11	12	13	14
6 Aug	(b)(6)-2	IVF's LRC 100 cc/h	06	✓			DC'd		8 Aug 03		
			18	[redacted]							
7 Aug	(b)(6)-2	IVF's LR @ 100 cc/h	06	[redacted]			D/C'd		9 AUG 03		
			18								
8 Aug	(b)(6)-2	Motrin 800mg PO	06	✓	✓	(b)(6)-2					
		TID c̄ each meal	12	✓	✓	(b)(6)-2					
			22	✓	(b)(6)-2						
8 Aug	(b)(6)-2	Motrin 800mg PO	06					✓	(b)(6)-2	D/C'd	
		TID c̄ each meal	12					✓		not included in [illegible] as of 10 Aug 03	
			18					✓			

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: <10% scalding burns to forehead (R) arm shoulders

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. Aug Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
		~~Percocet~~ error gw				
7 Aug	(b)(6)-2	MSO4 5mg IV x 1 predebridement	2215	7 Aug	2215	(b)(6)-2
7 Aug		MSO4 5mg IV x 1 prn during debridement	2230	7 Aug	2230	
9 AUG 03		Bolus 1500cc LR now	1530	9 Aug	1600	
9 AUG		DC IV	—	9 AUG	Done	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
7 Aug	(b)(6)-2	MSO4 1-2-4mg IV q 1°	5mg IV 7 Aug 2215	5mg IV 7 Aug 2230	4mg IV 8 Aug	2115	2mg 8 Aug	2130 IV 8 Aug	2mg 2145 8 Aug	2mg 2230 8 Aug	2mg 2245 8 Aug	2mg 2315 8 Aug			
		prn pain	[redacted]	[redacted]	[redacted]		[redacted]		[redacted]	[redacted]	[redacted]	[redacted]			
7 Aug	(b)(6)-2	Percocet 1-2 PO	8 AUG 1100	8 AUG 1100 PO	0900 8 AUG	1100	11 AUG 2315	12 AUG 1210	12 AUG 2300	12 AUG 2115		14 AUG 1450			
		q 4-6 prn pain	0 PO	[redacted]			[redacted]	[redacted]	[redacted]	[redacted]					

b(6) 2

USAPA V1.00

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. M... L ...TION (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: 2 2	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: [redacted]	27 28 29: 2 3 Y	30: X	31: 9	UNK

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34	b(6)-4	35 36: 9 9	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: U	2130	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49: N O	50 51 52: K ~~8~~ ~~5~~ 78 EPW	53 54 55 56 57 58 59 60 61: [redacted]

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
62 63: [redacted]	64 65 66 67 68 69 70	71: 9	YEAR; X NO b(6)-4

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

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y Y Y M M D D)
73 74: 0 5	75 76 77 78 79 80	81 82 83 84 85 86 87 88: 2 0 0 3 0 8 0 9

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y Y Y M M D D)
89 90 91 92: A B M A	93 94 95 96 97 98	99 100 101 102 103 104 105 106: 2 0 0 3 0 8 0 7

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: [redacted] b(3)-1	109 110 111 112 113 114	115 116 117 118 119 120 121 122

FOR LOCAL USE

DX: 40% BSA BURNS 2ND DEGREE
BURN RIGHT FOREARM
BURN LEFT SHOULDER
BURN RIGHT ABDOMEN

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK
(b)(6)-2 LTC, MC (b)(6)-2	(b)(6)-2, SPC 91G10

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

MEDCOM - 6984

(b)(3)-1

IMPATIENT 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	23	X	UNK			NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99	(b)(6)-4		ICW

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
		K78			BC

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
0	0400	AEAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	HOME	20 AUG 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		19 AUG 03	COL (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		

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

This 23 y/o Iraqi ambulance driver was wounded in the right calf at 2330 on 18 Aug 03 when enemy forces attempted to use his vehicle as cover to attack a US check point in Tikrit.

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: FRAGMENT WOUND RIGHT CALF PROCEDURES

PROCEDURES: WOUND IRRIGATION

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
0	0	0	0	1	1

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
0	0	0	0	1	1

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER
(b)(6)-2 COL, MC	(b)(6)-2 SSG, PAD, NCOIC

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

MEDCOM - 6985

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

(b)(6)-4

PHYSICAL EXAMINATION

(b)(6)-4

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

IDENTIFICATION NO.	ORGANIZATION

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19 Aug	
0322	CBC, Met8
0327	X-Ray (R. leg)
	5g morphine refused
19 AUG 03 @ 0420	Nsg admission note: Pt was transferred from ER via stretcher. Appears A+O x 4 (spoke w/ interpreter). Has an ace bandage wrapped around his rt leg where he apparently received a fragment wound from a "crossfire" incident. Pt to be NPO until seen by Dr (b)(6)-2 Denies any pain at this time. VS are WNL. Resp are even/unlabored, sats are 98% on RA (b)(6)-2
19 Aug 03 1600	Nurses Shift note Pt. received in lying position w/ FOB ↑. Pt. surgery cancelled on IV antibiotic. Dressing A'd by physician. Visitors this shift. Comfort (b)(6)-2 CPA

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

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

REGISTER NO.	WARD NO.

(b)(6)-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19AUG03 @ 2330	NSG shift assessment: Pt denies any current pain. Has been very quiet throughout shift. Leg is still elevated. Breath sounds are clear, resps even + unlabored. Capr refill to (R) toes WNL. Will continue to monitor (b)(6)-2
20AUG03 0600	S NO C/O O VSSA WND BENIGN NVI A DOING WELL P D/C SOE WARSAW (b)(6)-2

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

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
20 AUG 03	NARRATIVE SUMMARY
	ADMITTED 19 AUG 03 D/C'D 20 AUG 03
	DX - FRAGMENT WOUND RIGHT CALF
	PROCEDURES - WOUND IRRIGATION - 19 AUG 03
	RESUME - THIS 23 y/o INAQ1 AMBULANCE
	DRIVER WAS WOUNDED IN THE RIGHT
	CALF AT 2330 18 AUG WHEN ENEMY
	FORCES ATTEMPTED TO USE HIS VEHICLE
	AS COVER TO ATTACK A US CHECKPOINT
	IN TIKRIT. HE SHOWED A SINGLE 1/2 CM
	WOUND OF THE DISTAL POSTERO MEDIAL
	CALF. THE LIMB WAS NEUROVASCULARLY
	INTACT. XRAY SHOWED SEVERAL SMALL
	METALLIC FRAGMENTS IN THE DISTAL
	TRICEPS SURAE. HE WAS TREATED WITH
	WOUND TRACK IRRIGATION IN EMT
	AND ADMITTED FOR 24° IV ABX. HIS
	COURSE WAS UNREMARKABLE.
	DISPO - D/C TO HOME F/U - [redacted] PRN
	ACTIVITY - PWB CRUTCHES x 1 WK
	MEDS - KEFLEX 500 Q.I.D x 7D, TYLENOL 3 PRN [redacted]

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

LTC, MC
ORTHOPEDIC SERVICE

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

REGISTER NO. | WARD NO.

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

EMERGENCY CARE AND TREATMENT
(Medical Record)

EMT

LOG NUMBER

ARRIVAL
DATE: DAY 19 MONTH YR. TIME 0319

TRANSPORTATION TO HOSPITAL (Attach ambulance chrono chart)
☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (Including medication and other data.)
Ancef @ BDS (−)

HISTORY OBTAINED FROM
☐ PATIENT ☐ OTHER (Specify)

ALLERGIES
NKDA.

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT (S) (Include symptom(s), duration)
gun shot wound (R) leg

SEX M AGE 23

POSSIBLE THIRD PARTY PAYER
☐ YES ☐ NO

VITAL SIGNS

TIME	0319		
BP	174/97		
PULSE	98		
RESP.	16		
TEMP.	98.4		
SPO2 (Pulse Ox)	99%		

CATEGORY (See reverse)
☐ EMERGENT
☒ URGENT
☐ NON-URGENT

ORDERS / RESULTS / TIME
X-RAY 0327
CBC, Met8 [redacted] 0322
5g morphine refused
Irrig at 2L outward

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

S-23 yo ♂ Iraqi c/o GSW to (R) leg. distal calf. His vehicle was being used as a sheild and he got caught in the crossfire. Pt is an Iraqi Ambulance driver, Not an EPW. occurred downtown Tikrit near Palace. ? if bullet or fragment. near 122 area.

O- pt appears to be in no distress
Non toxic A+O×4, ⊖ Resp distress
HEENT: NCAT PERRL EOMI.
Lungs ⊖ CTA.
Cor RRR
Abd: BS.S. NT NDRS
Ext: (R) LE c medial calf posterior to Tibia frag wound
NL sensation ++PP 3x phase doppler pulses

Last Meal 2230.
TOI 0330

PMHx ⊖.
PSHx Appy

TIME SEEN BY PROVIDER
0300

ASSESSMENT/DIAGNOSIS
frag to (R) lower leg.

Intramuscular frags. ⊖ fx.

13 > 17 < 266
52
139 | 102 < 9, 1.1, 103
4.9 | 24
Hemolyzed.

DISPOSITION (Check all that apply)
HOME | FULL DUTY
QUARTERS: 24 Hrs. | 48 Hrs. | 72 Hrs.
MODIFIED DUTY UNTIL: DAY | MONTH | YEAR
REFERRED TO (Indicate clinic)
Ortho
EMERGENCY | ☒ TODAY
72 HOURS | ROUTINE
ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
☒ IMPROVED | UNCHANGED
DETERIORATED
TIME OF RELEASE: 0400

PATIENT'S IDENTIFICATION (Mechanical imprint)
(IF WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN, DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).

(b)(6)-4

(b)(6)-2

NEEDED)

STAMP
MAJ MC.

medications ordered, any limitations and follow-up plans)

TO ICW

EMERGENCY CARE AND TREATMENT
Medical Record Copy

STANDARD FORM 556 (Rev.
Prescribed by GSA and ICMP

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY	1	2	3	4	5	6	7
POST- DAY							
MONTH-YEAR AUG03 DAY	19	20	21	22	23	24	25
19 HOUR	18	18					

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

RESPIRATION RECORD

BLOOD PRESSURE: 141/75, 133/71, 125/71, 122/69, 111/51

HEIGHT: WEIGHT →

Spo2: 98, 95%, 98%

Record special data only when so ordered

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

(b)(6)-4

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

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

Ward/Section: EMT	Requesting Physician: DR (b)(6)-2	Laboratory Result Form (Subject to the Privacy Act of 1974)
LAST, FIRST, MI (b)(6)-4	DATE 19 AUG	TIME 0322	SSN/PSEUDO SSN:

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC	13.6	4.8-10.8 x 10
RBC	6.05	4.7-6.1 x 10
Hgb	17.3	14-18g/dl (M) 12-16 g/dl (F)
Hct	52.1	45-52% (M) 37-47% (F)
MCV	86.2	80-94 fl (M) 81-99 fl (F)
Plt	258	130-500 x 10 Verified
Lymph %	12.6	20.5-51.1%

(Hematology) Manual Diff

Segs		
Bands		
Lymph		
Atyp		
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Coagulation Studies

Test	Result	Ref. Range
PT		9.8-13.6 secs
APTT		21-34 secs
INR		

Urinalysis

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

MET 8

TEST	RESULT	REF. RANGE
GLU	103	73-118 mg/dl
BUN	9	7-22 mg/dl
CRE	1.1	0.6-1.2 mg/dl
CK	126	39-380 u/l (M) 30-190 u/l (F)
NA*	139	128-145 mmol/l
K* ①	4.9 *	3.3-4.7 mmol/l
CL*	103	98-108 mmol/l
CO2	24	18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANG
PRP		Negative
Mono		Negative

Chemistry 12

Test	Result	Ref. Rang
ALB		3.5-5.5 g/d
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg
BUN		7-22 mg/dl
CA**		8.0-10.3 m
CHOL		100-200 m
CRE		0.6-1.2 mg
GLU		73-118 mg
TP		6.4-8.1 g/d

MISC

Results:

Microscopic UA

Results:

Remarks: ① Specimen Hemolyzed - may falsely ↑ K+

Reported by: (b)(6)-2	DATE: 19 Aug 03	LAB ID NO:

RADIOLOGIC CONSULATION REQUEST

PATIENTS NAME: (b)(6)-4

SSN:

UNIT:

PROVIDER/ CLINIC: EMT 1DR (b)(6)-2

DATE REQUESTED: 19 Aug 03

EXAMINATION REQUESTED:

R leg

SPECIFIC REASON(S) FOR REQEST:

GSW

RADIOLOGIC REPORT:

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 19 Aug 03 TIME OF ORDER: 0400 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit to ICW
2. Dx frag wound to (R) Leg.
3. Cord Status
4. Vs q Shift
5. NPDA-
6. Actn: BR & BRP.
7. Nursing: wound Care, elevate (R) LE

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER:

8. IV NS @ 125 cc/hr HOURS
9. NPO until seen by Dr (b)(6)-2 then Reg Diet
10. MSO4 5-10mg IV q 2-4 prn.
11. Ancef 1gm IV q 8° Last dose ~ 0100

(b)(6)-2

Notified 19AUG

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 19 AUG 03 TIME OF ORDER: 0815 HOURS

REG DIET

ANCEF 1GM IV NOW, THEN

ANCEF IV Q8° BEGINNING AT 1400

(b)(6)-2

(b)(6)-2

CMTHR 19AUG03 0815

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER:

20 AUG 03 0500 HOURS

D/C HOME - MUST BE AT GATE AT 1000, PLEASE COORDINATE C 1 SG

CRUTCH TRAIN A D/C

MEDS - KEFLEX, TYLENOL 3, BACITRACIN

PROVIDE 4X4S & COBAN FOR DSG AS

(b)(6)-2

(b)(6)-4

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

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

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 19	20	21	22	23
19AUG	(b)(6)-2	IV NS @ 125cc/hr	06	(b)(6)-2				
	.....		14					
	.....		22	(b)(6)-2				
~~19AUG~~	~~(b)(6)-2~~	~~NPO until seen~~	~~06~~					
	.....	~~by Dr Granville~~	~~14~~					
	.....	~~then Regulat~~	~~22~~					
19AUG	(b)(6)-2	Ancef 1 GM	06	(b)(6)-2				
		IV Q8 resume	14					
	.....	Q8 at 1400	22					
	.....							
	.....							
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	.....							
	.....							
	.....							
	.....							
	.....							

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS:

Frag wound to (R) leg

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

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

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
18AUG	(b)(6)-2	MSO4 5-10mg														
.....	.....	IV Q2-4° PRN														
.....	.....	(b)(6)-2														
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															

USAPA V1.00

CLINICAL RECORD

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

Mo AUG Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 19	20	21	22	23
19AUG	(b)(6)-2	VS Q shift	06	(b)(6)-2				
			14					
			22					
19AUG	(b)(6)-2	Activity: Bedrest	06					
		C BRP	14					
			22					
19AUG	(b)(6)-2	Nursing: wound	06	(b)(6)-2				
		care, elevate	14					
		(R) LE	22	(b)(6)-2				
19AUG	(b)(6)-2	NPO until seen	06					
		by Dr (b)(6)-2	12					
		then Reg diet	18	(b)(6)-2				
19Aug	(b)(6)-2	Reg diet	6					
			12	(b)(6)-2				
			17					

D/C

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS:

Frag wound to (R) leg

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				Mo._____ Yr. _____
Order Date	**Clerk/ Nurse**	**SINGLE ORDER, PRE-OPERATIVES**	**Date to be Given**	**Time to be Given**	**Time Given**	**Initials**
	-----	Admit to ICW				
	-----	Dx: Frag wound to (R) leg				
	-----	Condition: Stable				

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

b(6)-2

1. LAST NAME, FIRST NAME, MIDDLE INITIAL
(b)(6)-4

RANK / GRADE

X MALE / HOMME
FEMALE / FEMME

SOCIAL SECURITY NUMBER

MEDICAL CODE / GPM

RELIGION / RELIGION

2. UNIT / UNITÉ

FORCE / ÉLÉMENT

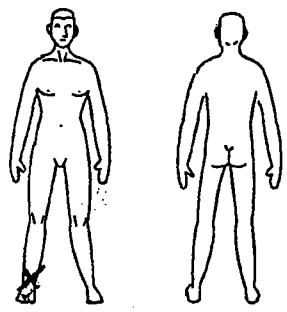
A/T | AF/A | N/M | MC/M

NATIONALITY / NATIONALITÉ
Iraqi EPW

BC / BC | NBI / BNC | DISEASE / MALADIE | PSYCH / PSYCH

3. INJURY / BLESSURE

FRONT / DEVANT | BACK / ARRIÈRE



- AIRWAY / TRACHÉE
- HEAD / TÊTE
- X WOUND / BLESSURE
- NECK/BACK INJURY / BLESSURE AU COU/AU DOS
- BURN / BRÛLURE
- AMPUTATION / AMPUTATION
- STRESS / TENSION
- OTHER (Specify) / AUTRE (Spécifier)

gunshot wound
to lower R. calf

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE

- X ALERT / ALERTE
- VERBAL RESPONSE / RÉPONSE VERBALE
- PAIN RESPONSE / RÉPONSE À LA DOULEUR
- UNRESPONSIVE / SANS RÉPONSE

5. PULSE / POULS: 82 | TIME / HEURE: 0151

6. TOURNIQUET / GARROT: NO / NON | YES / OUI | TIME / HEURE

7. MORPHINE / MORPHINE: X NO / NON | YES / OUI | DOSE / DOSE | TIME / HEURE

8. IV / IV | TIME / HEURE

9. TREATMENT / OBSERVATIONS / CURRENT MEDICATION / ALLERGIES / NBC (ANTIDOTE)
TRAITEMENT / OBSERVATIONS / PRESENTE MEDICATION / ALLERGIES / ANTIDOTES

Feild Dressing
Initiated IV
Temp 100.0
Acetaminophen 1,000 mg PO
~~Acetaminophen~~
Ancef 1gm IV

10. DISPOSITION / DISPOSITION

- RETURNED TO DUTY / RETOUR À L'UNITÉ
- X EVACUATED / EVACUÉ
- DECEASED / DÉCÉDÉ

TIME / HEURE

11. PROVIDER / UNIT / OFFICIER MÉDICALE / UNITÉ

DATE/DATE (YYMMDD)

DD Form 1380, DEC 91

This form replaces previous editions of DD Form 1380 and DD Form 1380 (TEST), which are obsolete.

U.S. FIELD MEDICAL CARD
FICHE MÉDICALE DE L'AVANT ÉTATS-UNIS

12. REASSESSMENT / RÉASSESSMENT

DATE / DATE (YYMMDD)	TIME OF ARRIVAL / HEURE D'ARRIVÉE
030814	0130

TIME / HEURE	0154	0222		
BP / PS	172/90	169/91		
PULSE / POULS	82	68		
RESP / RESP	17	24		

DATE / TIME
DATE / HEURE

13. CLINICAL COMMENTS / DIAGNOSIS
INFORMATION MÉDICALE / DIAGNOSTIQUES

S: 23 y.o. ♂ GSW TA (R) ~~[illegible]~~ medial Relief/HA distal calf.
O: Lying ↑ in MAD, HR↑ BP↑, VS BP↑
HEENT: Eyes clear PERRL
Ears clear
Throat clear
Neck clear.

14. ORDERS / ANTIBIOTICS (Specify) / TETANUS / IV FLUIDS
DIRECTIVES MÉDICALES / ANTIBIOTIQUES (Spécifier) / TÉTANOS / IV FLUIDE

HEART: S1 S2, RRR w/o m.
LUNGS: CTA (B) w/o wheezes
ABD: (+) BS soft, NTND
UE: ⊘ DSX / dislocation
pulses ↑
LE: (R) leg: Entrance wound medial ~~[illegible]~~ distal calf ⊘ active bleed
NVZ
(L) leg: DSX / dislocat.

(b)(6)-2

(b)(6)-2

(b)(3)-1

DATE/DATE (YYMMDD) 030819

16. DISPOSITION / DISPOSITION

	RETURNED TO DUTY / RETOUR À L'UNITÉ	TIME / HEURE
	EVACUATED / EVACUÉ	
	DECEASED / DÉCÉDÉ	

17. RELIGIOUS SERVICES / SERVICES RELIGIEUX

	BAPTISM / BAPTISÉ		PRAYER / PRIÈRE
	ANOINTING / ONCTION		COMMUNION / COMMUNION
	CONFESSION / CONFESSION		OTHER / AUTRE

CHAPLAIN / CHAPELAIN

DD Form 1380, DEC 91 (Back)

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.)	
3. REGISTER NUMBER	(b)(6)-4
NAME (Last, First, Middle Initial)	EPW (b)(6)-4
4. PAY GRADE	
5. SEX	M
6. DATE OF BIRTH (Y Y Y Y M M D D)	[redacted]
7. AGE AT ADMISSION	23 Y
8. RACE	X
9. ETHNIC BACK-GROUND	9
RELIGION	UNK
10. LENGTH OF SERVICE	
ETS	b(6)-4
11. FMP	9 9
12. SOCIAL SECURITY NUMBER	(b)(3)-1
ORGANIZATION (Active Duty Only)	
13. MARITAL STATUS	Z
HOUR OF ADMISSION	0400
BRANCH / CORPS	EPW
14. FLYING STATUS	Z Z Z
15. BENEFICIARY CATEGORY	K 7 8
16. ZIP CODE OF RESIDENCE	[redacted]
17. UNIT LOCATION (State or Country Code)	[redacted]
18. MOS	
19. TRAUMA	Y 9
PREV. ADMISSION	YEAR [X] NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	O
WARD	ICW
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	0 1
22. MTF TRANSFERRED TO	
23. DATE OF DISPOSITION (Y Y Y Y M M D D)	2 0 0 3 0 8 2 0
24. CLINIC SVC - ADMITTING	A E A A
25. MTF TRANSFERRED FROM	~~93 94 95 96 97 98~~
26. DATE THIS ADMISSION (Y Y Y Y M M D D)	2 0 0 3 0 8 1 9
27. LOCATION OF OCCURRENCE (Battle Casualty Only)	[redacted] b(3)-1
28. MTF OF INITIAL ADMISSION	~~109 110 111 112 113 114~~
29. DATE INITIAL ADMISSION (Y Y Y Y M M D D)	~~115 116 117 118 119 120 121 122~~

FOR LOCAL USE

DX: FRAGMENT WOUND RIGHT CALF

PROCEDURES: WOUND IRRIGATION

Dx: 8911 E9919 Proc: 9659

Trg Trauma
443 1

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

SIGNATURE OF ADMITTING CLERK (b)(6)-2 SSG, PAD, NCOIC

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

MEDCOM - 7001

(b)(3)-1

INP... NT TREATMENT RECORD COVER SH...

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

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

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	24	X	UNK			NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
	(b)(6)-4		ICU

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
		K76			INJ

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
0	0050	AAEA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	HOME	21 AUG 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		19 AUG 03	COL (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		

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: CONCUSSION
CERVICAL STRAIN
RIGHT ELBOW CONTUSION

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
0	0	0	0	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
0	0	0	0	2	2

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER
(b)(6)-2 COL, MC (b)(6)-2	(b)(6)-2 SSG, PAD, NCOIC

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

MEDCOM - 7002

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

26 YM syrian contractor admitted last night via ER
p̄ sustaining a fall w/ brief LOC. Distance ~ 3m.
Had residual confusion in ER.
No obvious fx by x-ray series. Neck is sore, Rt elbow hurts.

pmH/meds/sHx - unknown
NKDA.

PHYSICAL EXAMINATION

120/80, 60, 12, resting - Interpreter not available at present.
Lungs CTA, neck collar in place, Reg S, S2, Ø sig ⓜ, abd soft.
Rt elbow - mild tenderness/swelling
X-ray: skull/c-spine/Rt elbow all s̄ fx. W/A - concentrated.
CBC w/ WBC 18 H/H 16/50, lytes NL.

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

Imp: ① CHI s/p fall - mild concussion - some confusion last night. Neuro ✓'s remain NL.
- continue to monitor
② Neck sprain
③ Rt elbow contusion - analgesia.

(b)(6)-2

	DATE	IDENTIFICATION NO.	ORGANIZATION
M.C. LTC	20AUG03		

ed or written entries give Name last, first, grade; date; hospital or medical facility)

REGISTER NO.	WARD NO.

(b)(6)-4

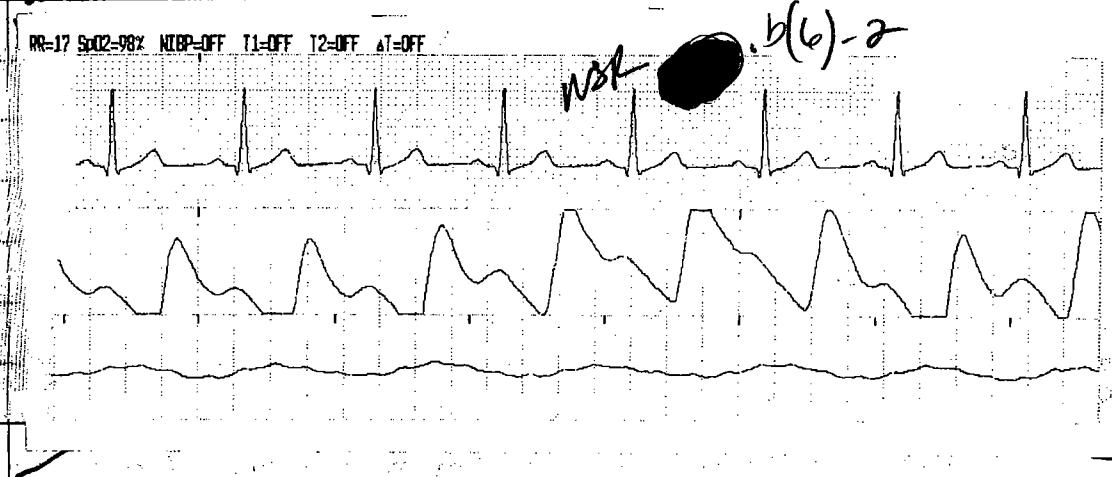
ABBREVIATED MEDICAL RECORD
Standard Form 539

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

Aug 03 0230 Client admitted to icu on litter c̄ two staff members and RN. Placed on monitor, assessment and neuro checks done. see Dt from 4700. Vomited x̄ on admission, 25 mg Phenergan given IV. c/o H/A, 650 mg tylenol PO for H/A. Pain noted to right elbow area. Dr (b)(6)-2 in to see client (b)(6)-2 ICU Nurse.



0300 Ice applied to right elbow. (b)(6)-2 CPA

0300 Soft neck collar intact. (b)(6)-2 ICU RN

0400 no changes in neuro checks. (b)(6)-2 Hunkins

0500 ice reapplied to right elbow. (b)(6)-2 ICU RN

0600 Ice pack removed from R elbow, report given to day shift RN, client in bed connected to monitor, soft c-collar intact. NS @ 200 cc/hr infusing. (b)(6)-2 ICU RN

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

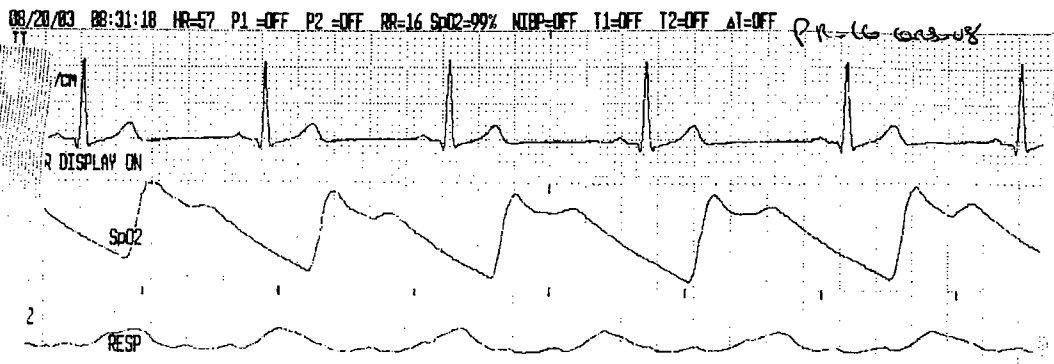
(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV.
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.2(
USA

AME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES



08/20/03 1080 Patient reports received from previous shift. Patient lying in supine position. Given Clear liquid diet, ate 1/3 of [illegible]. C/o headache given 2 tylenol (PO). Neuro status unremarkable, 5 equal hand grasps, pedal pulses equal. Pupils equal reacted to light, no nystagmus noted. Remains in SR 5 [illegible] - 1 [illegible] 98% on monitor. Further assessments as per DA Form 7501. Plan ① Watch Neuro checks 2 x + record ② Notify MD if any status changes ③ Keep elbow elevated to ↓ swelling + pain [(b)(6)-2] [illegible]

20 Aug 03 0830 IV/A drawn + sent to lab as ordered. [(b)(6)-2] [illegible]

20 Aug 03 1100 Foley D/C'd as ordered CBC drawn, sent to lab [(b)(6)-2] [illegible]

20 Aug 03 1200 Ice Pack applied to elbow and elevated as ordered. Patient resting comfortably at present. Remains in SR [(b)(6)-2] [illegible]

1400 Reports quests CPT [(b)(6)-2]. Patient denies headache. Alert to name, place, year. IV infusing (L) arm. NSS @ 200cc/hr. No urine since foley D/C'd @ 1100. To ICW via litter. [(b)(6)-2] [illegible]

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
20 AUG 03 - 1915 - ASSESSMENT - A&O x3, PERRLA, LUNGS CTA BILAT, S1, S2 STRONG AND REGULAR, (P) BS x4. Ø % PAIN, Ø % NAUSEA, C-SPINE PRECAUTIONS. D/T HAS P-COCUAR. NEURO CHECKS q 2 MOTOR, SENSORY SKILLS INTACT. TOLERATED RCC DIET. LU RS ⊠ 2 GUECC/HR. WILL CONTINUE TO MONITOR THROUGHOUT (b)(6)-2 USEFICW	
total intake = 3000cc total output = 7000cc	

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

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

(b)(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
21 AUG 03	NARRATIVE SUMMARY
	ADMITTED 19 AUG 03 D/C'D 21 AUG 03
	Dx - CONCUSSION
	CERVICAL STRAIN
	RT ELBOW CONTUSION
	PROCEDURES - NONE
	RESUME - 26 y/o CONTRACT TRUCK DRIVER, SYRIAN, FELL 10 FT STRIKING OCCIPUT. AMNESIC FOR INCIDENT. CONFUSED UPON PRESENTATION c/o (R) ELBOW & NECK PAIN. PE TENDER OCCIPUT & PARA CERVICAL MUSCLES & TENDER (R) DISTAL TRICEPS.
	NO - PERIPHERAL NEURO FINDINGS. NO ELBOW LAXITY. XR SKULL, C-SPINE, ELBOW AP. SENSORIUM CLEARED & NECK FLEXION/EXTENSION VIEWS AT OPEN ENSUING 36 HR.
	DISPO - D/C
	MED - MOTRIN, TYLENOL 3
	FU - PERSONAL PHYSICIAN AT HOME AS NEEDED
	ACT - NO DRIVING ON TYLENOL 3. NO PROLONGED DRIVING FOR ONE WEEK.

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE
		(b)(6)-2 (b)(6)-2 ERC, MC ORTHOPEDIC SERVICE
SPONSOR'S NAME	**SSN/ID NO.**	**RELATIONSHIP TO SPONSOR**

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

(b)(6)-4

REGISTER NO.	WARD NO.

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
21 AUG 03	NARRATIVE SUMMARY
	ADMITTED 19 AUG 03 D/C'D 21 AUG 03
	Dx - CONCUSSION
	CERVICAL STRAIN
	RT ELBOW CONTUSION
	PROCEDURES - NONE
	RESULT - 26 y/o CONTRACT TRUCK DRIVER, SYMPTOMS, FELL 10 FT STRIKING OCCIPUT. AMNESIC FOR INCIDENT, CONFUSED MSE ON PRESENTATION C/O (R) ELBOW & NECK PAIN. PE TENDER OCCIPUT & PARA CERVICAL MUSCLES & TENDER (R) DISTAL TRICEPS.
	NO - PERIPHERAL NEURO FINDINGS. NO ELBOW LAXITY. XR SKULL, C-SPINE, ELBOW ~~W~~. SENSORIUM CLEARED & NECK FLEXION/EXTENSION VIEWS ~~W~~ OVER ENSUING 36 HR.
	DISPO - D/C
	MED - MOTRIN, TYLENOL 3
	FU - PERSONAL PHYSICIAN AT HOME AS NEEDED
	ACT - NO DRIVING ON TYLENOL 3. NO PROLONGED DRIVING FOR ONE WEEK.

(b)(6)-2

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

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

(b)(6)-4

REGISTER NO.	WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19AUG03	26 y/o ♂ c/o trauma to (R) head, neck and arm. Interpreter states TTP to (L) Ear slight deformity, TTP to (R) arm, upper, tricep area.
BP: 142/62	
Pulse: 106	
Temp: 98.0	2312 - Vomited
Resp: 18	s/p Hx as above. pt Fell (possibly) 3 meters. hit (L) occipital region ⊕ LOC x 3 mins per witness c/o Head/neck and (R) arm pain.
Allergies: NKAD	
Medications: Ø	o/w WDWN AG'O moves all extr. Eyes perrl EOMI Head - non traumatic
PMHx:	ears TM's clear ⊕ mouth/throat clear
PSHx:	neck - ⊕ midline TTP ⊖ step offs
	lungs - CTAB insp/exp
Tobacco:	CVS RRR S1S2 S m
	ABD - ⊕ BS soft NTND ⊖ masses
ETOH:	extr - (R) arm - ⊕ TTP mid and ~~lower~~ distal 1/3 humerus ⊖ sensory deficit Radial pulses = (R) CR < 2 sec ⊖ deformity, ecchymosis but pt

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
Ironhorse Consolidated Aid Station; Tikrit, Iraq			over →
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

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

(b)(6)-4

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

USAPA V2.00

19 Aug 03

extremely TTP
pelvis - stable
LE - ⊕ TTP & deformity

Dx skeletal civ sub contractor Tell approx
3 meters ⊕ LOC, ⊕ emesis x1 in ambulatory
neurologically intact. closed then using
bro ⊕ arm using c-spine tenderness

plan ① EVAC to CSH
for further treatment
and evaluation

(b)(6)-2

CPT (b)(6)-2 PDC

DATE: Aug 03 | TIME: 0045

PRIVATE VEHICLE / AMBULANCE / OTHER (Specify) AIR

PRIOR TO HOSPITAL: Ø

CURRENT MEDS.

HISTORY OBTAINED FROM: PATIENT / OTHER

ALLERGIES: NKDA

HOME TELE. NO.

(b)(6)-4

Fall from Height TOI ~2300 | SEX: M | AGE: 24

POSSIBLE THIRD PARTY PAYER: YES / NO

TIME SEEN BY PROVIDER: 0045

(1) Subjective data (Patient History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

0045
144/60
105
34
96 ⊕ 98 ⊕
SpO2 97 RA

CATEGORY (See reverse): EMERGENT / URGENT / NON-URGENT

ORDERS | PRTS. | TIME
Urine ⊖ Spin [redacted] ⊖
CBC Chem Met ⊖ UA [redacted]
Sles
FAST ⊖ [redacted] 0040
5 morphine/hol [redacted] 0040

ASSESSMENT/DIAGNOSIS: CHI, Neck Strain, Bellows Contusion.

DUTY: FULL DUTY

QUARTERS: 24 HRS. | 48 HRS. | 72 HRS.

MODIFIED DUTY UNTIL: DAY | MONTH | YEAR

REFERRED TO: Gen Surg

EMERGENCY ☒ TODAY | 72 HOURS | ROUTINE

ADMIT. TO HOSP. UNIT/SERVICE: ICU.

CONDITION UPON RELEASE: IMPROVED | UNCHANGED | DETERIORATED

TIME OF RELEASE: 0130.

Sip + ⊖ on 26yo (b)(6)-4 who was reported to have fallen 3 meters (10 feet) c̄ ⊕ LOC. Vom x1 in Ambulance @ 2312. Seen @ Iron Horse Aid Sta in Tikrit then sent by Helo. No vom in A/c. ⊕ Repetitive questions to Interpreter. Pt thinks he is at home in Syria & doesn't remember any fall.

Urinary ⊖
Urinary ⊖
Tob ⊖

O: Uncomfortable in NAD. A+O x person, Not Place, Not date. GCS 15/14 (confused) ⊖ Resp dist. No Trauma.
HEENT: NC/AT. ⊖ Battles, Raccoon, ⊖ HT. PERRL EOMI 4mm. ⊖ oral lesions ⊖ malocclusion. ⊖ mod occip swelling ⊖ stepoff.
Neck: ⊖ ML tend ~ C4 ⊖ stepoffs ⊖ Crep.
Chest: NT ⊕ ag CTA. Cor RRR ⊖
Abd: ⊕ BS. NT no masses FAST ⊖
Pelvis Stable NT ⊖ Crep.
GU: NL ⊖ Scrotal HT
Rectal: NT NL Pros. Brn Stool guaiac ⊖.
Ext: ⊕ mild swelling to ⊕ Supraacromyoclavicular area. N/vascular. ⊖ Crep. ⊖ Instability.

C/Spine: ⊖ Tr/Sacr ⊕ Elbow ⊖ Tr ⊖ anterior

EDC: persisted c̄ repetitive questions with Interpreter.

FAST ⊖
Hemocrit ⊖
18 16 50 (181
7.41/427/426/27/29/3/100%
Yel/SL Cloudy/1.020/mod Blood
⊖ WBCs 10-20 RBC Hyp Mucus Fair Bact
136 | 104 | 8 / 4.1 | 24 | 1.0 / 129
Cl 94
LFT's NL.

(b)(6)-2

MAT MC

To ICU.

(b)(6)-4

EMERGENCY CARE AND TREATMENT

Medical Record Copy

STANDARD FORM 558 (Rev. 1)
Prescribed by GSA and ICMF

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM 1800 HOURS
TO 0001 HOURS

TOTAL HOURS COVERED

DATE 20 Aug 03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1800	H_2O	500	500

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
?	1L	NS	1L	1820	1L
1820	1L	NS	1L	2325	2L
2325	1L	NS	500		2500
					+ 500
					3000

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. B1, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																			
POST- DAY																			
MONTH-YEAR July	DAY		20		21														
19 2003	HOUR																		
PULSE (O)	TEMP. F (°)																		
	105°																		
180	104°																		
170	103°																		
160	102°																		
150	101°																		
140	100°																		
130	99°																		
	98.6°																		
120	98°																		
110	97°																		
100	96°																		
90	95°																		
80																			
70																			
60																			
50																			
40																			
RESPIRATION RECORD																			
BLOOD PRESSURE		108/40		114/50															
		111/49		110/53															
HEIGHT:	WEIGHT →	99%		99%															
5'02"		99%		99%															

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

(Centigrade Equivalents, for Reference only)

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

(b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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