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

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT: ICW 2 | ROOM NO. | BED NO. [redacted]

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

D/C Incentive Spirometry

noted 18 JUL 03 (b)(6)-2 [redacted]

(b)(6)-2 [redacted]

04° √ done [redacted]

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT: ICW 2 | ROOM NO. | BED NO. [redacted]

DATE OF ORDER: 21 JUL 03 | TIME OF ORDER: 01:14 HOURS

Benadryl 25-50mg PO x 1 now for sleep

noted 01:14 21 JUL 03

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

04° √ done [redacted]

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT: ICW 2 | ROOM NO. | BED NO. [redacted]

DATE OF ORDER: 21 Jul 03 | TIME OF ORDER: HOURS

(1) Transfer to EPW conf (b)(6)-2

[redacted] (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

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

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 6 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 13	14	15										
13 June	[redacted]	LR @ 130 cc/o	05	/	[redacted]											
			17	LR	[redacted]											
		(b)(6)-2														

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: GSW Abd; S/P Ex LAP Lysis of Adhesions, Appendectomy

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
13 June	[redacted]	MSO4 1-6mg IV q1° Prn pain	13 JUN 3mg 2300 [redacted]	14 JUN 3mg 0005 [redacted]	14 JUN 2mg 0130	14 Jun 0630 2mg IVP [redacted]	14 Jun 1100 2mg IVP [redacted]	14 JUN 1730 3mg IV [redacted]								
13 June	[redacted]	Phenergan 25mg IV q6 Prn nausea				[redacted]										
13 June	[redacted]	Reglan 10mg IV q6° Prn nausea														
13 June	[redacted]	TORADOL 15mg IV q8° Prn	13 JUN 2307 15mg [redacted]	14 Jan 0730 15mg [redacted]	14 Jan 1500 15mg [redacted]											

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All (b)(6)-2 except one at bottom

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 06 Yr 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 14	15	16	17	18	19	20	21	22	23	24	25	26	27
14	[redacted]	IVF: LR @ 125cc/hr	5	/													
			13	[redacted]					See								
			21	[redacted]													
15	[redacted]	IVF: LR @ 75cc/hr	05	\	[redacted]												
			13	\	[redacted]						See	below					
			21	\	[redacted]												
16	[redacted]	HL IV	05	\	\	[redacted]											
			13	\	\	[redacted]					See						
			21	\	\	[redacted]					below						
16	[redacted]	Ancef ÷ gm IV q 8°	8	\	\	\	[redacted]										
			16	\	\	[redacted]									DC		
			24	\	\	[redacted]											
18 June 03	[redacted]	IVF: LR @ 100cc/hr	06	/	/	/	/	/	[redacted]					See			
			14	/	/	/	/	[redacted]						new order			
			22	/	/	/	/	[redacted]									
22	[redacted]	IVF: LR @ 50cc/hr	05	/	/	/	/	/	/	/	/	[redacted]					
			13	/	/	/	/	/	/	/	/	[redacted]			DC		
			21	/	/	/	/	/	/	/	/	[redacted]					
23 Jun	[redacted]	HL IV	05	→								[redacted]					
			13	→								[redacted]					
			21	→								[redacted]					

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS: S/P EX-LAP GSW LUQ Flank

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

PATIENT IDENTIFICATION:

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

DISPENSING TIMES
USE PENCIL. CIRCLE MED TIMES

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

A11 (b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. JUNE Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
15Jun	[redacted]	ii Tylenol x 1 now PO for	15Jun	2129	2129	[redacted]
		fever >101.0				
18June	[redacted]	30cc Mylanta & simethicone PO	18June	2130	2130	[redacted]
		x 1 now				
23June	[redacted]	30cc Mylanta & simethicone PO	23June	2200	2200	[redacted]
		x 1 now				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED											
14	[redacted]	MSO4 1-6mg IV	15Jun 4mg 0452	15Jun 6mg 0849	15June 4mg 1400 IV	16June 0130 4mg IV	17Jun 03 6mg 2000	21June 2300						
		Q1° PRN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]						
14	[redacted]	TORADOL 15mg IV	15Jun 03 0000											
		Q 8° PRN	[redacted]											
14	[redacted]	Reglan 10mg IV												
		Q6° PRN												
14	[redacted]	Phenergan 25mg												
		IV Q6° PRN												
16	[redacted]	Tylenol #3 ÷ ii tabs	16Jun 1900 ii BRS ⊕	1700 1930 ii BRS ⊕	16June 0830 ii [redacted]	15June 2030 ii [redacted]	16Jun	22June 2049 ii PO [redacted]	23 June 0000 [redacted]	23 June 2000 BRS ⊕	24 June 1100 ii PO	25 June 1200 ii [redacted]		
		PO q 4° PRN												

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all (b)(6)-2 except bottom

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 Jun Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 27	28	29	30	1	2	3	4	5	6	7	8	9	10
27 Jun 03	[redacted]	Colace 100 mg PO BID	10	[redacted]													
			20														
27	[redacted]	HL IV	6	/	[redacted]												
			13	/													
			21	/													
10	[redacted]	Flush HL-QS	05														/
			13														/
			21														/ [redacted]

DIC

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
sp ex lap GSW to (R) flank

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

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

A11 (b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 6 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
[redacted]	[redacted]	500cc LR Bolus x1 now	2001	2300	2325	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
14	[redacted]	MSO4 1-6mg IV	28 Jun 4mg 0745 [redacted]													
		Q1° PRN														
14	[redacted]	Toradol 15mg IV														
		Q8° PRN														
14	[redacted]	Reglan 10mg IV														
		Q6° PRN														
14	[redacted]	Phenergan 25mg														
		IV Q6° PRN														
16	[redacted]	Tylenol #3 1-2 tabs	28 Jun 0820 [redacted]	28 June 1030 [redacted]	2001 [redacted]	29 Jun 0818 [redacted]	29 Jun 0817 [redacted]	[redacted]	July 0730 [redacted]	2 Jul 0946 [redacted]	2 Jul 1030 [redacted]	4 Jul 1130 [redacted]	5 July 1000 [redacted]	6 July 1000 [redacted]	7 July 1200 [redacted]	9 Jul 0209 [redacted]	9 Jul 0715 [redacted]
		PO Q4° PRN														

See other white sheet

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All (b)(6)-2 except one at bottom

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 11	12	13	14	15	16	17	18	19	20	21
10 July	[redacted]	Colace 100mg po BID	10	[redacted]										
			20	[redacted]										
11 Jul 03	[redacted]	Flush HL QS	05	[redacted]										
			13	[redacted]										
			21	[redacted]										
17 Jul	[redacted]	Indocin 25mg po TID	06								[redacted]			
			14								[redacted]			
			22								[redacted]			

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P ex lap

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

A11 (b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. July Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
21JUL	[redacted]	Benadryl 25 ~~50mg~~ x1 now PO	21JUL	now	0116	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
7	[redacted]	Simethicone 80mg	20JUL 0000	21 2 July 0000	22JUL 80mg	14JUL 0346 80mg	14 July 2200	15JUL 2335	15 July 1100	16JUL 2330	18JUL 1800	19JUL 1415	20JUL 0348			
		PO TID PRN	PIOS	20cc	PO	PO	80mg	PO			30cc	30cc noabx	30cc PO			
7	[redacted]	Tylenol #3 1 11 tabs	10JUL 1130	11 July 0930	11 July 1300	12 July 0945	13 July 1130	14 July 2234	15 July 1000	15 July 2150	16 July 1000	16 July 2210	17 July 2200	19JUL 0045		
		PO q4° PRN	11 PO	11	11	11	11	11 PO	11	11 PO	11	11	11	11 PO		
10July	[redacted]	2-4mg MSO4 IVP PRN	10JUL 05:38 4mg	11th July 0000 4mg	11JUL 0830 4mg	13 July 1100 4mg	14 July 0930 4mg	15JUL 2330 2mg	15 July 2000 2mg	17 July 2000	17 July 2400 3mg	20JUL 0910 4mg				
		prior to dressing Δ's	IVP		IVP			IVP	IVP	IVP						

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C (All (b)(6)-2 except one at bottom

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. 6 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 13	14	15
13 June 03	[redacted]	Admit: Dr Spence	05	/	[redacted]	
			17	[redacted]	[redacted]	
13 June 03	[redacted]	Activity: OOB in Am	05	/	[redacted]	
		Ambulate BID (at least)	17	[redacted]	[redacted]	
13 June 03	[redacted]	DIET: NPO	05	/	[redacted]	
			17	[redacted]	[redacted]	
13 June 03	[redacted]	NGT to LIS	05	/	[redacted]	
			17	[redacted]	[redacted]	
13 June 03	[redacted]	Incentive Spirometry Q1°	05	/	[redacted]	
			17	[redacted]	[redacted]	
13 June 03	[redacted]	I & O'S	05	/	[redacted]	
			17	[redacted]	[redacted]	
13 June 03	[redacted]	Foley to gravity	05	/	[redacted]	
			07	[redacted]	[redacted]	

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: GSW to Abd; S/P Ex-Lap; Lysis of Adhesions, Appendectomy

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

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

EPW

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

all (b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo ____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
13 June	[redacted]	CBC in AM	14 June	0400	0400	[redacted]
13 June	[redacted]	HCT now	13 June	2200	2200	[redacted]
14 Jun	[redacted]	Clamp NGT, D/C this pm if no N/V	14 Jun	pm		

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

USAPA V1.00

All (b)(6)-2 except one at bottom

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. 06 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 14	15	16	17	18	19	20	21	22	23	24	25	26	27
14	[redacted]	Vitals per WARD	5	/	[redacted]												
		ROUTINE	13	[redacted]													
			21	[redacted]													
14	[redacted]	ACT: OOB TID	5	/	[redacted]												
			13	/	[redacted]												
			21	[redacted]	[redacted]												
14	[redacted]	Diet NPO	6	/	[redacted]												
			11	/	[redacted]												
			17	/	[redacted]												
14	[redacted]	I+O's	5	/													
			13	/													
			21	[redacted]													
14	[redacted]	IS Q1° WA	5	/	[redacted]												
16	[redacted]	aggressive pulmonary	13	/	[redacted]												
		toilet - C&DB	21	[redacted]													
14	[redacted]	Foley to Gravity	5	/	[redacted]												
			13	[redacted]													
			21	[redacted]													
15	[redacted]	when Pt. off of O2 mask	05	/	[redacted]												
		and use NC @ 2L O2	13	/	[redacted]												
		to keep sats ≥95%	21	/	[redacted]												

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS: S/P EX-LAP GSW to (R) Flank

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

All (b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo JUNE Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
14	[redacted]	TRANSFER IEW#2 : STABLE	14		2000	[redacted]
15	[redacted]	Stat CXR x1 now	15	now	—	[redacted]
15	[redacted]	EKG x1 Stat now	15	now	—	[redacted]
15	[redacted]	CBC, Chem 8, ABG x1 now	15	now	—	[redacted]
16	[redacted]	CXR this Am	16	Am	0945	[redacted]
16	[redacted]	D/C Foley when Ambulating	16	today	1250	[redacted]
20	[redacted]	CBC, CHEM 7 in AM	20	AM	0730	[redacted]

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

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All (b)(6)-2 except one at bottom

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.	Mature Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 15	16	17	18	19	20	21	22	23
15	[redacted]	~~Record~~ [redacted] Record I+O	4	/			[redacted]					
		q 4° if UOP	8	[redacted]								
		<120cc q4° notify MD	12	[redacted]								
			16	[redacted]								
			20	[redacted]								
			24	[redacted]								
16	[redacted]	Aggressive pulmonary	05	/	[redacted]						[redacted]	
		toilet & Ambulation,	13	/	[redacted]							
		cough and IS	21	/	[redacted]							
16	[redacted]	Wound CARE W→D Kerlex	10	/	[redacted]							
updated on 18 June		Dsg & NACL to OPEN PACKS	22	/	[redacted]							
[redacted]		of Abdominal wound BID										
		MD will do in AM										
16	[redacted]	Diet: Clear Tactful	07	/	/	[redacted]						
			12	/	[redacted]							
			18	/	[redacted]							
17 Jun	[redacted]	Diet: sips of	07	\	\	[redacted]						
		clear Do not	12	\	\	[redacted]						
		advance diet	18	\	\	[redacted]						
18 June 03	[redacted]	Dressing Δ's to abdominal	08	/	/	/	[redacted]					
		wound TID	14	/	/	/	[redacted]					
			22	/	/	/	[redacted]					

repeat orders

rewritten 18 June 1230 [redacted]

DC [redacted] 18 June 1200

DC [redacted] 18 June 1200 sheet

ALLERGIES: ☐ YES ☐ NO	PRIMARY DIAGNOSIS:	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
NKDA	S/p Ex-lap GSW to (R) Flank	PAGE NO: 2

PATIENT IDENTIFICATION:

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

All (b)(6)-2 except for one at bottom

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. 6 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 18	19	20	21	22	23	24	25	26	27	28	29	30	1
18Jun03	[redacted]	Bacitracin to R hand	10	[redacted]													
		wound & R flank wound	20														
		BID															
20Jun03	[redacted]	Accurate I&O's	05	/	/	[redacted]											
			13	/	/												
			21	/	/												
21June	[redacted]	Advance diet: Anything	05	/	/	/	/	[redacted]									
		Pt wants to eat	12	/	/	/											
			18	/	/	/											
22	[redacted]	Wound care: 2x2 c	10	/	/	/	/	[redacted]									
		NaCl to each open	22	/	/	/	/	[redacted]									
		wound BID															
24Jun03	[redacted]	WOUND VAC APPLIED	05	/	/	/	/	/	/	[redacted]							
		BULB SUCTION @	13	/	/	/	/	/	/								
		all times	21	/	/	/	/	/	/								
27Jun03	[redacted]	Please record % pt	07	/	/	/	/	/	/	/	/	/	/	[redacted]			
		meals eaten	11	/	/	/	/	/	/	/	/	/	/				
			17	/	/	/	/	/	/	/	/	/	/				
27Jun03	[redacted]	Suction to JP drain: max suction	16	/	/	/	/	/	/	/	/	/	/	[redacted]			
		max time on, min time off	14	/	/	/	/	/	/	/	/	/	/				
		intermittent, may clamp	22	/	/	/	/	/	/	/	/	/	/				
		tube to ambulate															

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P ex lap gsw R flank

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

All (b)(6)-2 except one at bottom

recopied

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* 6 *Yr.* 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	28	29	30	1	2	3	4	5	6	7	8	9	10	11
14	[redacted]	Vitals per routine	5	[redacted]													
			13														
			21														
14	[redacted]	act: OOB TID	5														
			13														
			21														
14	[redacted]	IS q1° WA aggressive	5														
		pulmonary toilet - C&DB	13														
15	[redacted]		21														
[redacted]																	
			/			80%		80%									
21	[redacted]	Advance diet: anything	07	/	/	[redacted]			100%	[redacted]			[redacted]				
		pt. wants to eat	11	/	50%	[redacted]		75%	90%	15%	[redacted]						
27	[redacted]	record % of meal eaten	17	/	30%	40%	[illegible]	50%	[illegible]	[redacted]							
	[redacted]	Ensure / C/B supplement	/														
[redacted]																	

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
S/P Ex-lap GSW to (R) Flank

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*				Mo 6 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
[redacted]						
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					

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

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All (b)(6)-2 except (b)(6)-4 at bottom.

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. 6 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 30	1	2	3	4	5	6	7	8	9	10	11	12	13
30	[redacted]	Δ dsg BID - wet to	08	[redacted]													
		dry - mod to do Am Δ	20	[redacted]													
1 Jul	[redacted]	Δ dsg TID	08	/	/												
			16	/	/												
			24	/	[redacted]												
2 Jul	[redacted]	Wound VAC Applied.	05	[redacted]													
		Dressing Δ's Needed	13	[redacted]	/	[redacted]											
			21	[redacted]	/	[redacted]											
5 July	[redacted]	W→D wound dressings	10	[redacted]	/	/	/	/	[redacted]								
		to APPD TID: Pack center	16	/	/	/	/	/	[redacted]								
		wound c̄ sterile gauze	22	/	/	/	/	/	[redacted]								
7	[redacted]	Δ W→D Dsg Δ	00	/	/	/	/	/	/	/	[redacted]						
		BID	22	/	/	/	/	/	/	/	[redacted]						

DC'd

DC'd See below

Δ'D

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/P ex-lap GSW to (R) flank

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

(b)(6)-4

EPW [redacted]

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

All (b)(6)-2 except one at bottom

Rewritten

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 12	13	14	15	16	17	18	19	20	21	22	23	24	25
12JUL	[redacted]	Vitals per routine	05	[redacted]													
			13														
			21														
12JUL	[redacted]	Act: OOB TID	05	[redacted]													
			13														
			21														
12JUL	[redacted]	I.S q 1° WA aggressive	05	[redacted]													
		pulmonary toilet C+DB	13														
			21														
12JUL	[redacted]	Regular Diet	08	[redacted]													
			12														
			17														
12JUL	[redacted]	Record % of meal eaten	08	[redacted]		100	[redacted]		80	[redacted]	50	100%	100%				
		Ensure/CIB supplement	12	[redacted]			[redacted]		100	90%	100%	75%	75%				
			17	[redacted]			[redacted]			75%	[redacted]	75%					
12JUL	[redacted]	W→D Dsg Δ	10	[redacted]	→	[redacted]											
			22		→	[redacted]											

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/p ex lap

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verify 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
21	[redacted]	transfer to EPW camp	21	ASAP		
	-----	(b)(6) -2				

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

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

1. REPORTING MTF						2. M.. LOCATION		(State or Country Code.)
1	2	3	4	5	6	7	8	
A	1	1	D	1		I	Z	

3. REGISTER NUMBER						
9	10	11	12	13	14	15
[redacted]						

NAME (Last, First, Middle Initial) (b)(6)-4 EPW [redacted] (b)(6)-4

4. PAY GRADE	
16	17

5. SEX
18
M

6. DATE OF BIRTH (Y Y Y Y M M D D)							
19	20	21	22	23	24	25	26

7. AGE AT ADMISSION		
27	28	29
[redacted]		4

8. RACE	
30	
Z	

9. ETHNIC BACKGROUND	
31	
9	

RELIGION unk

10. LENGTH OF SERVICE		
32	33	34

ETS N/A

11. FMP	
35	36
~~9~~	~~9~~ 20

(b)(6)-4

12. SOCIAL SECURITY NUMBER								
37	38	39	40	41	42	43	44	45
[redacted]								

ORGANIZATION (Active Duty Only) N/A

13. MARITAL STATUS	
46	
U	

HOUR OF ADMISSION ~~2040~~

BRANCH / CORPS (b)(6)-4 N/A

14. FLYING STATUS		
47	48	49

15. BENEFICIARY CATEGORY		
50	51	52
~~K79~~		K78

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

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

18. MOS						
64	65	66	67	68	69	70

19. TRAUMA
71

PREV. ADMISSION YEAR [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION
72
Ø

WARD ICU2

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] (b)(2)-2

21. TYPE OF DISPOSITION	
73	74
5	Ø

22. MTF TRANSFERRED TO					
75	76	77	78	79	80

23. DATE OF DISPOSITION (Y Y M M D D)					
81	82	83	84	85	86
Ø	3	Ø	6	2	2

24. CLINIC SVC - ADMITTING			
87	88	89	90
A	B	A	A

25. MTF TRANSFERRED FROM					
91	92	93	94	95	96

26. DATE THIS ADMISSION (Y Y M M D D)					
97	98	99	100	101	102
Ø	3	Ø	6	1	3

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

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

29. DATE INITIAL ADMISSION (Y Y M M D D)					
111	112	113	114	115	116

FOR LOCAL USE

Dx: s/p Ex-lap GSW (R) flank

Dx: 86813
E9912

Px: 54

(b)(6)-2 [redacted] as required) JCUWR

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

SIGNATURE OF ADMITTING CLERK (b)(6)-2 [redacted] SPC 9/6/10

DA F... MAR 80

INPATIENT TREATMENT RECORD COVER SHEET

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

(b)(6)-4

1. REGISTER NUMBER [redacted]	2. NAME (Last, First, MI) [redacted] (EPW)					3. GRADE EPW	ADMISSION REMARKS
4. SEX M	5. AGE [redacted]	6. RACE X	7. RELIGION MUSLIM	8. LENGTH OF SVC —	9. ETS —	10. PREVIOUS ADMISSION NO.	
11. FMP 99 (b)(6)-4	12. SSN (b)(6)-4 [redacted]			13. ORGANIZATION —		14. WARD ICW2	
15. FLYING STATUS NO	16. [redacted] DSG —	17. [redacted] BEN K78		18. BRANCH/CORPS —	19. UIC/ZIP —	20. TYPE CASE WIA.	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION DIRECT FROM ER.				22. HOURS OF ADMISSION 1000	23. CLINIC SERVICE AEAA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE —				25. TYPE DISPOSITION D/C HOME.		26. DATE OF DISPOSITION 14 JUN 2003	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) —				27b. TELEPHONE NO. —		28. DATE OF THIS ADMISSION 13 JUN 2003	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] (b)(2)-2						30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31.

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW (L) upper arm

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 [redacted]	[redacted]	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDIC[redacted]

DR. [redacted]

(b)(6)-2 → [redacted]

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

(b)(6)-4 [redacted] yo ♂ Iraqi s/p GSW (L) upper arm, through & through. Ø other complaints. distal (L) hand ⅋ c/o.

Last meal 1700

PMHx: Ø

meds: Ø

NKDA

PSHx: Ø

PHYSICAL EXAMINATION 102 133/77 22 98% 25 kg

JS = CTA (B) Ω = ARR ABD = BS

(L) upper arm = in-out GSW; bleeding controlled. distal (L) hand FROM/pulse intact & sensation intact.

Legs ⅋ injury.

(C) X X-ray CXR = ok (L) arm = Ø Fx.

PROGRESS (Enter date of discharge and final diagnosis)

- Admit; hold for GSW wash out.

Ancef given / Td given.

(b)(6)-2 [redacted]

SIGNATURE OF PHYSICIAN	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted] MAJ MC	13 Jun 03		

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

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

539-106

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
13 June 03 1825	R. vitals taken BP 110/70, P. 104, R. 16, Temp: 98.0 SPO2 [redacted] (b)(6)-2
13 June 03 1825	Rec'd pt from EMT via litter, dx GSW condition stable. pt awake & alert, speaks a little english. VSS. airway patent, lung sounds CTA, abd soft nontender, BS(+)x4 quads. BLE c̄ FROM c̄ strong (+) pulses. (L) UE c̄ GSW, drsng CDI, pt able to move fingers. good cap refill. (R) LE c̄ FROM strong (+) pulse IV RAC infusing 3 diff, (-) s/sx of infiltration noted. (-) complaints voiced. Will cont to monitor — [redacted] 9/WMG (b)(6)-2
13 JUN 03 2210	Ortho Op Note Pre Op Dx - FSW (L) arm Post Op Dx - same Procedure - I + D (L) arm Surgeon - [redacted] b6-2 GBL - none Bullets 350 cgs Findings - Through + through GSW to mid left arm, through

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.

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

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	[illegible]
	[illegible]
	[illegible]
	[redacted]
2345	Pt returned from OR @ 2330. Pt had I+D performed on LUE, and dressing applied with ace wrap. VSS, pt resting, awoken by painful stimuli. Pt has 125cc/hr LR flowing to RFA @ diff. Dressing on LUE CDI, pt able to wiggle fingers, (+) sensation, + ROM, + cap refill. c/o slight pain, no medicine requested. Lung sounds CTA, pulses palpable x4. Bowel sounds absent, pt been NPO today. Resting w/o complaints and stable, will continue to monitor. (b)(6)-2 SPC [redacted] 91WM6
14 JUN 03 0640	Assumed pt care @ 0500. Pt. A+O x3. Lungs CTA. (+) pulses x4. Hypo active BS x4. HL (R) AC patent. Dressing (R) arm CDI. Denies any discomfort @ this time. [redacted] (b)(6)-2 91WM6
14 JUN 03 0640	(S) N/A (O) VSS [illegible] DRUGS [illegible] (P) D/C [illegible] [redacted] (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

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

LOG NUMBER

ARRIVAL				TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)	CURRENT MEDS. (Tetanus immunization and other data)	HISTORY OBTAINED FROM
DATE			TIME	☐ PRIVATE VEHICLE ☐ AMBULANCE ☑ OTHER (Specify) UNKNOWN	NONE	☒ PATIENT ☐ OTHER (Specify)
DAY	MONTH	YR.				ALLERGIES
13	JUNE	03	1735			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): GSW (L) ARM

SEX: M

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

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER

VITAL SIGNS			
TIME	1735		
BP	133/77		
PULSE	102	(b)(6)-2	
RESP.	22	[redacted]	
TEMP.	98.6		
WT. (Child)	75K		

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)

6 [redacted] DID PRESENT C GSW TO (L) UPPER (b)(6)-4 ARM. LAST MEAL 12 HRS TODAY.

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

ORDERS	INITS.	TIME
CXR	[redacted]	
AP & LAT (L) ARM	[redacted]	1745
CBC	[redacted]	
KM ANCEF	[redacted]	1745
TETANUS .5	[redacted]	1745
MORPHINE 5mg	[redacted]	1745

(b)(6)-2

ASSESSMENT/DIAGNOSIS: GSW (L) ARM

H&P

see

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)
- EMERGENCY / TODAY
- 72 HOURS / ROUTINE
- ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
- IMPROVED
- UNCHANGED
- DETERIORATED

TIME OF RELEASE:

(b)(6)-2

MD [redacted]

(CONTINUE ON S[redacted]ED)

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).

[redacted] (b)(6)-4

SIGNATURE OF PROVIDER AND [redacted]

INSTRUCTIONS TO PATIENT (Inclu[redacted]edications ordered, any limitations and follow-up plans)

EMERGENCY CARE AND TREATMENT

MEDCOM - 10866 opy

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

MEDICAL RECORD	**PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT** For use of this form, see AR 40-66; the proponent agency is The Office of the Surgeon General.
1. AGE: [redacted] (b)(6)-4 HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): NKDA 3. PREVIOUS SURGERY [ ] NO [ ] YES (type): ?

4. PROPOSED SURGICAL PROCEDURE: (L) ARM I & D

5. ADDITIONAL INFORMATION: Last PO: Medical Hx: Ø Implants: Ø Medications: Ø
Jewelry removed: yes/no Family waiting: yes/no
awake, able to move, alert

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ___ Potential for anxiety related to traumatic injury; language barrier; family separation; surgical environment	o Pt. verbalizes any specific anxiety. o Pt. exhibits relaxed body posture.	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~~.
B. AERATION ___ Potential for respiratory dysfunction due to sedation; positioning; injury	o PT. will be able to breathe without difficulty during immediate intra-operative phase.	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 ___ Potential impairment of skin integuity due to bovi e pad; position; fluid shift	o PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	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)

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

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ___ Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; shock; previous surgery	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. ~~o Place and take down legs from stirrups with slow bilateral motion~~ [redacted] o Check that rings have been removed. (b)(6)-2
E. NEUROMUSCULAR CONTROL E.1. ___ Potential impairment of mobility due to sedation; pain; injury E.2. ___ Potential discomfort due to injury; pain	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. ___ Disminished visual perception due to being injury; sedation; F.2. ___ Potential for decreased communictaion due to language barrier; sedation F.3. Potential injury due to dentures. ___	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from ___ side. o Validate pt.'s understanding of verbal communications. o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs. (b)(6)-2	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS. Or continuation of above interventions.

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted] MAJ A ___ 13 June 03 DATE

11. POSTOPERATIVE EVALUATION:

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title) (b)(6)-2	13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title) (b)(6)-2
[redacted] MAJ A DATE: 13 June 03 TIME: 2015	[redacted] MAJ A DATE: 13 June 03 TIME: 2230

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.01

MEDICAL RECORD — **INTRAOPER[illegible] [illegible]OCUMENT**

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
3. DATE 13 JUNE 03 TIME PATIENT ARRIVED IN SUITE 2130	4. PATIENT IN ROOM TIME 2132 NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA. able to move, follow commands

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)* Prepped in on pad. arms on arm boards 250° strapped

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

COMMENTS: Strap above knees, pillow under knees

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

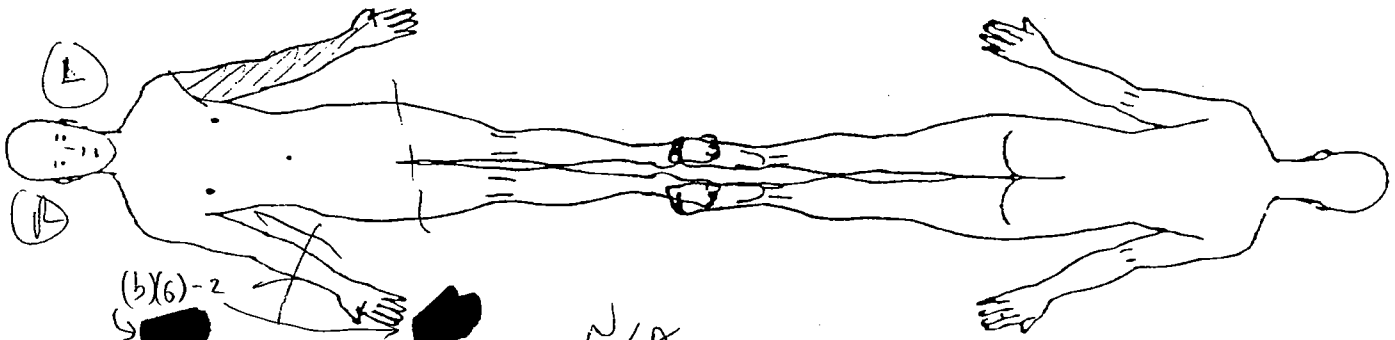
PREP SOLUTION *(Specify)* Betadine / ASEPTA

SITE (L) arm BY WHOM: (b)(6)-2

SITE: BY WHOM [redacted] HA

COMMENTS: ↓ pooling of solution noted

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

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

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

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

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

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

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

☐ BIPOLAR NO: _____

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

(b)(6)-2

PHYSICIAN'S SIGNATURE [redacted]

15. X-RAY IN OPERATING R[redacted]YES, SITE
YES ☐ NO ☒

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
fluff IODOFORM PACKING
Kerlix
ACE

19. ADDITIONAL INFORMATION
WC
Surgeons: [redacted] Anesthesia: Maj [redacted] Anesthesia Type: General
(b)(6)-2 (b)(6)-2

Bovie Pad site intact pre-op N/A; post-op N/A Bovie Settings: Coag/Cut N/A

20. OPERATION(S) PERFORMED
Dann I & D

21. PATIENT TRANSFERRED TO (b)(6)-2 ICU TIME 2220 METHOD WTER

22. REGISTERED NURSE SIGNATURE [redacted] MAJ

REVERSE OF DA FORM 5179-1, OCT 87

MEDCOM - 10870

USAPA V1.01

19

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

ST- DAY

ONTH-YEAR Jun 03 DAY 13 | 00 | 14

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°

90 | 95°

80

70

60

50

40

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

SpO2

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)*

680cc light yellow @ 0134

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

Please see accompanying Prescribing Information

ALTACE

MEDCOM - 10871

[redacted] (b)(6)-4

[redacted] (b)(6)-2

(Hematology) CBC		
TEST	RESULT	REF. RANGE
WBC	16.0	4.8-10.8 x 10^3
RBC	4.58	4.7-6.1 x 10^9
Hgb	13.1	14-18 g/dl (M) 12-16 g/dl (F)
Hct	43.1	42-52% (M) 37-47% (F)
MCV	94.1	80-94 fl (M) 81-99 fl (F)
Plt	328	130-500 x 10^3 verified
Lymph %	13.4	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

CSF		
Cell Count		
Directigen		Negative

Misc. Serology		
TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

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

Microscopic Urinalysis

Blood Bank	
MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED	
ABO/Rh	

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

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

REMARKS:

REPORTED BY: (b)(6)-2 [redacted]	DATE: 15 Jan 03	LAB ID NO.:

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)	
Fentanyl	(µg)	100
pentothal	(mg)	350
SUX	(mg)	100
MSO4	(mg)	[redacted] (b)(6)-2
	( )	
	( )	
VOLAT AGENT I-60	% del	1.5X
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	6 — 2 — 6

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

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS ① ② ③ ④

TOTALS	
100	
350	min
100	
None	

TOTAL FLUIDS: min

TOTAL URINE: Ø

FLUIDS – SUMMARY
CRYSTALLOID– 350
COLLOID– Ø
BLOOD– Ø

LINE site 18g RFA ☐ Warmed — RL — 200 — 350
☐ Warmed
☐ Warmed
☐ Warmed

LOSSES: EST BLOOD LOSS / URINE –

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 60 KG / LB

HEMATOCRIT: 43.1

INITIAL DATA: BP – 133/70 HR– 117

EQUIP CHECK: OK? – Y N

PATIENT RECHECK: OK for PROCEDURE? – Y TIME – 2115

TIME → 20 × 21 × 30 × 22 × 30 × 23

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

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

VENTIL				
VT – ml	650	250	300	
f – breaths/min	10	10	12	
Peak inf pres / PEEP	19	—	—	
MODE– S(pon), A(ssist), C(on)	S	C	S	S

MONITORS / ACCESSORIES					
✓ BP/Auto Cuff	✓ ET CO2 (torr)	38	34	50	48
BP / oth	✓ FIO2 (Frac or %)	0.6	0.6	0.6	
ART line	✓ SpO2 (%)	100	100	100	99
Steth- PC/ES	✓ ECG	SR	SR	SR	SR
Gas analyzer	TEMP- site avail				
	N-M Block (T/4)				
Warming blkt					
Conv warmer					

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

REMARKS – Code drugs with numbers, events with letters

Pt ⅌ char + ✓. OK to proceed to OR
① To room via litter SOC monitors ⅌ applied pre O2
② RSI ⅌ 1 ⅌ CCP.
③ Zofran 4mg IV.
④ Responsive adeq Vt ⅌ RR. Suctioned ⅌ ext ⅌ diff. To recovery stable.

RECOVERY AT: PACU (ICU) 1 (Specify) OTHER 4
CONDITION: 96
RESP– 12 SpO2– 99
BP– 123/79 HR– 94

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	2125	2132	2225
	Ready	Begin	End
PROC	2140	2152	2205

PROCEDURES and CPT Codes: I & D GSW Lt upper arm

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Eyes taped, DL x 1 ⅌ trauma, ⊕ETCO2, BJEB, 22cm @ teeth, 8.0 ETT, 4 Mac.

PATIENT IDENTIFICATION – Typed or written entries: Name, Grade/Rate, Medical facility: EPW (b)(6)-2 [redacted]

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

ANESTHETISTS: [redacted] MAJ, CRNA

PROCEDURE LOCATION: 2-1
DATE: 6/13/03
PAGE 1 OF 1

[redacted] RD – ANESTHESIA
(b)(6)-2 [redacted] EVISED
PATIENT RECORD 1 Jan 99

MEDCOM - 10873

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

ICW 2 (Re y ICU2)

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age [redacted] DAYS MOS YRS (b)(6)-4 Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: I & D (L) Arm
SURGICAL SERVICE: Ortho
NPO SINCE: Food @ 1700

ASA Physical State 1 2 3 4 5 E
WT: 54 KG/LB HT: IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: (-)
ETOH:
DRUGS:

CURRENT MEDICATIONS:
( ) = ordered as premed
() Ancef 1gm IV EMT
() Tetnus
() MSO4 5g EMT
()
()
()

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

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

16.0 > 13.1 / 43.1 < 328

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Ø

110 PHYSICAL EXAMINATION
BP 120 HR 105 R 16 T 98° 98%
Pain Scale 0-10
HEENT - Teeth Intact, dentition
Trachea mid line
TMJ/Neck
Oropharnyx MP I
Nares
CHEST: (+) BBS
CARDIAC: RRR
EXTREMITIES:
IV Access: (R) AC
Ulnar Filling:
BACK:
OTHER:

NPO Since Food @ 1700

ANESTHETIC PLAN: ( ) LOCAL ( ) MAC ( ) Regional (Specify): ____ (X) General: Mask Intubation
Pt interviewed c Interpreter (Speaks Some English)

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

The patient [redacted] seems to understand and agrees. Questions answered.
Signed: [redacted] (b)(6)-2 Date: 13 Jun 03 Time: 1900 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

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.

Patient Identification: (Ward) ICW2

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

WAMC Form 2300 (Revised) 15 Mar 01 MCXC-DOS

Previous edition is obsolete
☆ U.S. GPO: 2002-729-283

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT: ICW 2 | ROOM NO. | BED NO.

DATE OF ORDER: 13 Jan 03 | TIME OF ORDER: _____ HOURS | LIST TIME ORDER NOTED AND SIGN

Admit ICW 2
Dx = GSW (L) upper arm
Cond = stable
VS = q 4°
ALL = NKDA
Act = AB 1.3
Nursing = dressing care

PATIENT IDENTIFICATION

(b)(6)-4

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

Diet = NPO
Labs = ø
IV = Saline lock p̄ bag
Special = General Surgery consult
Meds = Tylenol 325 mg II p̄o q 4° PRN
MSO4 1-4 mg IVP q 1° PRN pain
Ancef 1 gm IVq 6° ✱ 4, 10, 16, 22
mrt Jan

All (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

Not [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 13 JAN 03 | TIME OF ORDER: 2147 HOURS

Resume above orders
General Surg consult applied
IVF LRC 125cc/h [redacted]
heplock in Arm [redacted] (b)(6)-2
Tylenol #3 1-3, 10 q 4° PRN [redacted]
13 JAN 03 2300 (b)(6)-2
Promethazine 25 mg IV Q 4 hrs PRN [redacted]

(b)(6)-2

(b)(6)-4

24 hrs 0315 [redacted]

13 Jan

(b)(6)-2 [redacted]

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			↓	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
GPW [redacted] (b)(6)-4				14 JUN 03 0910 HOURS	
			(1)	DISCHARGE TODAY	
			(2)	KEFLEX 250 mg Q10 #40	
			(3)	D/C IV.	
				(b)(6)-2 [redacted]	
NURSING UNIT	ROOM NO.	BED NO.			
PATIENT IDENTIFICATION				DATE OF ORDER / TIME OF ORDER _____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.			
PATIENT IDENTIFICATION				DATE OF ORDER / TIME OF ORDER _____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.			
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.

All (b)(6)-2 except one at bottom.

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 06 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 13	14
13	[redacted]	VS Q4°	5	/	[redacted]
			13	/	
			21	[redacted]	
13	[redacted]	ACT AD LIB	5	/	[redacted]
			13	/	
			21	[redacted]	
13	[redacted]	Nursing: Dsg CARE	5	/	
			13	/	
			21	[redacted]	
13	[redacted]	Diet: NPO	5	/	[redacted]
			11	/	
			17	/	

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
GSW ⓒ upper arm

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

all: (b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo JUNE Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
13	[redacted]	ADMIT ICW#2 STABLE	13		1820	[redacted]
13	[redacted]	General Surgery Consult				

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

USAPA V1.00

All: (b)(6)-2 except one at bottom.

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. 06 YR 3

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 13 [redacted]
13	[redacted]	IV: SL 5 Bag	5	/
13	[redacted]	Heplock in AM (14Jun)	17	/ DC
			21	[redacted]
13	[redacted]	Ancef 1 gram IV Q6°	4	/
			10	/ rescheduled
			16	/
			22	[redacted] see below
13Jun	[redacted]	IVF LR 125cc/hr	5	/ [redacted]
		Heplock in AM	13	/
			21	[redacted]
13Jun	[redacted]	Ancef 1 gram IV Q6°	6	/ [redacted]
			12	/
			18	/
			24	[redacted]

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: GSW (L) upper arm

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. June Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
- - - -	- - - - -	Tylenol 325mg II PO														
- - - -	- - - - -	Q4° PRN														
- - - -	- - - - -															
- - - -	- - - - -	MSO4 1-1½mg IVP														
- - - -	- - - - -	Q1° PRN pain														
- - - -	- - - - -															
- - - -	- - - - -	Phenergan 25mg IV														
- - - -	- - - - -	Q4° PRN														
- - - -	- - - - -															
- - - -	- - - - -	Tylenol 3 II - II PO														
- - - -	- - - - -	Q4 PRN														
- - - -	- - - - -															
- - - -	- - - - -															

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. MTF LOCATION (State or Country Code)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A 1 1 D 1	F E	[redacted]	EPW [redacted] (b)(6)-4	EPW	M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
U W K	[redacted] Y	X	9	MUSLIM

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
—	—	9 9	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—	U	1000	— (b)(6)-4

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 YEAR	NO
—	—	1		☒

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø	ICW2	—

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

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYYYMMDD)
Ø 5		2 0 0 3 0 6 1 4

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
A E A A		2 0 0 3 0 6 1 3

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

FOR LOCAL USE

DX: GSW (L) Upper arm

DX: 88023
8991.2
PX: 8236
8689

880.03
E991.2
86.28

(b)(6)-2

ADMITTING OFFICER (Signature, as required)
(b)(6)-2
DR. [redacted]

[redacted]

DA FORM 2985, MAR 2000 EDITIO USAPA V1.00

MEDCOM - 10881

(b)(6)-4

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER [redacted]	2. NAME (Last, First, MI) EPW # [redacted] (b)(6)-4				3. GRADE —	ADMISSION REMARKS
4. SEX M	5. AGE Unk	6. RACE IRAQI	7. RELIGION —	8. LENGTH OF SVC —	9. ETS —	10. PREVIOUS ADMISSION NO
11. FMP —	12. SSN [redacted]		13. ORGANIZATION —			14. WARD ICU2
15. FLYING STATUS —	16. RATING DSG —	17. DEPT./BEN (b)(6)-4	18. BRANCH/CORPS —	19. UIC/ZIP —		20. TYPE CASE VSI

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from ER	22. HOURS OF ADMISSION: 2030	23. CLINIC SERVICE: Ortho	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE —	25. TYPE DISPOSITION: D/C to EPW CAMP	26. DATE OF DISPOSITION: 2003 June 14	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) —	27b. TELEPHONE NO. —	28. DATE OF THIS ADMISSION: 2003 June 13	ADMITTING OFFICER (b)(6)-2 [redacted]
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] (b)(2)-2		30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA [redacted]

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX → GSW (L) shoulder

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

SIGNATURE OF ATTENDING MED [redacted] SIGNATURE OF RAD OR MEDICAL RECORDS OFFICER [redacted] SPC

DA [redacted]

EDITION OF 1 AUG 76 IS OBSOLETE

USAPPC V1.10

(b)(6)-2

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

? (b)(6)-4 [redacted] IRAQI ARMY, GSW TO (L) DORSUM DURING PRISON RIOT, PT SPEAKS NO ENGLISH, NO OTHER HX AVAILABLE

PHYSICAL EXAMINATION

NAD

FULLNESS OF TRAUMA SQ WOUND (L) DORSUM CHEST AT

6 3 6 - BURN

NV INTACT

XRAYS: NO FRACTURES NOTED

PROGRESS (Enter date of discharge and final diagnosis)

(A). GSW (L) DORSUM

(P) I+D N OIR

(b)(6)-2

SIGNATURE OF [redacted]	DATE 13JAN04	IDENTIFICATION NO.	ORGANIZATION

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

[redacted]

(b)(6)-4

REGISTER NO.	WARD NO.

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505.
OCTOBER 1975 539-106

(b)(6)-4

[redacted]

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	Pt Admitted from [redacted] (b)(6)-2 EMT. VSS, A+O x3. Ambulate from stretcher to BED GSW (2) Deltoid. Irrigated c̄ 1L sterile water. New Drsg Applied 4x4's c̄ Kerlex, CD. (1) Hand warm, palapable pulse (+) sensation (+) mvt. Waiting OR. Q4H assessment WNL. Will Monitor
2100	: Pt. OR for Surgery. (b)(6)-2 [redacted]

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

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

[redacted] (b)(6)-4

REGISTER NO.	WARD NO.

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

(b)(6)-4

558-103 [redacted] [redacted] (this Sheet) [redacted]-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

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

LOG NUMBER [redacted]

ARRIVAL			
DATE			TIME
DAY	MONTH	YR.	
13	06	03	1732

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

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): Arm shot

SEX: M AGE:

POSSIBLE THIRD PARTY PAYER? ☒ YES ☐ NO

TIME SEEN BY PROVIDER: 1735

VITAL SIGNS			
TIME	1732	1810	
BP	116/60	116/60	
PULSE	90	89	
RESP.	16	17	
TEMP.	97.4		
WT. (Child)			

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

ORDERS	INITS.	TIME
Ancef	[redacted]	1746
5mg Morphine	[redacted]	1750
5mg morphine	[redacted]	1810
(b)(6)-2		

ASSESSMENT/DIAGNOSIS: (L) Arm GSW thigh L/thoracic

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)
- EMERGENCY / TODAY
- 72 HOURS / ROUTINE
- ADMIT. TO HOSP. UNIT/SERVICE: ICW-2

CONDITION UPON RELEASE
- IMPROVED
- UNCHANGED
- DETERIORATED

TIME OF RELEASE: 18.0

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)

1735 ♂ approx 30 yo GSW (L) upper Arm. IN + OUT
IV (R) AC (L) EJ 5.56 (C) Diffo automatic
1746 5g Ancef. 17:55: 3 mg morphine. Tetanus toxoid
CTA (B) RRR
ABD - soft, NT, ND & bowel
Ext: (A) GSW (L) thoracic & arm & deformity, ok etc.
Pulse - clear
X-RAY CHEST (L) Arm - incl
A: GSW (L) thoracic
P: 1) Admit & ortho - ICW 2 / Pt. [redacted] b6-2
2) Bring to ward

(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).

[redacted] (b)(6)-4

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

INSTRUCTIONS (Include medications ordered, any limitations and follow-up plans)

EMERGENCY CARE AND TREATMENT
MEDCOM - 10885
Copy

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
13 JUN 03 2210	Author Op Note Pre-Op Dx - GSW (L) deltoid Post Op Dx - same Procedure - I + D (L) deltoid Surgeon - [redacted] (b)(6)-2 SBL - min Findings - Through and through GSW over (L) deltoid. No fascial involvement. Edges debrided. No muscle involved all in SQ tissue. Pulses - Good extremities. Clean wound.
	[redacted] (b)(6)-2
2245	Pt. back from ICU#1 @ 2230 s/p I & Drainage. Pt. c/o pain to (L) UE. T#3 x 2 given PO. Drains to (L) UE CDI. (R) UE cool c̄ pulses 2+, capr refill <3 sec, (+) sensation, (+) RAM. HR Reg, Lungs CTA. ABD soft c̄ BS (+) XY. Pt. voided 600cc prior to

(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	
	Surgery. Pt. UTV @ this time. ABDT ⊘ distension. Will cont. to monitor. IV to (R) FA HL, EJ to (L) side neck HL. (b)(6)-2 [redacted]
14June03	0805 Assume pt care @ 0500. Pt awake. VSS (b)(6)-2 stable. c/o pain to head and (L) shoulder. ~~VSS~~ [redacted] HR regular Lungs CTA. Abd soft non-tender non distended BS X4 active. Pulses palpable x4. IV HL to (R) FA no s/s redness/infiltration ⊂̄ flush. HL to (L) EJ no s/s redness/infiltration ⊂̄ flush. Dsg to (L) shoulder CDI. pt c/o pain [redacted] (b)(6)-2 ⊂̄ movement of fingers on (L) hand. ⊂̄ Tylenol #3 adm for pain. Will continue to monitor. [redacted]
	(b)(6)-2
14 Jun 03	(S) N/A
0400	(O) VSS [illegible]
	[illegible]
	(A) [illegible]
	(P) [illegible]
	[redacted] (b)(6)-2
	[redacted] MD COL, MC Orthopedic Services

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

Emergency

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

4. PROPOSED SURGICAL PROCEDURE:
I & D (L) upper arm

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

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to traumatic injury; language barrier; family separation; surgical environment	o Pt. verbalizes any specific anxiety. o Pt. exhibits relaxed body posture.	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.
B. AERATION ✓ Potential for respiratory dysfunction due to sedation; positioning; injury	o PT. will be able to breathe without difficulty during immediate intra-operative phase.	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 ✓ Potential impairment of skin integuity due to bovi e pad; position; fluid shift	o PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	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)
(b)(6)-4
#[redacted] EPW

Emergency

DA FORM 5179, JUN 91 Previous editions are obsolete. USAPA V1.01

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; shock; previous surgery	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. (b)(6)-2 o ~~Place and take down legs from stirrups with slow bilateral motion.~~ [redacted] o Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to sedation; pain; injury E.2. ✓ Potential discomfort due to injury; pain	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. ✓ Disminished visual perception due to being injury; sedation; F.2. ✓ Potential for decreased communictaion due to language barrier; sedation F.3. Potential injury due to dentures. Ø	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from _____ side. o Validate pt.'s understanding of verbal communications. o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs. (b)(6)-2	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS. Or continuation of above interventions.

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted] MAJ AN 13 Jun 03 DATE

11. PO[redacted]ERATIVE EVALUATION:

Pt aware. VSS. No complaints verbalized. DSG to left T arm dry and intact. Borrie pad site intact

12. PREOPERTIVE EVA[redacted]UATION PREPARED BY (Signature and Title)	13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)
[redacted] MAJ AN (b)(6)-2	[redacted] MAJ AN (b)(6)-2
DATE: 13 Jun 03 TIME: 2130	DATE: 13 Jun 03 TIME: 2145

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: Emergency

3. DATE: 13 Jun 03 TIME PATIENT ARRIVED IN SUITE: 2123

4. PATIENT IN ROOM TIME: 2123 NUMBER: 2-2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ [redacted]	RELIEF CIRCULATOR	

(b)(6)-2

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS: pillow under knees.

8. SKIN PREPARATION

HAIR REMOVAL DONE BY: ☐ YES ☒ NO

METHOD: ☐ OR ☐ NURSING UNIT ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION (Specify): Betadine/Betadine

SITE: (L) arm BY WHOM: MAJ [redacted]

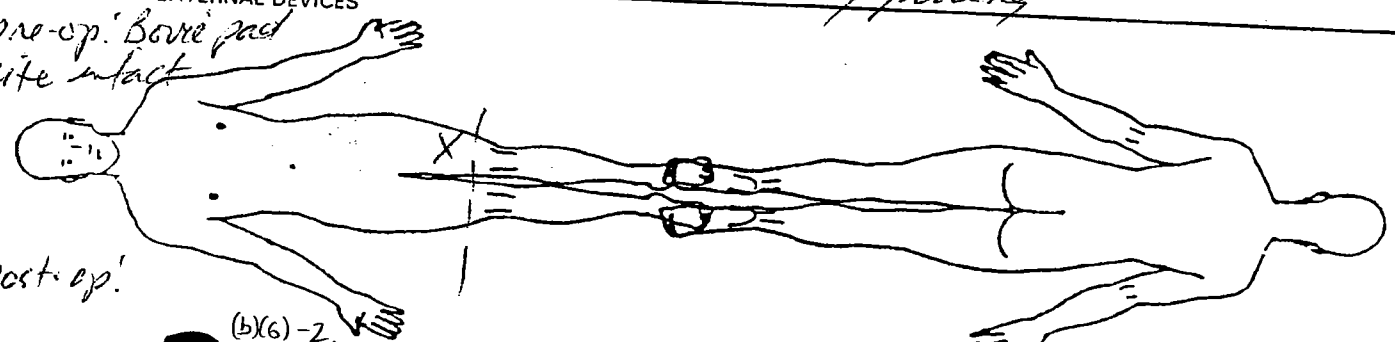
SITE: BY WHOM:

COMMENTS: ∅ prepping

(b)(6)-2

9. LOCATION OF EXTERNAL DEVICES

pre-op: Bovie pad site intact



post-op:

LEGEND X Ground Pad – Safety Strap = = = Tourniquet

(b)(6)-2

10. COUNTS

C = Correct I = Incorrect I: SSG [redacted] MAJ [redacted]

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

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

[redacted] EPW

(b)(6)-4

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

Cut 30 Coag 30

☒ ESU NO: Valleylab

GROUND PAD: BRAND: Valleylab LOT NO: 65938

☐ ESU NO:

GROUND PAD: BRAND: LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179, 1 JUL 72, WHICH IS OBSOLETE.

MEDCOM - 10890

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):
NS

OTHER ORDERS	TIME	CARRIED OUT BY
none		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

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

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

20. OPERATION(S) PERFORMED
I + D (L) upper arm

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU 1	2152	Litter

22. REGISTERED NURSE SIGNATURE
[redacted] MAJ

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.01
(b)(6)-2

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

(b)(6)-2

HOSPITAL DAY

POST-DAY

MONTH-YEAR June 2003

DAY: 13 14

HOUR: 8 8 8

PULSE (0) / TEMP. F (•)

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: 46 12

BLOOD PRESSURE: 124/0 110/80

(b)(6)-2 [redacted]

HEIGHT: WEIGHT [redacted] 97# 97#

(b)(6)-2 [redacted]

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

d/Section: EMT | RE[redacted] | [redacted] PHYSICIAN: (b)(6)-2 | [redacted]

ST, FIRST, MI: [redacted] (b)(6)-4 | DATE: 13 June | TIME: 1740 | SSN/PSEUDO SSN: [redacted] (b)(6)-4

(i-STAT)

TEST	RESULT	REF. RANGE
		138-146 mmol/L
		3.5-4.9 mmol/L
		98-109 mmol/L
		7.31-7.45
O2		35-45 mmHg (art) 41-51 mmHg (ven)
2		80-105 mmHg (art) N/A (ven)
O2		23-27 mmol/L (art) 24-29 mmol/L (ven)
CO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
2		95-98%
ecf		(-2) – (+3) mmol/L
Gap		10-20 mmol/L
		1.12-1.32 mmol/L
N		8-26 mg/dl
U		70-105 mg/dl
eat		0.7-1.5 mg/dl
t		38-51% PCV
gb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
opomn-I		
rug of buse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB	4.1	3.5-5.5 g/dl
ALP	60	26-84 u/l
ALT	25	10-47 u/l
AMY	45	14-97 u/l
AST	30	11-38 u/l
TBIL	0.7	0.2-1.6 mg/dl
BUN	16	7-22 mg/dl
CA^{++}	8.9	8.0-10.3mg/dl
CHOL	149	100-200 mg/dl
CRE	1.0	0.6-1.2 mg/dl
GLU	104	73-118 mg/dl
TP	7.8	6.4-8.1 g/dl

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^+	138	128-145 mmol/l
K^+	4.3	3.3-4.7 mmol/l
CL^-	106	98-108 mmol/l
tCO_2	25	18-33 mmol/l

REMARKS:

[redacted] (b)(6)-4

REPORTED BY: (b)(6)-2 [redacted] | **DATE:** 13 Jun 03 | **LAB ID NO.:**

EMT

[redacted] (b)(6)-2

[redacted] (b)(6)-4 13 June 03 1740 [redacted] (b)(6)-4

(Hematology) CBC		
TEST	RESULT	REF. RANGE
WBC	6.5	4.8-10.8 x 10^3
RBC	4.64	4.7-6.1 x 10^9
Hgb	13.5	14-18 g/dl (M) 12-16 g/dl (F)
Hct	44.1	42-52% (M) 37-47% (F)
MCV	95.0	80-94 fl (M) 81-99 fl (F)
Plt	251	130-500 x 10^3 verified
Lymph %	37.2	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

CSF		
Cell Count		
Directigen		Negative

Misc. Serology		
TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

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

Microscopic Urinalysis

Blood Bank	
MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED	
ABO/Rh	

Coagulation Studies		
TEST	RESULT	REF. RANGE
PT	13.3	9.8-13.6 secs
APTT	25.3	21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

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

REMARKS:

REPORTED BY: (b)(6)-2 [redacted]	DATE: 13 Jun 03	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

[redacted]

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 13 JUN 03 TIME OF ORDER: 2130 HOURS

LIST TIME ORDER NOTED AND SIGN

1. TO ICW 2
2. OX GSW TO (2) SYMPTOM
3. CONTINUE STATUS
4. VS ROUTINE
5. RESTRAINTS PER CPN PROTOCOL UP TO 48

PATIENT IDENTIFICATION

[redacted]

(b)(6)-2

noted/[illegible] 1030 6-13-03

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

6. RESTRAINTS DIST
7. IV - LR AT 100 CC/HR HOLD LOCK WHEN TOLERATE P.O. WELL
8. ANCEF 1 GRAM IVPB Q 8 HRS
9. TYLENOL ES, 1-2 P.O. Q 4-6 HRS PRN
10. TYLENOL 650 mg P.O. Q 4 HRS PRN

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 13 JUN 03 TIME OF ORDER: 2[redacted] (b)(6)-2

Ambien 10 mg PO HS

[redacted]

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 14 JUN 03 TIME OF ORDER: 0900 HOURS

1. DISCHARGE TODAY
2. KEFLEX 250 mg Q 15 # 40.
3. D/C IV

(b)(6)-2 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

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

1. Admit ICW 2
2. Dx GSW to (R) deltoid
3. Stable
4. NKDA
5. Vitals per protocol
6. BR
7. IV bolus + L NS ft 120 a/o

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER _____ HOURS

8. Irrigate wound copiously
9. Call Dr [redacted] upon pts arrival to WRD (b)(6)-2

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

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)-4 [redacted]

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

DATE OF ORDER | TIME OF ORDER _____ HOURS

Not [redacted] ICTA (b)(6)-2

10. Meds = MSO4 2-6 mg IVP q 1° PRN pain No more than 12 mg in 2 hrs.

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

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)-4 [redacted]

DATE OF ORDER | TIME OF ORDER _____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1984 - 800-710

All: (b)(6)-2 except one at bottom.

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. 06 Yr. 2003

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 13
13	[redacted]	Vitals per protocol	5	✓
			13	[redacted]
			21	[redacted]
13	[redacted]	BR	5	✓
			13	[redacted]
			21	[redacted]

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
GSW to (L) Deltoid

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

All: (b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo July Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
13	----- [redacted]	ADMIT ICW2 : STABLE	13		1820	[redacted]
13	----- [redacted]	IRRIGATE WOUND copiously	13		1830	[redacted]
13	----- [redacted]	Call Dr [redacted] prompt to arrival	13		1830	[redacted]
	-----	toward				

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

USAPA V1.00

All (b)(6)-2 except one at bottom.

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 18/4/15															
6.13	[redacted]	VS per routine,	5	X	[redacted]														
		restraints per EPW	13	X															
		protocol. URADCIB	21	[redacted]															
6.13	[redacted]																		
		Reg Diet	7	X	[redacted]														
			11	X															
			17	X															

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW (L) shoulder

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ___

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

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

both: (b)(6)-2

Verify Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*				Mo _____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
6B	[redacted]	ICW #2	6B			[redacted]

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

USAPA V1.00

All: (b)(6)-2 except 2 at bottom.

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		
				B	M	L
6-13	[redacted]	Ancef 1gm IVPB	08	X	[redacted]	
			16	X		
			24	[redacted]		
6-13	[redacted]	CRG @ 100cc/hr.	5	X	[redacted]	
		HL when to/RQ	13	X		
			21	[redacted]		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: #[redacted] - GSW (L) Shoulder.

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ___

PATIENT IDENTIFICATION:

#[redacted] — (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

All: (b)(6) -2

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
6-13	[redacted]	Ambien 10mg PO x 1 now	6-13	2230	2230	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
6-13	[redacted]	Tylenol #3 1-2 PO	6-13 11 PM	6-14 0 AM PO												
		Q 4° PRN Pain.	[redacted] 2230	[redacted] 0005												
6-15	[redacted]	Tylenol 650mg														
		PO Q4hrs 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. 06 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED															
				13															
13	[redacted]	NS @ 120cc/hr	5																
		(b)(6)-2	13	[redacted]															
			21	[redacted]															

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS:

GSW to (L) Deltoid

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

EPW

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

USAPA V1.00

All: (b)(6)-2

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

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
13	[redacted]	IV Bolus T L (then see pg 1)	[redacted] 13		1820	[redacted]
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
6-13	[redacted]	Morphine 2-6 mg IV														
- - - -	- - - - -	Q 1° PRN pain, no														
- - - -	- - - - -	more than 12mg Q2°														
- - - -	- - - - -															
- - - -	- - - - -															
- - - -	- - - - -															
- - - -	- - - - -															
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- - - -	- - - - -															
- - - -	- - - - -															

USAPA V1.00

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 13JUN 03
Time In: 1000
Allergies: NKDA
Pre-op V/S: [illegible]
Procedures: I&D Osteo GSW - upper arm

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 400 Colloid Ø
OR Output: UOP Ø EBL Minimal
Meds/Times: Fentanyl/propofol

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

Pre Op Meds

History

Time	1000	1015	1030
SaO2	100		
FiO2	RA		
Methods	RA		
240			
220			
200			
180			
160			
140			
120	^	^	^
100			
80	•	•	
60	V	V	V
40			
20			
RR	16	16	16
T	98.8	98.9	
Time	1000		
Pain (0-10)	Ø		
LOS	Intact		

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1000	LR	60	DEJ	[redacted]	Ø

X-rays:

Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2		
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2		
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2		
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2		
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2		
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2		
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	12		

Codes

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

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

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

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

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

(Continue on reverse)

PREPARED [redacted] SGT/LPN

DEPARTMENT/SERVICE/CLINIC: ICU/PACU

DATE: 13JUN03

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

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

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

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

USAPPC V2.00

10mg Ambien

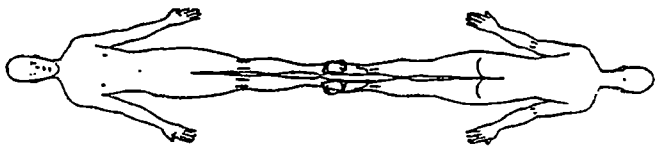
MEDICATIONS						
Allergies:						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1000	Ø					

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

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

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

DRESSINGS			
Time	Location	Type	Drainage
Adm	Rupper arm	Kerlix	Ø noted
30'			
60'			
D/C			



PACU OUTPUT			
Time	Source	Color/Appearance	Amount
			Ø

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1000	NSR	Ø	Ø

NURSING NOTES

Rec'd pt @ 2200 A+O / awake in NAD. Ø complaints voiced. (R) EJ / PFA IVs patent / benign. Sutz in the upper 90s c̄ RA. dsg to (R) upper arm c̄ D, + I. Pt somewhat irritated regarding family fr members? / involvement? event. Speaks some english. Max. Emotional Support / Reassurance provided. Ambien 10mg given @ 2205 per Dr. [redacted] [redacted] Staff / LPN

(b)(6)-2

Discharge Criteria:
Date: 13 JUN 03 Time: 1030 PARS: 12
BP: 105/68 T: 98.0 HR: 84 RR: 16 Sa02: 97%
Pain Level at D/C (0-10):
Intake: 600cc Output: Ø
Additional Data: dsg to Rarm c̄ D, + I
Transferred To: FCW 3
Report Given To: ICW 3 Staff
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: Sgt [redacted] / Spc. [redacted]
Cleared [redacted] Recovery Room [redacted] OP B [redacted]
[redacted] Nurse Signature: [redacted] Sgt/LPN
[redacted] RN / LPN

(b)(6)-2

(b)(6)-2

WAMC OP 173-E

ADMISSION AND CODING INFORMATION

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

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

3. REGISTER NUMBER						
9	10	11	12	13	14	15
[redacted]						

NAME (Last, First, Middle Initial): EPW #[redacted] (b)(6)-4

4. PAY GRADE		5. SEX
16	17	18
—		M

DATE OF BIRTH (Y Y Y Y M M D D) (b)(6)-4								7. AGE AT ADMISSION			8. RACE	9. ETHNIC BACKGROUND	RELIGION
19	20	21	22	23	24	25	26	27	28	29	30	31	
—								U	n	K	I	9	—

10. LENGTH OF SERVICE			ETS	11. FMP		12. SOCIAL SECURITY NUMBER							
32	33	34		35	36	37	38	39	40	41	42	43	44
—			—	—	20	[redacted]							

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS (b)(6)-4
—	46: U	2030	—

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

K78

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: Ø Direct from ER	ICW 2	—

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): —

NAME AND LOCATION OF MEDICAL TREATMENT [redacted] (b)(2)-2

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: —

TYPE OF DISPOSITION		22. MTF TRANSFERRED TO						23. DATE OF DISPOSITION (Y Y M M D D)					
73	74	75	76	77	78	79	80	81	82	83	84	85	86
5	Ø							0	3	0	6	1	4

05 Discharge to EPW Amp

24. CLINIC SVC - ADMITTING				25. MTF TRANSFERRED FROM						26. DATE THIS ADMISSION (Y Y M M D D)					
87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102
										0	3	0	6	1	3

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

FOR LOCAL USE

DX → BSM (L) shoulder

Dx: 88000
E9912

Px: 8622
83.02

ADMITTING OFFICER (S[redacted]uired) [redacted]

SIGNATURE OF ADMITTING CLERK [redacted]

DA FORM 2085, MAR 80

(b)(6)-2

(b)(6)-4

PATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER: 0013477	2. NAME (Last, First, MI): EPW # [redacted] (b)(6)-4			3. GRADE: EPW	ADMISSION REMARKS
4. SEX: M	5. AGE: [redacted]	6. RACE: —	7. RELIGION: muslim	8. LENGTH OF SVC: —	9. ETS: —
10. PREVIOUS ADMISSION: NO	11. FMP: K	12. SSN: [redacted]	13. ORGANIZATION: — (b)(6)-4	14. WARD: ICU2	
15. FLYING STATUS: —	16. RATING/DSG: —	17. DEPT./BEN: —	18. BRANCH/CORPS: —	19. UIC/ZIP: —	20. TYPE CASE: WIA
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct From ER			22. HOURS OF ADMISSION: 1730	23. CLINIC SERVICE: AEAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: UNK			25. TYPE DISPOSITION: 05	26. DATE OF DISPOSITION: 15 June 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK			27b. TELEPHONE NO.: —	28. DATE OF THIS ADMISSION: 13 June 03	ADMITTING OFFICER: Dr [redacted] (b)(6)-2
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] (b)(2)-2				30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW to left Buttocks

35. Total Days This Facility

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

SIGNATURE OF AT[redacted]ER [redacted]

SIG[redacted]EDICAL RECORDS OFFICER

Dr. [redacted]

DA FORM [redacted], MA[redacted]

EDITION OF 1 AUG 7[redacted] IS OBSOLETE

USAPPC V1.10

All: (b)(6)-2

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

31 yo Iraqi male EPW who sustained a lower back GSW during a prison riot. alert/oriented on transport Ø hypotension

PMHx	PSHx	meds	allergy
Ø	Head ISD	Ø	— NKDA

PHYSICAL EXAMINATION:

BP 123/67 P 91 R 20 98° O2Sat 100% on 2L FM

NC/AT

PERL

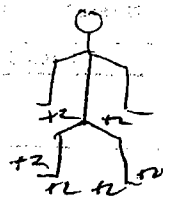
NECK supple NTP Ø JVD / trachea ML

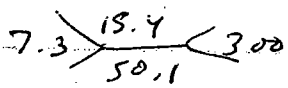
Lungs clear

Heart RRR (-) murmur

Abd Soft nondistended Ø masses (+) BS

back GSW to L





PROGRESS (Enter date of discharge and final diagnosis):

① GSW to buttock / Low back (L) — Sonosight (-)

- Foley catheter inserted — CXR Ø PTX
- Sonosight (-) — Ø pneumo
- Labs sent — abd: bullet ant Ø free air; pelvis: pelvis
- O2 in place
- X-ray — CXR / abd / pelvis / flat plate / lat — Ø fx seen

(b)(6)-2 [redacted] | DATE 13 JAN 0 | IDENTIFICATION NO. | ORGANIZATION

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

[redacted] (b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975 539-106

(b)(6)-4 [redacted]

LAST NAME	NAME	MI	ID NUMBER

DATE	NOTES
	General Surgery
14 June 03	Pain with dp. dsw to (1) buttocks. Force overnight.
0815	Force Hot. Neg post exam, no immediate c/o.
	Resting comfortably - looks well
LWBS	VSS 97.1 HR 60-70 BP 108/60 RR 10-14 96% RA
1st void	void 100cc (+)/o
blood	CHESTO CBT B/L
Hct 50 max	cox RRR (+)
40 (post op)	ABS flat, soft NT, ND
43 max	Buttocks - (1) - dressing dry - tender - min drainage
	(2) - wound VERY MUCH INTO deep
98.7 (23)	Ext - left (-) edema
	Ins/plan: s/p dsw to (2) buttocks
138 84/10	Rounds impressive surgical pt to Stanton on x-ray
72/36 1.0	Force
MISS	- transfer to ICU
Antibiotic	- N/c foley if insertion
Vancomycin	- monitor Lab - HR if worsen for Lab
Morphine	- oral analgesic
	- N/c CBS
	[redacted] (b)(6)-2 MS
	MTO ne
June 03	Tol po juices. IV HL'd. ↑ amb ward accomp by staff ▽ mp's.
0830	Amb ▽ difficulty. Gait steady. Ø % gain. [redacted] CPT AN
June 03 0900	Report given to ICW 2. Pt transferred to ward per orders. VSS,
	Condition stable. [redacted] CPT AN
	(b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPROD

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
13 June 03 1920	Received pt. from ER @ 1820. Neuro: Pt. is alert & oriented x 3. Responds appropriately to commands. PERLA. Resp: BS CTA throughout. RR 14. O2 Sat 100% RA. Cardio: Sinus tach. c̄ HR in low 90's. GI: (+) BS x 4 quadrants. GU: Foley catheter to gravity drainage c̄ clear light yellow urine. Skin: GSW to (D) hip. 4x4 gauze dressing CDI. Pt. denies pain @ this time. Lines: 16g IV (R) AC c̄ LR @ 150 cc/hr infusing s̄ difficulty. 18g IV (L) AC HL. flushes s̄ difficulty. Pt. bathed on arrival to unit. (b)(6)-2 [redacted] 14 Am
13 June 03 2130	Pt. c/o pain @ wound site. Total of 15mg MSO4 IVP given. VSS. Old dressing removed from wound. 1/2 of 4x4 gauze saturated c̄ serosanguinous fluid. New dressing applied to site c̄ triple antibiotic cream. (b)(6)-2 [redacted] 14 Am
14 June 03 0400	Pt. slept well through the night. Ø additional need for pain meds. Am labs drawn. (b)(6)-2 [redacted] 14 Am
14 June 03 0515	Recvd in bed. Eyes closed, Resp deep & even. Ø apparent distress. Cont to monitor. (b)(6)-2 [redacted] Cpt SN
14 June 03 0630	Assessment completed. See DA Form 4700. Dressing to (D) hip CDI. Denies pain. All pulses palp. bilat. Wrist restraints intact. VSS. Cont to monitor (b)(6)-2
14 June 03 0710	Dr [redacted] (b)(6)-2 at bedside. New orders noted [redacted] Cpt SN

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/199
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1
USAPA V1.0

NSN 7540-00-634-4176

HEALTH RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE** | 600-108

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
14 Jun 03	1200 - Pt received from ICU via ambulating c nurse. alert & oriented, VSS, lungs clear, BS⊕, HR reg. HL to ⓪ forearm. Dsg to ⓛ buttock CDI. Voicing no complaints. Tolerating a clear diet - will advance as tol. Will cont. to monitor — (b)(6)-2 [redacted] 2HAN
14 June 03 1350	assumed pt care @ 1300. VSS. pt resting quietly. lung sounds CTA throughout. abd soft nontender BS⊕x4. BLE & UE c̄ Full rom c̄ strong ⊕ pulses x4. HL to ⓡFA ⓪ s/sx of infection noted. Drsng to ⓛ buttock CDI. Pt voices ⓪ c/o pain or discomfort @ this time. Will cont to monitor — (b)(6)-2 [redacted] 9WMe
2240	Pt. care assumed @ 2100. Pt. resting quietly, easily awakened. HR Reg, lungs CTA, BS⊕x4. drsng to ⓛ Buttocks CDI. Will cont. to monitor. (b)(6)-2 [redacted] 1CTAN
15 Jun 03 0515	Assumed pt care @ 0500. Pt. awake A+Ox3 VSS. lungs CTA. ⊕ pulses x4. Hypo active BS x4. Drsng to ⓛ buttock CDI. HL to ⓡFA ⓪ s/sx of infection noted. Pt. denies any discomfort @ this time. will continue to monitor — [redacted] 9WM6 (b)(6)-2

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

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

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
15 June 03 1355	assumed pt care @ 1300. pt awake & alert. VSS. airway patent, lung sounds CTA, abd soft nontender, BS hypoactive. BLE & BUE c full ROM strong ⊕ pulses x 4. hx to (L) LA ⊖ redness or edema noted. dressing to (L) buttock CDI. ⊖ c/o discomfort or pain voiced @ this time. Will cont to monitor. Pt has discharge orders written, awaiting transportation to EPW camp — (b)(6)-2 [redacted] 9 Kumar
2210.	Pt. alert. Dressing to (L) flank reinforced. HR Res, Lungs CTA, BS ⊕ x4. Will cont to monitor. [redacted] / 07/ [illegible] (b)(6)-2

558-103 [redacted] (b)(2)-2 [redacted]

(See Instructions on Back of this Sheet)

EMERGENCY CARE AND TREATMENT
(Medical Record)

NSN 7540-01-075-3786

TREATMENT FACILITY (Stamp): EMT

LOG NUMBER:

ARRIVAL DATE DAY	MONTH	YR.	TIME
13	Jun	03	1730

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

CURRENT MEDS. (tetanus immunization and other data): NONE

HISTORY OBTAINED FROM: ☒ PATIENT ☐ OTHER (Specify)

ALLERGIES: NONE

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): GSW Smoke +

(b)(6)-4

SEX: M AGE: [redacted]

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER:

VITAL SIGNS			
TIME	1738	1753	1805
BP	116/71	119/64	123/67
PULSE	101	87	91
RESP.	22	20	20
TEMP.	98.8	98.8	98
WT. (Child)	85 kg		

Pox 9 95 96

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

ORDERS	INITS.	TIME
KUB	[redacted]	1805
Chest Ray		1805
2 Lr Bolus		1645
CBC UA		1650
Met 8		1650
Type Cross		1650

ASSESSMENT/DIAGNOSIS: MSDY Sz IVP none

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)

[redacted] Y/B Iraqi @ GSW Lower L Back

(b)(6)-4

Pulse Ox 91

(b)(6)-2

Gram avicef IV 1650

.5 Tetanus IM 1654

Foley @ 1805 IV 16 gage

O² - 2 Hrs 1800

UA. 1805

3rd bag IV @ 1805 TCO

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):
- ☐ EMERGENCY ☐ TODAY
- ☐ 72 HOURS ☐ ROUTINE
- ADMIT. TO HOSP. UNIT/SERVICE:

CONDITION UPON RELEASE
- ☐ IMPROVED ☐ UNCHANGED
- ☐ DETERIORATED

TIME OF RELEASE:

(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).

[redacted] (b)(6)-4

~~ICU~~ ICU 2

SIGNATURE OF PROVIDER AND ID STAMP

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR June 03 | DAY | 14 | 15 | 16 | 17 | 18 | 19 | 20

19 | HOUR | 1200 | 3 | 8 | 12 | 2 | 4 | 8

PULSE (O) | TEMP. F (•)

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

	14	15	16	17	18	19	20
RESPIRATION	16	16	16	16	16	16	16
BLOOD PRESSURE	118/60	110/66	118/60	108/70	116/60	98/60	98/70

HEIGHT: | WEIGHT

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICW2

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

STANDARD FORM 511 (REV. 7-95) BACK

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM 1200 HOURS TO 1200 HOURS | TOTAL HOURS COVERED 12 | DATE 14 Jun 03

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

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

IRRIGATIONS (IV/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
	Urine		
1300	Urine	800cc	800cc
1840	urine	700	

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

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

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

INTAKE EQUIVALENTS (Serving levels cc)

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

DD FORM 1 JAN 74 792

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

*U.S.GPO:1998-404-613/30343

d/Section: EWT

REQ[redacted]ING PHYSICIAN: [redacted] (b)(6)-2

[redacted]

ST, FIRST, MI: [redacted] (b)(6)-2

DATE: 13 Jun 10 | TIME: 1545 | SSN/PSEUDO SSN

(i-STAT)

TEST	RESULT	REF. RANGE
		138-146 mmol/L
		3.5-4.9 mmol/L
		98-109 mmol/L
		7.31-7.45
O2		35-45 mmHg (art) 41-51 mmHg (ven)
2		80-105 mmHg (art) N/A (ven)
O2		23-27 mmol/L (art) 24-29 mmol/L (ven)
'O3		22-26 mmol/L (art) 23-28 mmol/L (ven)
2		95-98%
ect		(-2) – (+3) mmol/L
Gap		10-20 mmol/L
		1.12-1.32 mmol/L
N		8-26 mg/dl
L		70-105 mg/dl
eat		0.7-1.5 mg/dl
t		38-51% PCV
gb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
opomin-I		
rug of buse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	93	73-118 mg/dl
BUN	15	7-22 mg/dl
CRE	1.0	0.6-1.2 mg/dl
CK	191	39-380 u/l (M) 30-190 u/l (F)
NA^+	136	128-145 mmol/l
K^+	3.8	3.3-4.7 mmol/l
CL^-	104	98-108 mmol/l
tCO_2	26	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

REMARKS: [redacted] — (b)(6)-4

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

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

[redacted] (b)(6)-4

13 Jan 03 1545

(Hematology) CBC		
TEST	RESULT	REF. RANGE
WBC	7.3	4.8-10.8 x 10^3
RBC	5.60	4.7-6.1 x 10^9
Hgb	15.4	14-18 g/dl (M) 12-16 g/dl (F)
Hct	50.1	42-52% (M) 37-47% (F)
MCV	89.4	80-94 fl (M) 81-99 fl (F)
Plt	300	130-500 x 10^3 verified
Lymph %	38.6	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	yell	N/A
App	clr	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	neg	Negative
SG	1.025	N/A
Bld	Trace	Negative
pH	6.0	N/A
Prot	Trace	Negative
Urob	neg	0.2-1.0
Nit	neg	Negative
Leuk		Negative
HCG		Negative

CSF		
Cell Count		
Directigen		Negative

Misc. Serology		
TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

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

Microscopic Urinalysis
5-10 RBC / hpf moderate epis

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: [redacted] (b)(6)-2 **DATE:** 13 Jan 03 **LAB ID NO.:**

'ard/Section: ICU 2

RE[redacted]STING PHYSICIAN: [redacted] (b)(6)-2

AST, FIRST, MI: (b)(6)-4 #[redacted]

DATE: 13 June 03 TIME: 2215

SSN/PSEUDO SSN:

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

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	12.4	4.8-10.8 x 10^3
RBC	4.62	4.7-6.1 x 10^9
Hgb	13.0	14-18 g/dl (M) 12-16 g/dl (F)
Hct	40.8	42-52% (M) 37-47% (F)
MCV	88.2	80-94 fl (M) 81-99 fl (F)
Plt	219	130-500 x 10^3 verified
Lymph %	21.6	20.5-51.1%

(Hematology) Manual Differential

egs		Mono	
ands		Eos	
ymph		Baso	
typ		Imm	
BC lorph			
oun ematocrit		42-52% (M) 37-47% (F)	
ed Rate			
ther			

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
T		9.8-13.6 secs
PTT		21-34 secs
dimer		<20 ug/ml
DP		<10 ug/ml

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

UNIT	TYPE	CROSSMATCH

EMARKS: CBC [redacted] (b)(6)-2

[redacted] 19 Jun 03

Ward/Section: ICU #2 | REQUESTING PHYSICIAN:

LABORATORY RESULT FC
(Subject to the Privacy Act of 19

LAST, FIRST, MI. #[redacted] (b)(6)-4 | DATE 6-5 | TIME AM | SSN/PSEUDO SSN: [redacted] (b)(6)-4

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
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	Yellow	N/A
App	Clear	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	neg	Negative
SG	1.010	N/A
Bld	neg	Negative
pH	7.0	N/A
Prot	neg	Negative
Urob	neg	0.2-1.0
Nit	neg	Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATC

Misc. Se[redacted]y

TEST	RESULT	REF. R
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WI EVERY UNIT REQUESTE

ABO/Rh	

REMARKS:

(b)(6)-2 [redacted]

15 Jan 03

rd/Section: ICU #2

REQ ING PHYSICIAN:

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

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

DATE 14 June 03 | TIME 0430 | SSN/PSEUDO SSN:

(i-STAT)

EST	RESULT	REF. RANGE
		138-146 mmol/L
		3.5-4.9 mmol/L
		98-109 mmol/L
		7.31-7.45
O2		35-45 mmHg (art) 41-51 mmHg (ven)
2		80-105 mmHg (art) N/A (ven)
O2		23-27 mmol/L (art) 24-29 mmol/L (ven)
O3		22-26 mmol/L (art) 23-28 mmol/L (ven)
2		95-98%
ecf		(-2) – (+3) mmol/L
Gap		10-20 mmol/L
		1.12-1.32 mmol/L
JN		8-26 mg/dl
U		70-105 mg/dl
eat		0.7-1.5 mg/dl
t		38-51% PCV
b		12-17 g/dl

Misc. Chemistry

EST	RESULT	REF. RANGE
ponin-I		Negative
ug of use		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	86	73-118 mg/dl
BUN	10	7-22 mg/dl
CRE	1.0	0.6-1.2 mg/dl
CK	175	39-380 u/l (M) 30-190 u/l (F)
NA^+	138	128-145 mmol/l
K^+	4.2	3.3-4.7 mmol/l
CL^-	106	98-108 mmol/l
tCO_2	26	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

EMARKS:

Chem 8

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

Ward/Section: ICU #2

REQUESTING PHYSICIAN:

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

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

DATE: 14 Jan 03 TIME: 0430

SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	10.8	4.8-10.8 x 10^3
RBC	4.94	4.7-6.1 x 10^9
Hgb	14.1	14-18 g/dl (M) 12-16 g/dl (F)
Hct	43.7	42-52% (M) 37-47% (F)
MCV	88.4	80-94 fl (M) 81-99 fl (F)
Plt	239	130-500 x 10^3 verified
Lymph %	33.5	20.5-51.1%

(Hematology) Manual Differential

egs		Mono	
ands		Eos	
ymph		Baso	
typ		Imm	
BC lorph			
oun ematocrit		42-52% (M) 37-47% (F)	
ed Rate			
ther			

Coagulation Studies

TEST	RESULT	REF. RANGE
T		9.8-13.6 secs
PTT		21-34 secs
dimer		<20 ug/ml
DP		<10 ug/ml

Urinalysis

TEST	RESULT	REF. RANGE
Color	Yel	N/A
App	clear	N/A
Glu	Neg	Negative
Bili	Neg	Negative
Ket	Neg	Negative
SG	1.010	N/A
Bld	Mod	Negative
pH	7.5	N/A
Prot	Neg	Negative
Urob	0.2	0.2-1.0
Nit	Neg	Negative
Leuk	N/A	Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

2-5 RBC's

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: CBC, UA

(b)(6)-2 [redacted] 14 Jan 03

MEDCOM - 10922

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

PWH [redacted]

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 13 JUN 03 — TIME OF ORDER: 1836 — HOURS — LIST TIME ORDER NOTED AND SIGN

- Admit to ICU 2
- Dx: GSW to buttock
- Condition stable
- VS q 2°
- IVF LR @ 150 cc/hr
- Diet NPO
- O2 4L NC wean as tolerated

PATIENT IDENTIFICATION

UPW # [redacted]

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER — TIME OF ORDER — HOURS

- Foley to gravity drainage
- meds:
- Ancef 1 gm IVPB q 8°
- MSO4 2-8 mg IVP q 2° prn
- Phenergan 12.5 mg IVP q 6° prn
- Lab:
- CBC q 6° (last @ 1545)
- Chem 8 in AM

(b)(6)-2

Noted [redacted] CPT 13 JUN [redacted] 915

PATIENT IDENTIFICATION

UPW # [redacted]

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER — TIME OF ORDER — HOURS

- UA in AM
- NKDA
- Dr [redacted]
- 24° Chart ✓ 14 June 03 @ 0330 [redacted]

AN (b)(6)-2

PATIENT IDENTIFICATION

UPW # [redacted]

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 14 JUNE 03 — TIME OF ORDER: 0710 — HOURS

1. CLEARS → AMOUNTS AS TOL
2. D/C CABG
3. AMBULATE
4. PROCEED T TUB q 8° PRN
5. HL IVF WHEN TOL DIET

(b)(6)-2

noted [redacted] CPT AN 14 June 03 0720

[redacted] (b)(6)-2 July 5 [redacted] UTAR 6-15-03 2315

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

☆ U.S. GOVERNMENT

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 14 JUN 03 TIME OF ORDER: 0830 HOURS

LIST TIME ORDER NOTED AND SIGN

1. TRANSFER to ICW - f/u OSW for [redacted] BUTTOCKS
2. DRESSING
3. ✓ UREA
4. ✓ VITALS per protocol
5. ✓ AMBULATE c ASSISTANCE
6. ✓ IS - I/O's

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW2		

DATE OF ORDER: 14 Mar 03 TIME OF ORDER: 1200 HOURS

7. ✓ NCC: CLEAN - ANALGESIA AS PRN
8. ✓ IVP: LR @ 120 cc/h HC WATER TOR PO
9. MEDS: ✓ ANZEMET 7 gm IV q 8° x 3 doses
   ✓ PERCOCET 7 TAB PO q 4° PRN
   ✓ MSO4 1-5 mg IV q 1° PRN

(b)(6)-2 [redacted] 14 Mar 03 1200

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW2		

DATE OF ORDER: TIME OF ORDER: HOURS

10. ✓ CBC, UA in AM
11. ✓ NC foley if not already done by ICU nurse

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

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW2	24° VS	

DATE OF ORDER: 14 Jun 03 TIME OF ORDER: 1900 HOURS

1. D/C I & O's

Noted

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

(b)(6)-2 [redacted]

Taken by [redacted] 29 15

[redacted] (b)(6)-2 6/14/03 2335

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

EPW # [redacted]

(b)(6)-4

NURSING UNIT: ICW #2 | ROOM NO. | BED NO.

DATE OF ORDER: 15 JUNE 03 | TIME OF ORDER: 0945 HOURS | LIST TIME ORDER NOTED AND SIGN

1. D/C IV
2. D/C TO POW CAMP
3. D/C MEDS / MEDICAL
4. BACITRACIN TO WOUNDS BID

[redacted] NO MAS ME

(b)(6)-2

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

9/14 June 03 1351

PATIENT IDENTIFICATION

EPW # [redacted]

(b)(6)-4

NURSING UNIT: ICW #2 | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

PATIENT IDENTIFICATION

EPW # [redacted]

(b)(6)-4

NURSING UNIT: ICW #2 | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

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

All: (b)(6)-2 except one at bottom.

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. 6 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 13	14	15
13 Jun	[redacted]	VS q 20	05	/	[redacted]	
			17		[redacted]	
13	[redacted]	Diet NPO	05	/	[redacted]	D/C 14 June 03
			17		[redacted]	
13	[redacted]	O2 4L NC when	05	/	[redacted]	
		as tolerated	17		[redacted]	
13	[redacted]	Foley to gravity	05	/	[redacted]	
		drainage	17		[redacted]	
13	[redacted]	CBC q 6°	04		[redacted]	
			10	/		D/C 14 June 03
			16	/		
			22		[redacted]	
14 June	[redacted]	Chem 8 if Cleared	06	/	[redacted]	
		Advance as tol.	12	/		
			18	/		
14 June	[redacted]	Ambulate	05	/	[redacted]	
			17	/		

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: G-SW to buttock

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

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

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 1 OCT 78 4677

EDITION OF 1 DEC 77 MAY BE USED.

all: (b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)					Mo JUN Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
13 JUN	[redacted]	Admit to ICU #2	13 June 03		1820	[redacted]	
JUN	[redacted]	Condition stable	"		"	[redacted]	
13	[redacted]	Chem 8 in A.M.	14 June		0430	[redacted]	
13	[redacted]	UA in A.M	14 June		0430	[redacted]	

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

☆ U.S. GPO -290/55267

all (b)(6)-2 except one at bottom.

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. 6 Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 14	15	16	17	18	19	20	21	22	23	24	25
14 Jun 03	[redacted]	Vital signs per	06	/	[redacted]										
		protocol	14	[redacted]											
			22	[redacted]											
14 Jun	[redacted]	Ambulate c assistance	06	/	[redacted]										
			14	[redacted]											
			22	[redacted]											
14 Jun	[redacted]	Clears → advance	06	/	[redacted]										
		as tol - regular	14	[redacted]											
			22	[redacted]											
14 Jun	[redacted]	I/Os	06	O											
			14	[redacted]											
			22												

DC'd 14 Jun [redacted]

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: GSW to (L) Buttocks

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

all : (b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*				Mo _____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
17 Jun	[redacted]	Transfer to ICW-II for GSW to	— done	—		[redacted]
	-----	(L) buttocks				
14 Jun	[redacted]	stable	—	done	—	[redacted]
14 Jun	[redacted]	UA in AM (15 Jun)	15 Jun	done	—	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
-----	-----															
-----	-----															
-----	-----															
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USAPA V1.00

All (b)(6)-2 except one at bottom.

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.

Month Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 13	14	15
13	[redacted]	IVF LRG 150cc/hr	05	/	[redacted]	
14 June	[redacted]	(HL IVF w/non-tol Diet)	11		[redacted]	
13	[redacted]	Ancef 1gm IVPB	08	/	[redacted]	
		q8°	16	/	[redacted]	
			24	[redacted]		

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS:

GSW to buttock

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION:

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

USAPA V1.00

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)					Mo 06 Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
13	[redacted]	MSO4 2-8mg IVP	1330	1330												
		q 2° prn pain	2mg IVP	4mg IVP												
13	[redacted]	Phenergan 12.5mg														
		IVP q 6° prn														
14 June	[redacted]	Percocet ÷ tab po														
		Q 4° prn														

☆ U.S. GPO -290/55267

All: (b)(6) -2

All (b)(6)-2 except one at bottom.

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 14	15	16	17	18	19	20
14 Jun	[redacted]	Ancef 1gm IV Q8	08	/	[redacted]					
		x 3 doses	16	[redacted]			DC'd			
		(3rd dose at 1600)	24	/						
14 Jun	[redacted]	LR @ 120 ml/h HL	06							
		when tol PO	14				HL			
			22							
15 June	[redacted]	Bacitracin to wound	08	/	/					
Cr		BID	20	/	0					

14 Jun 03 1200

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: GSW to (L) Buttocks

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

USAPA V1.00

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**													
14 Jun	[redacted]	Percocet 1 tab	14 Jun 1220 T													
- - - -	- - - - -	PO Q4° PRN	[redacted]													
14 Jun	[redacted]	MSO4 1-5 mg IV														
- - - -	- - - - -	Q1° PRN														
- - - -	- - - - -	All (b)(6) - 2														
- - - -	- - - - -															
- - - -	- - - - -															
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- - - -	- - - - -															

DC'd

USAPA V1.00

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

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

INITIAL SHIFT ASSESSMENT

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

See progress note

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)* [redacted] 1Lt (b)(6)-2

DEPARTMENT/SERVICE/CLINIC ICU 2 unit

DATE 13 June 03

PATIENT'S IDE[redacted] *typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)*

[redacted] (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

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

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE 13 June 03 | DX GSW (L) Hip | HOSPITAL DAY

VITALS SIGNS																		
TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line																		
BP Cuff																		
Temperature																		
Pulse																		
Respiratory Rate																		
pain																		
intervention																		

INTAKE																		
TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
LR																		
TOTALS																		

OUTPUT																		
URINE	HOUR / TOTAL																	
	sp gr																	
	S/A																	
NG	OUTPUT																	
	pH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

1645
Ancef 1gm

Admit
1820

(b)(6)-2

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	
BP		122/65		117/49	104/59	100/59		109/60	
T		98.3		97.8	98.4	98.1		97.5	
P		101		87	85	85		71	
R		14		14	12	12		12	
A		100 RA		100	100	100		96	

INTAKE	16	17	18	19	20	21	22	23	8° T
LR	↑	150	150	150	150	150	150	150	

OUTPUT									
Urine	300		400/700		250/950		150/1100		

ACUITY LEVEL CLASSIFICATION

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

LABORATORY DATA	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 I&O TOTALS		NURSE'S SIGNATURE	INITIALS
wt Yesterday	wt Today	[redacted]	[redacted]
INTAKE	OUTPUT	(b)(6)-2	
IV	Urine:		
po			
TOTAL	TOTAL		
BALANCE			

NEUROLOGICAL ASSESSMENT

COMA SCALE		HOURS	LEGEND
EYES OPEN	SPONTANEOUSLY	4	C Closed by swelling
	TO SPEECH	3	
	TO PAIN	2	
	NO EYE OPENING	1	
BEST VERBAL RESPONSE	ORIENTED	5	T Trach/Endo
	CONFUSED	4	S Slurring
	VERBALIZES	3	D Dysphasia
	VOCALIZES	2	R Receptive
	NO VOCALIZATION	1	E Expressive
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			LEGEND
ARMS	NORMAL POWER		R Right
	MILD WEAKNESS		L Left
	SEVERE WEAKNESS		Record separately if there is a difference between the two sides.
	ABNORMAL FLEXION		
	ABNORMAL EXTENSION		
	NO RESPONSE		
LEGS	NORMAL POWER		
	MILD WEAKNESS		
	SEVERE WEAKNESS		
	ABNORMAL FLEXION		
	ABNORMAL EXTENSION		
	NO RESPONSE		

PUPILS			LEGEND
RIGHT	SIZE		++ Brisk
	REACTION		+ Slow
LEFT	SIZE		- No Response
	REACTION		
PUPIL SCALE		● 2 ● 3 ● 4 ● 5 ● 6 ● 7 mm	
ICP			+ Intact
CEREBRAL PERFUSION PRESSURE			- Abnormal

See Progress Note

VASCULAR ASSESSMENT

HOURS		LEGEND
	R L	++ Normal
	R L	+ Weak
	R L	- Absent
	R L	D Doppler
	R L	R Right
	R L	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	0630	INITIALS [redacted]	(b)(6)-2	INITIALS		INITIALS
NEURO	PUPILS	equal, reactive					
	SENSORIUM	Awake, Alert, oriented					
		yes interpreter					
RESPIRATORY	RESPIRATORY PATTERN	even/unlabored					
	BREATH SOUNDS	CTA bilat					
	SECRETIONS	None					
SKIN	COLOR	Normal for race					
	INTEGRITY	Warm dry. Surg site					
		dressings C&I					
IV SITE	LOCATION	(L) FA #4 (R) AC 18ga					
	CONDITION	LR infusing @ 150 ml/hr					
		Bil sites ⊃ S/S of					
		infection or infiltration					
GASTRO	ABDOMEN	Soft,					
	BOWEL SOUNDS	active x 4 quads					
GU	URINE:	foley					
	COLOR/CLARITY	yellow/clr.					
CARDIOVASCULAR	CARDIAC RHYTHM	SR @ 120 bpm ⊃					
		ectopy					

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)

(b)(6)-2 PREPARED BY (Signature & Title) [redacted] 14/hr

DEPARTMENT/SERVICE/CLINIC: ICU 2 east

DATE: 14 June 03

PATIENT (If typed or written entries give: Name—last, first, middle [redacted] hospital or medical facility)

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE 14 June 03 DX GSW (L) thigh HOSPITAL DAY 1

VITALS SIGNS	TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
	BP Arterial Line																		
	BP Cuff	101/54		97/51		99/56		108/60			114/62								
	Temperature	98.1				98.5		97.1											
	Pulse	72		67		100		60			64								
	Respiratory Rate	14		14		12		10			16								
	O_2 Sat	96%		95%		98%		96%			96%								
	pain intensity																		

INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	LR @ 150	150	150	150	150	150	150	150	150	1200	150								
	Ancef	50								50									
	TOTALS																		

OUTPUT		HOUR / TOTAL	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	URINE		200/200		400/600		450/1050		400/1250		1250	1275/2525								
		sp gr																		
		S/A																		
	NG	OUTPUT																		
		pH																		
		GUIAC																		
	EMESIS																			
	STOOL																			
	DRAINS																			
	TOTALS																			

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	

INTAKE	16	17	18	19	20	21	22	23	8°T

OUTPUT									

ACUITY LEVEL CLASSIFICATION

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

LABORATORY	TIME	0430								
	GLUCOSE	86								
	Na/K	138/4.2								
	Cl/CO_2	102/26								
	BUN/Cr	10/1.0								
	WBC/PLATELET	10.8/237								
	Hct/Hgb	43.7/14.1								

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

TURN	TIME					
SUCTION						

24°I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE _____

NURSE'S SIGNATURE	INITIALS
[redacted] 4Am	[redacted]
[redacted] JgAm	[redacted]
(b)(6)-2 All	

ADMISSION AND CODING INFORMATION

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

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

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
(b)(6)-4	[redacted]	Z	Z	Muslim

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
Z	—	99 (b)(6)-4	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
UNK	Z	1730	—

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
NO	A11	

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
IZ	Z	9	YEAR / [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø	ICU#2	UNK

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

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
Ø5		030615

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
AEAA		030613

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

FOR LOCAL USE

Dx: GSW to Left Buttocks

Dx: 8771 E9912
Px: 8028

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

SIGNATURE OF ADMITTING CLERK [redacted] (b)(6)-2

DA FORM [redacted] MAR 90

(b)(6)-4

IN...TIENT TREATMENT RECORD COVER ...EET

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

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	[redacted] (b)(6)	X	MUSLIM	—	—	NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99	[redacted] (b)(6)-4	—	ICW2

15. FLYING STATUS	16. DAYING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
NO	—	K78	—	—	WIA.

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
DIRECT FROM ER	1840	AEAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
UNK	D/C TO CAMP	14 JUN 2003

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
UNK	UNK	13 JUN 2003	

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

31. SELECTED ADMINISTRATIVE DATA [redacted]

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: (1) GSW (L) ARM
(2) S/P I&D (L) ARM

884.1
E991.2
86.28

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	SI[redacted]ECORDS OFFICER
DR. [redacted]	[redacted]

(b)(6)-2

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

[redacted] YID [illegible], [illegible] TO (L) [illegible] NO [illegible]
(b)(6)-4 HISTORY [illegible]

PHYSICAL EXAMINATION

HEENT - [illegible]/NL
NECK - [illegible]
CHEST - [illegible]
ABD - [illegible]
(L) [illegible] - [illegible] [illegible] OVER MID - [illegible]
MOTION [illegible] [illegible]

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

SIGNATURE OF [redacted]	DATE	IDENTIFICATION NO.	ORGANIZATION
(b)(6)-2	13 [illegible]		

PATI[redacted] (If typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)	REGISTER NO.	WARD NO.
[illegible] [redacted] (b)(6)-4		

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

539-106

(b)(6)-4 [redacted]

AUTHORIZED FOR LOCAL REPRODUCTI

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
13Jun03 1915	pt. admitted to ICW2 GS yo ♂ EPW C GSW (L) UE, entrance wound irrigated & covered c Kerlix, no exit wound noted - no c/o pain @ this time - 20g IV in (R) wrist c NS @ 100cc/hr - hematoma noted on (R) hand 2° to failed IV start - lungs CTA (B), pulse ox 90% on RA, pt. reports he smokes, in no apparent distress - (+) BS - +2 pulses in all extremeties - on call to OR - [redacted] on (b)(6)-2
13Nov03 2251	Ortho Op Note: Pre Op Dx: GSW (L) arm Post Op Dx: Same Procedure: I+D (L) arm Surgeon: [redacted] (b)(6)-2 Anes: MAC Tourniquet: 500 LM Findings: GSW site thigh. Unable to remove bullet. Edges debrided. Irrigated. Hypotension Ass 2000/118 in OR

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME		SPONSOR'S ID NUMBER
	LAST	FIRST	MI
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS	

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. ICW2

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10
USAPA V1.0

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
#800			

DATE	NOTES
14JUN03	13Jun03 22:00 - Pt to OR - [redacted] RT/MD
0152	00:20 - Pt returned from [redacted] recovery VS WNL x O2 sat 90%. No visible signs of Resp distress. Skin W+D. Pt. alert able to walk to bed from stretcher. PERRLA⊕ WNL. LCA(B). BS⊕x4 ⊕PPP(B) PIV(R) FA patent c̄ LR@ 100cc/hr. ACE wrap bandage to (L) forearm C/D/I. No complaints @ this time/ [redacted] RT/MD (b)(6)-2
14Jun03	0630 - Pt sleeping comfortable, easily arousable. VSS, HR regular, Lungs CTA, BS⊕ x4. IV to (R) forearm infusing LR, WNL. DSG to (L) upper arm CDI. Pt voicing no complaints at this time. Will cont. to monitor - [redacted] RT/MD (b)(6)-2
14JUN03 0445	(S) N/A (O) DIAPHORETIC CLEAN AND DRY (P) DISCHARGED TO DET

[redacted] (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA 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): EMT

LOG NUMBER:

ARRIVAL — DATE: DAY 13, MONTH 6, YR. 03 — TIME: 1745

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: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code): (b)(6)-4

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

CHIEF COMPLAINT(S) (Include symptom(s), duration): C/O GSW L-Arm

SEX: M AGE: [redacted]

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 1745

VITAL SIGNS			
TIME	1745		
BP	161/91		
PULSE	100		
RESP.	16		
TEMP.	97.3		
WT. (Child)			

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

ORDERS	INITS.	TIME
xRay L-Arm	[redacted]	
5 cc Tetanus		1735
1g Ancef		1810
IV (0.9 NS)		1810
CBC Chem 12		1916
Cont Ancef O/C to OR		1900

all: (b)(6)-2

ASSESSMENT/DIAGNOSIS: GSW (L) humerus

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: [redacted] yr OM ♂ GSW L-Arm in firefight
(b)(6)-4
∅ hx avail Pt does not speak english

O: A&O x4 - no distress.
HEENT ∅ lym chan / JVD
neck supple
Chest: CTA(B), =
Cardiac II/VI SEM ∅ G/R
Abd: soft NT w dsg ∅
Ext: S/T / N/V intact
⊕ GSW to (L) prox humerus laterally
∅ active bleed, ∅ palpable lesions
Rt shoulder

16.1 / 205
8.7 / 34.3

Xrays

A/P Stable [redacted] (b)(6)-2

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)
- ☐ EMERGENCY ☐ TODAY ☐ 72 HOURS ☐ ROUTINE
- ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
- ☐ IMPROVED ☐ UNCHANGED
- ☐ DETERIORATED

TIME OF RELEASE:

(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).

[redacted] (b)(6)-4

SIGNATURE OF PROVIDER AND ID STAMP: [redacted] (b)(6)-2

INSTRUCTIONS TO PATIENT (Include medica[redacted]itations and follow-up plans)

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

HEIGHT:

WEIGHT:

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

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

4. PROPOSED SURGICAL PROCEDURE:
IAD (L) arm

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition clear
Tobacco ✓ ppd X___ yrs. Body Piercing ∅ Diabetes (Y) (N) ROM ✓ ASA/Motrin w/72 hrs (Y) (N)
ETOH ✓ Implants ∅ Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contacts (Y) (N) Dentures ∅ Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to: ✓ 1) Surgical Procedure & Operating Room Environment ✓ 2) ~~Separation Anxiety (Child)~~ ✓ 3) Surgical Outcomes	✓ o Pt. verbalizes any specific anxiety. ✓ o Pt. Exhibits relaxed body posture.	✓ 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 inter~~ [redacted] Parents to ~~stay with pt.~~ (b)(6)-2
B. AERATION ✓ Potential for respiratory dysfunction due to: ✓ 1) Positioning ✓ 2) Effects of Anesthesia ✓ 3) Medical/Smoking History	✓ o Pt. will be able to breathe without difficulty during immediate intraoperative phase .	✓ 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 ✓ Potential impairment of skin integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement ✓ 3) Positional Aids ✓ 4) Prosthesis ✓ 5) Pooling of Prep Solutions	✓ o Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	✓ 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)

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

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

6. PATIENT PROBLEMS AND NEEDS	PATIENT GOALS AND EXPECTED OUTCOMES	OR NURSING INTERVENTIONS
D. CIRCULATION ____ Potential for inadequate tissue perfusion due to: ____ 1) Intraoperative Mobility ____ 2) Positioning ____ 3) Existing Disease ____ 4) Safety Devices ____ 5) Hypothermia	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. ____ Potential impairment of mobility due to: ____ 1) Pain ____ 2) Intraoperative Hazards ____ 3) Prosthesis ____ 4) Positioning ____ 5) Transfer pt. to/from OR table E.2. ____ Potential discomfort due to: ____ 1) Length of Surgery ____ 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 ____ 2) W/O Glasses F.2. ____ Potential for decreased communication due to: ____ 1) Diminished Hearing ____ 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 INTERVENTION S NOTED.

MA [redacted] (b)(6)-2 13 June 07 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 Title) [redacted] (b)(6)-2
DATE: 13 Jun 07 TIME: 2230

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] (b)(6)-2 MA
DATE: 13 Jun 07 TIME: 2300

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 any staff

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] MAJ

3. DATE 13 June 07 TIME PATIENT ARRIVED IN SUITE 2225

4. PATIENT IN ROOM TIME 2226 (b)(6)-2 NUMBER 12-2

(b)(6)-4

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKDA, [redacted] y old HTN. awake, able to move, able to follow commands

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ [redacted]	RELIEF CIRCULATOR	

(b)(6)-2

7. POSITION AND POSITIONAL AIDS (Specify) Pt placed in arm board (<90°) strapped

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

COMMENTS: Strap above knees. Pillow under knees.

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

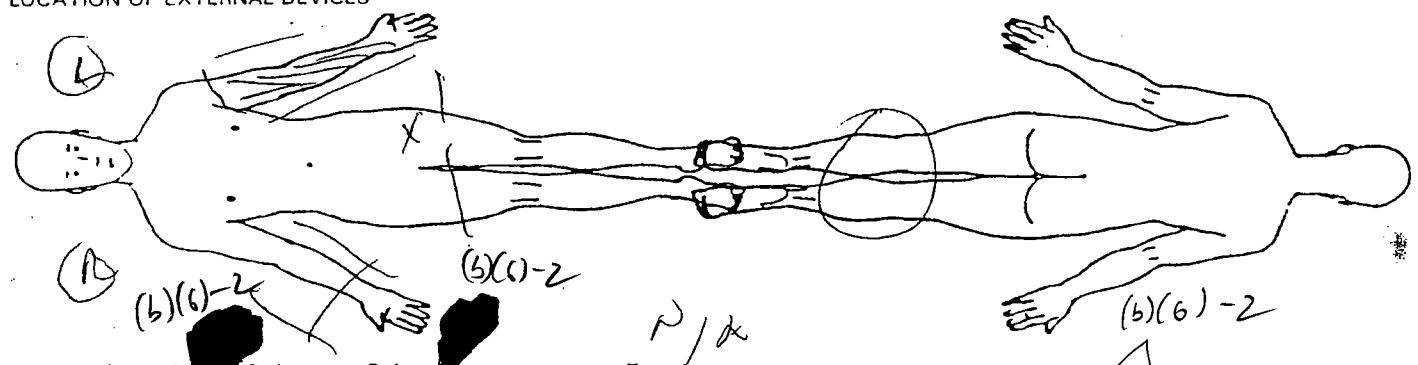
PREP SOLUTION (Specify) BETA / BETA (b)(6)-2

SITE: (L) arm BY WHOM:

SITE: ☒ BY WHOM: MAJ [redacted]

COMMENTS: ∅ pooling of solution

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No	C	C	C	[redacted]	[redacted]
Needle Sharp	☒ Yes	☐ No	C	C		SSG	MAJ
Instrument	☐ Yes	☒ No	C				
Other	☐ Yes	☒ No	C				

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

EPW # [redacted] —(b)(6)-4

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

☐ ESU NO:

GROUND PAD: BRAND Valleylab

LOT NO: [redacted]

☐ ESU NO:

GROUND PAD: BRAND (b)(6)-4

LOT NO:

☐ BIPOLAR NO:

MEDCOM - 10949

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):

NS

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

PHYSICIAN'S SIGNATURE [redacted]

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

YES ☐ NO ☒

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*

Iodoform packing
Fluff
Kerlix
ACE

19. ADDITIONAL INFORMATION

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

A. [redacted]

TYPE: General

Bowie site clean dry intact pre-prep of
Dressing dry intact

20. OPERATION(S) PERFORMED

I & D (2) arm

21. PATIENT TRANSFERRED TO ICU 1 TIME 2300 METHOD GURNEY

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

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	1	2	3	4	5	6	7
POST- DAY							
MONTH-YEAR June 2003 / DAY	13	14	15	16	17	18	19
HOUR		0630					

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE: 100/90

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

[redacted]

EPW

REGISTER NO.

WARD NO. LCW2

VITAL SIGNS RECORDS

Medical Record

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

(b)(6)-2 [redacted]

d/Section: EMT | R STING PHYSICIAN: [redacted]

ST. FIRST MI: [redacted] (b)(6)-4 | DATE: 1/10 | TIME: 1800 | SSN/PSEUDO SSN: [redacted] (b)(6)-4

(i-STAT)

TEST	RESULT	REF. RANGE
		138-146 mmol/L
		3.5-4.9 mmol/L
		98-109 mmol/L
		7.31-7.45
O2		35-45 mmHg (art) 41-51 mmHg (ven)
2		80-105 mmHg (art) N/A (ven)
O2		23-27 mmol/L (art) 24-29 mmol/L (ven)
O3		22-26 mmol/L (art) 23-28 mmol/L (ven)
2		95-98%
ect		(-2) - (+3) mmol/L
Gap		10-20 mmol/L
		1.12-1.32 mmol/L
N		8-26 mg/dl
L		70-105 mg/dl
eat		0.7-1.5 mg/dl
t		38-51% PCV
gb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
oponin-I		
rug of buse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB	3.7	3.5-5.5 g/dl
ALP	76	26-84 u/l
ALT	28	10-47 u/l
AMY	63	14-97 u/l
AST	13	11-38 u/l
TBIL	0.9	0.2-1.6 mg/dl
BUN	15	7-22 mg/dl
CA++	9.0	8.0-10.3mg/dl
CHOL	188	100-200 mg/dl
CRE	1.4	0.6-1.2 mg/dl
GLU	109	73-118 mg/dl
TP	8.1	6.4-8.1 g/dl

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO_2		18-33 mmol/l

EMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
(b)(6)-2 [redacted]	13 Jan 03	

EMT

[redacted] (b)(6)-2

[redacted] (b)(6)-4 | 6-12-03 | 1810 | [redacted] (b)(6)-4

(Hematology) CBC		
TEST	RESULT	REF. RANGE
WBC	8.7	4.8-10.8 x 10^3
RBC	6.25	4.7-6.1 x 10^9
Hgb	16.4	14-18 g/dl (M) 12-16 g/dl (F)
Hct	54.3	42-52% (M) 37-47% (F)
MCV	86.9	80-94 fl (M) 81-99 fl (F)
Plt	283	130-500 x 10^3 verified
Lymph %	23.2	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

CSF		
Cell Count		
Directigen		Negative

Misc. Serology		
TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

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

Microscopic Urinalysis

Blood Bank	
MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED	
ABO/Rh	

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

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

REMARKS:

REPORTED BY: (b)(6)-2 [redacted] | DATE: 13 Jun 03 | LAB ID NO.:

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "I" = CONSTANT INFUSION	DRUG	(Units)	
	Fentanyl	(mg)	250
	lidocaine	(mg)	100
	propofol	(mg)	130
	Sch	(mg)	100
	LABETOLOL	(g)	5/5/5
		( )	
VOLAT AGENT	ISO	% del	0.6
		% e.t.	
	AIR	L/Min	
	N2O	L/Min	
	O2	L/Min	6/2 2

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

TOTALS	TOTAL FLUID
250	mi
	TOTAL URINE
	Ø

FLUIDS – SUMMARY
CRYSTALLOID– LR 500
COLLOID– Ø
BLOOD– Ø

FLUIDS		
LINE site	☐ Warmed	(b)(6)-2
LR	☐ Warmed	[redacted] 300
	☐ Warmed	
	☐ Warmed	

LOSSES	
	EST BLOOD LOSS
	URINE –

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 90 KG LB

HEMATOCRIT: 54

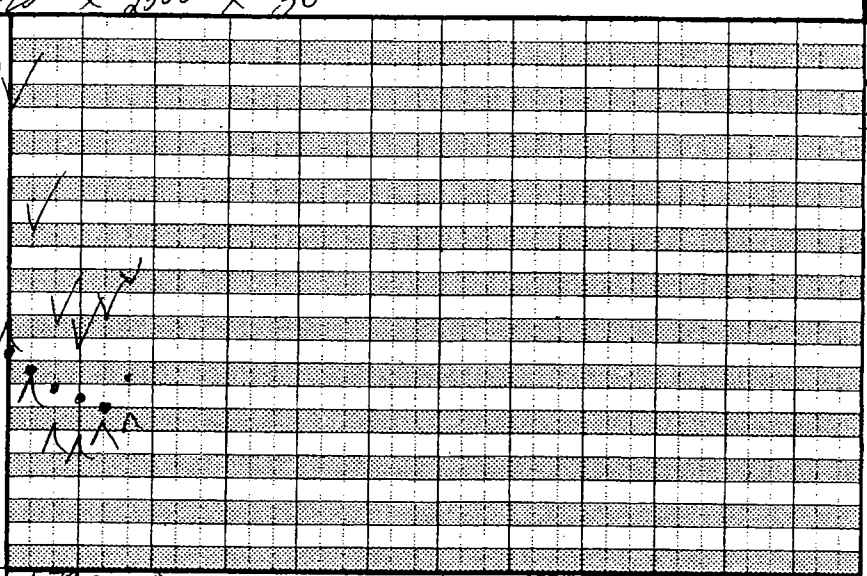
INITIAL DATA: BP 165/90 HR– 92

EQUIP CHECK: OK?– Y N

PATIENT RECHECK: OK for PROCEDURE? Y TIME– 2220

TIME → 2230 X 2300 X 30

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



VENTIL			
	VT – ml	SV-720	660
	f – breaths/min	10	8
	Peak inf pres / PEEP	21	22
	MODE– S(pon), A(ssist), C(on)	S/C	C

MONITORS & ACCESSORIES			
Y	BP/Auto Cuff	ET CO2 (torr)	34 31
	BP / oth	FIO2 (Frac or %)	.8 .8
Y	ART line	SpO2 (%)	99 99
Y	Steth- PC/ES	ECG	SR SR
	Gas analyzer	TEMP- site	Availability
Y		N-M Block (T/4)	
	Warming blkt		
	Conv warmer		

REMARKS– Code drugs with numbers, events with letters

Pt ID'd. Chart Reviewed. To OR, monitors on – induction & intubation 5 complication or difficulty

22YO WF [redacted] Pt VSS. (b)(6)-2 OG suction drain in SV extubated To ICU #1 for recovery comfortable cooperative

PR: 2L NC SpO2 94%

RECOVERY AT 2305

PACU ICU #1 (Specify)

OTHER

CONDITION:

RESP– 16 SpO2– 90% RA

BP– 159/81 HR– 88

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	2215	2226	2315
	Ready	Begin	End
PROC	2237	2247	2300

Mark with letters & symbols, explain under REMARKS — EVENTS

Position → Supine

PROCEDURES and CPT Codes

I & D (L) ARM

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

GETA – Cyclo Taped ETT @ 23 cm @ teeth

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

Pre-O2 · AT DLX/C Miller 3 Blade – Gr I view – 7.0 ETT in – (+) ETCO2 – equal BS

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

Recover in ICU #1

[redacted]

(b)(6)-4

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

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

PROCEDURE LOCATION /

DATE 13 JUNE 03

PAGE / OF /

(b)(6)-2 [redacted]

(b)(6)-4

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

Age [redacted] DAYS MOS (YRS) Sex (X) MALE ( ) FEMALE

ASA Physical State 1 (2) 3 4 5 E
WT: 90 (KG) LB HT: ____ IN.
ALLERGIES: NKDA

PROPOSED PROCEDURE: I&D (L) Arm
SURGICAL SERVICE: Ortho
NPO SINCE: Food @ 1200

HABITS:
TOBACCO: (+) 1 ppd x 50 yrs
ETOH: ____
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Ion Ancef @ 1810
( ) TAnus Sec @ 1735
( ) ____
( ) ____
( ) NS @ 100cc/hr
( ) ____

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

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

13 Jun 03
8.7 > 16.4 / 54.3 < 283

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	Smoking
Bronchitis/URI	N	Y	
COPD	N	Y	
Other	N	Y	
Renal System:			
Acute/Chronic RF	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	
Hiatal Hernia	N	Y	
PUD/GERD	N	Y	
Endocrine System:			
Diabetes	N	Y	
Steriods	N	Y	
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	
Other	N	Y	
Gynecological :			
Pregnancy	N	Y	N/A
Other Significant Hx:			
	N	(Y)	GSW (L) prox humerus 13 Jun 03
	N	Y	
Familial HX	N	Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC
1980 (R) Shoulder SX - Comp

PHYSICAL EXAMINATION
BP 90 HR 92 R 16 T 100
Pain Scale 0-10 0
HEENT - Teeth Poor Dentition
Trachea midline
TMJ/Neck ____
Oropharnyx MPII
Nares ____
CHEST: (+) BBS
CARDIAC: RRR
EXTREMITIES: ____
IV Access: 18g (R) Arm
Ulnar Filling: ____
BACK: Lorney Driver x 14 yrs - c/o LBP
OTHER: ____

NPO Since food @ 1200

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ (X) General: Mask Intubation
Pt intoxicated c intoxication

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]dian seems to [redacted]stand and agrees. Questions answered. ← (b)(6)-2
Signed: [redacted] Date: 13 Jun 03 Time: 1920 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

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.

Patient Identification: (Ward) ____

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

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.
X-RAY C-Arm	[redacted] m	(b)(6)-4	EMT	
	FILM NO.			PREGNANT ☐ YES ☐ NO
	REQUESTED BY *(Print)*			TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR	(b)(6)-2 Dr [redacted]		DATE REQUESTED

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

GSW (L) Arm

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
[redacted] (b)(6)-4	LOCATION OF RADIOLOGIC FACILITY
[redacted] (b)(6)-4	SIGNATURE

MEDCOM - 10956 ULTATION REQUEST/REPORT

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
EPW (b)(6)-4 [redacted]	ICW2		16	13 JUL 03	1840 HOURS	
				TO ICW2	(b)(6)-2 [redacted]	
				GSW (L) arm		
				NPO		
				TO OR TODAY,		
				[illegible] of [illegible] NPO		
				N/G at 100 cc/hr		
PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	
EPW (b)(6)-4 [redacted]	ICW2		16		[redacted] (b)(6)-2	
PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER HOURS	
EPW (b)(6)-4 [redacted]	ICW2		16			
PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER HOURS	
EPW (b)(6)-4 [redacted]	ICW2		16			

DA FORM 4256

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

DATE OF ORDER: 13 JUL 03 TIME OF ORDER: 2310 HOURS

LIST TIME ORDER NOTED AND SIGN

1. TO ICW 2
2. S/P I+D L ANM
3. COMOTIAN ELIX
4. VS - RENTIV
5. UP AD LIB, EPW ASSISTED
6. IV LR at 100 cc/hr. HOP

13 JUL 03 2355 [redacted] (b)(6)-2

NURSING UNIT: ICW #2 ROOM NO. BED NO. [redacted] (b)(6)-4

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

DATE OF ORDER: LORIL NOW FILLING P.O. WHEN TIME OF ORDER: HOURS

7. RISBURGL DIET
8. TYLENOL 650 mg P.O. Q 4 HRS PRN
9. TYLENOL #3, 1-2 P.O Q 4-6 HRS PRN
10. MSO4 2-6 mg IVP Q 2 HRS PRN
11. ZANTAC 50 mg IVPB Q 8 HRS
12. LORAZOL 5 mg IVP Q 15 MINS
13. [redacted] DILAUDID 7100 [redacted]

(b)(6)-4

NURSING UNIT: ICW #2 ROOM NO. BED NO. [redacted]

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

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

NURSING UNIT: ICW #2 ROOM NO. BED NO. [redacted]

(b)(6)-2 [redacted]

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

DATE OF ORDER: 14 JUL 03 TIME OF ORDER: 0915 HOURS

1. DISCONTINUE TODAY
2. KEFLEX 250 mg Q 10 #40
3. D/C IV.

[redacted] 14 Jul 03

(b)(6)-4

NURSING UNIT: ICW #2 ROOM NO. BED NO. [redacted]

(b)(6)-2 [redacted]

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

All (b)(6)-2 except one at bottom

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. 6 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 13	14	15	16										
13 Jun	[redacted]	VS: ROUTINE	05	/	[redacted]												
			13	/													
			21	[redacted]													
			/														/
13 Jun	[redacted]	UP AD-LIB, EPW RESTRAINTS	05	/	[redacted]												
			13	/													
			21	[redacted]													
			/														/
13 Jun	[redacted]	REGULAR DIET	07	/	[redacted]												
			11	/	[redacted]												
			17	/													

ALLERGIES: ☐ YES ☐ NO ?

PRIMARY DIAGNOSIS: GSW (L) arm / S/P I&D (L) ARM (13 Jun)

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

All: (b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 6 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
13	[redacted]	admit to ICW 2	13	now	1900	[redacted]
13	[redacted]	NPO for surgery	13	noted		[redacted]
13	[redacted]	O/C to OR	13		2130	[redacted]
13 Jun	[redacted]	TO ICW #2	13 JUN	NOW	2335	[redacted]
13 Jun	[redacted]	S/P I&D (L) ARM	13 Jun	"	2335	[redacted]
13 Jun	[redacted]	CONDITION: FAIR	13 Jun		2335	[redacted]
14 Jun	[redacted]	D/C IV.	14 Jun			[redacted]
14 Jun	[redacted]	D/C today	Jun			[redacted]

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

USAPA V1.00

All (b)(6)-2 except one at bottom

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. 6 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 13	14	15	16	17	18	19	20	21
13	[redacted]	LR @ 100cc/hr	06	/								
			14	[redacted]			D/C'd			13 Jun 03		
			22								21 30hrs	
			1									
13	[redacted]	Ancef 1gm IVPB	08									
		q8°	16 1800	[redacted]			D/C'd			13 June 03		
			24								21 30hrs	
13 Jun 03	[redacted]	IV: LR @ 100cc; HEPLOCK WHEN	06	/	[redacted]							
		TOLERATING PO WELL	14	/								
			22	[redacted]								
13 Jun 03	[redacted]	ANCEF 1gm IVPB q8hrs	06	/	[redacted]							
			14	/								
			22	/								

ALLERGIES: ☐ YES ☐ NO
?

PRIMARY DIAGNOSIS: GSW (1) arm / S/P I&D (2) ARM (13 Jun)

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

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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**
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -	All (b)(6) -2				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED													
13 Jun	[redacted]	TYLENOL 650mg p.o. q4hrs PRN														
- - - - -	- - - - -															
13 Jun	[redacted]	TYLENOL #3; 1-2 tabs p.o.	14 Jun 0730 AM													
- - - - -	- - - - -	q 4-8 hrs PRN														
- - - - -	- - - - -															
13 Jun	[redacted]	MSO4 2-6mg IVP q 2hrs PRN														
- - - - -	- - - - -															
13 Jun	[redacted]	LABETOLOL, 5mg IVP q 15mins														
- - - - -	- - - - -	PRN, DIASTOLIC > 100														
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															

USAPA V1.00

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 13 JAN 03 Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block

Time In:

Allergies: Ø OR Intake: Crystalloid Colloid

Pre-op V/S: OR Output: UOP EBL

Procedures: I+D(L)ARM Meds/Times:

Smoker Ankeed

Fentanyl 250 LaBetaLol

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

Pre Op Meds History

Time	2305	2315	2325	2335
SaO2	90	93	96	
FiO2	35			
Methods				
240				
220				
200				
180				
160		157	155	
140				
120				
100				
80				
60				
40				
20				
RR				
T				

165 90 92 BP HR

Time	
Pain (0-10)	
LOS	

Patient teaching done; Wound Care, Pain Management, T, C, & DB,. Incentive Spirometer, Comfort Measures

Safety: SR up X 2, Falls Precautions. Privacy Maintained

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	2	
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2	
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2	2	
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	11	12	

Codes

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

V/S
X = A-line BP
˙ = Cuff BP
= Pulse

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

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

PREPARED BY (Signature) [redacted] DEPARTMENT/SERVICE/CLINIC Nursing Icu DATE 13 JAN

PATIENT'S [redacted] (For typed or written entries give first, middle; grade; date; hospital or medical facility) Name – last, [redacted] – (b)(6)-2

[redacted] – (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

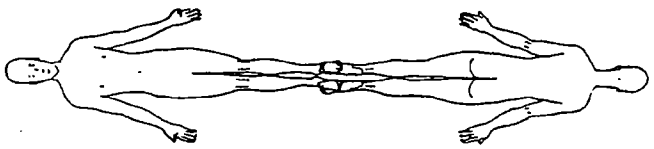
MEDICATIONS						
Allergies:						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

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

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

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

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



PACU OUTPUT			
Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?

NURSING NOTES

2305 - pt Brought to ICU on A Litter
C Anesthesia @ BS. O2 Sat @
94% on 2L N/C. Past Hx: Smoker
& wet C/Cough. Awake, oriented.
[redacted] MAJ/A
(b)(6)-2

Discharge Criteria:
Date: **Time:** **PARS:**
BP: **T:** **HR:** **RR:** **Sa02:**
Pain Level at D/C (0-10):
Intake:_____ **Output:**_____
Additional Data:_____
Transferred To: ICW 2
Report Given To:_____
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By:_____
Cleared IAW Recovery Room SOP: [redacted]
Charge Nurse Signature:
(b)(6)-2

WAMC OP 173-E

ADMISSION AND CODING INFORMATION

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

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

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
U N K	[redacted] 4 (b)(6)-4	X	9	MUSLIM

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
—	—	9 9	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—	U	1840	—

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
—	—	1	YEAR ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø	ICW2	—

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

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
Ø 5		0 3 0 6 1 4

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
A E A A		0 3 0 6 1 3

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

FOR LOCAL USE

Dx: ① GSW (L) ARM
② S/P I&D (L) ARM

DX. 94120 PROC I Trauma
94323 E9229 8628 1 450
(b)(6)-2 [redacted]

ADMITTING OFFICER (Signature, as required)

(b)(6)-2 [redacted]

DR [redacted]

DA FORM 2085, MAR 80 (b)(6)-2

.TIENT TREATMENT RECORD COVER .ET

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

(b)(6)-4

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
[redacted]	EPW # [redacted] (b)(6)-4	—	

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

11. EMP	12. SSN	13. ORGANIZATION	14. WARD
99	[redacted]	(b)(6)-4	ICU2

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
—	—	K78	—	UNK	NBI

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
DIRECT FROM ER	1800	AEAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
UNK	EPW CAMP	20030614

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
UNK	UNK	20030613	

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

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW (L) ARM

884.0
E991.2

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	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
			(b)(6)-2		

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF WARD OR MEDICAL RECORDS
(b)(6)-2 [redacted]	[redacted]

ADMISSION AND CODING INFORMATION

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

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

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

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER (b)(6)-4
—	—	99	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—	Z	1800	—

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
O	ICU2	UNK

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

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYYYMMDD)
EPW CAMP		20030614

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
AEAA		20030613

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

FOR LOCAL USE

DX: GSW (L) ARM

8840 I Trauma
E9912 450 1

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

ADMITTING [redacted] (Signature) SIGNATURE OF ADMITTING [redacted]

(b)(6)-4

INPATIENT TREATMENT RECORD COVER

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

(b)(6)-4

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

4. SEX	5. AGE	6. RACE	7. RELIGION	9. ETS	10. PREVIOUS ADMISSION
M	[redacted]	X	MUSLIM	—	NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99	[redacted]	(b)(6)-4	TCW2

15. FLYING STATUS	16. RATING/DSG	17. DEPT./BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
—	—	K78	—	—	WIA

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
DIRECT FROM ER.	1120	ABAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
—	D/C TO EPW CAMP	19 JUN 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
—	—	14 JUN 03	

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED
[redacted] (b)(2)-2		

31. SELECTED ADMINISTRATIVE [illegible]

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: (1) S/P exlap gsw (R) flank
(2) gsw (R) Forearm

879.4
881.00
E991.2

54.11 6/14/03

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	6	6

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER: DR. [redacted]

SIGNATURE [redacted]

DA FORM 3647, MAY 79 (b)(6)-2 [redacted] (b)(6)-2 (b)(6)-2 C V1.10

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

(b)(6)-4

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

[redacted] yo male was riding a motorcycle when he fell off bike to right posterior flank & (R) forearm - fell against curb. Brought to CCS ER - stable - unrelated abdominal complaints for ? intra-abdominal injury -> negative exam.

Pressure cast pm @ 0030 14 June 03 - uncomplicated

Pulse	Resp	Wgt	
C	Ex cap	Avg	(+) glucose - clear yellow urine
		Avg	Negative

PHYSICAL EXAMINATION

Alert male, ~~NAD~~ c/o left chest pain, right forearm pain, abdominal pain pelvic,

Chest clear BP 130/88 P 102 T 99.3

on RA 5 (w)

Abd soft ~~ND~~ ss, dressing - white

Ext (R) forearm - normal aspect, fascia intact, (R) posterior thigh contusion - small ecchymosis, ~~cyanosis~~ ~~cyanosis~~ ~~cyanosis~~

✓ROM Rom flexion & extension c/o ✓ sensation throughout limbs - warm, pink, dry

PROGRESS (Enter date of discharge and final diagnosis)

[redacted] (b)(6)-2

MVC post-op neg ER-UP STD CSW to (R) post flank - pass AS, CIVE CSW to (R) forearm c/o paresthesia

- admit to ICW
- ortho forearm films - K/O fx
- ~~[illegible]~~ routine post op care.

[redacted] (b)(6)-2

[redacted]	DATE	IDENTIFICATION NO.	ORGANIZATION
AO	14 June 03		

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

REGISTER NO.	WARD NO.

[redacted]

(b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.506
OCTOBER 1975

539-106

(b)(6)-4 [redacted]

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
14 June '03	BRIEF OP NOTE: Exploratory Laparotomy - Negative - No intrabdominal penetration.
	PROCEDURE: Exploratory Lap.
	PRE-OP DIAGNOSIS: GSW (R) Flank - Tender (R) LQ.
	POST-OP DIAGNOSIS: Same c̄ No Intrabdominal Injuries
	SURGEON: [redacted] (b)(6)-2 ASSISTANT:
	EBL: <100 cc
	FLUIDS: 2100 cc NS
	UOP: 400 cc
	TT:
	POST-OP PLAN: Recovery + Routine Post Op.
Post Op Orders	[redacted] (b)(6)-2
	NPO ̄ sips of H_2O + Ice Chips MO
	IV NS TRA 125 c/hr. MAJOR. [redacted]
	D/c Foley in AM
	Ancef 1 gram IVPB q 8° x 2 doses.
	Morphine 4-8 mg IV q 1-2° PRN pain. (b)(6)-2
	Up in Chair in AM

NSHIP TO SPONSOR	SPONSOR'S NAME		SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	
SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORD MAINTAINED AT	

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] EPW		

#:
V#:
1E:

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 REPRO

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
14 June 03 1150	Pt. admitted to ICW #2 via litter. A+O x 3, (+) Pulse x 4. No bowel sounds heard x 4 quadrants. Pain over mid abd and (R) flank c DI. IV LR @ 125cc/hr infusing in (R) AC 5 difficulty. Foley to gravity. Will continue to monitor [redacted] (b)(6)-2 9/WMC
1900	Assumed care of Pt @ 1300. VSS. A+O x 3. Pain controlled with MSO4. Foley to Gravity CLU, (+) BS x 4 hypoactive tol liquid diet. ABD dsng Dry Bloody drainage. Palpable pulses x 4. (+) productive cough. O/W assess. WNL. Will monitor (b)(6)-2 [redacted]
2000	Pt ambulated x 10 m.w., D/C foley cath. DTV in 6° Will Monitor (b)(6)-2 [redacted]
2130:	pt. care assumed @ 2100. Pt. easily awakened. PERRLA. Pt. c/o ABD pain. 5mg MSO4 given IV T good resp Hs. HR Reg, Lungs CTA. BS (+) & active x4. ABD drsng has old marked drainage. Pulses 2+ x4 T brisk cap. refill. Will cont. tomorrow (b)(6)-2 [redacted]
0400	Input: 750cc; LR & Ancef. Output: 900 cc urine

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/199
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1
USAPA V1.0

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
15 Jun 03	0900 - Pt alert & able to get out of bed with little assistance. Voiding adequately in urinal s̄ difficulty. Dsg to abd intact c̄ old drainage on it. IV to (R) arm infusing LR. Lungs CTA, BS (+), HR regular - Will cont. to monitor. [redacted] (b)(6)-2
15 JUNE 03	General Surgery
0930	POD #1 s/p Ex-Lap for GSW to flank (-) injuries
	here for recovery. No problems overnight. (R) arm [illegible]
	VS: Tm 99.? BP 80/[illegible] HR 90 96% RA [illegible] NR
CABS [redacted] (b)(6)-2	[illegible] - [illegible] c̄ min [illegible] [illegible]
	Chest CTA - [illegible] [illegible] [illegible]
	[illegible] [illegible]
	COR RRR
	ABD soft, non distended [illegible], [illegible] [illegible]
	[illegible]
	EXT (R) [illegible] [illegible] [illegible]
	IMP/PLAN Doing well POD #1
	- [illegible] [illegible] (b)(6)-2
	- [illegible] [illegible] -> advance [illegible]. [redacted] MD

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

AUTHORIZED FOR LOCAL REPRODUCT

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
15 June 03 1300	Pt intake taken BP. 122/80, P. 90, R. 20, Temp. 98.0 [redacted] (b)(6)-2
15 Jun 03 1900	assumed care @ 1300 - VSS - pt. ambulated x10 minutes - using IS q1° & CBDB c̄ pad as a support - pt. pulled out IV and is not cooperating enough to let us restart it - I/O discontinued - pt. ate fruit, milk and small amount of pudding for dinner - used BRS assistance - no c/o pain @ this time [redacted] (b)(6)-2 CRA
15 Jun 03 21:25	Pt. awake and alert in bed. PERRLA WNL. Skin w+D. ~~TCA~~ error (b)(6)-2 ~~(b)~~ (b)(6)-2 lung sounds crackles and +@ error (b)(6)-2 bases (B) BS(+) x4. Mid line ABD incision well approx. staples intact. ⊖ Sxs infection Pt c/o pain @ ML incision ii Tylenol given. (+) PPP(B). Will cont. to mon. (b)(6)-2 [redacted] DZT/AN (b)(6)-2
0417	Pt c/o pain ML ABD. ii Tylenol #3 given [redacted]
16 Jun 03	1150 - Pt alert OOB, ambulating x1. Staples intact to abd. ⊘ S/S of infection. VSS, HR reg, lungs CTA, BS(+). Will cont. to mon. (b)(6)-2 [redacted] JLAN

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. ICW2

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

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
16 June 03	General Surgery
0900	Pt #2 [illegible] - [illegible] to (2) flank, (R) foreearm.
	Negative exploration.
	Wound fairly clean. Bl. [illegible] clear.
	c/o back pain, incisional pain.
	Tmax 99° 120/82 - 100 - 18 - 95% RA
	Lots of [illegible]
	Chest clear bil. -
	Abd soft.
	Pt soft. [illegible] c minimal infra-umbilical tenderness
	(+) BS. Drain inst drainage c [illegible]
	[illegible] of [illegible].
	(R) forearm - [illegible] dressing, [illegible] [illegible] (R) [illegible]
	[illegible] [illegible]. [redacted] (b)(6)-2
[illegible]	Wing [illegible]
	Yellow drainage from [illegible]
	- [illegible] [illegible]
16 June 03	Pt. vitals taken BP 120/82, P. 90, R-20 Temp 98.6
1300	[redacted] (b)(6)-2

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

AUTHORIZED FOR LOCAL REPRODUCTI

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

General Surgery

17 JUNE 03 1030 POD # [redacted] s/p ex lap - wed - gsw (R) flank
(b)(6)-2
gsw (R) forearm

Pt's wife, family in attendance / [illegible] pain
Tolerating fluids [illegible] food - [illegible] [redacted] (b)(6)-2

T 99.5 HR 90s BP 122/80 [illegible]

Lungs wet

chest clear BL

abd [illegible]

[illegible] highly distended (+) BS

[illegible] & [illegible] of drainage.

EXT: better movement (R) hand.

Impression: Stable area

- bowel function returning (b)(6)-2

- [illegible] [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. CCW2

[redacted] (b)(6)-4

EPW

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
6-16-03	2215: Pt care assumed @ 2100. VSS HR Reg. lungs ⊂ insp. wheezes to ⅓ lobes, otherwise CTA. BS ⊕ x4. ABD soft. Midline ABD incision ⊂ staples OTA. ∅ S/S infection. Will cont. to monitor. (b)(6)-2 [redacted]
17 Jun 03	0906 - Pt alert OOB x1. VSS HR reg. lungs CTA BS⊕. Staples to abd intact ⊖ S/S of infx. Had AM care. Voicing ∅ complaints at this time. Will cont to monitor - (b)(6)-2 [redacted] 2Lt AN
17 Jun 03 1900	assumed care @ 1300 - VSS - staples intact, no drainage - pt. using IS q1°, C&D & encouraged q1°, ambulated this shift - ⊕ BS - tolerated regular diet - no c/o pain at this time (b)(6)-2 [redacted] CPT AT
2125	Pt. care assumed @ 2100. HR Reg. lungs CTA. ABD soft ⊂ hypoactive BS x4. incision to midline ⊖ staples OTA. ∅ S/S infection @ incision site. Will cont. to monitor. (b)(6)-2 [redacted] TSgt AN
2130	Pt. using IS. Tylenol #3 ⅟₁₁ given for pain & temp of 99.8. Pt. c/o pain to ⓡ hand. ⓡ hand has pulse 2+ ⊂ Brisk cap refill. Pt unable to completely make a fist ⊂ ⓡ hand. Will cont. to monitor - [redacted] CPT AN (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

MEDICAL RECORD	PROGRESS NOTES
DATE	
18 June 03	1030 - Pt alert OOB x 2 this shift. Incision intact to abd ∃ S/S of infx. Voiding adequately lungs clear, HR reg, BS(+)x4. Required ∅ pain medication. Sleeping comfortably in bed. Ate 75% of breakfast. Will cont. to monitor [redacted] 2Lt AN
0635 T98.9	
P81	
R20	
BP 130/89	(b)(6)-2
94%	
18 June 03	General surgery PO [redacted] (b)(6)-2
1130	s/p [illegible] 2° [illegible] to [illegible], (R) [illegible]
	Bring well, ambulating, diet, [illegible]
	Looks well VSS HR 80 BP 130/80, 99% RA
	Cont CPA B/L
	Con SRR ∃ ⊖
	NSD soft, (+)BS, tender incision
	staples ∃ ⊖ erythema
	MD from: Bring well
	transfer to row bldg in AM 19 June 03
	[redacted] (b)(6)-2

(Continue on reverse side)

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

[redacted] (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	
18JUN03 1545	Assumed care of Pt @ 1300. VSS A+O x3. Mid Abd incision c̄ staples OTA CDI. c/o pain. Ambulate, c̄ assistance. [redacted] (b)(6)-2 Assessment WNL. Will continue [redacted]
18Jun03 2215	Assumed pt care @ 2100. VSS, alert and awake, ~~oz~~ T3 given for c/o pain @ head and stomach. Lungs CTA, pulses palpable x4, bowel sounds present x4 quads. Midline Abd incision c̄ staples OTA CDI, dsg on @ 1 and CDI. Will continue to monitor. SPC [redacted] (b)(6)-2 9WMY
19June03 0600	Assume pt care @ 0500. pt asleep, easy to awake for assessment. VSS. HR Reg. Lungs CTA throughout. Midline incision staples intact. No drainage noted. BS x4 active. pt c/o pain tenderness to all 4 quadrants on palpation. Plan to transport to Camp today. [redacted] (b)(6)-2 9WM6
19June03 1345	assumed pt care @ 1300. pt resting quietly easily aroused to verbal stimuli. VSS. assessment finds WNL. and incision c̄ staples OTA & signs of infection noted. pt has discharge orders, awaiting transportation to EPW Camp. pt denies pain or discomfort @ this time. Will cont to monitor [redacted] (b)(6)-2 9WM6
2300	Pt care assumed @ 2100. VSS, a&x3, c/o pain infront of head. Lung sounds CTA, pulses palpable x4, bowel sounds present x4 quads. Abd incision c̄ staples Ota, CDI @ S/S infection. Pt is awaiting transportation for discharge, will continue to monitor. SPC [redacted] (b)(6)-2 9WM6

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
19 June 03	Discharge Summary (b)(6)-4 [redacted] [illegible] [illegible] [illegible] [illegible] given to @/Unit & @/Bn Cmdr. Sent to [illegible]. [illegible] PEO - negative for abnormal findings on 14 June 03 - given to CSM for recovery. Pain well. Tol diet & ambulates. Uneventful postop course - Plan - Remove staples on 21 June 03 - Tylenol #3 1-2 tabs po q 6° prn pain [redacted] (b)(6)-2 [illegible] [illegible] ~~19 June 03 Pt vitals taken BP 120/72, P 70, R 16, Temp 97.5°, SpO2 [redacted]~~ [redacted] (b)(6)-2 (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.

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

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	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13JUNE03	S: (b)(6)-4 [redacted] YO ♂ DRIVER OF MOTORCYCLE
2355	PENETRATING TRAUMA IN (R) HI SACROILL ILIUM, NO EXIT
	WOUND, PENETRATING TRAUMA TO (R) FOREARM
ALLERGIES	I.V. 2 LG BORE, NORMAL SALINE, 1000 ML X 3 BAGS
NKDA	PT CANNOT FEEL (R) HAND
0030	A LUNGS. SOUND CLEAR
BP 138/[illegible]	ANCEF INJ 1 GRAM 0039
P 99	2 MG VERCED 0040
R 24	X RAYS TAKEN BY SGT (b)(6)-2 [redacted] 0040
O2 98	
0835	(No xray followed patient to (b)(2)-2 [redacted])
BP 140/90	
P 102	
R. 2	
O2 97	
LAST MEAL	
1700	
0040	
BP 120/43	
P 112	
R 26	
O2 97	

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

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

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
14JUN 03	(b)(6)-4 [redacted] yo EPW who had two penetrating trauma
EMT note:	one to (R) SI posteriorly one (R) forearm
	No intra-abdominal injury s/p Lap.
	No results forearm xray here @ [redacted] (b)(2)-2
	Pt stable s/p lap. for abdominal penetrating injury
	sent here for post op recovery. Surgery notified.
	VS: stable afebrile
	BP 130/68
	P 102
	T 99.3
	HEENT moist dry. Output, good yellow.
	lungs - clear fields
	heart rr nt rr (R)
	Abd bowel
	Back: wounds intact clean
	forearm wounds cleaned
	xray (R) forearm pending
	Pt. EPW motorcycle accident i 2 GSW (R) leg.
	xray forearm pending
	to ICW for post op care
	P. surgery notified ICW2.
	(b)(6)-2
	[redacted] MC MC

STANDARD FORM 600 (REV. 6-97) BACK
USAPA V2.00

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6/14/03 0200	Pt is a middle age Iraqi male c/o single GSW to just superior to (R) clavicle. Pt s/p exploratory lap which was negative at that time. 198 BP 125/60 RR22 P74 SAO2 on mask 100%. At arrival lungs are clear & bowel sounds are diminished. All distals are present palpable. Pt placed in soft wrist restraints for pt/staff safety & security due. — Lt (b)(6)-2
0210	Abd soft c̄ ↓ sounds. Mid line abd dressing is dry & intact. Plan is to remove from anesthesia & monitor abd & dressing / surgical site. RR24 Sat 100% P90 BP139/67 — Rt (b)(6)-2
0230	BP 143/63 RR24 P92 SAO2 100% on mask. Alert & Orientated. Pupils 2mm & sluggish. — Rt
0300	Abd dressing dry & intact. Pt also has what appears as a through & through GSW to ↓ (R) arm (+) PMS to arm, cap refill 2-3 sec. no active bleeding — Rt (b)(6)-2
0500	BP 135/72 P100 RR20 SAO2 100%. Pt has had 1000cc urine output since ICU admission — Rt
0515	RR28 P108 MS 2.5mg SIVP for pain. — Rt
0600	BP 130/76 RR20 P100, mask removal SAT 96% RA. Rt

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAI
(b)(2)-2			(b)(6)-2
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.

EPW

(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	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
14 June '03	Pt awake - alert stable this AM
0640	Abd - soft, dressing dry.
	Stable - f/u [redacted] (b)(6)-2 Transport to [redacted] (b)(2)-2
	when transportation available.
	[redacted] (b)(6)-2
0645	Cpt [redacted] (b)(6)-2 contacted → transportation pending Pt [redacted]
	BP 143/76 RR 18 P 86 SAT 98% RA - pt enroute [redacted]
0845	[redacted] (b)(2)-2 -, no Δ — Pt [redacted]
	(b)(6)-2

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY: 14, 15, 16, 17, 18, 19, 20

19 HOUR

PULSE (0) / TEMP. F (°): 105°, 104°, 103°, 102°, 101°, 100°, 99°, 98.6°, 98°, 97°, 96°, 95°

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

(Centigrade Equivalents, for Reference only)

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

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICW2

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

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD - ANESTHESIA

f this form, see AR 40-66; the proponant agency is the OT

0030

DRUG	U/ml	45	0	15	30	45	0200
Robinul	(mg)	0.4					
Anapsine	(mg)	1					
Versed	(mg)	2.5					
anectine	(mg)	100					
NA pnt	(mg)	250					
MS	(mg)	10				23	
VOLAT AGENT: Sevo	% del	2.5	--	--	--	1.5	
	% e.t.						
AIR	L/Min						
N2O	L/Min						
O2	L/Min	3	--	--	--	--	

SPECIFY UNITS - MG/MCG/ML, "T"=CONSTANT INFUSION

NGLE DOSE DRUGS-MARK ON GRID ITH NUMBERS & ENTER IN REMARKS →

IV site							
Norcuron	☐ Warmed						
	☐ Warmed	1	9				
	☐ Warmed	NS	900				
	☐ Warmed	NS	1000	NS	100		

SES							
	EST BLOOD LOSS						
	URINE -						

TOTALS	TOTAL BLD
	Min
	TOTAL URINE
	400

FLUIDS - SUMMARY

CRYSTALLOID- 2100

COLLOID-

BLOOD-

REMARKS

Code drugs with numbers, events with letters

2 Gms of Ancef
1 Gm Rocephin

18 Fr Salem Sump inserted @ 0115 out @ 0138

reversal
Neo 3mg
Glyco 6mg
@ 0135

TY STATUS: 1 2 3 4 5 E

DY WEIGHT: 75 KG LB

MATOCRIT:

TIAL DATA:

L

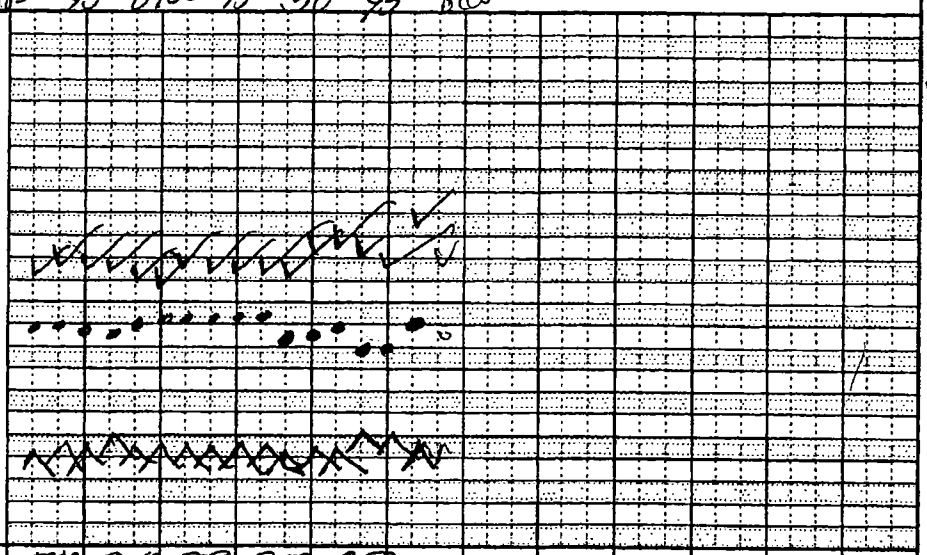
UIP CHECK: Y N

ENT RECHECK

DURE?

TIME → 0030 45 0100 15 30 45 0200

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



VT - ml		700	850	850	850	850	
f - breaths/min		8					16
Peak inf pres / PEEP		21	19	19	19	20	[redacted] (b)(6)-2
MODE - S(pon), A(assist), C(on)							
NIP/Auto Cuff	ET CO2 (torr)	42	48	44	45	43	
NIP/Jeth	FIO2 (Frac or %)		43	44	48	43	
ART line	SpO2 (%)	100	100	99	99	100	[redacted]
Stath- PC/ES	ECG	SR	SR	SR	SR	SR	
Gas analyzer	TEMP-site						
	N-M Block (T/4)						
Warming blkt							
Conv warmer							

letters & symbols, ter REMARKS

EVENTS Position → SUP NP

URE and CPT Codes: Exploratory Laparotomy

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

[redacted]

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

AE:

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

Gen c #7 ET tube

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

DL + ET BS Dilat = @ECG Atraumatic

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

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

PROCEDURE LOCATION: ORH1

DATE: (4) JUN 0

PAGE 1 OF 1

DISCHARGED AT

PACU ICU (Specify)

OTHER

CONDITION: Good

RESP. 16 SpO2 100 O2 via Mask

BP 120/60 HR 74

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0035	0045	0200
	Ready	Begin	End
PROC	0105	0110	0145

DRM 7389, FEB 1998 COPY 1 - PATIENT'S MEDICAL RECORD USAPA V1.00

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

NURSING UNIT: ICW2 | ROOM NO. | BED NO. [redacted]

DATE OF ORDER: 14 JUNE 03 | TIME OF ORDER: 1120 | HOURS | LIST TIME ORDER NOTED AND SIGN

1. ADMIT TO ICW 2 - Surgery
2. D/C ET-CAP D/C GOW to (R) flank / GOW to (R) forearm
3. DRESSING
4. NKDA
5. VITALS per ward protocol
6. Activity: OOB AMBULATE BID

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

NURSING UNIT: ICW2 | ROOM NO. | BED NO. [redacted] (b)(6)-4

DATE OF ORDER | TIME OF ORDER | HOURS

7. DIET: CLEARS - advance as tol.
8. IVFs LR @ 125 cc/hr
9. Nursing: IS q 1° wk
   D&O
   D/C FOLEY when
   AMBULATING
10. Please page I gm IV q 8° x 2 doses

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

NURSING UNIT: ICW2 | ROOM NO. | BED NO. [redacted] (b)(6)-4

DATE OF ORDER | TIME OF ORDER | HOURS

TORADOL 15 mg IV q 8° PRN
MSO4 1-5 mg IV q 1° PRN
PHENERGAN 25 mg IV q 6° PRN N/V
(b)(6)-2
11. CHEST 2 of [redacted] MD
MAT ME

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

NURSING UNIT: ICW2 | ROOM NO. | BED NO. [redacted] (b)(6)-4

DATE OF ORDER: 15 JUNE 03 | TIME OF ORDER: 0830 | HOURS

1. INCENTIVE SPIROMETRY q 1°
2. AMBULATE TID AM & PM
3. PLEASE GET A CHEST PTO FOR PT. ASTHMATIC - to COUGH AGAINST. - encourage pulmonary toilet
(b)(6)-2

15 June 03 1000

NURSING UNIT: ICW2 | ROOM NO. | BED NO. [redacted] (b)(6)-2 MD

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: [redacted]

(b)(6)-4

NURSING UNIT: ICW2 | ROOM NO.: | BED NO.: [redacted]

DATE OF ORDER: 15 Jun 03 | TIME OF ORDER: 1600 HOURS | LIST TIME ORDER NOTED AND SIGN

D/C IV's

per Dr. [redacted] (b)(6)-2

16 Mar 03 0200

PATIENT IDENTIFICATION: [redacted]

(b)(6)-4

NURSING UNIT: ICW2 | ROOM NO.: | BED NO.: [redacted]

DATE OF ORDER: 15 Jun 03 | TIME OF ORDER: 21:30 HOURS

VO

Tylenol II PO x1 now for pain (b)(6)-2

Dr. [redacted]

0200

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

PATIENT IDENTIFICATION

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

DATE OF ORDER: 15 Jun | TIME OF ORDER: 21:34 HOURS

Tylenol #3 1-2 PO PRN for pain

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

(b)(6)-2

PATIENT IDENTIFICATION: [redacted]

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

DATE OF ORDER: 16 June 03 | TIME OF ORDER: 0900 HOURS

(b)(6)-2 [redacted]

16 Mar 03 0900

[redacted]

(b)(6)-2

240 VS [redacted] LTMAN 6/16/03 2030

NURSING UNIT | ROOM NO. | BED NO.

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

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

TIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AN SIGN
EPW (b)(6)-4				19 JUNE 03	0700 HOURS	
# [redacted]			(1)	D/C IV	✓	
			(2)	D/C TO ROW camp	✓	
			(3)	TUCKER #3 I-II DRS pg 49		Noted [redacted] 19 June 03 0950 (b)(6)-2
			(4)	staple remover - staples	✓	
				D/C on 21 JUNE 03		
RSING UNIT	ROOM NO.	BED NO.				
ICW2	24	9		19 Jun 03 2215 [redacted] (b)(6)-2	✓	

TIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
RSING UNIT	ROOM NO.	BED NO.				

TIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
RSING UNIT	ROOM NO.	BED NO.				

TIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
RSING UNIT	ROOM NO.	BED NO.				

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 2001-478-000

All (b)(6)-2 except one at bottom

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 JUN Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 14	15	16	17	18	19	20	21	22	23	24	25	26	27
14 JUN 03	[redacted]	Vital Signs per	05	[redacted]													
		Ward Protocol	13														
			21														
14 JUN 03	[redacted]	ACTIVITY: OOB	10	[redacted]													
		ambulate bid	22	[redacted]													
14 JUN 03	[redacted]	DIET: clear	07	[redacted]													
		advance as tol.	11	[redacted]													
			17	[redacted]													
14 JUN 03	[redacted]	IS q 1° w/A	05	[redacted]													
			13	[redacted]													
			21	[redacted]													
14 JUN 03	[redacted]	I & O's	05	[redacted]													
			13	[redacted]													
			21	[redacted]													
14 JUN 03	[redacted]	DC foley when	05	[redacted]													
		ambulating	13	[redacted]													
			21	[redacted]													
15 JUN 03	[redacted]	IS Q1°	05	[redacted]													
			13	[redacted]													
			21	[redacted]													
15 JUN 03	[redacted]	Ambulate thru AM	05	[redacted]													
		& TID	13	[redacted]													
			21	[redacted]													
15 JUN 03	[redacted]	Encourage pulmonary	05	[redacted]													
		toilet	13	[redacted]													
			21	[redacted]													

Ad See below

rewritten See below

DC'd 15 Jun 03

None

ALLERGIES: ☐ YES ☑ NO
NKDA

PRIMARY DIAGNOSIS: s/p Lap GSW ⓡ flank GSW ⓡ forearm

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

all: (b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo JUNE Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
14 Jun 03	[redacted]	Admit to ICW 2 Surgery	14 Jun 03	NOW	1145	[redacted]
	-----	DX: SPEF Jap GSW (R) flank				
	-----	GSW (R) forearm stable				
15 Jun 03	[redacted]	Get abd pad for abd to	15 Jun	done		[redacted]
	-----	cough against				
19	[redacted]	DC to EPW camp	19	when done		
19	[redacted]	Staple remover, staples D/C	21 Jun			

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
-----	-----															
-----	-----															
-----	-----															
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USAPA V1.00

all (b)(6)-2 except one at bottom

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. 06 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 14	15	16										
14 JUN 03	[redacted]	IVF 2R @ 125cc	05	[redacted]												
		per hour	13	[redacted]												
			21	[redacted]												
14 JUN 03	[redacted]	Ancef 1 Gm q8°	13	[redacted]												
		x 2 doses	21	[redacted]												

ALLERGIES: ☐ YES ☑ NO

NKDA

PRIMARY DIAGNOSIS: S/P Ex. Lap GSW (R) flank GSW (R) forearm

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

all: (b)(6)-2

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
15Jun	[redacted]	Tylenol #3 PO x1 now for pain	15Jun	21:30	21:30	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
14Jun	[redacted]	TORADOL 15mg IV														
		q8° prn														
14Jun	[redacted]	MSO4 1-5mg IV	1400 14Jun 4mg [redacted]	2100 14Jun 5mg IV [redacted]	6/15/0 0400 5mg IV [redacted]	[redacted]										
		q10° prn														
14Jun	[redacted]	Phenergan 25mg														
		IV q8° prn N/V														
15Jun	[redacted]	Tylenol #3 1-2tabs PO	16Jun 0410 2tab PO [redacted]	16Jun 1630 [redacted]	17Jun 2130 [redacted]	18Jun [redacted]										
15Jun	[redacted]	for pain PRN														

USAPA V1.00

ADMISSION / CODING INFORMATION

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

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

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

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

10. LENGTH OF SERVICE			ETS	11. FMP		12. SOCIAL SECURITY NUMBER								
32	33	34		35	36	37	38	39	40	41	42	43	44	45
—			—	9	9	[redacted]								

(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—	46: U	1120	—

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: Ø	ICW2	—

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

21. TYPE OF DISPOSITION		22. MTF TRANSFERRED TO						23. DATE OF DISPOSITION (Y Y M M D D)					
73	74	75	76	77	78	79	80	81	82	83	84	85	86
Ø	5							0	3	0	6	1	9

24. CLINIC SVC - ADMITTING				25. MTF TRANSFERRED FROM						26. DATE THIS ADMISSION (Y Y M M D D)					
87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102
A	B	A	A							0	3	0	6	1	4

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

FOR LOCAL USE

DX: (1) S/P exlap gsw (R) flank
(2) gsw (R) Forearm

D.X. ~~8794~~ 88100, E9912

Proc. 5411

Injury 9 T 569

ADMITTING OFFICER (Signature) [redacted]

DR. [redacted]

SIGNATURE OF [redacted]

all: (b)(6)-2

all (b)(6)-4

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER [redacted]	2. NAME (Last, First, MI) EPW [redacted]				3. GRADE N/A	ADMISSION REMARKS
4. SEX m	5. AGE [redacted]	6. RACE Z	7. RELIGION UNK ~~Unk~~	8. [redacted] NA ~~NA~~	9. ETS N/A	10. PREVIOUS ADMISSION No
11. FMP 99	12. SSN [redacted]		13. ORGANIZATION N/A			14. WARD ICW2
15. FLYING STATUS NA	16. DSG	17. DEPT/BEN K79	18. BRANCH/CORPS N/A	19. UIC/ZIP		20. TYPE CASE B1
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from ER				22. HOURS OF ADMISSION 1450	23. CLINIC SERVICE ABAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE —			25. TYPE DISPOSITION 50		26. DATE OF DISPOSITION 2 Jul 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) —			27b. TELEPHONE NO. —		28. DATE OF THIS ADMISSION 16 Jun 03	ADMITTING OFFICER (b)(6)-2 Dr [redacted]
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] (b)(2)-2					30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
31.						

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW thigh

Procedure:
Delayed Primary Closure buttock wound.

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	16	16

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
[redacted]	Ø	Ø	Ø	16	16

[redacted] Dr [redacted] SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

DA F[redacted]79 EDITION OF 1 AUG 76 IS OBSOLETE USAPPC V1.10

(b)(6)-2

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

(b)(6)-4 [redacted] 40 Iraqi SPW who sustained GSW to (R) ant thigh 2 days, s/p I&D 2 days ago @ FST. Here for further recovery

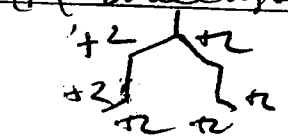
PMHx	PSHx	Meds	NKDA
Ø	wound exploration	Ø	

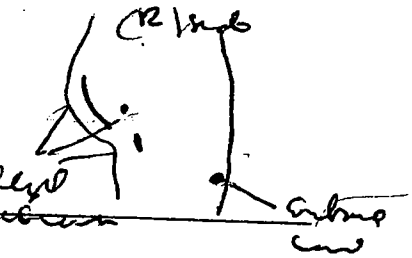
11.6 / 6.0 / 37.2 / 299

Serosight (–)
(L) hybrid (5)
hyperactive BS x 4
Respiratory pale
(+) small hydrocele

PHYSICAL EXAMINATION

WD/WN ♂ NAD
NC/AT
oropharynx clear
neck supple ∅ JVD – small lacerations superficial zone II
chest ∅ wounds
lungs clear / unremarkable
abd soft NTTP
ne pens – (R) testicle nl / (L) cord, c̄ fragment hole / testis ⊖ nl
Ext GSW to (R) thigh





PROGRESS (Enter date of discharge and final diagnosis)

Dx: ① GSW to (R) thigh c̄ Buttock Fracture
② fragment to (L) hemiscrotum.

→ to ward

[redacted] (b)(6)-2

SIGNATURE	DATE	IDENTIFICATION NO.	ORGANIZATION

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

REGISTER NO.	WARD NO.

[redacted] EPW
(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 [redacted]

AUTHORIZED FOR LOCAL REPRODUCTIC

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
16JUN03 1545	Pt admitted from EMT via stretcher. VSS, A+O x3. LR @ 75cc via (R) FA IV patent. Disc to (R) thigh, Buttock CDI. Ø c/o pain. D9520 prison TAG. (+) palpable pulses x4. (+) cap refill / sensation (R) LE. O/W assessment WNL. Will cont. to MONITOR (b)(6)-2 [redacted]
17Jun03 0100	Pt care assumed @ 2100. VSS, alert and awake, [redacted] (b)(6)-2 ii T3 given during dsg Δ for pain. Lung sounds CTA, pulses palpable x4, bowel sounds present x4 quads. IV @ RFA patent. Dsg Δ done, wound is red and moist, Ø drainage noted. Patient has (+) sensation, cap refill in RLE. No complaints at this time, will continue to monitor. SPC [redacted] (b)(6)-2 9llwmc
17Jun03 1110	Assumed care of pt @ 0500. Pt is asleep. VSS. Alert + awake. Pt ~~w~~ Lungs CTA. Bowel sounds x4 quads. Pt was [redacted] (b)(6)-2 given Tylenol #3 ii before dsg Δ. Pt dsg Δ done. Ø discharge. IV @ RA patent. LR @ 75 cc/hr. Pt didn't have any urine output on 3rd shift. Spoke with Dr. [redacted] (b)(6)-2 and he ordered a foley cath. Pt suddenly put out 800 cc's of urine. Pt did not recieve foley. Pt is now resting quietly. Ø c/o pain or discomfort. Will continue to monitor. — [redacted] 9/12mg (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

EPW

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

All: (b)(6)-2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17 June 03 1330	Pt vitals taken. BP 116/56, P. 60, R. 16 TEMP. 99.2 SPC [redacted]
17 June 03 1400	Assumed pt care @ 1300. pt resting quietly. VSS assessment WNL. Drsng to (R) hip & buttock CDI. NV (R) LE infusing 3 diff ⊕ S/Sx of infiltration noted. pt voices ⊖ complaints @ this time. Will cont to monitor [redacted] 91WM6
17 June 03 1530	Pt voided 700cc clear yellow urine. SPC [redacted]
2240:	Pt. care assumed @ 2100. Pt. premedicated for drsng Δ c̄ 4mg MSO4 IV & T#3 ⅓. W→D drsng done GSW (L) gluteal. Wound beefy red. HR reg, lungs CTA, BS ⊕ X4. Drsng to (R) scrip dry & intact. Pt c/o numbness in (R) index & middle fingers. Cap refill c̄ 3sec c̄ pulses 2+. Will cont. to monitor. [redacted] 1LT ANN
18 June 1120	Assumed care of pt @ 0500. Pt is awake and alert. Pt looks as if his in pain but doesn't want anything for it. Drsg Δ done @ 1030. Pt was medicated 30 min prior with T-3 and 10 min prior 4mg MSO4. Wound bleeds a little during drsg Δ. Pt went to sleep afterward [redacted], 91WM6, SGT
8 June 03 1315	Pt vitals taken BP 110/68, P. 76, R. 16, TEMP. 98.4 SPC [redacted]

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

MEDICAL RECORD	PROGRESS NOTES
DATE 18 JUN 03	Progress note Slip (R) high GSW ō buttock Exit wound Patient c/o difficulty navy Right underfoot. small wound to lat foot. Buttock wound progressing slowly w/ granulation tissue Plan: Ortho consult WM complete DPC in 3-5 days [redacted] (b)(6)-2

(Continue on reverse side)

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

EPW [redacted] (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

All: (b)(6)-2 except one on the very bottom

MEDICAL RECORD	PROGRESS NOTES
DATE	
18 June 03	Assumed pt care @ 1300. VSS pt awake &
1330	alert, voices Ø complaints @ this time. Assessment
	findings WNL. drsing to (R) buttock & hip CDI.
	IV infusing LR @ 75cc/hr ⅂ diff, Ø S/S of infiltration
	noted. pt on I&O's. Will cont to monitor [redacted] 9LWMC
19 Jun 03	Pt care assumed @ 2100. VSS, alert and awake, received 5mg
0030	MSO4 prior to W→D. Dsg Δ. Lungsounds CTA,
	pulses palpable x4, bowel sounds present x4 quads. Dsg
	Δ on RLE, wound is red and moist ⅂ minimal bloody
	drainage. IV infusing LR @ 75cc/hr, Ø S/S infiltration or
	infection. Ø complaints, will continue to monitor. Spc [redacted] 9LWMC
19 June 03	Assume pt care @ 0500. pt awake and alert. No
0520	c/o pain. LR @ 75cc/hr do (R) FA no s/s redness/infiltration.
B/P 100/56	VSS. HR regular. Lungs CTA throughout. Abd. flat, soft
P 70	BS x4 active. Dsg to (R) buttock draining serosanguinous.
R 16	Dsg to (L) UE CDI. Amb. ⅂ difficulty to BR. Plan
T 97.6	today dsg Δ's, pain control. Will continue to monitor.
	[redacted] 9LWMC
19 JUN 03	Progress note
	Progressing well ⅂ BID dressing Δ's
	Plan DPC post op day 5
	[redacted]

(Continue on reverse side)

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

REGISTER NO.

WARD NO. CW2

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

PROGRESS NOTES
Medical Record

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

all: (b)(6)-2

PROGRESS NOTES

DATE	
19 June 03 1200	Dsg Δ @ 1000. Area cleaned c̄ steril water. Area bleeding red during dsg Δ. Site free of S/S infection. Premedicated c̄ 6mg MSO4 by 2Lt Tinch IVP. and ii tylenol #3. New Dsg CD&I. [redacted] 91WMP
19 Jun 03 2045	Assumed care @ 1300 - VSS - dsg intact on buttock - IV d/c'd, site S S/S infection - ambulated to xray, schrapnel noted in (R) index finger, no tendon damage [redacted] CPT
20 Jun 03 0130	Pt care assumed @ 2100. VSS, alert and awake, 5mg MSO4 given prior to w→D dsg Δ. Lungs CTA, pulses palpable x4, BS present x4 quads. Dsg Δ done, wound is red and moist c̄ some bleeding noted, no s/s infection noted. (R) index finger wound is closed, no pain noted. will continue to monitor. SPC [redacted] 91WMP
20 Jun 03	0943 - Pt alert OOB x1. Lungs clear, BS+, HR reg. DSG to buttocks intact. Will cont to monitor [redacted] 2Lt [illegible]
20 Jun	Progress Note Post consult - Surgical wound on pt @ (R) brachial - PT removed Buttock wound - PPC 2x [redacted]

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

all: (b)(6)-2

PROGRESS NOTES

DATE	
21 Jun 03	1030- Pt alert & OOB x 2. AM care completed. WSS, HR reg, Lungs CTA, BS⊕. DSG Δ'd to buttocks wet → Dry. Dsg Δ'd to ® upper arm. HL to ® forearm. Voicing no complaints at this time. Will cont. to monitor. [redacted]
21 June 03 1440	Assumed pt care @ 1300. pt resting quietly. lung sounds CTA, abd soft BS⊕. ↓ & ↑ Ext full ROM ⊕ pulses. drains to RUE CDI. HL to RFA ⊕ S/S of infection noted. Drains to buttock area CDI. ⊕ C/O pain voiced @ this time. Will cont to monitor [redacted]
21 Jun 03 21:40	Assumed c/o Pt @ 21:00 Awake + alert in bed. VS WNL Skin W/D. PERRLA ⊕ WNL. 2CA®. BS⊕x4/⊕APP®. Dsgs Δ'd @ this time. Dsg to ® Buttock c̄ moderate amt. sang. drainage. New DSG CDI. DSG to ® ↑ ext. c̄ old blood to it and thick yellow drainage. New DSG C/D/I. Dsg to ® ↑ ext old dsg c̄ thick yellow drainage New C/D/I. Dsg to ® thigh old dsg c̄ thick yellow drainage. New dsg C/D/I. Pt. premedicated c̄ 5 mg MSO4 ā dsg Δs. Will cont. to mon [redacted]
22 June 03 0630	Pt sleeping in bed easily aroused by verbal stimuli. HL to ® FA flushes easily c̄ 3cc NS s̄ S/S infection or infiltration. 2x2 dressings on VE bilat, CDI. Dressing on buttocks CDI. All other assessment findings WNL. Pt. s̄ complaints @ this time. Pt - on call to OR. Will continue to monitor. [redacted]

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

All (b)(6)-2 except one at bottom

AUTHORIZED FOR LOCAL RE

:DICAL RECORD | PROGRESS NOTES

DATE	NOTES
22 Jun 03 ~~1345~~ 1445	pt. returned from OR @ 1400 - VSS - no c/o pain @ this time - dsg CDI on (R) buttock - pt. has limited movement in (B) legs due to Spinal anesthesia - IV patent, LR @ 75 cc/hr into (L) antecubital IV - (+) BS, lungs CTA (B) - pt. alert and following commands [redacted] CPJMN
22 Jun 03 1600	pt. voided 750cc amber urine - [redacted] CPJMN
2245	Pt. care assumed @ 2100. VSS. Drsg to thigh done c̄ 4x4 gauze sponges. Pt. pre-medicated ō MSO4. IV site to (L) AC p/c'd ∴ infiltration. [redacted] Reg, lungs CTA, ABD soft c̄ BS (+) x4. will cont. to monitor. [redacted] CTAN
23 June 03 0650	Assume pt care @ 0500. pt asleep easy to awake. VSS. Lungs CTA. BS x4 active. Dsgs to RUE and LUE CD+I. Dsg CD+I to (R) buttock and (R) thigh. No c/o pain @ this time. pt on 24° bedrest to end @ 14 today. HL to (L) AC patent. [redacted] SLUMC

NSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NI (SSN or Other)
	LAST	FIRST	MI	

/SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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. ICW2

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (F
Prescribed by GSA/ICMP FPMR (41CFR) 101-1

All (b)(6)-2 except one at bottom

MEDICAL RECORD	PROGRESS NOTES
DATE	
20Jun03	1100 - Dsg Δd to buttock area. W→D dsg applied. [redacted] 2LT AW
1900	Assumed care of Pt @ 1300. VSS, A+Ox3 tol PO diet well. Ambulate x 2 to void in BR. Dsg to (R) buttock/thigh intact c̄ serosanguinous drainage re-reinforced c̄ 4x4 gauze. Ø c/o pain. Ø/w Assessment ongoing. Will cont to monitor. [redacted]
20Jun03 2145	Pt. vitals taken BP 102/62, P. 58, R. 16, Temp. 98.2 [redacted]
2230	Pt. care assumed @ 2100. VSS. Pt [redacted] premedicated for dsng Δ c̄ 6mg MSO4. W→D dsng done on GSW (L) buttock. Wound beefy red c̄ s/s infection. HR Reg, Lungs CTA, BS (+) XY. Will cont. to monitor. [redacted] WTAW
21Jun03	Progress Note Day well → to OR to close wound in AM
Error [redacted] 21Jun03	[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. ICW

PROGRESS NOTES
Medical Record

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

[redacted] (b)(6)-4

EPW

MEDCOM - 11003

all: b(6)-2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
23 June 03	1020 Dsg Δ to (R) buttock, (R) thigh, (R) AE anal (L) UE. All Dsg's CDI. Sites free of s/s infection. (R) buttock sm amt drainage present, yellow. 5mg MSO4 premedicated for dsg Δ. Pt amb to BR 300cc c/u output. Will continue to monitor [redacted] SLWMP
1400	Assumed care Pt @ 1300. VSS. A+O x 3. IV ABX w/a (2) FAPIV infusing well. Dsg to (R) thigh/buttock CDI. ∅ c/o pain palopalle pulses x 4. I+O protocol. O/w assessment WNL. Will cont. to monitor [redacted]
24 Jun 03 0230	Pt care assumed @ 2100. VSS, AOX3, [redacted] 5mg MSO4 given prior to dsg Δ. Lung sounds CTA, pulses (+) x4, bs (+) x4 quads. Dsg Δ dbre to RUE, wound red ∅ drainage. IV abx, ht patent. Dsg's on RUE and LUE CDI, will continue to monitor. Spo [redacted] SLWM
24 Jun 03	0835. Pt alert lying in bed. VSS, lungs CTA, HR regular, BS (+), Pulses to ↑ & ↓ extremities equal & strong bilat. Dsg to (R) buttock intact. Dsg to (R) arm CDI. Pt voicing ∅ complaints at this time. Will cont to monitor - [redacted] 24 AM
	1200 - Dsg Δ'd to buttock CDI → old Dsg c̄ minimal drainage. Incision closed c̄ one open, circular wound. Dsg Δ'd to both upper extremities CDI. [redacted] 24 AM
24 Jun 03 1950	Assumed care @ 1300 - VSS - IV patent - no c/o pain - dsg c̄ small amount of drainage on it - ambulating c̄ difficulty [redacted] CPM

all : (b)(6)-2 except one at bottom

MEDICAL RECORD	PROGRESS NOTES
DATE	
24 Jun 03 0800	Pt care assumed @ 2100. VSS, a+ox3, no c/o pain. Lungs CTA, pulse palpable x4, bs(+)x4 quads. Dsg Δ done to (R) thigh, buttocks, and both upper extremeties. (R) thigh dsg draining serous fluid, buttocks wound draining small amount of blood. All wounds appear free of infection, both [redacted] dsg's intact. HL flushes well, no complaints at this time. [redacted] 91WM6
25 JUN 03	0600 Assume pt care @ 0500. Pt asleep easy to awake for assessment. No c/o pain @ this time. VSS. HL to (L) FA flushes well. HR reg. Lungs CTA, BS x 4 active. Dsg to (R) thigh, buttocks and (B)LE C.D.I. Urine continue to monitor. [redacted] 91WM6
25 JUN 03	Urology Note Healing well s/p DPC butterfly Concerned about Arm paresthesia Plan → Discuss c̄ ortho / PT Cont current [redacted] care [redacted]
1050	Dsg Δ done, healing well. No drainage noted. PT in to see pt, see note [redacted] 91WM6

(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. 7E W 2

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

PROGRESS NOTES
Medical Record

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

All. (b)(6) -2

PROGRESS NOTES

DATE	
25 JAN	1300 Assumed care of Pt @ 1300. VSS. A+O x3. Ø c/o pain. Cmb. 5 assist. Drsg to (R) buttock CDI. Palpable pulse x4. (B) LS CTA. O/N assess WNL. Will MONITOR [redacted]
1500	PT NOTE
	HX: ROM (L) FOREARM & HAND
	T/M: PNT ALERT. PNT c/o ↓ SENSATION & STRENGTH RADIAL SIDE (L) FOREARM & DIGITS 1, 2, 3
1, (PT) WS	(L) HAND; GMM ~ 3/5. ~~PNT (I) HEP's~~; PNT (R) FAROM; ~75% PRO/SUP/PIP/MCP JTS. PAT
	HAS EMBEADED PIECE ~ 1/4" SHRAPNEL IN LAT. SIDE (L) INDEX FINGER/2ND DIGIT AT PIP JT.
	HEP's: MAKING FIST/HAND SQUEEZE, FLEX/EXT DIP/PIP/MCP JT, 1st DIGIT OPPOSITION, PRO/SUP
	OF FOREARM X 10 REPS EACH. PNT (L) FOREARM/HAND FATIGUES EASILY. PNT ALSO
	AMBUL ~ 6 LAPS ICW 2 ARCH.
	DX: ROM. STRENGTHENING EXERCISES.
	I: SAME
	G: ↑ STRENGTH TO: PNT (L) FOREARM/HAND BY 25% X 2 wks.
	Spc [redacted]
	91W10 NG PT TECH.
2310	Pt care assumed @ 2100. VSS, A+Ox3, Ø pain. Dsg's on upper extremeties CDI, dsg on thigh and buttocks CDI. Pt c̄ (+) sensation and ROM in RE. Lungs CTA, pulses palpable x4, bs(+) x4 quads. Dsg Δ to be done @ 24, will continue to monitor. [redacted] 91WM6

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

all (b)(6)-2 except one on bottom.

MEDICAL RECORD	PROGRESS NOTES
DATE	
1100 26 Jun	Assumed care of pt @ 0580. VSS. Lungs CTA Bowel sounds x4 quads. Dsg A done @ 1000. Pt had Ø drainage. Ø s/s of infection. Pt was oob walking for 15 minutes. Ø c/o pain / discomfort @ this time. — [redacted] 9/WM6, SGT —
26 Jun 03 1530	assumed care of pt. @ 1300 - VSS - IV patent, abd continue, - dsg intact to buttock/thigh - pt. has no c/o pain @ this time - ambulated this shift and washed for prayers - [redacted] CHAN
2245	Pt. care assumed @ 2100. HR Reg, Lungs CTA. ABD soft c̄ BS ⊕ xy. Dsng to ® thigh reinforced c̄ tape. Drainage noted slightly larger than 1/2 dollar size on dsng, serosanguinous quality. IV to ⓐ AC ⊽ s/s infection or infiltration. will cont. to monitor. — [redacted] LUTAN
27 Jun 03	1015 - Pt alert lying in bed. VSS, lungs CTA, HR reg, BS⊕. Dsg to ® thigh Δ'd. Dsg to ® arm Δ'd. Both c̄ minimal drainage. HL to Ⓛ forearm. Voiding Ø complaints. Will cont to monitor. — [redacted] 2LtAN
1245	18g IV c̄ heplock in Ⓛ forearm — [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. ICW2

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

PROGRESS NOTES
Medical Record

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

All: (b)(6)-2

PROGRESS NOTES

DATE	
27JUN03	1400 Assumed care of pt @ 1300. VSS. A+O x3. Ø c/o pain. (L) FA HL patent, WABX, (R) thigh/buttock drsg CDI. Amb ~~5~~ assistance. [redacted] WNL. Will monitor
2100	Drsg Δ done. Scant amount of drainage from incision site, Ø drainage from penrose drain. Ø sign of infection. New Drsg applied CDI. Will monitor [redacted]
27Jun03 21:29	Rec'd pt @ 21:00. Awake + alert in bed. Skin W/D. PERRLA (R) WNL LCA (R). BS (+) x4 (+) PPP (R). Drsg to (R) buttocks C/D/I. PIV (R) patent. Painful upon flushing. Will initiate new PIV. Will man [redacted] DET/MO
28Jun	Assumed care of pt @ 0500. Pt is alert and awake. VSS. Lungs CTA. Bowel sounds x4 quads. HL to (L) hand Patent. Pt has Ø c/o pain/discomfort @ this time. Will continue to monitor. [redacted], CPN, SGT
28 Jun	Progress Note No well I dressed Cont as is c̄ meds [redacted]
1250	PT NOTE HX: ROM (R) FOREARM, WRIST, 1ST & 2ND DIGIT T/M: PNT ALERT. PNT DEMONSTRATES > (F) DIRECTIONAL EXERCISES 6 WAY WRIST & HAND X 15 REPS EACH, 20 REPS FINGER FLEX (1ST + 2ND DIGIT) c̄ EXTRA THIN THERABAND. PNT DENY PAIN W/T. c̄ RX. STRENGTH > PREV DAY ~~3/5 GRM~~. 3/5 GRM. PX: ROM FINGER FLEXION c̄ THERABAND I: SAME

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

all (b)(6)-2 except bottom one

MEDICAL RECORD | PROGRESS NOTES | AUTHORIZED FOR LOCAL R

DATE	NOTES
01 JULY 03	PT NOTE
	HX: ROM, HEP'S (STRENGTHENING) ® 1ST & 2ND DIGIT & FOREARM
	T/M: PNT ALERT > GMMT ~ 4/5. PNT ⊖ ō HEP'S FINGER FLEX/EXT &
	1ST DIGIT OPPOSITION ROMS X 15 REPS EACH. PNT DEMONSTRATE ~ FULL
	PRO/SUP. PNT DENY PAIN.
	DX: ROM, HEP'S
	I: SAME
	G: ↑ PNT GMMT ~ 4/5 X 2 wks.
	SPC [redacted]
	SIMONS PT TECH.
1 July 03 1520	assumed pt care @ 1300. VSS. pt awake et alert. lung sounds CTA, abd soft BS ⊕. BU/ext c̄ full ROM ⊕ pulses. drsing to ® hip CDI. BUE c̄ full ROM ⊕ pulses. HL CTA flushes well ⊖ S/Sx of infection noted. ⊖ c/o pain voiced @ this time. Will cont to monitor — [redacted] 91WMC SGT
1 July 03 @ 2300	pt awake & alert, VSS, LCTA ®, ⊕ BS x4 qds. abd: soft ND, ⊖ TTP, ⊕ ROM to U&L extremeties, ⊕ pulses. HL flushes easily. no c/o pain voiced @ this time. will cont to monitor — [redacted]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR'S ID NO (SSN or Other)

BRANCH OF SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

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

PROGRESS NOTES
Medical Record
STANDARD FORM 509

all : (b)(6) - 2

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
28 Jun 03	PT NOTE (CONT)
	G: ↑ PNT STRENGTH ~ 3+-4/5 GHM 1ST + 2ND DIGIT X 2 wks
	SPC [redacted]
	SIMIONE PT TECH
28 Jun 03 1930	assumed care @ 1300 - VSS - IV patent - dsg intact - pt. ambulated and said prayers - no c/o pain @ this time
	[redacted] CPT/AN
28 Jun 03 21:33	Pt rec'd @ 21:00 Awake and Alert in bed. Restraints x 2. Skin PWD. PERRLA WNL. LCA (B). PIV (D) FA patent. BS (+) x 4. (+) PPP (B). DSG to (R) buttock intact c̄ serosanguinous drainage. ∅ c/o pain @ this time. Will cont to mon. [redacted] DZT/AN
23:27	DSG ND c̄ difficulty. Sutures intact. incision well approximated. Wound below incision well approximated. ∅ sxs infection noted. Will cont. to mon. [redacted] DZT/AN
29 Jun 03 0600	Pt. Sleeping in bed easily aroused by verbal stimuli. Dressing on (R) buttocks CDI. HL in (L) FA flushed well c̄ 3cc NS c̄ s/s of infection. Lungsounds clear bilat. + bowel sounds x 4 quads. All other assessment findings WNL. Pt. c̄ complaints @ this time. Will continue to monitor. [redacted] DZT/AN

NSN 7540-00-634-4176

all (b)(6)-2 except bottom one.

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
29JUN03	Proper note
	Patient dry gent
	BL Pain 2 on Am
	Renew Suture RoD # 8-20
	[redacted]
29JUN03	Assumed care of Pt @ 1300. VSS. AHO x3. Ø c/o pain. (L) UE PIV
1715	HL c̄ IV patent. D/D dressing (R) hip/thigh/buttock. Site approx well c̄ sticks, penrose drain in place, little bldy drainage. New Dressing applied CDI. (+) palpable pulse, cap refill <3sec (R) foot. Amb assistance. O/A Assessment will Monitor [redacted]
2340	Pt. care assumed @ 2100. VSS. HR Reg, lungs CTA, BS (+) x4. Dressing to (R) Buttock CDI & secure. Pulse to (R) foot 2+ c̄ Brisk cap refill, (+) ROM, (+) Sensation. will cont. to monitor. [redacted]
30June03 0830	Pt. VSS, asleep in bed easily arousable to verbal stimuli. HL in (L) FA flushes well c̄ 3cc NS. S/S of infection. Dressing to (R) thigh CDI, pedal pulses (+), sensation (+), cap refill <3sec, full ROM in (L) LE digits. Pt. has no complaints @ this time. All other assessment findings WNL. Will continue to monitor. [redacted]
1130	Pt. pen rose drain D/c'd by MD. Dressing to (R) buttocks D/d. Wound draining clear yellow fluid. Incision site not approximated well, MD observed. [redacted]

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

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

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

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

NSN 7540-00-634-4176

All (b)(6)-2 except bottom one

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
30 JUN 03	Program note least drain D/C'd today Plan: Cont Pain control
	[redacted]
30JUN03 1600	Assumed care of Pt @ 1300. VSS. A+Ox3 Ø c/o pain (2) ~~almost~~ FA PIV patent, HL. (R) bulkt/thigh dsg CDI. (+) sensation, cap refill <3sec, full ROM (R) LE. O/N Assessment WNL. Will cont. Monitor. — [redacted]
2130	Pt. care assumed @ 2100. HR Reg. lungs CTA, ABD soft ē BS (+) x4. Dsng to (R) hip CDI. (R) LE ē brisk cap refill, pedal pulses 2+, (+) ROM, (+) sensation. Pt. c/o pain to (R) FA. Pt. has ↓ sensation to thumb, index & middle finger of (R) hand. Pt. has ↓ strength (R) hand & ↓ ROM (R) elbow. HL to (C) UE flushed. Ø s/s infection @ site. Will cont. to monitor. — [redacted]
1JUL03 0710	Assume pt care @ 0500. pt Awake and Alert. VSS. HR regular. Lungs CTA throughout. BS x 4 active abd soft. Dsg to (R) hip CD+I. (+) sensation (+) movement below dsg. Pt c/o small amt of pain to (R) FA and (R) hand. ↓ strength in (R) hand. pain occurs when touching and moving arm. Will continue to monitor. — [redacted]

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

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

[redacted] (b)(6)-4

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	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1 July 03	1100 Dsg D done to (L) thigh area free of signs of infection. No c/o pain — [redacted] SIUM/C
	(b)(6) -2

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

2 Jly 03 Pt. USS. Pt. asleep in bed easily aroused by verbal stimuli.
0700 Dressing to (R) buttocks CDI, pulses to LE (+), sensation (+), Full ROM.
0700 96.8 Lung sounds clear bilat. Bowel sounds (+) in all 4 quads. All
108/62 other assessment findings WNL. Pt. has no complaints
65 @ this time. Will continue to monitor. [redacted] 2LT/AN
14
97%

(b)(6)-2

NOTES

FIRST NAME	MIDDLE INITIAL	ID NUMBER

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7/2/03	Discharge Summary
	DOA 16 JUN 03
	DOD 2 JUL 03
	LTC [redacted] MD (b)(6)-2
	REASON FOR ADMISSION:
	EPW s/p GSW to thigh/buttock
	Hospital Course.
	Patient admitted after I/D by FST. Wet to dry dressings Δ's x 5 days. Taken to OR for Delayed Primary Closure on 22 JUN 03.
	wound healed well ō 5 day course unsp. Post op. Sutures + drains out by 2 JUL 03
	Now ready for D/C.
	Final Dx: GSW to thigh c̄ Exit wound @ buttock.
	Plan: DC to EPW Corp.
	Pain meds – Tylenol #3 PRN
	Flu as needed [redacted] (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.)*

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

REGISTER NO. | WARD NO.

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

MEDICAL RECORD — **INTRAOPERA . 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 CPT [redacted]

3. DATE 22 June 03 TIME PATIENT ARRIVED IN SUITE 1040

4. PATIENT IN ROOM TIME 1040 NUMBER 1-1 | 3

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: nkda
npo p̄ midnight

(b)(6)-2

6. NURSING PERSONNEL

ASSIGNED SCRUB	PJC [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	

(b)(6)-2

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: proper body alignment maintained, beanbag utilized for decub position, position approved by surgeon + anesthesia, pillow between legs

8. SKIN PREPARATION

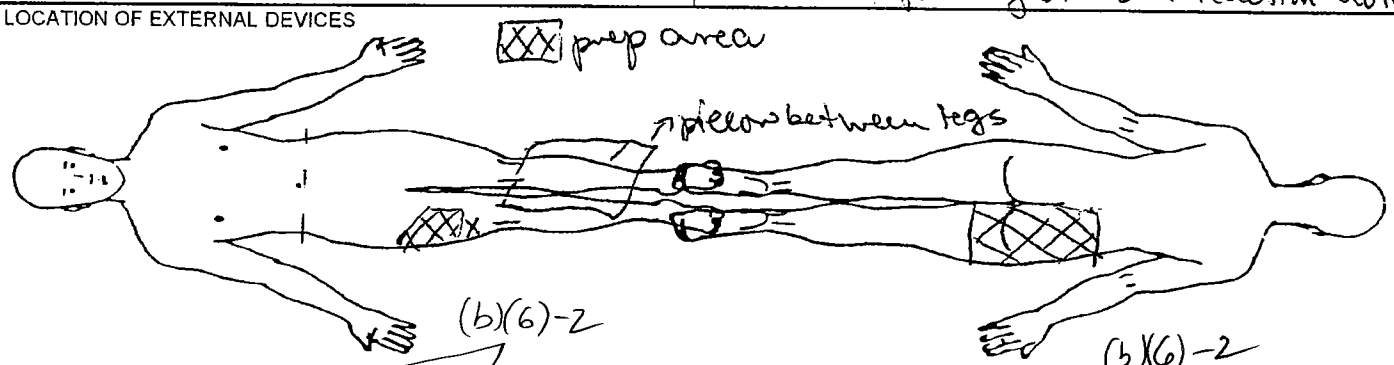
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine / Betadine (b)(6)-2
SITE: (R) buttock + thigh BY WHOM: [redacted]
SITE: BY WHOM: [redacted]

COMMENTS: no pooling or skin reaction noted

9. LOCATION OF EXTERNAL DEVICES



(b)(6)-2

(b)(6)-2

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

C = Correct I = Incorrect

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

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

EPW [redacted]
ICW 2

(b)(6)-4

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

☐ ESU NO: _____
GROUND PAD: BRAND Valleylab Polyhesive
LOT NO: [redacted]

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

☐ BIPOLAR NO: _____

All: (b)(6)-2

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS

	TIME	CARRIED OUT BY
none		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 3/8 Penrose x2	2.	3.
SITE	1. (R) Buttock	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
~~Fluffs~~ [redacted] 4x8's
Tape

19. ADDITIONAL INFORMATION
WC
Surgeons [redacted] Anesthesia: [redacted] Anesthesia Type: Spinal

Bovie Pad site intact pre-op yes; post-op C/I Bovie Settings: Coag/Cut - NA
Tourniquet Site intact pre-op _____: post-op _____ > N/A
Tourniquet Time: Up____ Down_____

20. OPERATION(S) PERFORMED
Delayed 1° closure of (R) buttock wound

21. PATIENT TRANSFERRED TO
ICU

TIME see DA 7389

METHOD
Litter c safety strap on

22. REGISTERED NURSE SIGNATURE
[redacted] CPT IAW

REVERS[redacted] OCT 87.

USAPA V1.01

MEDCOM - 11017

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR June 2005

DAY: 16, 17, 18, 19, 19, 20, 21, 22

HOUR

PULSE (0) / TEMP. F (°): 105°, 104°, 103°, 102°, 101°, 100°, 99°, 98.6°, 98°, 97°, 96°, 95°

PULSE: 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)

(b)(6)-2

RESPIRATION RECORD

BLOOD PRESSURE

SpO2

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. BCW2

EPW# [redacted] —(b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR June 2003 DAY

19 HOUR

PULSE (0) 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

23 24 25 26 27 28 29

TEMP. C

40.6° both (b)(6)-2 40.0° 39.4° 38.9° 38.3° 37.8° 37.2° 37.0° 36.7° 36.1° 35.6° 35.0°

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICW2

[redacted] [redacted] PW

E

(b)(6)-4

STANDARD FORM 511 (REV. 7–95) BACK

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR June DAY

~~19~~ 2007 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° / 98.6°	37.2° / 37.0°
120	98°	36.7°
110	97°	36.1°
100	96°	35.6°
90	95°	35.0°
80		
70		
60		
50		
40		

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

O2Sats → 99% 96% 99% 97%

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.

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

STANDARD FORM 511 (REV. 7–95) BACK

Section: EMT | REQU[illegible]NG PHYSICIAN: [redacted] (b)(6)-2

FIRST, MI. # [redacted] (b)(6)-4 | DATE 10 June | TIME 1420

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

SSN/PSEUDO SSN: # [redacted] (b)(6)-4

(Hematology) CBC

T	RESULT	REF. RANGE
WBC	6.0	4.8-10.8 x 10^3
RBC	4.03	4.7-6.1 x 10^9
Hgb	11.6	14-18 g/dl (M) 12-16 g/dl (F)
Hct	37.2	42-52% (M) 37-47% (F)
MCV	92.2	80-94 fl (M) 81-99 fl (F)
PLT	299	130-500 x 10^3 verified
Lymph %	23.8	20.5-51.1%

matology) Manual Differential

		Mono	
		Eos	
h		Baso	
		Imm	
)			
ocrit		42-52% (M) 37-47% (F)	
ite			

Urinalysis

TEST	RESULT	REF. RANGE
Color	Yellow	N/A
App	Cloudy	N/A
Glu	Neg	Negative
Bili	Neg	Negative
Ket	Neg	Negative
SG	1.015	N/A
Bld	Neg	Negative
pH	7.5	N/A
Prot	Neg	Negative
Urob	0.2	0.2-1.0
Nit	Neg	Negative
Leuk	/	Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

occasional RBC
occ WBC
Amorph Sediment-Large

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

[illegible] Studies

r	RESULT	REF. RANGE
		9.8-13.6 secs
		21-34 secs
er		<20 ug/ml
		<10 ug/ml

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

UNIT	TYPE	CROSSMATCH

ARKS:

ORTED BY: [redacted] (b)(6)-2 | DATE: 16 Jun 03 | LAB ID NO.:

Ward/Section: EMT

TESTING PHYSICIAN: [redacted] (b)(6)-2

CHEMISTRY RESULT FO

Subject to the Privacy Act of 19

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

DATE: 16 Jun

TIME: 1420

SSN PSEUDO SSN: # [redacted] (b)(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	1	73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RA
GLU	139	73-118 mg
BUN	8	7-22 mg/dl
CA		8.0-10.3 mg
CRE	0.6	0.6-1.2 mg
NA	140 ~~4.3~~	128-145 mm
K	4.3	3.3-4.7 mmol
CL	102	98-108 mm
tCO_2	24	18-33 mmol

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RA
ALB		3.3-5.5 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
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RA
NA^+		128-145 mm
K^+		3.3-4.7 mm
CL^-		98-108 mm
tCO_2		18-33 mmol

REMARKS:

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

DATE:

LAB ID NO.:

Sterile H_2O lot # 80-1 [redacted] (9/03)
(b)(6)-2

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS & ADJUNCTS — CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "1"=CONSTANT INFUSION	DRUG	(Units)	1	2	3
	versed	(mg)	2	1	0.5/0.5 1
	fentanyl	(Mcg)	50	25/25	
		( )			
		( )			
		( )			
		( )			
	VOLAT AGENT	% del			
		% e.t.			
	AIR	L/Min			
	N2O	L/Min			
	O2	L/Min			
SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS			1	2	3

FLUIDS			
LINE site	20g RW	☐ Warmed	NS 1000 — 500
		☐ Warmed	
		☐ Warmed	
		☐ Warmed	
LOSSES	EST BLOOD LOSS		
	URINE –		

TOTALS	
5 mg	
100 µg	
TOTAL EBL	min
TOTAL URINE	Ø

FLUIDS – SUMMARY	
CRYSTALLOID–	450
COLLOID–	Ø
BLOOD–	Ø

REMARKS– Code drugs with numbers, events with letters

Pt ☆ chart r. OK to proceed.
1 To room, SOC monitors. Positioned for sur. c slight-burg.
2 SAB placed.
3 To recovery stable & comfortable.

PHYS STATUS 1 2 3 4 5 E	TIME →	30	11	30	12	30	13
BODY WEIGHT: 50 (KG) LB	SYMBOLS:						
HEMATOCRIT: 37.2	BP by cuff V						
INITIAL DATA: BP – 99/50	Heart rate ●						
HR– 88	Resp rate						
EQUIP CHECK: OK?– ✓ N	BP (transduced) ⊥ T						
PATIENT ID CHECK: OK for PROCEDURE? ✓	TOURNIQUET T – ✗						
TIME– 1015	ANES– X-X						
	PROC ⊙ – Ø						

	VT – ml				
	f – breaths/min	16	16	16	16
	Peak inf pres / PEEP				
	MODE– S(pon), A(ssist), C(on)	S	S	S	S
✓ BP/Auto Cuff	ET CO2 (torr)				
BP / oth	FIO2 (Frac or %)	RA	RA	RA	RA
ART line	✓ SpO2 (%)	99	99	99	99
Steth- PC/ES	✓ ECG	SR	SR	SR	SR
Gas analyzer	TEMP- site				
	N-M Block (T/4)				
Warming blkt					
Conv warmer					

RECOVERY AT: PACU (ICU) (Specify) OTHER 102 C

CONDITION: RESP– 14 SpO2– 99 BP– 90/60 HR– 103

ANESTHESIA / PROCEDURE TIMES	Start	Room	End
ANES	1030	1040	
PROC	Ready	Begin	End
	1050	1105	1130

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

PROCEDURES and CPT Codes

DPC Rt Buttocks Wound

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

SAB. Pt lt lateral. L3-4 prep betadine x3. 1% xylo to skin. 25g Quincke via 18g introducer for clear CSF 1st pass. Ø paresthesia. 10mg hypobaric tetracaine injec c ⊕ CSF asp & sp. All needles removed. Level T12 @ 10 mins.

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

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

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

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

ANESTHETISTS: [redacted] MAJ / CRNA

WAM[redacted] ANESTHESIA

[redacted]ISED

PROCEDURE LOCATION	1-1
DATE	6/22/03
PAGE	1 OF 1

PATIENT [redacted]

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

(b)(6)-4

ESTHESIA PLAN OF CARE PH... PROCEDURAL ASSESSMENT (Sedation/Anesthesia)

[redacted] DAYS MOS (YRS) Sex (X) MALE ( ) FEMALE

POSED PROCEDURE: I+D Buttock wound (Jaime)

GICAL SERVICE:

SINCE:

ASA Physical State 1 2 3 4 5 E

WT: 50 (KG)/LB HT: ____ IN.

ALLERGIES: NKDA

ITS:

BACCO: 0

ETOH: +

DRUGS: 0

IRENT MEDICATIONS:

ordered as premed

MEDICATIONS:

e Yes (@ ____ Hrs) /CC

___ . ____ mg IV IM PO

___ . ____ mg IV IM PO

___ . ____ mg IV IM PO

ORATORY STUDIES:

HCT: ____/____

IER:

16 Jun 11.6 / 37.2 299K

140 | 102 | 139
4.3 | 24 | 8 | .6

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT

PAST SURGICAL/ANESTHETIC

GSW Rt thigh - I+D @ FST

PHYSICAL EXAMINATION

BP 115/70 HR 55 RR ____ T ____ 98% 2L

Pain Scale 0-10 ____

HEENT - Teeth intact

Trachea mi

TMJ/Neck 3

Oropharnyx MI

Nares

CHEST: CTA

CARDIAC: RRRSm

EXTREMITIES: 0

IV Access: Rt arm

Ulnar Filling:

BACK:

OTHER:

NPO Since 2400

IESTHETIC PLAN: { } LOCAL { } MAC (X) Regional (Specify): SAB [redacted] (b)(6)-2 General: Mask Intubation

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

patient/[redacted] gua[redacted] understand and agrees. Questions answered. (b)(6)-2

ned: [redacted] CRNA Date: 6/22/03 Time: 0240 Hrs

ST-A[redacted]STHESIA EVALUATION [redacted]N ASU)

NO APPARENT ANESTHETIC [redacted]S { } OTHER

ned: ____ Date: ____ Time: ____ Hrs

ient Identification: (Ward) ICW 2

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

SEDATION KEY:

1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is n necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
		[redacted]

DATE OF ORDER: 16 JUN 03 TIME OF ORDER: 1450 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit to ICW2
2. Dx: GSW to Thyroid
3. Condition stable
4. IVF LR @ 75 cc/hr.
5. Diet ~~NPO~~ Regular Diet
6. Dressing S's wet to dry to (R) buttock BID

PATIENT IDENTIFICATION

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

NURSING UNIT	ROOM NO.	BED NO.
ICW2		[redacted]

DATE OF ORDER: TIME OF ORDER: HOURS

7. Strict I/O
8. VS q 4° x 24 Then q 8°
9. Ancef 1gm q 8° x 3 doses
10. MSO4 2-8 mg IVP q 2° PRN pain
11. Tylenol #3 2 tabs PO q 4° PRN pain
12. Phenergan 12.5 mg IVP q 6° PRN nausea
13. Tylenol 650 mg PO q 4° PRN

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.
24VS	0030	17 Jun 03 [redacted]

DATE OF ORDER: TIME OF ORDER: HOURS

14. NKDA

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

[redacted]

all (b)(6)-2

PATIENT IDENTIFICATION

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

NURSING UNIT	ROOM NO.	BED NO.
ICW2		[redacted]

DATE OF ORDER: 17 JUN 3 TIME OF ORDER: 1038 HOURS

Insert Foley Cathet prn

[redacted]

Co 17 03 [redacted]

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW II	11 24 PA	0130 20

DATE OF ORDER: 19 JUN 03 — TIME OF ORDER: 1618 HOURS — LIST TIME ORDER NOTED AND SIGN

DC IV

DC I/O

VS q shift - repeat [redacted] noted

(R) Indwelling [redacted] 1020

[redacted] (b)(6)-2

20 JUN 03 [redacted]

PATIENT IDENTIFICATION

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

NURSING UNIT	ROOM NO.	BED NO.
ICW2		[redacted] (b)(6)-4

DATE OF ORDER: 21 JUN 03 — TIME OF ORDER: 0927 HOURS

NPO after midnight

Anal lgn on call to OR in AM

May take pan[redacted] small sip H2O

noted 21 JUN 03 0945

[redacted] (b)(6)-2

21° done [redacted] 24/AW

PATIENT IDENTIFICATION

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

NURSING UNIT	ROOM NO.	BED NO.
ICW2	(b)(6)-4	[redacted]

DATE OF ORDER: 22 JUN 03 — TIME OF ORDER: 1138 HOURS

Dx s/p buttock / thigh BSW

IVF LR @ 75 cc/h heplock when taking PO [redacted] (b)(6)-2

~~Anal lgn q 8° x 24°~~ [redacted]

~~Start keflex 500 mg PO QID~~

Diet regular / I/O

~~DC~~ Change dressing BID & 4x4 / Dry

PATIENT IDENTIFICATION

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

NURSING UNIT	ROOM NO.	BED NO.
ICW2		[redacted] (b)(6)-4

DATE OF ORDER: US q 4° x 24° then q 8° — TIME OF ORDER: HOURS

Bed rest x 24° then OOB as tolerated [redacted] (b)(6)-2

Diet to start by 1400 [redacted]

MSO4 2-5 mg IV q 2° PRN pain

Percocet 1-2 tabs PO q 4° PRN

Phenergan 12.5 mg IV q 6° PRN nausea

Tylenol 650 mg PO q 4° PRN [redacted] (b)(6)-2

DA FORM 1 APR 79 4256 REPLACES EDITI[illegible] BE USED. [illegible] AR

MEDCOM - 11026

EDICAL RECORD | PROGRESS NOTES

DATE

6/22/03 Brief Op Note

Procedure: Irrigate wound
Delayed 1° Closure

Surg Dr [redacted]
GBL Ø
Fluids 600 cc
Blx Anesf Lgn WPB
Cylinin Ø

(b)(6)-2

[redacted]

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

ATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
#[redacted] (b)(6)-4				6/22/03	1145 HOURS	
				① Demerol 25mg IVP now. May repeat q 10 mins PRN to max dose 50mg		1150
				[redacted] MAS, CRNA		(b)(6)-2 [redacted]
ARSING UNIT	ROOM NO.	BED		(b)(6)-2 [redacted]		
TIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
				6/22/03	1205 HOURS	
				Benadryl 50mg IM now		1205
				[redacted]		
IRSING UNIT	ROOM NO.	BED NO.		(b)(6)-2		
TIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
				6/22/03	1223 HOURS	
				Zosyn 3.375g IVPB q 6°		
				done → Ciprofloxacin 400mg IVPB q 12		
				1st dose now		
IRSING UNIT	ROOM NO.	BED NO.		(b)(6)-2 [redacted]		(b)(6)-2
		21°		[redacted]		
TIENT IDENTIFICATION				[redacted]		
(b)(6)-4 [redacted]					HOURS	
NG UNIT	ROOM NO.	BED NO.				

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

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CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] (b)(6)-4 EPW	22 JAN 03 1242 HOURS DC Cefpr / Levaqin Start Unasyn 3gm IVPB q6°	done 1300 [redacted] (b)(6)-2 CPT A
NURSING UNIT: ICW2 / ROOM NO. / BED NO. [redacted]	24° VS [redacted] (b)(6)-2	(b)(6)-2
PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER	
EPW [redacted] (b)(6)-4	24 Jan 03 1600 HOURS DC I/O's (b)(6)-2 [redacted] (b)(6)-2 noted Per Dr. [redacted] (b)(6)-2	CPT A
NURSING UNIT: ICW2 / ROOM NO.: 24° VS / BED NO. [redacted]	Talenby [redacted] CPT AN	
PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER	
24° VS [redacted] (b)(6)-2 EPW [redacted] (b)(6)-4	2300 29 Jan 03 [redacted] (b)(6)-2 CPT AN 29 Jan 03 2355 HOURS DC Unasyn [redacted] (b)(6)-2 (b)(6)-2	
NURSING UNIT: ICW 2 / ROOM NO. / BED NO. [redacted]	NOTED [redacted] (b)(6)-2	
PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER	
24° VS [redacted] # [redacted] (b)(6)-4 [redacted]	CPT AN 1117 HOURS May have ensure shake TID DC [redacted] (b)(6)-2 Done May Start [redacted] (b)(6)-2 noted 30 Jan 1130 [redacted] (b)(6)-2	
NURSING UNIT: ICW2 / ROOM NO. / BED NO. [redacted]	24° V [redacted] CPT AN 1130	

A FORM 1 APR 79 4256 REPLACES EDITION OF 1 [illegible] MAY BE USED.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

EPW# [redacted]

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 2 JUL 03 TIME OF ORDER: 1120 HOURS

LIST TIME ORDER NOTED AND SIGN

OK for transfer to EPW

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

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER _____ HOURS

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER _____ HOURS

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER _____ HOURS

All: (b)(6)-2

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. 6 Yr. 03

Verify by Initialing: 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														
22 25	[redacted]	MSO4 25mg IVP q2°	6-22 2245	6-23 1100	23 Jun 0800	24 Jun 1045	26 Jun 1100										
-----	-----	prn-pain	STAT IVP	5mg IVP	5mg	5mg	5mg										
-----	-----		[redacted]														
22 25	[redacted]	Percocet 1-11 tabs	6-22 2310	6-23 0330													
-----	-----	po q4° prn-pain	[redacted]														
22 06	[redacted]	Phenergan 12.5mg															
-----	-----	IVP q6° prn-nausea															
22 06	[redacted]	Tylenol 650mg PO															
-----	-----	q4° prn-PO/PR															

USAPA V1.00

A11:(b)(6)-2

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
29	[redacted]	MSO4 2-5mg IVPQ3°														
- - - -	- - - -	PRN PAIN														
- - - -	- - - -															
29	[redacted]	Percocet 1/1, 2/1 tabs														
- - - -	- - - -	PO Q4° prn pain														
- - - -	- - - -															
29	[redacted]	Phenergan 12.5mg														
- - - -	- - - -	IVP Q6° prn nausea														
- - - -	- - - -															
29	[redacted]	Tylenol 650mg														
- - - -	- - - -	PO Q4° prn PO/PR														
- - - -	- - - -															
- - - -	- - - -															

USAPA V1.00

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 30	1	2											
29	[redacted]	HL	5	[redacted]													
		(b)(6)-2	13														
			21														

ALLERGIES: ☐ YES ☐ NO — NKDA

PRIMARY DIAGNOSIS: GSW to thigh

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

All: (b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. JUNE Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
21 Jun 03	[redacted]	Ancef 1 Gram in AM: on call	22 Jun 03	AM	1000	[redacted]
~~21 Jun~~	[redacted]	~~Tylenol 650 PO x1 now for ↑ temp~~ error [redacted]	~~21 Jun 03~~	~~2230~~	~~2230~~	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
1W	[redacted]	MSO4 2-8mg IVP	6 Jun 2220	19 Jun 0015	19 Jun 0930	20 Jun 03 0115	20 Jun 03 2145	21 Jun 03 0930	21 Jun 03 1500						
-----	-----	Q 2° PRN pain	4mg IV	5mg	6mg IV	5mg	6mg	5mg	8mg IVP						
-----	-----		[redacted]		[redacted]	[redacted]	[redacted]								
1W	[redacted]	Tylenol #3 1/1 PO	20 Jun 0900 1/1	19 Jun 1000 1/1	19 Jun 2205 1/1	19 Jun 0930 1/1	20 Jun 1700 1/1	21 Jun 0145 1/1							
-----	-----	Q4° PRN pain	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
-----	-----														
1W	[redacted]	Phenergan 12.5g													
-----	-----	IVP q 6° prn nausea													
-----	-----														
1W	[redacted]	Tylenol 650mg PO													
-----	-----	Q4° PRN													
-----	-----														
17 Jun	[redacted]	Foley Cath if needed													

Reviewed 22 Jun 03

[redacted]

USAPA V1.00

All (b)(6)-2 except bottom one

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 06 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 16	17	18	19	20	21	22	23	24	25	26	27	28	29
16	[redacted]	IVF LR@75cc/hr	5	/	[redacted]												
			13	[redacted]													
			21	[redacted]								[redacted]					
16	[redacted]	Ancef 1gm Q8° x 3doses	08	/	[redacted]												
			16	[redacted]	/												
			24	[redacted]	/												
			/														
22	[redacted]	LR@75cc/hr - (HL) when taking PO	06	—	—	—	—	—	—	/	[redacted]						
			14	—	—	—	—	—	/	[redacted]							
			22	—	—	—	—	—	/	[redacted]							
			/														
22	[redacted]	Unasyn 3gm IVPB q6°	06	—	—	—	—	—	—	/	[redacted]						
			12	—	—	—	—	—	/	[redacted]							D/C
			18	—	—	—	—	—	/	[redacted]							
			24	—	—	—	—	—	/	[redacted]							

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: GSW to thigh

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

SPW

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

All: (b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo June Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
16	[redacted]	ADMIT ICW#2 : STABLE	16		1530	[redacted]
16	[redacted]	VS @4° x 24 hrs	16	1600	1600	[redacted]
	-----		16	2000		
	-----		16	2400	2400	[redacted]
	-----		17	0400	0400	[redacted]
	-----		17	0800	0800	[redacted]
	-----		17	1200	1200	[redacted]
6-17	[redacted]	Insert Foley cath PRN				
19	[redacted]	(R) index finger x-rays	19	now	1700	[redacted]
21 June	[redacted]	NPO p̄ MN : on call to OR : may take	22 June	0000	done	[redacted]
	-----	pain meds c̄ small amts of H_2O				
22	[redacted]	DTV by 1400	22	1400		[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
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USAPA V1.00

All (b)(6)2 except bottom one

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. 06 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 16	17	18	19	20	21	22	23	24	25	26	27	28	29
16	[redacted]	DIET REGULAR	5	/	[redacted]												
22	[redacted]	regular	13														
			21														
16	[redacted]	DRSG Δ's W→D to	10	[redacted]													
		(R) Buttock BID	22														
16	[redacted]	STRICT I+O's	5	/	[redacted]												
			13														
			21														
16	[redacted]	VS Q4° x 24 then Q8°	5	/	[redacted]												
22	[redacted]	VS q4° x 24° then q8°	13														
			21														
			/														
22	[redacted]	I & O's	06	—	—	—	—	/	/	[redacted]							
			14	—	—	—	—		/								
			22	—	—	—	—		/								
			/														
22	[redacted]	Δ dsg BID c 4x4 &	10	—	—	—	—		/	[redacted]							
		Elastics	22	—	—	—	—		/								
			/														
22	[redacted]	Bedrest x 24° then	06	—	—	—	—		/	[redacted]							
		OOB as tol.	14	—	—	—	—		/								
			22	—	—	—	—		/								

ALLERGIES: ☐ YES ☐ NO — NKDA

PRIMARY DIAGNOSIS: GSW to thigh

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

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

ACTION TIMES — USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo June Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
30June	[redacted]	D/C penrose drain	30June	NOW	1115	[redacted]
		(b)(6)-2				

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

USAPA V1.00

All (b)(6)-2 except bottom one.

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. 6 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 30	1	2
29	[redacted]	DIST REGULAR	4	[redacted]		
			11	[redacted]		
			17	[redacted]		
29	[redacted]	VS Q8°	5	[redacted]		
			13	[redacted]		
			21	[redacted]		
29	[redacted]	ADSG BID C 4x4	10	[redacted]		
		and fluffs	22	[redacted]		
29	[redacted]	ACT-OOB AS TOL	5	[redacted]		
			13	[redacted]		
			21	[redacted]		
30 AM	[redacted]	Pt may have ensure	07	/ [redacted]		
		drinks PO	11	[redacted]		
			17	[redacted]		

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS: GSW to thigh

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

[redacted]

(b)(6)-4

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

ASA I Tetracaine

OTSG APPROVED (Date)

Date: 22 Jun 03
Time In: 1140
Allergies: NKDA
Pre-op V/S: 99/50, 88
Procedures: Closure (R) Butt wound

Anesthesia Type (Circle)): General Spinal Epidural
IV Sedation Nerve Block
OR Intake: Crystalloid 500 Colloid
OR Output: UOP Ø EBL Minimal
Meds/Times: Versa 5, fent 100mcg

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

Pre Op Meds

History

Time	1140	1145	1150	1155	1210	1225	1240	1310	1340	1355
SaO2	99	98	100	100	100	97	97	97	99	99
FiO2			10	10	10	RA	RA	RA	RA	RA
Methods		NR	NR							
240										
220										
200										
180										
160										
140										
120								V		
100										
80										
60										
40										
20										
RR	31	26	27	12	20	22	28	23	12	19
T	101		103		103		101		102	
Time										
Pain (0-10)										
LOS										

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1300	Unasyn	3gm			

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	1 ~~2~~	1	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2	2	2
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	8	8	10

Codes

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

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

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

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

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

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] CPT (b)(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU 2

DATE: 22 Jun 03

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

[redacted] (b)(6)-4

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