PROGRESS NOTES

0200 .7 mg MORAPHINE FOLEY STARTED URINE AMBER, NO SIGN OF BLOOD
X RAY SHOOT AT 0203 — [redacted] 18 JUN 03
B6-2

0200 — 2nd liter LR Begun.
0320 — LAST 5 mg OF MORAPHINE — [redacted]

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							NAME (Last, First, Middle Initial)	4. PAY GRADE		5. SEX
9	10	11	12	13	14	15	B6-4 EPW [redacted] B6-4	16	17	18
[redacted]										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	
								3	5	y	Z	9	unk

10. LENGTH OF SERVICE			ETS	11. FMP		12. SOCIAL SECURITY NUMBER								
32	33	34	N/A	35	36	37	38	39	40	41	42	43	44	45
				9	9	[redacted]								

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
N/A	46: U	0545	N/A B6-4

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	9									

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: 0	ICW2	~~ADDRESS OF EMERGENCY ADDRESSEE~~ (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] B2-2		~~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
5	0							0	3	0	7	0	6

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	8

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: GSW (L) arm
GSW (R) flank

ADMITTIN[redacted] B6-2 [redacted] Dr, [redacted]

SIGNATURE OF ADMITTING CLERK

B6-2 [redacted] SPC, 91G10

DA FO[redacted]

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

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

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

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

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

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

Apprehending Unit: [redacted] B2-2 | Location Grid: MB 475 931

Date of Incident: (D/M/Y)	Time of Incident:	Date of Report: (D/M/Y)	Time of Report:
17 06 03 to / /	2315 hrs to 2415 hrs	/ /	hrs

Detainee #:	Key Connected Person: [ ] Victim [ ] Witness
Last Name: B6-4	Last Name:
First Name: [redacted] Given Name:	First Name: Given Name:
Hair Color: Scars/Tattoos/Deformities:	Hair Color: Scars/Tattoos/Deformities:
Eye-Color: Weight: lb Height: in	Eye-Color: Weight: lb Height: in
Address:	Address:
Place of Birth:	Place of Birth:
Ethn/Tribe/ Sect: Sex: [ ] M [ ] F Phone#: DOB D/M/Y: [ ] Mobile [ ] Regular	Ethn/Tribe/ Sect: Sex: [x] M [ ] F Phone#: DOB D/M/Y: [ ] Mobile [ ] Regular
[ ] Passport [ ] Dr. license [ ] Other (specify) Document #:	[ ] Passport [ ] Dr. license [ ] Other (specify) Document #:

Total Number of Persons Involved 3 (list names/identifying info on reverse under "Additional Helpful Information")

[ ] Vehicle Information	Vehicle Number ____ of ____ Vehicle(s)		Owner:
Make:	Color:	VIN:	
Model:	Type:	Plate No.:	Number of People in Vehicle:
Year:	Names of People in Vehicle:		
Contraband/Weapons in Vehicle:			

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

Name of Assisting Interpreter: [redacted] Email, Phone, or Contact Info: B6-3

Detaining Soldier's Name (Print): [redacted] Last, First MI	Supervising Officer's Name (Print): [redacted] Last, First MI
Signature: [redacted] B6-2	Signature: [redacted] B6-2
Email: Unit Phone: Date: 18 06 1003	Email: Unit Phone: Date: / /

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

Why was this person detained? Pulled a illegal weapon on a Coalition force, DEMONSTRATED INTENT TO FIRE ON US FORCES

Who witnessed this person being detained or the reason for detention? Give names, contact numbers, addresses.
SFC [redacted], SSG [redacted], SSG [redacted], SGT [redacted], SPC [redacted]

B6-2

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

Who was with this person?

What weapons was this person carrying? AK 47

What contraband was this person carrying?

What other weapons were seized?

What other information did you get from this person?

Additional Helpful Information:

PATIENT'S CLEARANCE RECORD

For use of this form, see AR 40-2; the proponent agency is OTSG

[redacted] B6-4

PATIENT'S IDENTIFICATION

DATE OF DISCHARGE: 22 June

TIME OF DISCHARGE:

SIGNATURE OF WARD OFFICER: [redacted] B6-2

ACTIVITY CLEARANCE

(The final activity with which the patient must clear will be the disposition office.)

Military	INITIALS*	Non-military	INITIALS*
1. Patient's Trust Fund		1. Patient's Trust Fund	
2. Medical Services Account Officer		2. Medical Services Account Officer	
3. Clothing and Baggage		3. Clothing and Baggage	
4. Medical Holding Unit		4. Postal Service	
a. Supply		5. Change of Address	
b. Pay Section		6. Other *(Specify)*	
c. Service Records		7.	
d. Insurance and Allotments		8.	
5. Postal Service		9.	
6. Change of Address		10.	
7. Other *(Specify)*		11.	
8.		12.	
9.		13.	

REMARKS

DATE 22 Jun 03

[redacted] B6-2

* INITIALS OF PERSON AUTHORIZING CLEARANCE.

DA FORM 4029, MAR 73 [redacted] USAPPC V1.00

INPATIENT TREATMENT RECORD COVER SHEET

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

B6-4

1. REGISTER NUMBER [redacted]	2. NAME (Last, First, MI) EPW [redacted] B6-4			3. GRADE EPW	ADMISSION REMARKS
4. SEX 35	5. AGE M	6. RACE UNK	7. RELIGION UNK	8. LENGTH OF SVC —	9. ETS —	10. PREVIOUS ADMISSION N
11. FMP 99	12. SSN [redacted]	13. ORGANIZATION B6-4				14. WARD ICW1
15. FLYING STATUS —	16. RATING/DSG —	17. DEPT./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 1230	23. CLINIC SERVICE ABAA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK			25. TYPE DISPOSITION 50	26. DATE OF DISPOSITION 22JUNE03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK			27b. TELEPHONE NO. UNK	28. DATE OF THIS ADMISSION 19JUNE03	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] BZ-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

blast injury (R) chest, (L) flank, (L) lower extremity

875.1
879.5
891.1
E991.2

86.05

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	3	3

36. Total Days All Facilites

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

SIGNA[redacted] B6-2 [redacted] B6-2

DA FOR[redacted] EDITION OF 1 AUG[redacted] USAPPC V1.10

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

[illegible] Shotgun [illegible]

[illegible]

PHYSICAL EXAMINATION

[illegible]

[illegible]

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

A) Blast Injury c multiple Fx (D) leg

P) Admit [illegible] (D) leg (P) Thigh

SIGN[redacted]

B6-2	DATE 14 [illegible]	IDENTIFICATION NO.	ORGANIZATION
[redacted]ION (For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)		REGISTER NO.	WARD NO.

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

All B6-2 (except last)

PROGRESS NOTES

DATE	
19 JUNE 2100	Postop - #315 S/P blast injury, readmitted to ICW c̄ recovering on ICU-2. VS 124/84, P114, R15, T99.- Ax Pt c̄ dsgs to (R) lat area, Several dsg to abdomen, C/D/I. Pt c̄ dsg and JP drain to (L)LE, C/D/I. JP c̄ 1.5cc blood in bulb. Dsg c̄ ace wrap to (R) thigh C/D/I. Foley in place draining clear yellow urine. (B) 18G IVs to ACs running LR, will H/L when taking good PO. LCTA(B). BS x 4 hypoactive. Will continue to monitor. ——— [redacted] LT AN —
20 JUNE 0500	JP drain since 2100 last night put out 2cc of serosang drainage. ——— [redacted] LT AN —
20 Jun 0700	- Pt asleep but easily aroused, VSS, A+OX3, LS CTA (B), ⊖BS x4, S1 S2 present, skin warm + dry, IV (L) AC patent infusing LR@125cc/hr Foley cath in place, urine amber, DSG on abd CDI, wound on (L) thigh ⊘ bleeding, JP drain to (L)LE minimal amount of blood, ACE Wrap (R) thigh CDI. [redacted] AN/M6
20 JUNE 03 1035	General Surgery [illegible] S/P [illegible] multiple [illegible] wounds - (L) flank (R) [illegible] [illegible] - [illegible] [illegible] [illegible] - [illegible] [illegible] [illegible] [illegible] [illegible] [illegible], [illegible] x 45° [illegible] [illegible] [illegible]. - D/C foley cath. [redacted]

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

#[redacted] B6-4

MEDICAL RECORD	PROGRESS NOTES
DATE	
[illegible]	General Surgery
1835	35 yo ♂ complains [illegible] injury to (R) chest
	(L) temple [illegible] – stable hemodynamically
0955	No known prior/past [illegible]
25 / 31 / 313	BP 132/87 HR 102 RR 22 [illegible] RA
	Neuro – [illegible] (–) eye injury [illegible]
ABS 3.8	Chest CBT [illegible] (+) [illegible] (R) [illegible] – hemothorax
LFT WL	Does not appear to [illegible] chest. [illegible]
136	Abd: Soft, NT, ND (+) BS
	(L) flank wound, (C) [illegible] wound
UA – trace blood	hemorrhoids – does not [illegible]
15 RL	Ext: multiple fragment wounds [illegible]
OR NP	[illegible]
FB (R) Eye	(M) / REE : Multiple [illegible] wounds
Remove	– DDP [illegible]
OPTX/HTX	– follow [illegible]
CBC CT	– facial [illegible]
OPTX/HTX	– [illegible]
OFS	[illegible]
ABN	
FB Left [illegible] (L)	[redacted]
	B6-2
Left [illegible]	

(Continue on reverse side)

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

PROGRESS NOTES
Medical Record

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

[redacted]

B6-4

A11 B6-Z

MEDICAL RECORD	PROGRESS NOTES
DATE	
20 Jun 03	Pt resting in bed. A&O x3 PERRLA, Pupils 3mm in size. LS CTA (B). S1 S2 Present, HRRR. (+) BS x 4 quads Abdomen [redacted] soft Flat non tender. - BM Today. Voiding spontaneous clear yellow urine qs. Patient has Drsg LLE [redacted] CDI, Drsg ↑ RLE CDI. Multible abdomenal Drsg's CDI. Pt has puncture wounds (shrapnel) on face, Anterior Trunk, Anterior LE Bilat. Will continue to monitor. [redacted] -PN
20 Jun 03	0715 - Pt lying in bed, A+O x3, VSS, LS CTA (B), (+) BS x 4 quads, S1 S2 present, peripheral pulses strong, cap ret <3sec, Dsg on Abd CDI, Dsg on (L) LE ∈ signs of blood, Dsg (R) LE CDI, JP drain had 42 ml of watery blood, Pt has puncture wound throughout body ∈ ∅ bleeding. IV HL (R) AC in good condition [redacted] 9WH
21 Jun 03 0925	General Surgery POD #2 s/p [illegible] multiple blast wounds. Pt is complaining [illegible] 188 All wounds ∈ (L) [illegible] ∈ of [illegible] (contaminated) [illegible] area. ∅ signs of infection, only closed injury is (R) thigh ∈ [illegible] [illegible]: Cont wound care - dressing [illegible] / [illegible] in AM. [illegible] / [illegible]. Cont IV ABX x 24° for [illegible] (L) [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.

PROGRESS NOTES
Medical Record

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

A11 B6-2

PROGRESS NOTES

DATE	
	Ortho
21 Jun	ASCO
	VSS AF
	Wounds clean, some serous drng, Oly
	+45 cc out JP Drn
	A) S/P I&D open brea Drn
	P) Cont JP till tamp
	Add Omnicyn / Clndmy
	Redress wounds
21 Jun	1552 - JP drain emptied, contained 30ml [redacted]
	watery blood. [redacted]
21 Jun 03	(1700) Pt resting in bed. PERRLA, [redacted] Pupils 3mm in size. Lungs CTA Through out. S_1 S_2 Present, HRRR. (+) BS x 4 quads. Abdomen soft Flat non tender. 4x4 drsg on [redacted] (L) Flank CDI. Multiple shrapnel wounds to Face Trunk (Anterior), (B) LE (Anterior). (R) LE has JP drain sutured into [redacted] extremity 4 inches Superior to Patela. ~~Drano~~ Draining Bright red blood. No Pain issues at this time. Will continue to monitor. - [redacted] Spc LPN
22 June 0410	Dr [redacted] reviewed record. Message left for Dr Drainger in am. Transportation will pick up all 5 Syliant pt of all are ready for d/c. Pt still needs JP removed & d/c orders in am. [redacted]

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

AUTHORIZED FOR LOCAL REPRO

DICAL RECORD | PROGRESS NOTES

DATE	NOTES
	MMO
22 Jun 0600	asked of pt could be DC'd
	wants always been
	TJP in place 30cc sm PR
	drainage
	will PULSP
	DC to D/C and
	Augmentin 875 PO TID
	Clindamycin 300 PO TID
	TB 3 prn
	[redacted] B6-2
22 Jun 0630	VS Temp 99 - [redacted] 18 - 121/72 Alert
	Lungs clear. BS (+) x4 quad. MS 5 by ZVP
	given anxiety D/C SP. JP emptied @ 0550
	c 30cc cy red clear drainage. Dressing intact
	B6-2 [redacted] ZKT RN
22 Jun 0700	Drsg Med Heparin flush Blunted wire
	pulling D/C RX [redacted] ZC 7/17
	B6-2

NSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUM (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.

[redacted] B6-4

PROGRESS NOTES
Medical Record

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

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

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Imp) [redacted] B2-2

LOG NUMBER

ARRIVAL DATE			TIME	TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)	CURRENT MEDS. (Tetanus immunization and other data)	HISTORY OBTAINED FROM
DAY	MONTH	YR.		☐ PRIVATE VEHICLE ☐ AMBULANCE ☑ OTHER (Specify) Medevac	Ø	☐ PATIENT ☐ OTHER (Specify)
19	Jun	03	0935			ALLERGIES NKDA

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

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

CHIEF COMPLAINT(S) (Include symptom(s), duration): GSW Abd

SEX: M AGE: 35

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 0915

VITAL SIGNS			
TIME	0905	0945	1000
BP	104/65	122/73	128/87
PULSE	97	94	102
RESP.	20	16	20
TEMP.			
WT. (Child)	90kg		

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

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)

35 y/o ♂ S/p GSW ≈ 1000 this am. Unclear hx.

ROS unable/difficult to obtain 2° dysphasic dialect.

1°
O: Speech clear/articulate in Arabic
A: ↑ OP/UP clear/pat
B: CTA full breathing = (B)
C: IV (L) antecub ⊕2 pulses +4 ext PMS = ⊘ circ extremities
D: Ao o to environment
E: ⊕ multiple "pepper" wounds over abd/chest

ORDERS	IN[redacted]	TIME
IV, IVF's 2 L bolus		0915
CBC, Chem12, Lytes,		0915
U/A, T&S		0915
Foley		0920
Pulses, Sens &		0925
CXR, ABD X-ray		0945

BLE Xray [redacted] 0940
Ancef Tzp [redacted] 0950
Td .5cc sq [redacted] 0950

Foley placed w/ medk clear urine

ASSESSMENT/DIAGNOSIS: GSW

2° Trauma back s/p NT PERRL conj
Abd 10
Abd soft, NT over deep palp ⊕ GSW T7 level and stabilizing
GU NL circ ♂ prostate
Pelvis stable on lat compression
Neuro grossly intact Ext: Full ROM

25.0 / 12.6 / 39.5 / 3.3

CXR ⊕ FB low (L)
KUB
Ext. ⊕ ~11 FB [redacted] UA 1.030

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: A/P S/p GSW

CONDITION UPON RELEASE
- ✓ IMPROVED
- UNCHANGED
- DETERIORATED

TIME OF RELEASE:

(CONTINUE ON SF 507, IF NE[redacted]

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]

B6-4

SIGNATURE OF PROVIDER AND ID STAM[redacted]

INSTRUCTIONS TO PATIENT (Include medic[redacted]ollow-up plans)

B6-2

EMERGENCY CARE AND TREATMENT
Medical Record Copy

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

510-112 NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
19MAR03			Surgery Brief op note
PM			preop dx blast injury (L) flank, (R) chest
			postop dx same as above
			procedure ex lap exploration
			Surgeon [redacted] 66-2
			anesthesia general
			fluids 1000
			EBL min
			complications none
			findings: metal fragments from (R) chest/flank wound, rocks from (L) flank wound.
19MAR03			arrival operative [redacted]
			preop Dx: Blast Inj [redacted] B6-2
			procedure: I&D, washout
			(R) open wound Dx
			(R) Thor, (L) Dx
			Drains
			EBL: 2 ml
			To PACU stable
			2 large stones removed from
			(L) knee 9L washout
			[redacted] B6-2

(Continue on reverse s[redacted]

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

REGISTER NO. [redacted] WARD NO.

[redacted] NOTES

[redacted] Record

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

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: 35
HEIGHT: } unknown
WEIGHT: }

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

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

4. PROPOSED SURGICAL PROCEDURE: S/P blast injury I & D schrapnel wounds

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition ____
Tobacco 1/2 ppd X ___ yrs. Body Piercing Ø Diabetes (Y) (N) ROM ____ ASA/Motrin w/72 hrs (Y) (N)
ETOH Social Implants Ø Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures Ø 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	Ø Pt. verbalizes any specific anxiety. Ø Pt. Exhibits relaxed body posture.	Ø Allow pt. to verbalize freely. Ø Explain OR environment and answer questions regarding surgery. Ø Offer comfort measures. (e.g.. warm blanket. touch). Ø Explain all nursing procedures before they are done. Ø Remain with pt. whenever possible. Ø Maintain family interface. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: ✓ 1) Positioning ✓ 2) Effects of Anesthesia ✓ 3) Medical/Smoking History	Ø Pt. will be able to breathe without difficulty during immediate intraoperative phase.	Ø Offer to elevate head of litter or offer pillow. Ø Observe pt. while awaiting surgery for signs of distress. Ø Assist anesthesia during intubation and extubation.
C. INTEGUMENT ✓ Potential impairment of skin integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement ✓ 3) Positional Aids 4) Prosthesis ✓ 5) Pooling of Prep Solutions	Ø Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	Ø Utilize pressure preventing devices on OR table and accessories. Ø Check for proper positioning and support to maintain good body alignment. Ø Pad pressure points. Ø Place ESU ground pad on non compromised skin surface area. Ø Keep prep fluids from pooling.

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

EPW [redacted] B6-4

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: Ø

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. 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	Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	Check for support stockings or ace wraps. If none, check with doctors. Check that safety straps are correctly applied. Offer pillow for under knees. Place and take down legs from stirrups with slow bilateral motion. Check that rings 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	Pt. will be transferred to OR table without difficulty. Pt. will not experience unnecessary physical discomfort.	Have sufficient people available for transfer. Insure proper body alignment. Allow patient to lie in position of comfort while waiting for surgery. Offer support (i.e., pillows, 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	Pt. will be made aware of surroundings prior to anesthesia induction. Pt. will be transferred safely to OR table. Pt. will be able to understand instructions. Minimize danger of injury during intraop period.	Introduce self. Keep pt. informed as to where he/she is and what is happening. Inform pt. in which direction to move and assist if necessary. Speak clearly and slowly. Address pt. from Center side. Validate pt.'s understanding of verbal communication. Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

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

[redacted] B6-2 19 jun03 DATE

11. POSTOPERATIVE EVALUATION: SKIN INTEGRITY: Bovie Pad Site: ☐ Clean and Dry ☐ Red ☐ N/A DRESSING DRY & INTACT: (Y) (N)

LEVEL OF CONSCIOUSNESS: ☐ A&O ☐ Drowsy ☐ Sleepy ☐ Intubated BREATHING EASY: (Y) (N)

LEVEL OF ACTIVITY: ☐ Moves All Extremities ☐ Moves Upper Extremities ☐ Transferred to litter with roller due to spinal

12. PREOPERAT[redacted] PREPARED BY (Signature and Titl[redacted] B6-2

DATE: 19 jun03 TIME: 1245

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Titl[redacted] B6-2

DATE: 19 jun03 TIME:

REVERSE OF FORM 5179, JUN 91 USAPA V1.0

All B6-2 (except last)

MEDICAL RECORD — **INTRAOPERA[illegible] DOCUMENT**

For use of this form, see AR 40-66, the propo[illegible] 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: 1LT [redacted]

3. DATE 19Jun03 TIME PATIENT ARRIVED IN SUITE 1625

4. PATIENT IN ROOM TIME 1625 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA s/p Blast injury - multiple schrapnel wounds.
NPO ~ 1400 - Pt had "sip of water" - Anesthesia aware.

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	1LT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* Supine on padded OR table, BUE on padded arm boards <90°.

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

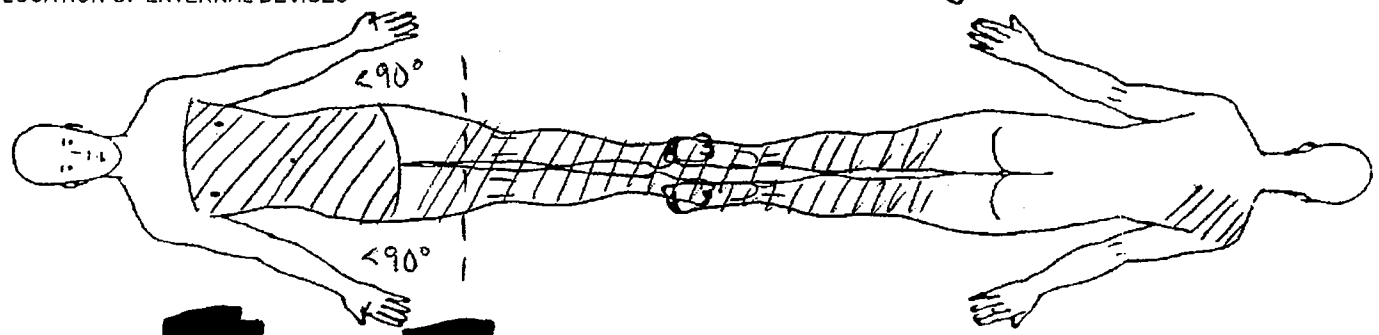
COMMENTS: Normal anatomic body alignment maintained.

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine / Betadine
SITE: Nipple line to pubis BY WHOM: 1LT [redacted]
SITE: BLE BY WHOM: CPT [redacted]
COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



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

Initial: SSG [redacted] 1LT [redacted]

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No	/	C	C	SSG [redacted]	1LT [redacted]
Needle Sharp	☒ Yes ☐ No	/	/	/		
Instrument	☐ Yes ☒ No	/	/	/		
Other	☐ Yes ☒ No	/	/	/		

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

[redacted]

B6-4

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

☒ ESU NO: # 1 CUT 30 COAG 30
GROUND PAD: BRAND VL Polyhesive
LOT NO: 55290 Exp 2003-10

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

All B6-2

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE [redacted]

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

16. [redacted] LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	#10 JP		
SITE	Left knee		

18. DRESSING/IMMOBILIZATION *(Specify)*
fluffs, 4x8, tape, ACE

19. ADDITIONAL INFORMATION
WC
Surgeons: Dr. [redacted] Dr. [redacted] Anesthesia: LTC [redacted] Anesthesia Type: Gen

Bovie Pad site intact pre-op ✓; post-op ✓ Bovie Settings: Coag/Cut 30/30
Tourniquet Site intact pre-op ____: post-op N/A
Tourniquet Time: Up____ Down____

DA5179 Initiated

20. OPERATION(S) PERFORMED

I&D of wounds

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU2	See DA7389	LITTER c O2

22. REGISTERED NURSE SIGNATURE [redacted]

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY	
POST- DAY	
MONTH-YEAR	DAY
19	HOUR

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

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

#[redacted] B6-4

VITAL SIGNS RECORDS

Medical Record

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

Ward/Section: ZMT | QUESTING P[redacted] B6-2 | CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST: EPW [redacted] B6-4 | DATE: 19 Jun 03 | TIME: 1930 | SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na	136	138-146 mmol/L
K	4.9	3.5-4.9 mmol/L
Cl	104	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	27	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	3.8	3.5-5.5 g/dl
ALP	45	26-84 u/l
ALT	47	10-47 u/l
AMY	35	14-97 u/l
AST	38	11-38 u/l
TBIL	1.0	0.2-1.6 mg/dl
BUN	16	7-22 mg/dl
CA^{++}	9.2	8.0-10.3mg/dl
CHOL	167	100-200 mg/dl
CRE	1.0	0.6-1.2 mg/dl
GLU	136	73-118 mg/dl
TP	6.6	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^+	136	128-145 mmol/l
K^+	4.9	3.3-4.7 mmol/l
CL^-	104	98-108 mmol/l
tCO_2	27	18-33 mmol/l

REMARKS:

REPORTED BY: [redacted]

DATE: 19 Jun 03

LAB ID NO.:

B6-2

B6-2

Ward/Section: EMT

NG P[redacted]

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

LAST, FIRST, M: [redacted] B6-4

[redacted]

TIME: 0930

SSN/PSEUDO SSN:

EPW

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	25.8	4.8-10.8 x 10^3
RBC	4.31	4.7-6.1 x 10^9
Hgb	12.6	14-18 g/dl (M) 12-16 g/dl (F)
Hct	39.5	42-52% (M) 37-47% (F)
MCV	91.7	80-94 fl (M) 81-99 fl (F)
Plt 313	~~29.~~ [redacted]	130-500 x 10^3 verified
Lymph %	6.8	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	Yell	N/A
App	Clear	N/A
Glu	Neg	Negative
Bili	Neg	Negative
Ket	Neg	Negative
SG	1.030	N/A
Bld	Trace	Negative
pH	6.0	N/A
Prot	30	Negative
Urob	0.2	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 BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

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

SSA-mod OCC gran cast
RBC-1-5
WBC-1-3
mucus small

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

REPORTED BY: [redacted] B6-2

DATE: 19 Jun 03

LAB ID NO.:

B6-2

Master Copy

Ward/Section: FCW-1	REQUESTING PHYSICIAN: [redacted] / [redacted]	LABORATORY RESUL (Subject to the Privacy Act	
LAST, FIRST, MI: B6-4 [redacted] EPW	DATE: 6/17/03	TIME: 1310	SSN/PSEUDO SSN

[redacted]

TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	R
WBC	15.2	4.8-10.8 x 10^3	Color		N/A	RPR		N
RBC	3.37	4.7-6.1 x 10^9	App		N/A	Mono		N
Hgb	9.6	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	[redacted]		
Hct	30.6	42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV	90.9	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt	227	130-500 x 10^3 verified	SG		N/A	Occ Bld		
Lymph %	9.7	20.5-51.1%	Bld		Negative	H. pylori		
[redacted]			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	[redacted]		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	[redacted]					
Sed Rate			Cell Count			MUST SUBMIT SE 5 EVERY UNIT REQU		
Other			Directigen		Negative	ABO/Rhe		

[redacted]

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

REMARKS:

REPORTED BY: [redacted] | DATE: 19 June 2003 | LAB ID NO.:

B6-2

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)	
Versed	( )	2.5
Fentanyl	( )	100 50 100
Propofol	( )	180
Sux / Vec	( )	100 / 4 2 1
Mason	( )	5 5 5
	( )	
VOLAT AGENT	Forane % del	.4 - 1.5 1.0 1.0 2.0 - 2.0 - 2.5 2.5 - 2.5 2.0
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	100 2 - 2 - 2 2 - 2 - 2 - 2 - 2 2

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

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

LINE site		
LR	RL	☐ Warmed
LR	LL	☐ Warmed
		☐ Warmed
		☐ Warmed

FLUIDS: 800 — 800 — 800 — 900; 500 — 350 — 650 — 350

LOSSES	
EST BLOOD LOSS	
URINE –	150 100 / 150 50 / 150

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 80 (KG) LB

HEMATOCRIT: 39.5

INITIAL DATA: BP – 133/79; HR – 110

EQUIP CHECK: OK? – (Y) N

PATIENT CONSENT: OK for PROCEDURE? Y; TIME – 1600

TIME → 1630 1700 30 1800 30 1900

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

220 200 180 160 140 120 100 80 60 40 20

VT – ml		920	870	800	840	830	860	830	840	850	860
f – breaths/min		7	9	7	7	7	7	9	9	8	8
Peak inf pres / PEEP		20	21	21	21	21	21	21	21	25	24
MODE– S(pon), A(ssist), C(on)		SV	CV	CV	CV	CV	CV	CV	CV	CV	CV	SV
BP/Auto Cuff	ET CO2 (torr)		31	36	32	32	31	37	34	35	31	30
BP / oth	FIO2 (Frac or %)	1.0	.85	.85	.85	.85	.85	.88	.88	.88	.86	.85	1.0
ART line	SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	ST	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP- site												
	N-M Block (T/4)												
Warming blkt													
Conv warmer													

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

TOTALS	
TOTAL BIL	100
TOTAL URINE	250

FLUIDS – SUMMARY: CRYSTALLOID – 1650; COLLOID –; BLOOD –

REMARKS – Code drugs with numbers, events with letters

PT ID chart Reviewed
Tx Rg Rt Lt
1635 In Room
Mask O2
1630 Smooth Induct
Intubated
1635 NG Passed Left Nares
1915 Bankson reported
1902 Rocuronium 40 mg IV
1910 Released
Neostigmine 3 mg
Glycopyrrolate 0.6 mg
TO 4/4
Sustained Lateral
1975 122/35 - 15
1930 SP Vent
Sx extubated
TX 02

RECOVERY AT 1935; PACU ICU (Specify); OTHER; CONDITION: Stable T 96.; RESP – 24; SpO2 – 100%; BP – 139/60; HR – 114

	Start	Room	End
ANES	1610	1625	1945
	Ready	Begin	End
PROC	1635	1658	1910

PROCEDURES and CPT Codes: I & D Schapel Left Chest Back

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA RSI Crico2 3 mell

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: DL x1 by DR Tekna 4.5 Preoxic Cetraxate B/S = Ecrox6 ETT Second attempted

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

EPW # [redacted] B6-4
35 ♂
ICW 1

B6-2

SURGEON: [redacted] / [redacted]

AN [redacted]

PROCEDURE LOCATION 1

DATE 19 Jan 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

PATIENT RECORD

MEDCOM - 11463

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

③ AO

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 35 DAYS MOS YRS Sex (✓) MALE ( ) FEMALE

PROPOSED PROCEDURE: I&D schrapnel wounds (L) Leg, GSW Abd
SURGICAL SERVICE: Ortho / Gen Surg
NPO SINCE: MN

ASA Physical State 1 (2) 3 4 5 (E)
WT: 80 KG/LB HT: ____ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: 1/2 pk day
ETOH: occ
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed

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

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

LABORATORY STUDIES:

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

250 > 12.6 / 39.5 < 313
136 | 104 | 16 < 136
~~4.0~~ 4.9 | 27 | 1.0

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	multiple blast
	N	Y	injuries ~~(R) arm~~
Familial HX	N	Y	(L) ~~thigh~~ Leg
			GSW Abd

ASSESSMENT

PAST SURGICAL/ANESTHETIC
denies

PHYSICAL EXAMINATION

BP 125/75 HR 94 R 16 T ____
Pain Scale 0-10 ____
HEENT - Teeth Bordentition all teeth
MP2 Trachea midline
TMJ/Neck ____
Oropharnyx ____
Nares ____
CHEST: CTA
CARDIAC: RRR
EXTREMITIES: ____
IV Access: 18ga (R) & (L)
Ulnar Filling: ____
BACK: ____
OTHER: Left pupil > Right Pupil. Surgeon notified

NPO Since MN

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

Questions asked. assistance of anesthetist, procedure risks, plan discussed. Questions answered.

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

[redacted] B6-2

The pa[redacted]d agrees. Questions answered.
Signed [redacted] Date: 6/19/03 Time: 1300 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ICW-1 / ICU-2
EPW
[redacted]
B6-4

SEDATION KEY:

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] — B6-4

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW1		

DATE OF ORDER 19 JUN 03 TIME OF ORDER 1230 HOURS

LIST TIME ORDER NOTED AND SIGN

1. [redacted]
2. [redacted]
3. [redacted]
4. [redacted]
5. [redacted]

PATIENT IDENTIFICATION

Jo Pharmacy [redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

6. [redacted]
7. [redacted]
8. [redacted]
9. [redacted]
10. [redacted]

[redacted] — B6-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER B6-2 [redacted] TIME OF ORDER HOURS

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

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

CLINICAL RECORD - 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] B6-4

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

DATE OF ORDER: 19 JUN 03 TIME OF ORDER: 1800 HOURS

LIST TIME ORDER NOTED AND SIGN

1. ADMIT TO PAIN - ICW
2. S/P TID BLOCK INJECTIONS
   (R) BACK, (L) FLANK/ABDOMEN
   (L) CEP
3. STABLE - VITALS PER PROTOCOL
4. NPO
5. ACTIVITY: OOB AMBULATION PRN

PATIENT IDENTIFICATION: [redacted] B6-4

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

DATE OF ORDER | TIME OF ORDER | HOURS

6. DIET: AS TOLERATED TO REGULAR
7. IOPS: CR @ 125 cc/hr WHEN TOL. PO WELL
8. MEDS: MSO4 1-5 mg IV q 1 PRN
   TYLENOL #3 1-2 TAB PO q 4 PRN
   PHENERGAN 25 mg IV q 6 PRN

PATIENT IDENTIFICATION

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

DATE OF ORDER | TIME OF ORDER | HOURS

9. VITALS: q
10. WORKING: D/C FOLEY WHEN AMBULATING
    DRESSING D/C BID - CLEAN TO DRY
    & NACL & KERLIX

[redacted] B6-2

PATIENT IDENTIFICATION

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

DATE OF ORDER: 19 JUN 03 TIME OF ORDER: 1100 HOURS

DRAIN (L) KNEE TO BULB SUCTION
ANCEF 1 gm IV Q8° x 48 hrs

B6-2

NURSING UNIT: OMV/2125 | ROOM NO.: 19 JUN 03 | BED NO.: [redacted]

[redacted]

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE [redacted]

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] B6-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 20 JUNE 03 | TIME OF ORDER: 1055 HOURS | LIST TIME ORDER NOTED AND SIGN

1. d/c Foley catheter
2. [illegible]
3. HCU wires [illegible]
4. [illegible] [redacted] bid

B6-2 [redacted] MD

MST pm

20 June 03 1573

LIST TIME ORDER NOTED AND SIGN: [redacted] 20 JUNE 03 1056

PATIENT IDENTIFICATION

[redacted] B6-4

b6-2

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

DATE OF ORDER: 21 JUNE 03 | TIME OF ORDER: 0530 HOURS

1. wound care

Bacitracin ointment, apply to open wounds, bid

B6-2 [redacted] MD B6-2

B6-2 [redacted] 21 June 03

PATIENT IDENTIFICATION

NURSING UNIT: MO/0115 | ROOM NO.: 22 June 03 | BED NO.: [redacted]

DATE OF ORDER: 21 June | TIME OF ORDER: 1530 HOURS

Cont Ancef

Unasyn 1.5 gm IVPB Q6°

Clindamycin 300 mg PO TID

Redress wounds BID

b6-2

B6-2 [redacted]

B6-2 [redacted] noted

PATIENT IDENTIFICATION

[redacted] B6-4

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

DATE OF ORDER: 22 June | TIME OF ORDER: [redacted] HOURS

D/C JP

D/C to TPN

B6-2 [redacted]

B6-2 [redacted] 22 June 03 0630

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

All B6-2 (except last)

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 19	20	21	22
6/19	[redacted]	Vitals q 1° x 3 then	05, 17				
		q 2°	05				
6/19	[redacted]	Activity: Bed rest	05, 17				
			17, 05				
6/19	[redacted]	Diet: NPO	05, 17				
			17, 05				
6/19	[redacted]	OOB, ambulation TID	6	[redacted]			
			14	[redacted]			
			22	[redacted]			
19	[redacted]	advance diet to Regular	5	[redacted]			
			17	[redacted]			
19	[redacted]	Drsg Δ's wet to Dry	6	[redacted]			
		BID c̄ NaCL &	18	[redacted]			
		Kerlix					
19	[redacted]	DRAIN (L) knee to	5	[redacted]			
		bulb suction					
21 June	[redacted]	Wound care: Bacitracin	10	[redacted]			
		Kerlex, wet to dry	20	[redacted]			
		c̄ NaCl to open					
		wounds BID					
21	[redacted]	Redress BID					

Pt off 22 Jun

ALLERGIES: ☐ YES ☐ NO — NKDA

PRIMARY DIAGNOSIS: S/P Blast Injury — (R) chest, (L) flank, lower extr. (L)

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO — PAGE NO: 1

PATIENT IDENTIFICATION: # [redacted]

S/P I+D (R) back, (L) flank, (L) leg

B6-4,

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 B6-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)					Mo June 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
6/19	[redacted]	Admit to ICW, Stable	6/19				
6/19	[redacted]	On Call To OR	6/19				
6/19	[redacted]	CBC @ 1300	6/19				
	[redacted]	↑ PREOP ↑					
19	[redacted]	admit to PACU, ICW #1, Stable	6/19	2100	—	[redacted]	
19	[redacted]	NSG: D/C Foley when ambulation	20 June 03				
20 June	[redacted]	D/C Foley cath	20 June 03	1100		[redacted]	
20	[redacted]	Advance diet	20 June 03	1100		[redacted]	
6/21	[redacted]	D/C JP	6/21	done by MD	0630	[redacted]	
6/21	[redacted]	D/C to TF 20	6/21			[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 B6-2 (except last)

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 19	20	21	22
6/19	[redacted]	LR @ 125cc	05	[redacted]			
			17				
			17	[redacted]			
			05				
19	[redacted]	LR @ 125cc /hr.	5	/ [redacted]			
		HL when TOL P.O. well	17				
19	[redacted]	ancef 1gm Q8 x 48°	6	/ [redacted]			
21	[redacted]	Continue Ancef	14	/			
			22				
20 JUN	[redacted]	Bacitracin to	10	/ [redacted]			
		wounds BID	22				
21	[redacted]	Unasyn 1.5gm IVPB	4 ~~6~~	/	/	/ [redacted]	
		Q6°	10 ~~12~~				
			16 ~~18~~				
			22 ~~24~~				
21	[redacted]	Clindamycin 300mg	6	/	/	/ [redacted]	
		PO TID	14				
			22				

PREOP

ALLERGIES: ☐ YES ☒ NO	PRIMARY DIAGNOSIS:	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
NKDA	S/P Blast Injury R Chest & Flank Lower est. (2)	PAGE NO. 1

PATIENT IDENTIFICATION:

[redacted]

B6-4

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 B6-2

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
20 JUN	[redacted]	HL IV when eating	20 Jun 03		1420	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED														
6/19 6/22	[redacted]	MSO4 1-5mg IVq 1° prn	Date Time Dose Sec 1/E														
6/19	[redacted]	Phenergan ~~28mg~~ 25 mg IVq 6° prn															
19	[redacted]	MSO4 1-5 mg IVQ 1° prn	20JUN 0430 5mg [redacted]	20JUN 0800 5mg [redacted]	20JUN 1200 5mg [redacted]	20JUN 1645 5mg [redacted]	22 Jun 26 [redacted]										
19	[redacted]	Tylenol #3 + 77 po Q4° prn	20JUN 11	[redacted]	20 Jun 1150												
				[redacted]													
19	[redacted]	Phenergan 25mg IV Q6° PRN															

PRECOP

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: 19 June 2003 Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block

Time In: 1930

Allergies: Ø OR Intake: Crystalloid 1650 Colloid

Pre-op V/S: OR Output: UOP 250 EBL 100

Procedures: I&D of wounds Meds/Times: Ø

(L) > (R) pupils (+) orbital edema

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

Pre Op Meds History

Time	1930	1940	1945	1950	1955	2000	2005	2030
SaO2	100	98	97	97	101	100	97	100
FiO2	10L	10L	10L	7L	6L	5L	10L	10L
Methods	FM	FM	FM	FM	FM	FM	FM	FM
240								
220								
200								
180								
160				V	V			
140	V	V	V			V	V	V
120								
100	X	X	X	X	X	X	X	
80								^
60			^	^	^	^	^	
40	^							
20								
RR	20	22	24	24	26	22	16	
T	95			98			98.5	

Time	1930	2000	2030		
Pain (0-10)	0	0	0		
LOS	3	3	2	1	

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
1930	LR	200	RFA	JA	200cc

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

[redacted] Name – last, B6-2

DEPARTMENT/SERVICE/CLINIC: ICU 2

DATE: June 19, 2003

[redacted] B6-4

☐ 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	Dleg	+	+	+	+	C	pale
15'	Dleg	+	+	+	+	C	pale
30'	Dleg	+	+	+	+	C	pale
45'							
60'							
90'							
D/C	Dleg	+	+	+	+	C	pale

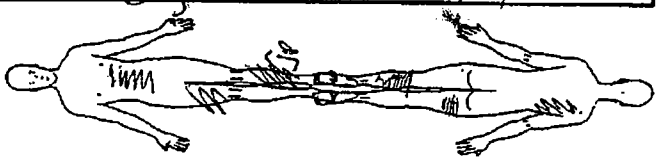
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	Dleg/chest	ace	Ø
30'	Dleg/chest	"	Ø
60'	Dleg/chest	"	Ø
D/C	Dleg/chest	"	Ø



NURSING NOTES

Pt received from OR awakable, sobbing, face mask c IOL NR, //USS poor hygiene, Ø u.o. foley cath gravity, amber, abdominal incision covered w/ dressing c D&I, JP drain to Rt leg scant serous sang drainage Dleg thigh c dressing ACE wrap c D&I, pumphrey posterior tibialis pulse palpable, cool digits brisk refill. dressing to Rt scapular area, Ø serous drainage, PIV's. Ø AC UR c 100cc Ø AC TKO.

PACU OUTPUT

Time	Source	Color/Appearance	Amount
2030	foley	cl yellow	200

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
2030	ST	Ø	no

WAMC OP 173-E

Discharge Criteria: 19 June
Date: ~~10-23~~ Time: 2030 PARS:
BP: 148/63 T: 98.3 HR: 120 RR: 18 Sa02: 100.
Pain Level at D/C (0-10): Ø
Intake: 200 Output: 200
Additional Data: Ø
Transferred To: ICW
Report Given To: [redacted] AW/RT
Transferred Via: [redacted] Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Recovery R[redacted]
Charge Nurse Signature [redacted]

867

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.)
A 1 1 D 1	I Z

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
B6-4 [redacted]	EPW # [redacted] B6-4	EPW	M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
Z Z Z Z Z Z Z Z	3 5 Y	X	9	UNK

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
—	Z	1230	— B6-4

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

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

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

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
UNK	[redacted] B2-2	UNK

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
5 Ø		Ø 3 Ø 6 2 2

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
A B A A		Ø 3 Ø 6 1 9

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

FOR LOCAL USE

blast injury: (R) chest, (L) flank, (L) lower extremity

Dx 8911 Proc 86 D
8751 Trauma 9
8795 Inj 597

B6-2 [redacted]

B6-2 [redacted] B6-2

ADM[redacted]ired)

[redacted]

MEDCOM - 11474

INPATIENT TREATMENT RECORD COVER SHEET

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

B6-4

REGISTER NUMBER [redacted] | 2. NAME (Last, First, MI) EPW [redacted] B6-4 | 3. GRADE N/A | ADMISSION REMARKS

M | 35y | Z | RELIGION unk | LENGTH OF SVC N/A | 9. ETS N/A | 10. PREVIOUS ADMISSION NO

99 | SSN [redacted] | 13. ORGANIZATION B6-4 N/A | 14. WARD

FLYING STATUS N/A | 16. RATING DSG | 17. DEPT/BEN 1C78 1C79 | 18. BRANCH/CORPS N/A | 19. UIC/ZIP | 20. TYPE CASE 1CW1

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from ER | 22. HOURS OF ADMISSION 1300 | 23. CLINIC SERVICE N/A

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE | 25. TYPE DISPOSITION 50 | 26. DATE OF DISPOSITION ABAR

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) | 27b. TELEPHONE NO. | 28. DATE OF THIS ADMISSION 22 Jun 03 | ADMITTING OFFICER

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] B2-2 | 30. DATE OF INTIAL ADMISSION 19 Jun 03 | 32. UNITS/COMPONENT TRANSFUSED Dr. [redacted] B6-2

31. SELECTED ADMINISTRATIVE DATA

33. CAUSE OF INJURY

☐ Check if Continued on Reverse

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Blast injury (B) LE

890.1
891.1
904.3
E922.9

39.32
86.05
86.22
86.59

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	4	4

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	4	4

SIGNATURE OF A[redacted] Dr. [redacted] | SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER [redacted]

DA FORM [redacted]

B6-2

MEDICAL RECORD

ABBREVIATED MEDICAL RECORD

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

35yo Sym EPW
c/o GSW UUE

NDNA

PHYSICAL EXAMINATION

117/64/64/18/97.8/98%

Alert & oriented
Clear
Pupils CTAB
Abd: soft, NT ND Bsx
(R) shoulder superficial wound clean
(R) Thigh 5x7 cm subcutaneous open c̄ skin
(R) Thigh Ant med nerve

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

A) GSW / multiple Blunt trauma

P) Tx D (R) Thigh (R) Tibia

[redacted] B6-2 | DATE 19 June | IDENTIFICATION NO. | ORGANIZATION

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

REGISTER NO. | WARD NO.

[redacted] EPW

B6-4

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

PROGRESS NOTES

DATE	
6/19/03 1700	VSS. Pt. very lethargic, but easily arousable. Received 20 mg $MgSO_4$ in OR. (+) N/V x1 and placed emesis in bag. Resting comfortably in bed c̄ basin on stomach. FTG draining light amber urine, quantity sufficient. BS (+) x4. (+) 2 pulses in all extremities [redacted] B6-2 DSG to (R) knee CDI c̄ sanguinous drainage noted and marker marked. [redacted] B6-2
19 Jun 03	1730 - Assumed care of pt. Pt lethargic, easily arousable. LS CTA (B). S_1 S_2 Present. HRRR. (+) BS x4 quads. Abdomen soft flat non-tender. Foley draining to gravity. Drsg on RLE. Small amount of blood seeping into bandage approx. 3 inches x 1 inch. Marked and Dated. Pt in 2 point Restraint. Will continue [redacted] LPN
19 Jun 03 @ 1830	I concur c̄ the above assessments [redacted] B6-2
20 JUN 03 0900	VSS. AO. PERRLA. LS CLAR. HRRR. BS (+) x4. Resting comfortably in bed c̄ c/o pain 4/10. Tolerated PO meal this AM. FTG draining light amber urine and quantity sufficient. Pt. sent to 2 pt restraint and scheduled for DSG I @ 10 AM. [redacted] B6-2
20 Jun 03	1730 Assumed care of Pt. Pt resting in bed. AO x3 PERRLA, Pupils 3mm in size. LS CTA (B), S_1 S_2 Present HRRR. (+) BS x4 quads. Abdomen soft flat non tender. Foley draining to gravity. Drsg on ↑ (R) LE CDI. Drsg ↓ (L) LE CDI. Will [redacted] LPN B6-2
21 JUN 03	(0040) Assumed care of pt @ 0900 p̄ report from night shift. Pt A/O. VSS. Pt medicate c̄ tid motrin this am for pain control. SL in (R) ac flushes well, dnbx infusing s̄ sbx infection/infiltration. Ace

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
19 JUN 03	ARMD OP NOTE / EVAC
	Preop Dx: (B) LE Blast Injuries
	Procedure: I&D c 1° Closure
	(R) Thigh wound
	Schrapnel Removal x 1
	Surgeon: [redacted] B6-2
	EBL 2 200 cc
	TT: 18 min
	Findings: Right Thigh 10x7cm L shape wound
	Saphenous Vein tied off x 1
	c 1° Closure & penrose Drain
	(R) Art Thrombosis Rest thrombus Removed
	Col wash out
	Plan: 48° IV Abx
	10 Days Keflex
	Roll Drain 48-72°
	TO EPW Comp 3 Days
	[redacted] B6-2
	(Continue on reverse)

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

REG [redacted] WARD NO.

PROGRESS NOTES
Medical Record

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
21 Jun 03	(1730) Pt Awake and resting in bed. PERRLA Pupils 3 mm in size. LS CTA (B). S1 S2 Present. HRRA. (+) BS x 4 quads. Void spontaneous Dark yellow Clear urine qS. [redacted] B6-2 Abdomen soft flat nontender. No pain issues at this time. Pt has Drsg c̄ Ace wrap to (R) LE, CDI. Drsg to (L) LE c̄ Ace wrap CDI. Will continue to monitor. — B6-2 [redacted] LPN
22 Jun 03	VS 98.4-60-10.0/18 Ao 18 Alert. Voiding under clear urine. (B) LE Drsg DJI. Lungs Clear B6-2 BS (+) x 4 quad. ∅ Distress noted. Will continue [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.

[redacted]

B6-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV 7-
Prescribed by GSA/ICMR, FIRMR
CFR)

558-103

(See Instructions on Back of this Sheet)

NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp): [redacted] B2-2

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) Bird	None	☐ PATIENT ☐ OTHER (Specify)
DAY	MONTH	YR.				ALLERGIES: NKDA
19	June	03	0911			

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) shoulder (R) leg PMH-denies PSH-denies

SEX: M AGE: 35

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER

VITAL SIGNS			
TIME	0911	0925	0955
BP	117/64	122/61	121/55
PULSE	64	60SR	70SR
RESP.	18	14	14
TEMP.		97.8	
WT. (Child)		98%	100%

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

ORDERS	INITS.	TIME
CBC	0913	
Chem 12	0913	
T Jorsen	0912	
50 Fentanyl	0919	
left tib/fib		
rt thigh/thy		

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)

Af of 3 c/o pain to rt thigh + left tib/fib. Wound Good PMS distal to injury noted to left shoulder c/o pain upon palpation HRRR. Lungs CTA (B). Abd soft + nontender. Good strength + pulse (B) LE. 16g IV started (R) AC labs drawn infusing NS. Wounds cleaned NS on monitor O2 sat 99% on RA. 16g Foley inserted draining dark yellow urine. Draining to gravity Tolerated well [redacted] B6-2 Tox-ray @1000

(0944) 1gm Ancef IM

(0946) .5 Tetnus IM

ASSESSMENT/DIAGNOSIS

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] B6-4

SIGNATURE OF PROVIDER AND ID STAMP

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

EMERGENCY CARE AND TREATMENT

MEDCOM - 11480 opy

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

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
21JUN03	0040		(cont) wrap drsgs to Ⓡ knee and Ⓛ calf CDI. Foley draining quantity sufficient clear yellow urine. Pt resting quietly @ this time. Will cont to monitor. B6-2 [redacted]
	1320		Drsg to Ⓡ knee and Ⓛ calf c/d/i. Wounds s̄ s/sx infection/infiltration. monitoring [redacted] B6-2
21Jun03	1510		Attend S/P I&D multiple [illegible] [illegible] Wounds clean & dry Close Ⓡ thigh wound [illegible] Penrose [illegible] A) S/P I&D multiple [illegible] P) Ad lib Act Redress Ⓡ leg [illegible] D/C Foley D/C 22Jun03 B6-2 [redacted]

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

STANDARD FORM 510 (REV. 7-91) BACK

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: 35

HEIGHT:

WEIGHT:

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

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

4. PROPOSED SURGICAL PROCEDURE:
I+D (R) thigh, (L)

EPW, not interview pt. language barrier

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition_____
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/Contact (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	Pt. verbalizes any specific anxiety. Pt. Exhibits relaxed body posture.	Allow pt. to verbalize freely. Explain OR environment and answer questions regarding surgery. Offer comfort measures. (e.g.. warm blanket. touch). Explain all nursing procedures before they are done. Remain with pt. whenever possible. c Maintain family interface. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: ✓ 1) Positioning ✓ 2) Effects of Anesthesia ___ 3) Medical/Smoking History	Pt. will be able to breathe without difficulty during immediate intraoperative phase .	Offer to elevate head of litter or offer pillow. Observe pt. while awaiting surgery for signs of distress. Assist anesthesia during intubation and extubation.
C. INTEGUMENT ✓ Potential impairment of skin integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement ___ 3) Positional Aids ___ 4) Prosthesis ✓ 5) Pooling of Prep Solutions	Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	Utilize pressure preventing devices on OR table and accessories. Check for proper positioning and support to maintain good body alignment. Pad pressure points. Place ESU ground pad on non compromised skin surface area. Keep prep fluids from pooling.

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

EPW [redacted] B6-4
ICW-1

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: Ø

A11 B6-2

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 — Thru 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.

[redacted] CPT IAN 19 June 03 DATE

11. POSTOPERATIVE EVALUATION:
LEVEL OF CONSCIOUSNESS: ☐ A&O ☒ Drowsy ☐ Sleepy ☐ Intubated
LEVEL OF ACTIVITY: ☒ Moves All Extremities ☐ Moves Upper Extremities ☐ Transferred to liter 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] CPT IAN
DATE: 19 June 03 TIME: 1145

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] CPT IAN
DATE: 19 June 03 TIME: 1525

REVERSE OF FORM 5179, JUN 91

USAPA V1.0

MEDICAL RECORD — **INTRAOPER E UMENT**

For use of this form, see AR 40-66, the proponent ag 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] B6-2

3. DATE 19 June 03 TIME PATIENT ARRIVED IN SUITE 1215

4. PATIENT IN ROOM TIME 1215 NUMBER 1-1 | 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: nkda

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] B6-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] B6-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: correct body alignment maintained, arms on padded armboards at less than 90°, position approved by surgeon + anesthesia

8. SKIN PREPARATION

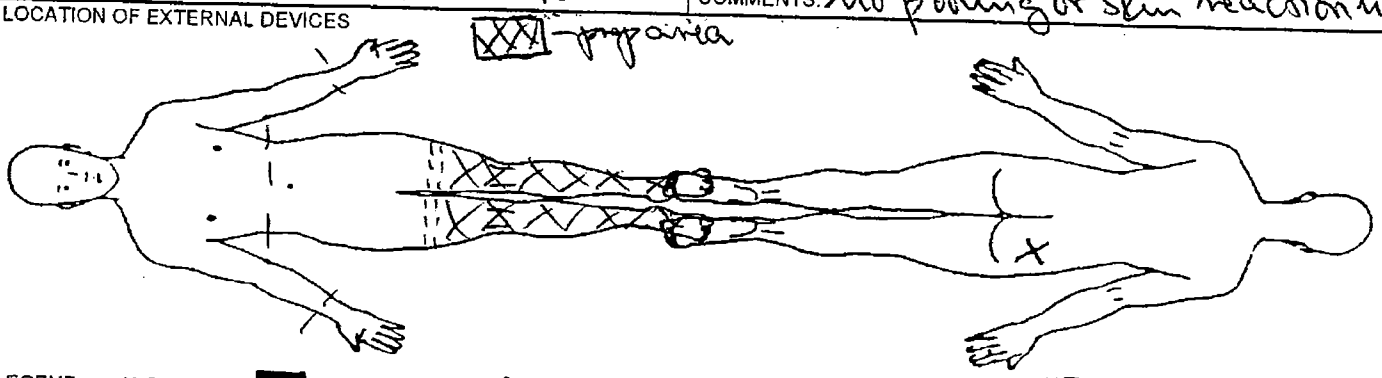
HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☒ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP

COMMENTS: no nicks or cuts noted

PREP SOLUTION *(Specify)* Betal Betal B6-2
SITE: (L) Leg BY WHOM: [redacted] B6-2
SITE: (R) Leg BY WHOM: [redacted]

COMMENTS: no pooling or skin reaction noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad [redacted] -- Safety Strap [redacted] === Tourniquet placed by Dr. [redacted]

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
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;)*

EPW [redacted] B6-4

ICW-1

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

☐ ESU NO:
GROUND PAD: BRAND Valleylab Polyhesive
LOT NO: 54179 2003-08

☐ 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):
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 ☐

	1.	2.	3.
TYPE/SIZE	3/8 Penrose		
SITE	(R) thigh		

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

19. ADDITIONAL INFORMATION
WC
Surgeons: [redacted] Anesthesia: [redacted] Anesthesia Type: General
B6-2 B6-2

Bovie Pad site intact pre-op yes ; post-op C/I Bovie Settings: Coag/Cut not used
Tourniquet Site intact pre-op yes : post-op C/I
Tourniquet Time: Up____ Down____ - monitored by anesthesia

20. OPERATION(S) PERFORMED
I+D (R) thigh, (L) Leg

21. PATIENT TRANSFERRED TO
I M2

TIME 5:00 DA7389

METHOD
Litter c safety strap on

22. REGISTERED NURSE SIGNATURE
[redacted] CPT

REVERSE OF DA FORM 517941, OCT 87
B6-2

MEDCOM - 11485

USAPA V1.01

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY																		
POST- DAY																		
MONTH-YEAR June	DAY	19		23JUN03		24JUN03												
~~19~~ 2003	HOUR	1		8		8												

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

Record special data only when so ordered																	
BLOOD PRESSURE		116/60		113/56		114/57											
Pulse		63															
Temp		98															
HEIGHT:	WEIGHT →																
				97%(RA)		97%(RA)											

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

REGISTER NO.

WARD NO.

[redacted]

B6-4

VITAL SIGNS RECORDS

Medical Record

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

Ward/Section: EMT | ESTI[redacted] B6-2 | TORY RESULT FORM (Su... to the Privacy Act of 1974)

LAST, FIRST, MI: [redacted] B6-4 | DATE: June 03 | TIME: 0913 | SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	13.8	4.8-10.8 x 10^3
RBC	4.63	4.7-6.1 x 10^6
Hgb	14.0	14-18 g/dl (M) 12-16 g/dl (F)
Hct	45.3	42-52% (M) 37-47% (F)
MCV	97.8	80-94 fl (M) 81-99 fl (F)
Plt	370	130-500 x 10^3 verified
Lymph %	13.5	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	Yellow	N/A
App	Clr	N/A
Glu	Neg	Negative
Bili	Neg	Negative
Ket	Neg	Negative
SG	1.030	N/A
Bld	Trace	Negative
pH	6.0	N/A
Prot	Trace	Negative
Urob	Neg	0.2-1.0
Nit	Neg	Negative
Leuk	Neg	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

WBL-occ
RBL-occ
Amorph sediment

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] B6-2 | **DATE:** 19 Jun 02 | **LAB ID NO.:**

Ward/Section: EUTT B62 [redacted] ATTENDING PHYSICIAN: 19JUN03

LAST, FIRST, MI: [redacted] B6-4

DATE: [redacted] TIME: 0915

SSN/PSEUDO SSN:

LABORATORY RESULT FORM

(Subject to the Privacy Act of 1974)

(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	4.3	3.5-5.5 g/dl
ALP	85	26-84 u/l
ALT	15	10-47 u/l
AMY	36	14-97 u/l
AST	20	11-38 u/l
TBIL	1.2	0.2-1.6 mg/dl
BUN	8	7-22 mg/dl
CA^{++}	9.3	8.0-10.3mg/dl
CHOL	178	100-200 mg/dl
CRE	0.8	0.6-1.2 mg/dl
GLU	119	73-118 mg/dl
TP	7.5	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

REMARKS: Hyps? SCREEN

REPORTED BY: [redacted] B6-2

DATE: 19Jun03

LAB ID NO.:

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)	
versed	(mg)	2.5
propofol	(mg)	150
MSO4	(mg)	4/2 2/2 4/2 2
Sux	(mg)	100
	( )	
	( )	
VOLAT AGENT	% del / % e.t.	1.5 1.5 1.5 x
AIR	L/Min	
N2O	L/Min	
O2	L/Min	6 — 2 — 2 — 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)

TOTALS	
2.5	250
20	TOTAL URINE 1100

FLUIDS – SUMMARY
CRYSTALLOID– 1000
COLLOID– Ø
BLOOD– Ø

LINE site		
14g PAC	☐ Warmed	600 ↑ — / #2 — 900
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES	
EST BLOOD LOSS	250
URINE –	1000 — 180

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

BODY WEIGHT: 85 (KG) LB

HEMATOCRIT: 45.3

INITIAL DATA: BP – 106/53 HR– 71

EQUIP CHECK: OK?– (Y) N

PATIENT CHECK: OK for PROCEDURE? Y TIME– 1200

TIME → 12 × 30 × 13 × 30 × 14 × 30 ×

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

T A Rt thigh 200mm Hg @ 1250, ↓ 139 TT 18

VT – ml	500	250	220	300	320
f – breaths/min	10	26	22	26	18
Peak inf pres / PEEP	22	—	—	—	—
MODE– S(pon), A(ssist), C(on)	C	S	S	S	S
✓ BP/Auto Cuff — ✓ ET-CO2 (torr)	36	38	40	38	41
BP / oth — ✓ FIO2 (Frac or %)	0.8	0.8	0.8	0.8	0.8
ART line — ✓ SpO2 (%)	100	100	100	100	100
Steth- PC/ES — ✓ ECG	SR	SR	SR	SR	SR
Gas analyzer — TEMP- site					
	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, labs, & char. V. OK to proceed
(1) To room, SOC monS, pre O2.
(2) Smooth IV RSI ≈ 12 CCP.
(3) Zofran 4mg IV
(4) Responsive, suctioned & extubated ≈ difficulty. To recovery stable Report given.

RECOVERY AT 1320
PACU ICU (2) (Specify)
OTHER 959
CONDITION:
RESP– 22 SpO2– 96
BP– 118/58 HR– 84

ANES	Start	Room	End
	1200	1210	1325
PROC	Ready	Begin	End
	1215	1240	1312

PROCEDURES and CPT Codes: Debride blast injuries lt calf & rt thigh

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Eyes taped, DL x1 ≈ trauma, @ ETCO2, BBS. Secured 22cm @ teeth ≈ tape. 8.0 [redacted]

PATIENT IDENTIFICATION – Typed or written entries: Name, Grade/Rate, Medical facility: (Syrian) EPW # [redacted] B6-4 ICW 1 35 yo ♂

SURGEONS: [redacted] B6-2 [redacted] MHS, CRNA

PROCEDURE LOCATION: 1-1

DATE: 6/19/03

PAGE 1 OF 1

[redacted] RECORD – ANESTHESIA 76 REVISED 99

MEDCOM - 11489 B6-2

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

① AO

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 35 **DAYS MOS YRS** **Sex** (✓) **MALE** ( ) **FEMALE**

PROPOSED PROCEDURE: I&D Schrapnel wound Rt thigh & lt tibia
SURGICAL SERVICE: Ortho
NPO SINCE: MN

ASA Physical State 1 (2) 3 4 5 (E)
WT: 85 KG/LB HT: ____ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: 1/2 PK day
ETOH: occ
DRUGS: Ø

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) LR
( )
( )
( )
( )
( )

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

LABORATORY STUDIES:
HB/HCT: 14 / 45.3
U/A:
OTHER:

Ancef 0945 in ER

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	multiple Blast Inj.
	N	Y	(2) Leg (R) Thigh
Familial HX	N	Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC

PHYSICAL EXAMINATION
BP 110/60 HR 64 R ___ T 98
Pain Scale 0-10 ____
HEENT - Teeth MP 2 - poor dentition, teeth intact
Trachea Midline
TMJ/Neck
Oropharnyx
Nares
CHEST: CTA
CARDIAC: RRR
EXTREMITIES:
IV Access:
Ulnar Filling:
BACK:
OTHER:

NPO Since MN

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

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

B6-2 [redacted] and and agrees. Questions answered.
[redacted] MAS, CRNA **Date:** 6/19/03 **Time:** 1200 **Hrs**

[redacted] ASU)
{ } OTHER

Signed: ____ **Date:** ____ **Time:** ____ **Hrs**

Patient Identification: (Ward) ICW/post ICU-2

[redacted] B6-4
EPW

SEDATION KEY:

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] B6-4

NURSING UNIT	ROOM NO.	BED NO.
ICW1		

DATE OF ORDER: 19JUN03 TIME OF ORDER: 1300 HOURS

Dx: Blast Injury (B) LE
Stable
US pernatine
Act: Ad lib w BAT cm
Bun Diet
IV: LR 100cc/hr
HL IV when DC'd

LIST TIME ORDER NOTED AND SIGN: [redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

meds: MSQ 2-6mg IVP Q3-4
Thim ∓ 60 Q9
Ancef ∓ 1gm IV Q8 x 48
Motrin 800 PO TID
(P) prn rose Dm Benne Q48
Reinforce DSG prn
Δ DSG Q8 Dry sterile Gauze

B6-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

c̄ Accuraps

[redacted] B6-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 19JUN03 TIME OF ORDER: 2359 HOURS

please change tylox to tylenol #3
B/c we are out of tylox

[redacted] B6-2

LIST TIME ORDER NOTED AND SIGN: Noted [redacted] B6-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
#[redacted] B6-4			21JUN03	1540 HOURS	
			DIC FORY		
			V.O. Dr [redacted]		
			B6-2	B6-2	
NURSING UNIT	ROOM NO.	BED NO.	B6-2		B6-2 [redacted]
2W 0100	22JUN03	[redacted]			

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

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

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

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

All B6-2 (except last)

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 1	19	20	21	22
6/19	[redacted]	VS per Routine	DS 17 17 DS	[redacted]				
6/19	[redacted]	Activity: Ad lib WBAT	DS 17 17 DS	[redacted]				
6/19	[redacted]	Regular Diet	DS 17 17 DS	[redacted]				
~~6/19~~	~~[redacted]~~	~~(R) Penrose drain remove~~						
6/19	[redacted]	Δ DSG QD dry sterile gauze & ace wraps	10 / /	[redacted]				

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Blast Injury BLE

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: 1

PATIENT IDENTIFICATION:

[redacted] B6-4

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

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

A11 B6-2

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	
6/19	[redacted]	Stable	6/19	noted		[redacted]	
6/19	[redacted]	R penrose drain Remove @ 48°	6/21	—	—	[redacted]	
21 JUN	[redacted]	DC Foley	24 JUN 03	—	1545	[redacted]	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
6/17	[redacted]	Reinforce drsg														
-----	-----	prn														
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															

USAPA V1.00

All B6-2 (except last)

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 19	20	21	22
6/19	[redacted]	LR @ 100 cc/hr	05	[redacted]			
		HL IV when tolerating PDs	17				
6/19	[redacted]	Ancef 1 gm IV q8° x48°	06	[redacted]			
			14				
			22				
6/19	[redacted]	Motrin PO 800mg TID	06	[redacted]			
			14				
			22				

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Blast Injury BLE

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. 1

PATIENT IDENTIFICATION: # [redacted] B6-21 (EPW)

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 B6-2

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													
6/19 Exp 6/22	[redacted]	MSO4 2-6mg IVP	19Jun 2330	2JUN 1535												
		Q 3° prn	4mg [redacted]	4mg [redacted]												
6/19 Exp 6/22	[redacted]	Tylox ii po Q4°	Did changed 19JUN03													
		prn														
19	[redacted]	Tylenol #3 i-ii po Q4° pm														

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)

ASA II SMOKER

Date: 19 JUNE 03
Time In: 1320
Allergies: NKDA
Pre-op V/S: 106/53 71
Procedures: TJD (R) Femoral
(L) Calf Blast Injury

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1100 Colloid Ø
OR Output: UOP 1100 EBL 250
Meds/Times: 2.5 VERSED 20 mg IV

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

Pre Op Meds / History

Time	1320	1330	1340	1350	1400	1410	1420	1430	1440	1450	1500
SaO2	99	99	98	99	100	97	100	99	100	99	99
FIO2	100	28	28	40	28	28	28	28	28	28	28
Methods	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
240											
220											
200											
180											
160											
140		✓									
120	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓
100	•										
80		^	•		•						
60	^		^	^	^	^	^	•	•	^	•
40											
20											
RR	20	24	21	13	15	17	12	17	22	22	
T	95		96		96		95		96	96	
Time											
Pain (0-10)											
LOS											

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

Pacu Intake

BG-2

Time	Solution	Amount	Site	By	Infused
1430	ICE CHPS	2	PO	[redacted]	

X-rays: Labs:

Post-Anesthesia Recovery score

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

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

(Continue on reverse)

PR[redacted] G DM.

DEPARTMENT/SERVICE/CLINIC: ICU #2

DATE: 19 JUNE 03

PAT[redacted] typed or written entries give: Name – last, first [redacted] al or medical facility)

BG-2

#[redacted] BG-4

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

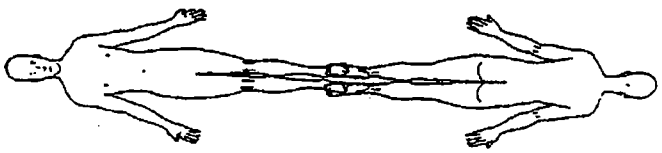
MEDICATIONS						
Allergies:						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

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	(L)(R) LEG	BULKY	Ø
30'	(L)(R) LEG	BULKY	(R) SLIGHT (L)
60'	(L)(R) LEG	INTACT/BULKY	SAME
D/C	"	INTACT	"



PACU OUTPUT			
Time	Source	Color/Appearance	Amount
1620	FOLEY	Amber Clear	125cc

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES 1325 19 JUNE 03

Neuro Sedated aroused to name. Resp CTA Bilaterally NAD SaO2 >98% on NRB 10L ▲ to NC 4L @ 1330 SaO2 99%. CV S1S2 (+) Pulses (+) throughout. Cap Refill ≤ 3secs throughout. GI (+) Hyperactive GU FTL voiding Amber Urine. Skin Intact Bulky Dressing to (L) Calf and (R) Lower Thigh to Upper Calf. Intact. Continue to Monitor [redacted] LTAN/ 1430 Pt had 2 ic[redacted]ps. Tolerated well. Pt still a bit drowsy but easily aroused. VSS. Pt on RA SaO2 97%. CV SB-NSR. GI BS (+) ↓ GU FTL. Dressings Intact [redacted] LTAN/ 1445 Pt used IS. Able to raise 3 balls 10xs.

1620 Pt to transfer to ICW 1. Pt still slightly groggy. VSS. NAD [redacted] NSR. NPO except Ice Chips. FTL Amber. Bulky Dressings Intact. [redacted] LTAN/ B6-2 1625 Noted small amount of sanguineous drainage [redacted] LTAN [redacted] B6-2

PACU OUTPUT			
Time	Source	Color/Appearance	Amount
1620	FOLEY	Amber Clear	125cc

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?

Discharge Criteria:
Date: 19 JUN **Time:** 1620 **PARS:** 11
BP: 110/57 **T:** 96.1 **HR:** 53 **RR:** 22 **SaO2:** 98% RA
Pain Level at D/C (0-10):
Intake: 2 ICE CHIPS **Output:** 125cc AMBER
Additional Data: Ø
Transferred To: ICW 1
Report Given To: 1LT [redacted] B6-2
Transferred Via: W/C [redacted] Gurney Ambulance
Transferred By: [redacted] LT / SGT [redacted] B6-2
Cleared IAW Re[redacted] SOP B-3
Charge Nurse Signatu[redacted] LTAN
B6-2 [redacted] B6-2

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
B6-4 [redacted]						

NAME (Last, First, Middle Initial): EPW [redacted] B6-4

4. PAY GRADE		5. SEX
16	17	18
		M

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

7. AGE AT ADMISSION		
27	28	29
3	5	4

8. RACE	9. ETHNIC BACKGROUND	
30	31	
Z	9	

RELIGION: unk

10. LENGTH OF SERVICE		
32	33	34

ETS: N/A

11. FMP	
35	36
9	9

B6-4

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: 1300

BRANCH / CORPS: N/A

14. FLYING STATUS		
47	48	49

15. BENEFICIARY CATEGORY		
50	51	52
K	7	9

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: ICW1

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] 622

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	
73	74
5	Ø

22. MTF TRANSFERRED TO					
75	76	77	78	79	80

23. DATE OF DISPOSITION (YYMMDD)					
81	82	83	84	85	86
Ø	3	Ø	Ø	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 (YYMMDD)					
97	98	99	100	101	102
Ø	3	Ø	6	1	9

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

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

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

FOR LOCAL USE

Dx: Blast injury (B) LE

Dx 8901 Proc 8604
28000 Traum 99
E993 Inj 599

B6-2 [redacted]

ADMITTING OFFICER (Signature, [redacted] B6-2

Dr [redacted] B6-2

SIGNATURE OF ADMITTING CLERK: B6-2 [redacted] B6-2 [redacted], PFC, 91610

DA FO[redacted]

PATIENT'S CLEARANCE RECORD

For use of this form, see AR 40-2; the proponent agency is OTSG

B6-4

[redacted]

PATIENT'S IDENTIFICATION

DATE OF DISCHARGE	TIME OF DISCHARGE
22 Jun 03	

SIGNATURE OF WARD OFFICER

[redacted] B6-2 2LT MC

ACTIVITY CLEARANCE

(The final activity with which the patient must clear will be the disposition office.)

Military	INITIALS*	Non-military	INITIALS*
1. Patient's Trust Fund		1. Patient's Trust Fund	
2. Medical Services Account Officer		2. Medical Services Account Officer	
3. Clothing and Baggage		3. Clothing and Baggage	
4. Medical Holding Unit		4. Postal Service	
a. Supply		5. Change of Address	
b. Pay Section		6. Other *(Specify)*	
c. Service Records		7.	
d. Insurance and Allotments		8.	
5. Postal Service		9.	
6. Change of Address		10.	
7. Other *(Specify)*		11.	
8.		12.	
9.		13.	

REMARKS

DATE	SIGNATURE OF PATIENT ADMINISTRATOR

* INITIALS OF PERSON AUTHORIZING CLEARANCE.

DA FORM 4029, MAR 73 REPLACES DA FORM 6-258, 1 DEC 59, WHICH WILL BE USED USAPPC V1.00

INPATIENT TREATMENT RECORD COVER SHEET

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

B6-4

1. REGISTER NUMBER [redacted]	2. NAME (Last, First, MI) SPW [redacted] B6-4				3. GRADE no	ADMISSION REMARKS
4. SEX M	5. AGE 354	6. RACE X	7. RELIGION Muslim	8. LENGTH OF SVC no	9. ETS no	10. PREVIOUS ADMISSION no
11. EMP 99	12. SSN no		13. ORGANIZATION unk			14. WARD ICW1
15. FLYING STATUS no	16. RATING/DSG	17. DEPT./BEN K78	18. BRANCH/CORPS unk	19. UIC/ZIP unk		20. TYPE CASE Surg
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Ø				22. HOURS OF ADMISSION 2110	23. CLINIC SERVICE ABAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE				25. TYPE DISPOSITION 21	26. DATE OF DISPOSITION 030621	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)				27b. TELEPHONE NO. unk	28. DATE OF THIS ADMISSION 030619	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] B2-2					30. DATE OF INTIAL ADMISSION 030619	32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

33. CAUSE OF INJURY

☐ Check if Continued on Reverse

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: MGSW

875.1
879.5
890.1
891.1
892.1
884.1
816.1
E991.2

86.22
86.59

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	3	3

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	3	3

[redacted] B6-2 FOR [redacted] S OFFICER [redacted] B6-2

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

35 yo Syrian male EPW

GSW 0100 hrs today

NKDA

N/O Heat problem

PHYSICAL EXAMINATION

Warm & dry NAD

113/67/98/18/99° / 100 kg

HEENT: wnl

CORR: RRR

Pulm: CTA (R)

ABD: soft, NTND, Bowel

(R) Flank wnl

(R) chest wall / Bruise

Laceration Subcutaneous tissue & muscle

(R) Thigh GSW Entrance Anterior thigh DIS

(R) Ankle puncture subcutaneous laceration

~~(R) Thigh GSW Exit Post Thigh~~

PROGRESS (Enter date of discharge and final diagnosis)

A) Multiple GSW (R) Thigh

(R) Arm (R) Chest wall / Bruising

(R) Heel (R) Flank

P) To OR for debridement wounds and closure

Pulm Endo Trigger

SIGN[redacted]

PATIENT'S IDEN[redacted] B6-2 | DATE | IDENTIFICATION NO. | ORGANIZATION

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

REGISTER NO. | WARD NO.

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

539-106

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD

PROGRESS NOTES

DATE	NOTES
19 MAR 03	General Surgery
1200	34 yo Iraqi who presents with multiple GSW to extremities & left flank & ORD this am.
	Eval & Ex
VS	BP 141/78 HR 98 RR 14 T 99 98% RA
	Heart RR
	Chest CTA B/L (R) chest tenderness w/ muscle
	tenderness (-) PX
	Abd RLF (R)
	Abd soft with gross obese - NT (+) BS
	left flank GSW just superior to iliac crest
	plain films show left comminuted
	Ext - right upper arm tenderness 2° GSW
	(R) thigh & calf 2° GSW surrounding
	(L) ankle tenderness crepitus
	LMP multiple GSW - Ext - ant (R)
	(L)
	Penile wound - left testicle
	(R) chest wound crepitus
	RR without wound
	observe (G) flank wound no →

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

PART/SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT
		B6-2 [redacted]

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

[redacted] B6-4

REGISTER NO. [redacted] NO.

PR[redacted]
Medical Record

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

6/19/03. USS. AO. LSC/AB. S_1, S_2. ⊕2 pulses in all extremities. BS⊕X4
1231 Voiding light amber urine quantity sufficient. DSG to ® upper
midline torso intact. Laceration of 1½" @ site. DSG to ® arm CDI. Pt.
denies pain @ this time. CBC drawn as ordered. Prepped for OR. Cont to
monitor. [redacted] RN

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
19 NOV 03	Begin Op Note
1915	pre-op dx: multiple gsw
	post-op dx: same as above
	procedure: (1) I&D left flank wound 2° GSW
	(2) I&D right thigh wound 2° GSW
	(3) I&D right medial upper thigh 2° GSW
	(4) I&D R gluteal area wound 2° GSW } closure
	(5) I&D left ankle/heel wounds & closure 2° GSW
	(6) I&D left index finger c fx
	findings: [redacted] / [redacted]
	see note
	pain 600
	UO foley
	anesthesia general
	complications: none
	specimens c [redacted] B6-2
	B6-2 [redacted] MD
	MC

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

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

REGISTER NO.	WARD NO.

[redacted] B6-4

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
19 JUNE 2130	Postop - Pt readmitted to ICW#1 S/P several I&Ds of blast injuries. Pt VS 126/69, P78, T99, R18. Pt with kerlix dsg to RUE, C/D/I, dsg to (R) axillary C/D/I. Pt ē dsg to (R) anterior thigh ē visible saturation but nothing coming through dsg. Pt ē dsg to (L) side above hip C/D/I. Pt ē kerlix wrap to (L) index finger C/D/I. IVF LR running via IBG W in (B) AC. Pt ē no c/o pain at this time. Will continue to monitor. [redacted] B6-2
20 JUNE 03 0745	General Surgery post op [illegible] [illegible] (L) thigh (R) arm (R) chest wall, (L) [illegible], [illegible] [illegible] chest tubes [illegible]. [illegible] [illegible] - [illegible] ē chest tubes [illegible]. [illegible] [illegible] [illegible]. [illegible] multiple [illegible] - no [illegible] [illegible] - [illegible]. - [illegible] [illegible] & 24°. - [illegible] [illegible].
	[redacted] B6-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

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

DATE	NOTES
20 Jun 03	0930 - Pt resting in bed AtOx3, VSS, LS CTA(B) (+) BS x4 quads, S1 S2 present, peripheral pulses +2, skin warm + dry, IV (L) AC patent running LR @ 125 cc/hr, Dsg's on (R) UE CDI, Dsg on (R) anterior thigh saturated = blood [redacted] ~~(+) seepage~~ but ∅ drainage, Dsg on (L) index finger CDI, Dsg (L) side above hip CDI, Ace wrap on (L) foot CDI, will continue to monitor. B6-2 [redacted] 91WM6
20 Jun 03 @ 2000	Pt resting in bed; AtOx3, All VSS, [illegible] S1 S2, strong pulses x4 & brisk Cap Ref; LS CTA(B), (+)BS; skin warm & dry; HL in (R) FA patent & flushing; drsg to RUE dry & intact; drsg to Anterior portion of (R) thigh CDI; reinforcement placed over it; drsg to (L) index finger CDI, drsg (L) flank CDI, Ace wrap on (L) foot CDI; will cont to monitor B6-2 [redacted]
20 Jun 03	0700 - Pt resting in bed, AtOx3, VSS, S1 S2 present, LS CTA(B), (+)BS x4 quads skin warm + dry, peripheral pulses +2, cap ref < 3sec, IV HL (R) FA patent, Dsg (R) UE signs of blood ∅ drainage, Dsg on (R) anterior thigh CDI, Dsg (L) index finger CDI, Dsg (L) side above hip CDI, Ace wrap on (L) foot CDI, c/o pain gave 2 Ty/ #3. Will continue to monitor. [redacted] 91WM6

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | [redacted] | [redacted] | SPONSOR'S ID NUMBER (SSN or Other) B6-2

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

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

[redacted]

B6-4

PROGRESS NOTES
Medical Record

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

E	FIRST NAME	MIDDLE INITIAL	ID NUMBER

TE	NOTES
21 JUNE 03	General surgery
0925	Pt #2 s/p IED & blast of OSIS. Pt ambulatory around
	doing well of complaint.
	AFEB VSS
	All wounds examined
	(R) arm - closed (-) purulence (-) drainage, pain not
	severe on minimal
	(R) chest - closed, looks good
	(L) knee - closed - looks good
	(L) flank - open wound packed looks clean
	(R) thigh - open wound looks clean
cont/pt	Doing well
	cont. wound care
	may DC w
	plan some family/memory [redacted] B6-2

[redacted] B6-2

21 June 0900 Received pt laying on bed VSS, Alert, non English speaking. Communicates with gestures. LSCTA, BSO, dsg Δ's done wet to dry on (R) thigh, (L) flank, and bacitracin applied to (R) chest & (R) UE suture lines. pt has puffy eyelid on (R) eye. Will medicate as appears appropriate [redacted] B6-2

22 June 0700 Alert. Lungs clear BS (+) x4 (-) drg D/I. VSS B6-2
& Distress noted. Will continue to monitor [redacted]

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER | TREATMENT FACILITY [redacted] B2-2

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS: EPW

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 19 JUNE 03 | TIME: 2110

TRANSPORTATION TO FACILITY: AIR EVAC

SEX: M

DUTY/LOCAL PHONE: AREA CODE | NUMBER

HOME PHONE: AREA CODE | NUMBER

AGE: 35

MILITARY STATUS

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

THIRD PARTY INSURANCE

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

CURRENT MEDICATIONS

ALLERGIES

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: GSW PMH - Cardiac Angina?

CATEGORY OF TREATMENT

☐ EMERGENT

☒ URGENT

☐ NON-URGENT

TIME: 0915

INITIALS: LS

VITAL SIGNS

TIME	0906	0915	0930	0945	1000
BP	113/60	132/65	131/76	122/60	141/79
PULSE	98	100	90	111	98
RESP	18	16	16	16	16
TEMP	99				
WT	100kg				

LAB ORDERS

☒ CBC/DIFF	☒ ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT
URINE C&S	UA MSCC/CATH		CHEM: 17 0930
BLOOD C&S X			
☒ .5 Tetanus 0925			☒ Mt pain 0930

X-RAY ORDERS

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

ORDERS

☒ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
	CXR [redacted]				
	Splint of Femur		Amp Tq		E mycin Dexa on [redacted] 1130
	(R) Thigh Knee Pelvis X Ray		Tdap Sq Im		12.5 Sq Phenergan (VO) [redacted]
	(L) Ankle Arm				

b6-2

DISPOSITION: ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

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

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS: 50mg phenteny 0920 unable to insert foley due to obstruction

CONDITION UPON RELEASE: ☒ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

EPW

[redacted] B6-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

NSN 7540-01-075-3786

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

TEST RESULTS

CBC		SMAC					ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
	WBC		127	105	3	92	SUP 02	PH	PO2	RESULTS	
	H/H		4.3	10	.7		PCO2	SAT	OTHER		
	PLT										
PT							U/A	DIP		EKG INTERPRETATION	
APTT		BHCG	ETOH	GLU				MICRO			

PROVIDER HISTORY/PHYSICAL

35 y/o ♂ s/p GSW / pm, then ... ⊕ ⊕ ⊕, Hx unclear, 2° language barrier

DOS / pm

10

A: Speech clear/articulate o/w/p clear/ant

B: CTA (B) = ⊕ lac (L) T 2/3 and ax 10cm to sternum

C: ⊕ ecchymosis, ⊕ 2 pulses x 4 ext

D: Alert to environment

E: (L) GSW mid (R) thigh

(L) GSW (R) upper ext to incep level ⊕ ecchymosis

(L) ankle ecchymosis wound from ⊂ pain

Foley unable to place 2° obstruction

Abdomen o/w/p clear/ant, pt ... (Diagnosis) ⊕ corneal abrasion on fluorescein dye

Clot: CTA (B)

CV: RRR II/VI SEM ⊕ G/T

Abd soft, NT ⊕ BS

Pain in "heart problem"

ABC stable, multiple GSW ⊂ (R) thigh injury

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL ST[redacted] STAMP

PROVIDER SIGNATUR[redacted]

B6-2

DIAGNOSIS

① Mult GSW

② GSW (R) thigh

③ (L) corneal abrasion

CODES

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

[redacted] B6-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

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: 35

HEIGHT:

WEIGHT: 100 kg

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

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

4. PROPOSED SURGICAL PROCEDURE:
I+D (R) arm, (R) thigh, (L) heel, (L) Index finger, (R) upper chest, (L) flank

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition_____
Tobacco 1/2 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/Contact (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	Pt. verbalizes any specific anxiety. Pt. Exhibits relaxed body posture.	Allow pt. to verbalize freely. Explain OR environment and answer questions regarding surgery. Offer comfort measures. (e.g., warm blanket, touch). Explain all nursing procedures before they are done. Remain with pt. whenever possible. Maintain family interface. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: ✓ 1) Positioning ✓ 2) Effects of Anesthesia ✓ 3) Medical/Smoking History	Pt. will be able to breathe without difficulty during immediate intraoperative phase .	Offer to elevate head of litter or offer pillow. Observe pt. while awaiting surgery for signs of distress. Assist anesthesia during intubation and extubation.
C. INTEGUMENT ✓ Potential impairment of skin integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement ✓ 3) Positional Aids ___ 4) Prosthesis ✓ 5) Pooling of Prep Solutions	Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	Utilize pressure preventing devices on OR table and accessories. Check for proper positioning and support to maintain good body alignment. Pad pressure points. Place ESU ground pad on non compromised skin surface area. Keep prep fluids from pooling.

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

EPW [redacted] B6-4

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	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. 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	✓ Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	✓ Check for support stockings or ace wraps. If none, check with doctors. ✓ Check that safety straps are correctly applied. ✓ Offer pillow for under knees. ✓ ~~Place and take down legs from stirrups with slow bilateral motion.~~ N/A ✓ 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	✓ Pt. will be transferred to OR table without difficulty. ✓ Pt. will not experience unnecessary physical discomfort.	✓ Have sufficient people available for transfer. ✓ Insure proper body alignment. ✓ Allow patient to lie in position of comfort while waiting for surgery. ✓ Offer support (i.e., pillows, 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	✓ Pt. will be made aware of surroundings prior to anesthesia induction. ✓ Pt. will be transferred safely to OR table. ✓ Pt. will be able to understand instructions. ✓ Minimize danger of injury during intraop period.	✓ Introduce self. Keep pt. informed as to where he/she is and what is happening. ✓ Inform pt. in which direction to move and assist if necessary. ✓ Speak clearly and slowly. ✓ Address pt. from LEFT side. ✓ Validate pt.'s understanding of verbal communication. ✓ Verify removal of dentures.
G OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

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

B6-2 [redacted] 19 JUN 03 DATE

11. POSTOPERATIVE EVALUATION: SKIN INTEGRITY: Bovie Pad Site: ☒ Clean and Dry ☐ Red ☐ N/A DRESSING DRY & INTACT (Y)(N)

LEVEL OF CONSCIOUSNESS: ☐ A&O ☒ Drowsy ☐ Sleepy ☐ Intubated BREATHING EASY (Y)(N)

LEVEL OF ACTIVITY: ☒ Moves All Extremities ☐ Moves Upper Extremities ☐ Transferred to liter with roller due to spinal

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] RN B6-2

DATE: 19 JUN 03 TIME: 1245

13. POSTOPERATIVE E[redacted] BY (Signature and Ti[redacted] B6-2

DATE: 19 June 03 TIME: 1952

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: Cart BY Anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted] B6-2

3. DATE 19 June 03 TIME PATIENT ARRIVED IN SUITE 1800

4. PATIENT IN ROOM TIME 1800 NUMBER 2-1 18

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: nkda

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] D6-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] B6-2	RELIEF CIRCULATOR	CPT [redacted] (1900-EOC) B6-2

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: correct body alignment maintained (R) arm on 2 padded armboards. position approved by surgeon + anesthesia

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO

DONE BY: ☒ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP

COMMENTS: no nicks or cuts noted

PREP SOLUTION *(Specify)* Betadine / Betadine

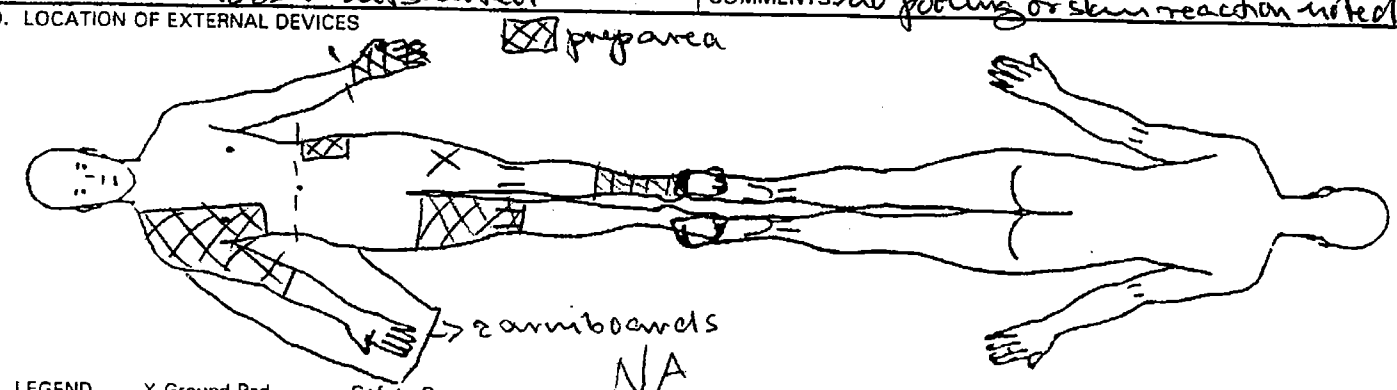
SITE: (R) arm / chest BY WHOM: [redacted]

SITE: (R) thigh BY WHOM: [redacted]

(L) hand, (L) flank, (L) heel B6-2 B6-2

COMMENTS: no pooling or skin reaction noted

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes	☐ No					
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;)*

EPW # [redacted] B6-4

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

☒ ESU NO: Valleylab Force II #4 30/30

GROUND PAD: BRAND Valleylab Rem Polyhesive II

LOT NO: 69652 2005-04

☐ 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):
Nacl

OTHER ORDERS	TIME	CARRIED OUT BY
none		

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM [redacted] IF YES, SITE
YES ☐ NO ☒ (L) HAND

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☒ [redacted]

TYPE/SIZE	1. 1/2 Iodoform gauze	2.	3.
SITE	1. (L) groin (R) thigh	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs Tape
Kerlix Tubular gauze
Acuwrap to (L)

19. ADDITIONAL INFORMATION
Surgeon: [redacted]
Anesthesia: [redacted]
B6-2

20. OPERATION(S) PERFORMED
I+D (R) arm, (R) thigh, (L) heel, (L) groin, (R) upper chest, (L) index finger
1952

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU-2	See DA7389	Litter c safety strap

22. REGISTERED NURSE SIGNATURE [redacted] CRTIAN [redacted]

REVERSE OF DA FORM 5179-1, OCT 8[illegible] USAPA V1.01

B6-2 MEDCOM - 11514

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY	1	2	3							
POST-DAY	DOS	1	2							
MONTH-YEAR June 1992003 — DAY		20JUN03			21		22			
HOUR	2130	8 14			06 18		6			

PULSE (O) / 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)

RESPIRATION RECORD: R18 6 16

BLOOD PRESSURE: 132/84 126/60 127/68 134/71 146/81 128/64 125/69 [redacted]/62

69 78 80 103

98.5 99 99.4 99

HEIGHT: WEIGHT → 98.9 [redacted] 99/96

99/(92) 94 96

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] B6-4

VITAL SIGNS RECORDS

Medical Record

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

Ward/Section: EMT

TESTING PHYSICIAN: [redacted] B6-2

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

LAST, FIRST, MI: [redacted] B6-4

DATE: 19 Jun 03 | TIME: 0958 | SSN/PSEUDO SSN: [redacted] B6-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	15.4	4.8-10.8 x 10^3
RBC	4.82	4.7-6.1 x 10^6
Hgb	13.1	14-18 g/dl (M) 12-16 g/dl (F)
Hct	42.1	42-52% (M) 37-47% (F)
MCV	87.3	80-94 fl (M) 81-99 fl (F)
Plt	405	130-500 x 10^3 verified
Lymph %	7.6	20.5-51.1%

(Hematology) Manual Differential

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

Urinalysis

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

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: [redacted] B6-2 | **DATE:** 19 June 03 | **LAB ID NO.:**

Ward/Section:	REQU[redacted]NG PHYSICIAN:	LAB[redacted]ATORY RESULT FORM (Subject to the Privacy Act of 1974)
1 Emt	[redacted] B6-2	

LAST, F[redacted]I.	DATE	TIME	S[redacted]O SSN:
[redacted] B6-4	18JUN03	2110	[redacted] B6-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	7.2	4.8-10.8 x 10^3
RBC	2.15	4.7-6.1 x 10^9
Hgb	6.0	14-18 g/dl (M) 12-16 g/dl (F)
Hct	19.0	42-52% (M) 37-47% (F)
MCV	88.3	80-94 fl (M) 81-99 fl (F)
Plt	206	130-500 x 10^3 verified
Lymph %	8.4	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		

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	Yell	N/A
App	Clear	N/A
Glu	1000	Negative
Bili	Nes	Negative
Ket	small	Negative
SG	1.020	N/A
Bld	nes	Negative
pH	6.0	N/A
Prot	Nes	Negative
Urob	0.2	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 BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

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

1-3 RBC
occ WBC
1+ mucous

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

REPORTED BY: DATE: LAB ID NO:

Ward/Section: EMT

ESTING PHYSICIAN: [redacted] B6-2

RY RESULT FORM
(Subj... to the Privacy Act of 1974)

LAST, FIRS[redacted] B6-4

DATE: 19 May 03 | TIME: 0988 | SSN/PSEUDO SSN: [redacted] B6-4

(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	3.9	3.5-5.5 g/dl
ALP	71	26-84 u/l
ALT	22	10-47 u/l
AMY	54	14-97 u/l
AST	14	11-38 u/l
TBIL	0.5	0.2-1.6 mg/dl
BUN	8	7-22 mg/dl
CA^{++}	9.2	8.0-10.3mg/dl
CHOL	330	100-200 mg/dl
CRE	0.9	0.6-1.2 mg/dl
GLU	176	73-118 mg/dl
TP	7.3	6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	~~168~~	73-118 mg/dl
BUN	~~9~~	7-22 mg/dl
CRE	~~0.8~~	0.6-1.2 mg/dl
CK	[redacted]	39-380 u/l (M) 30-190 u/l (F)
NA^+	[redacted]	128-145 mmol/l
K^+	~~4.9~~	3.3-4.7 mmol/l
CL^-	~~101~~	98-108 mmol/l
tCO_2	~~20~~	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU	168	73-118 mg/dl
BUN	9	7-22 mg/dl
CA^{++}	9.1	8.0-10.3 mg/dl
CRE	0.8	0.6-1.2 mg/dl
NA^+	135	128-145 mmol/l
K^+	4.9	3.3-4.7 mmol/l
CL^-	101	98-108 mmol/l
tCO_2	20	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:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted] B6-2	19 JUN 03	

Ward/Section: [redacted]

REQUESTING PHYSICIAN: [redacted] B6-2

CHEMISTRY RESULT
(Subject to the Privacy Act of

LAST, FIRST, MI: [redacted] B6-4

DATE: 18JAN03 | TIME: ~~2410~~ 0110

SOVEREIGN DO SSN: [redacted] B6-4

(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	1.2	3.5-5.5 g/dl
ALP	27	26-84 u/l
ALT	12	10-47 u/l
AMY	18	14-97 u/l
AST	11	11-38 u/l
TBIL	0.3	0.2-1.6 mg/dl
BUN	3	7-22 mg/dl
CA^{++}	6.9	8.0-10.3mg/dl
CHOL	151	100-200 mg/dl
CRE	0.7	0.6-1.2 mg/dl
GLU	92	73-118 mg/dl
TP	2.5	6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	~~86~~ [redacted]	73-118 mg/dl
BUN	~~4~~ [redacted]	7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK	b6-2	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 Pa

TEST	RESULT	REF.
GLU	86	73-118 n
BUN	4	7-22 mg/
CA^{++}	7.4	8.0-10.3
CRE	0.4	0.6-1.2 n
NA^+	127	128-145
K^+	4.3	3.3-4.7 m
CL^-	105	98-108 n
tCO_2	10	18-33 m

(Piccolo) Liver Panel P

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

(Piccolo) Electrolyte

TEST	RESULT	REF.
NA^+		128-145
K^+		3.3-4.7 r
CL^-		98-108 r
tCO_2		18-33 m

REMARKS:

REPORTED BY: [redacted] B6-2 | **DATE:** 19 Jan 03 | **LAB ID NO.:**

Ward/Section: ICW #1

REQUESTING PHYSICIAN: [redacted] B6-2

Master Copy

LABORATORY RESU
(Subject to the Privacy A

LAST, FIRST, MI: EPW # [redacted] B6-4

DATE: 19 Jun 03 TIME: 1240

SSN/PSEUDO SS

TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT
WBC	10.3	4.8-10.8 x 10^3	Color		N/A	RPR	
RBC	3.53	4.7-6.1 x 10^9	App		N/A	Mono	
Hgb	9.6	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative		
Hct	30.8	42-52% (M) 37-47% (F)	Bili		Negative	Source	
MCV	87.4	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain	
Plt	335	130-500 x 10^3 verified	SG		N/A	Occ Bld	
Lymph %	10.7	20.5-51.1%	Bld		Negative	H. pylori	
			pH		N/A	Micro Parasites	
Segs		Mono	Prot		Negative	Malaria	
Bands		Eos	Urob		0.2-1.0	O & P	
Lymph		Baso	Nit		Negative	Other	
Atyp		Imm	Leuk		Negative		
RBC Morph			HCG		Negative		
Spun Hematocrit		42-52% (M) 37-47% (F)					
Sed Rate			Cell Count			MUST SUBMIT SE EVERY UNIT REQ	
Other			Directigen		Negative	ABO/Rh	

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

REMARKS:

REPORTED BY: [redacted] DATE: 19 Jun 03 LAB ID NO:

B6-2

HTP
multiple shrapnel wounds

NKDA

MEDICAL RECORD — ANESTHESIA

"Anes"

DRUG	Units	
Fentanyl	mcg	50-<200> 5 5 3 3 2
MSO4	mg	
STP	mg	300-75
Succ	mg	100 50
Cisatracurium	mg	10
Propofol	mg	
VOLAT AGENT	ISO % del / % e.t.	2.0 1.0 1.4 1.4 1.4 1.4 ↑2 1.3 X
AIR	L/Min	
N2O	L/Min	
O2	L/Min	10 2 2 2 2 2 2 2 10 10

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

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

Neostig/Glyco 4/0.6 ev

TOTALS	
250	
18	
425	
100	
5	

TOTAL INS: 40

TOTAL URINE: Ø

FLUIDS — SUMMARY

CRYSTALLOID – 900

COLLOID – Ø

BLOOD – Ø

FLUIDS

LINE site		
18G RA	☒ Warmed	LR – #1
18G RA	☒ Warmed	LR – #2
Arcap	☐ Warmed	1gm IVPB
	☐ Warmed	

LOSSES: EST BLOOD LOSS / URINE –

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

BODY WEIGHT: 100 (KG) LB

HEMATOCRIT:

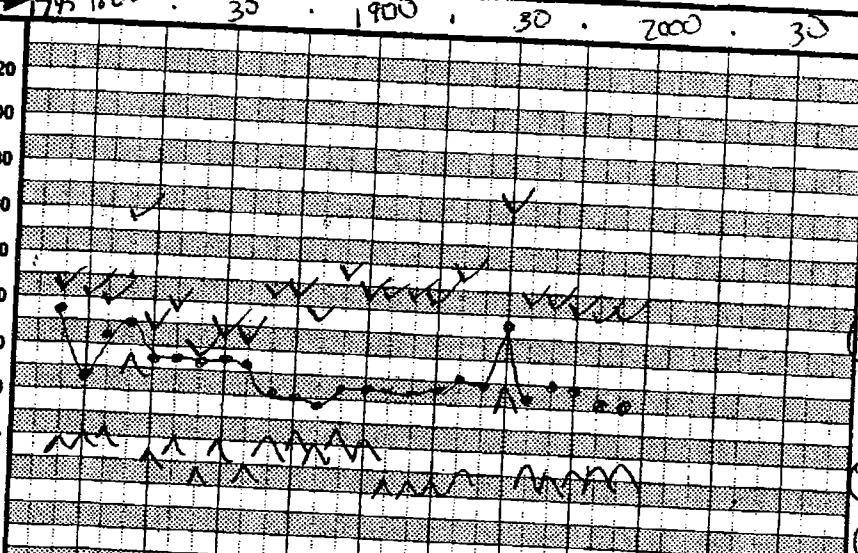
INITIAL DATA: BP – 113/67 HR – 99

COMP CHECK: OK? – (Y) N

PATIENT WRISTBAND: OK for PROCEDURE? B6-2 TIME – [redacted] 1745

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

TIME → 1745 1800 30 1900 30 2000 30



VT – ml	830	800	810	800	800	810	560	640	
f – breaths/min	10	10	9	9	7	7	11	10	
Peak inf pres / PEEP	21	21	21	22	22	22	—	—	
MODE – S(pon), A(assist), C(on)	C	C	C	C	C	C	S	S	
ET CO2 (torr)	38	37	34	32	34	34	46	47	
FIO2 (Frac or %)	94	96	96	100	100	100	100	100	
SpO2 (%)	0.74	0.74	0.74	0.74	0.74	0.73	0.73	0.73	0.73
ECG	SR			SR	SR	SR	SR		
TEMP – site					97.2 oral				
N-M Block (T/4)			0/4	0/4	4/4	4/4	4/4		4/4
Warming blkt	x	Blanket							
Conv warmer									

BP/Auto Cuff; BP / oth; ART line; Steth – PC/ES; Gas analyzer

Warming blkt; Conv warmer

Mark with letters & symbols, explain under REMARKS — EVENTS (1) (2) (3) (4) (5) (6)

Position → supine →

REMARKS – Code drugs with numbers, events with letters

(1) Pre-op assessment NPO, large CTA (B); RR (–) ND; NPO –
(2) stretcher, Room monitors, O2; Cricoid pressure see airway management
(3) DL, endotracheal induced into blood
(4) 16G (R) FA per surgeon's request 2° to finger work
(5) 1745 induc c OETT; Lidocaine 50mg IV; ETP 50mg MSO4 2mg
(6) Reversed, OPsuct. TV > 4ml/kg, RR > 8 + < 30BPM Extubated s complications
(7) To ICU-2 Report to RN. Pt. left attended

RECOVERY AT 1955

PACU (ICU) 2 (Specify)

OTHER T-96.3

CONDITION: Stable reflex

RESP – 20 SpO2 – 100

BP – 124/69 HR – 55

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1745	1756	2005
PROC	Ready	Begin	End
	1810	1830	1950

PROCEDURES and CPT Codes

I + D shrapnel wounds – (R) upper arm, (R) superficial chest, (L) fingers, (L) ankle

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

GETA Modified RSI – Ventilated through Cricoid

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

DL x1 MAC 3, Grade I view, 8.0 22 cm @ teeth; 10mL air cuff; + BBS + sust ETCO2

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

EPW# [redacted] B6-4

B6-2 [redacted]

SURGEONS: [redacted] / [redacted]

PROCEDURE LOCATION 1

DATE 19 Jun 03

PAGE 1 OF 1

MEDCOM - 11521 C OP 376 REVISED Jan 99

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 35 DAYS MOS YRS Sex (✓) MALE ( ) FEMALE

PROPOSED PROCEDURE: IED schrapnel wounds (R) arm + chest (R) thigh (L) lateral lower leg
SURGICAL SERVICE: Ortho
NPO SINCE: MN

ASA Physical State 1 (2) 3 4 5 (E)
WT: 100 KG/LB HT: ____ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: 1/2 pk/day
ETOH: occ –
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed

(✓) adventra 10? for heart
(✓) BP takes daily
( ) ____
( ) ____
( ) ____
( ) ____

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

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

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	(Y)	controled per pt
Angina	N	Y	
MI	N	Y	
CVA	N	Y	
Other	N	Y	
Pulmonary System:			denise
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	multiple schrapnel
	N	Y	wounds (R) arm (R) thigh, –
Familial HX	N	Y	unknown reason

ASSESSMENT
PAST SURGICAL/ANESTHETIC
denise

PHYSICAL EXAMINATION
BP 113/67 HR 98 R 18 T 99
Pain Scale 0-10 ____
HEENT - Teeth MP-2 Intact
Trachea Midline
TMJ/Neck ____
Oropharnyx ____
Nares ____
CHEST: CTA slight ↓ in (R) base
CARDIAC: RRR
EXTREMITIES: ____
IV Access: (R) 18ga (L) 20ga –
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since MN

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ {✓} General: Mask Intubation
procedure & Hx thru interpritor – questions answered –

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

The pati[redacted] B6-2 [redacted]rstand and agrees. Questions answered.
Signed [redacted] Date: 6/19/03 Time: 1200 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER
B6-2
Signed [redacted] Date: 6/20 Time: 0830 Hrs

Pati[redacted] (Ward) ICW-1/ICU-2
EPW
[redacted]
B6-4

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] B6-4

NURSING UNIT	ROOM NO.	BED NO.
ICW 1		

DATE OF ORDER: 19 June 03 TIME OF ORDER: 1115 HOURS

1. admit ICW
2. s/p multiple GSW to extremities & lower flank
3. Foley
4. NPO
5. vitals q 1° x 3 then q 2°
6. MIST, NPO

LIST TIME ORDER NOTED AND SIGN: [redacted] 1205 19 June 03

PATIENT IDENTIFICATION

[redacted] B6-2

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

5. IVF's KL @ 125 cc/h
6. Morphine 3 cc IVP
7. Morphine 1-5 mg IV q 1° prn
8. CBC @ 1200
9. O.R. [redacted] B6-2 NO

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

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

CLINICAL RECORD - 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] B6-4

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

DATE OF ORDER: 19 JUN 03 TIME OF ORDER: 1900 HOURS

1. admit to PACU → ICW
2. s/p TBS (L) arm, (R) chest (L) flank, (R) thigh, (L) knee wounds, & left index finger [illegible]
3. [illegible]
4. [illegible] per protocol

PATIENT IDENTIFICATION

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

DATE OF ORDER: TIME OF ORDER: HOURS

5. NKDA
6. Diet: advance to regular
7. IVF: LR @ 125cc/h KC wires for po
8. Meds: MSO4 1-5 mg IVS 1° prn; levaquin #3 T-II pills po q 4° prn

[redacted] B6-2

PATIENT IDENTIFICATION

NURSING UNIT: 2W0/2000 | ROOM NO. 19 JUN 03 | BED NO. [redacted] B6-2

DATE OF ORDER: TIME OF ORDER: HOURS

Meperidine 25 mg IVS 6° prn; Ativan 1 mg IVS 8° x 3 doses
9. [illegible]
10. Activity - ambulate TID
11. TS q 1° [illegible]

[redacted] B6-2

PATIENT IDENTIFICATION

[redacted] B6-4

NURSING UNIT: ICW | ROOM NO. 54°/0000 | BED NO. [redacted] B6-2

DATE OF ORDER: 21 JUN 03 TIME OF ORDER: 0925 HOURS

1. D/C IV
2. wound care BID, bacitracin & Kellex, NNC dressing to open wounds - (R) thigh & left flank

[redacted] B6-2

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

All B6-2 (except last)

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 19	20	21	27
6/19	[redacted]	Vitals q1° x3 then q 2°	05 17 17 05	[redacted]			PREOP
6/19	[redacted]	Diet: NPO	05 17 17 05	[redacted]			
6/19	[redacted]	Activity: Bedrest	05 17 17 05	[redacted]			POST-OP
19	[redacted]	VS: per protocol	6 14 22	[redacted]			
19	[redacted]	DIET: adv to Regular	5 17	[redacted]			
19	[redacted]	ACTIVITY - ambulate TID	6 14 22	[redacted]			
19	[redacted]	IS Q1° while awake	5 17	[redacted]			
21 June	[redacted]	Wound care BID, Bacitracin & Kerlix, NaCl wet -> dry to open wounds (R) thigh & (L) flank	10 20	[redacted]			

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: S/P GSW (multiple) to Extremities & (L) flank

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: 1

PATIENT IDENTIFICATION: # [redacted]

B6-4

* S/P I+D (R) arm, (R) chest, (L) flank, (R) thigh, (L) heel wounds

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

A11 B6-2

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo June Yr 2003

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS (Preop)	Date to be Done	Time to be Done	Time Done	Initials
6/19	[redacted]	Admit ICW1, Stable	6/19		1150	[redacted]
6/19	[redacted]	CBC @ 1200	6/19	6/19	1240	[redacted]
6/19	[redacted]	On Call to OR for washout	6/19	1240	1240	[redacted]

19	[redacted]	admit to PACU → ICW#1, stable				
19	[redacted]	labs = ø				

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

USAPA V1.00

All B6-2 (except last)

NICAL 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 Y 03

BY INITIALING ER TE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 19	20	21	
7/19	[redacted]	NF: 2L @ 125cc/hr	05 17	[redacted]			
			17 05	[redacted]			PRN OP
19	[redacted]	LR @ 125cc/hr.	05 17	[redacted]			
		HL when tol P.O.	17 05	[redacted]			D/C 21 June 03 0935 [redacted]
19	[redacted]	Ancef 1gm IV q8° x3doses	6	[redacted]			
			14	[redacted]			auto d/cp 3doses
			22	[redacted]			

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: S/P Multiple GSW to Extremities & (L) Flank

S/P I+D

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. 1

PATIENT IDENTIFICATION:

#[redacted]

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

USAPA V1.00

A11 B6-2

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													
19	[redacted]	MSO4 1-5mg IV q1° PRN														
19	[redacted]	Tylenol #3 + 2 tabs PO q4° PRN	2002 4/11 1215	2002 4/11 0650	6/21 2 1700											
			[redacted]													
19	[redacted]	Phenergan 25mg IV q6 prn														

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: 19 June 03
Time In: 1955
Allergies: NKDA
Pre-op V/S: 159 95
Procedures: Multi. Scrape Wound I&D

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

OR Intake: Crystalloid 900 Colloid
OR Output: UOP 0 EBL 400cc
Meds/Times:

hypertension
5mg Metoprolol
18mg MOS4
250 Fent
4 Ketam

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds

History

Time	1955	2000	2005	2010	2015	2020	2025	2030	2035	2040	2045	2050	2055	2100
SaO2	98	100	100	100	100	100	100	100	100	100	100	100	100	98
FiO2	10	10	10	10	10	10	10	10	10	10	12	12	12	6L
Methods	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM
240														
220														
200														
180														
160														
140														
120														
100														
80														
60														
40														
20														
RR	20	20	20	21	22	15	20	14	15	16	17	16	20	
T	98.6							98.8					99.1	
Time														
Pain (0-10)														
LOS														

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1955	LR		R Upper Ext		

X-rays:

Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	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	1	1	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	7	8	10

Codes

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

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

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

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

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

PREPARED BY (Signature & Title) [redacted] B6-2

(Continue on reverse)

DEPARTMENT/SERVICE/CLINIC: PACU/ICU #2

DATE: 19 June 03

ATION (If or typed or written entries give: ...ete; hospital or medical facility)

Name – last, [redacted] B6-4

☐ 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

A11 B6-2

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							

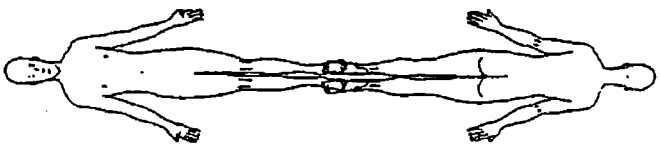
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 1955	(R) Arm (L) Ankle	Kerlix 4x4s	Ø
30'	See NN		
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

1955 Pt transport from Surgery to PACU/ICU#2 for recovery, LR (R) upper FA 5 s/s of infection & infiltration. O2 @ 10 L/Min high flow Face Mask (L) AC IV 5 s/s of infection or infiltration. (R) J Arm DSG CDI. (R) lateral chest DSG CDI. (R) thigh DSG moderate amt bloody drainage noted on DSG. (L) heel/foot DSG CDI. (L) index finger DSG CDI. (L) flank DSG. (L) Flank DSG small amt bloody drainage noted. Will monitor. Sig [redacted]

2025 DSG's same as above. Will monitor. Sig [redacted]

2055 DSG no A. O2 off SPO2 [illegible] transported by litter to ICU I. Sig [redacted]

Discharge Criteria:
Date: 19 June **Time:** **PARS:**
BP: 133/77 **T:** 97.4 **HR:** 78 **RR:** 26 **Sa02:** 98%
Pain Level at D/C (0-10):
Intake: @ 1000 **Output:** Ø
Additional Data:
Transferred To: ICU I
Report Given To: [redacted]
Transferred Via: W/C [redacted] Gurney Ambulance
Transferred By: Sgt [redacted]
Cleared IAW Recovery [redacted] B-3
Charge Nurse Signature: [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
A 1 1 D 1	I Z	B6-4 [redacted]

NAME (Last, First, Middle Initial): SPW# [redacted] B6-4

4. PAY GRADE	5. SEX
n o	m

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
unk	35y	X	9	Muslim

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
unk	unk	99	unk

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	unk	2110	no

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
no	K78	unk

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
IZ	unk	9	YEAR / ✓ NO

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

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted]

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
21		030621

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
ABAA		030619

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYMMDD)
		030619

FOR LOCAL USE

DX: MGSW

DX 8750 9181
87920 E9912
8900 Trauma 99
8910 Inj 569
88003
PROC 8604 X6 B6-2 [redacted]

ADMITTING OFFICER (Signature required): [redacted] Paige [redacted]

B6-2 B6-2

INPATIENT TREATMENT RECORD COVER SHEET

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

B6-4

1. REGISTER NUMBER [redacted]			2. NAME (Last, First, MI) EPW [redacted] B6-4				3. GRADE N/A	ADMISSION REMARKS
4. SEX M	5. AGE 35y	6. RACE Z	7. RELIGION unk	8. LENGTH OF SVC N/A	9. ETS N/A		10. PREVIOUS ADMISSION NO	
11. FMP 99		12. SSN [redacted]		13. ORGANIZATION N/A			14. WARD KW1	
15. FLYING STATUS N/A	16. DSG	BEN KM7		18. BRANCH/CORPS N/A	19. UIC/ZIP		20. TYPE CASE N/A	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from ER				22. HOURS OF ADMISSION	23. CLINIC SERVICE ABA			
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE —				25. TYPE DISPOSITION 05	26. DATE OF DISPOSITION 22 Jun 03			
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) —				27b. TELEPHONE NO. —	28. DATE OF THIS ADMISSION 19 June 03		ADMITTING OFFICER Dr. [redacted] B6-2	
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] BZ-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

GSW (1) thigh

Dx: 8770 Pr: 9659
8900 Inj Trauma
8910 450 1
7806
E9912

1st Admission

~~Dx: 8771 8901 E9912~~

~~Pr: 8622 86.04 86.28~~

~~Trauma 9 Drain 569~~

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	3	3

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	3	3

SIGNATURE OF ATTENDING MED [redacted] B6-2 — SIGNATURE OF PAD OR MEDICAL RECORDS OFFICE [redacted] B6-2 For [redacted] B6-2

DA FORM [redacted] EDITION OF 1 AUG 76 IS OBSOLETE

MEDCOM - 11532

USAPPC V1.10

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

35 yo EPW OS
GSW 3 Days Ago
Sent in for TIOW's
NKDA
QPMHx

PHYSICAL EXAMINATION

Wound Ad Ass
(R) LE 4 Open wounds (R) Buttk, Lt mid Thigh
Lateral Knee Ant/Post
Clean wounds c̄ serous Drainage

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

A/ (R) LE GSW's Clean SP Ex
P/ Ancef x 48°, PSG Ad's

B6-2

SIGNAT[redacted]	DATE 19 [illegible]	IDENTIFICATION NO.	ORGANIZATION

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

REGISTER NO.	WARD NO.

#[redacted]

B6-4

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

All B6-2 (except last)

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
19Jun@ 2345	admit note: 35 y/o ♂ c̄ GSW 3days ago to (L) thigh. Pt a/ox3, VS: 110/60 (P) 92 (R) 20 O2sat 96% Temp 99'. Drsg to (L) thigh c̄ no active bleeding, good pedal pulses & cap refill. Heplock to (L) AC flushing easily. Drsg changed in EMT. Will cont to monitor-Sp[redacted]
20Jun 03	0700 - Received pt sleep yet easily arousable. VSS. Antibiotic given. GSW to left thigh wet to dry dressing wrapped c̄ gauze. Ø evidence of bleeding. Will cont to monitor [redacted]
20Jun03 @ 1900	Rt a/ox3, vss, wet to dry drsg CDI c̄ no active bleeding. no drainage to drsg. pedal pulses +2., brisk cap refill. Ø complaints noted @ this time. Will cont to monitor Sp[redacted] LPN
21Jun 03	0730h Alert & responds appropriately. VSS Drsg to (L) thigh D/I. HL (L) hand patent & intact. Wrist restraints on properly Radial & pedal pulses palpable. Capillary refill to fingers <3sec. No discomfort noted. Vascular will continue to monitor & check restraints [redacted]
21Jun03@	1930 Rt a/ox3, VSS, LCTA(E) ±BS all quads, good pulses x4. HL flushing easily. Drsg changed prior to shift change. C/DI. Tolerated 100% of dinner. Ø complaints Will cont to monitor [redacted] LPN

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

#[redacted] B6-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

E	FIRST NAME	MIDDLE INITIAL	ID NUMBER

TE	NOTES
B2-2 [redacted]	Ortho FW CSW were ~~Bar wounds cleaned~~ A) CSW under Dlg B) Dic to EPW Camp Level 2 DSO Ds BED/QD Follow 250 QID x 10 Days [redacted] B6-2

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

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL — DATE: DAY 19, MONTH Jul, YR. 03 — TIME 2135

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

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): GSW

SEX: M AGE: 35

POSSIBLE THIRD PARTY PAYER? [ ] YES [ ] NO

TIME SEEN BY PROVIDER: 2135

VITAL SIGNS			
TIME	2135	2321	
BP	155/46	111/58	
PULSE	106	96	
RESP.	20	20	
TEMP.	100.4	99.6	
W/(CHILL)	95	—	

CATEGORY (See reverse)
- [ ] EMERGENT
- [ ] URGENT
- [X] NON-URGENT

ORDERS	INIT.	TIME
PTPCA	[redacted]	2140
Morphine, STAT		
UA		
Pelvis, Chest, Abdomen	[redacted]	2140

ASSESSMENT/DIAGNOSIS: GSW to L leg, Pelvis.

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

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

TIME OF RELEASE: 2338

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)

35 y/o ♂ c GSW's 3 days ago
no ⊖ buttocks/⊖ thigh/⊖ chest. Pt given Ancef
and Percocet @ 20:10 today. Sent here Bleed
concerns of infection and need for antibiotics.
History thigh, hepatitis, NKA. + . No food since 1000 A.M.
G'WD on, NAD, AAOx3
H: NCAT, PERRLA, EOMI, OP ⊖ Tm
NSR no murmurs
LCTA ⊖ rales
Abd: NT, ⊖ gaping wounds ⊕ thigh/Ant post ⊖ lower leg
⊕ FFP 77 thigh/leg ⊖ bruits
⊖ Bleeding, well vascular
Good DP ⊕ pulses. ⊖ steals
Rectal: Tone ⊖, good tone, Guaiac ⊖

66-2

Surgery [redacted] Consult

(AP)

to ward then to OR tomorrow
for Reconstruct

PMH - ⊖
PSH - ⊖
Im - ⊖

polio
⊖ shrapnel in Retroperitoneal
⊕ ⊖ thigh

T.S/F.S - ⊖ Sh

131 | 102 | 8 | <10
3.7 | 24 | 1.1

14
10.8 | 44 | 285

P7/277 - 12.8/26.7

UA - ⊕ ketone
Sm Blood - 5-10 RBC

(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).

EPW

[redacted] B6-4

SIGNATURE OF PROVIDER AND ID STAMP: [redacted] 2268 B6-2

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

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																	
POST-	DAY	20th															
MONTH-YEAR	DAY			20 JUN 03		21 June											
19	HOUR	0		0 17		0 1											
PULSE (O)	TEMP. F (•)	0 0 1		0 6		0 9 0 0											TEMP. C
	105°																40.6°
180	104°																40.0°
170	103°																39.4°
160	102°																38.9°
150	101°																38.3°
140	100°																37.8°
130	99°																37.2°
	98.6°																37.0°
120	98°																36.7°
110	97°																36.1°
100	96°																35.6°
90	95°																35.0°
80																	
70																	
60																	
50																	
40																	
RESPIRATION RECORD				20 0		1 9											
BLOOD PRESSURE		110/60		104/60 110/64		110/60 112/66											
HEIGHT:	WEIGHT →																
O2 SAT		96%		98(RA) 98%		98% 99%											

(Centigrade Equivalents, for Reference only)

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

#[redacted] B6-4

VITAL SIGNS RECORDS

Medical Record

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

Ward/Section: FMT	[redacted]ESTING PHYSICIAN: [redacted] B6-2	CH[redacted]ISTRY RESULT FORM (Subject to the Privacy Act of 1974)	B6-4
LAST, FIRST, MI.	DATE 19 Jan 03	TIME	SSN/PSEUDO SSN: [redacted]

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		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	~~130~~	73-118 mg/dl
BUN	8	7-22 mg/dl
CRE	8	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	100	73-118 mg/dl
BUN	8	7-22 mg/dl
CA^{++}	8.4	8.0-10.3 mg/dl
CRE	1.1	0.6-1.2 mg/dl
NA^+	131	128-145 mmol/l
K^+	3.7	3.3-4.7 mmol/l
CL^-	103	98-108 mmol/l
tCO_2	24	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:

REPORTED BY: [redacted] B6-2	DATE: 19Jan03	LAB ID NO.:

Ward/Section: EMT	[redacted] REQUESTING PHYSICIAN: [redacted] B6-2	[redacted] LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI:	DATE: 15 Jan	TIME: 2195	SSN/PSEUDO SSN: [redacted]

B6-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	10.8	4.8-10.8 x 10^3
RBC	5.09	4.7-6.1 x 10^9
Hgb	14.0	14-18 g/dl (M) 12-16 g/dl (F)
Hct	44.3	42-52% (M) 37-47% (F)
MCV	87.0	80-94 fl (M) 81-99 fl (F)
Plt	289	130-500 x 10^3 verified
Lymph %	15.5	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	12.8	9.8-13.6 secs
APTT	26.7	21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Urinalysis

TEST	RESULT	REF. RANGE
Color	Yellow	N/A
App	clr	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	40+	Negative
SG	1.030	N/A
Bld	pos	Negative
pH	6.0	N/A
Prot	neg	Negative
Urob	neg	0.2-1.0
Nit	neg	Negative
Leuk	trace	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
Sodium urate

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh: ONEG

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	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] B6-4

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

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

19JUN03 2230

Admit: Acute Pancreatitis Dx

Dos (R) Q8W Dry

Same

VS per unit

Acts Ad lib B6-2 noted [redacted]

Pt Diet

IV: Hoplock

PATIENT IDENTIFICATION: 8-16-24 [redacted] B6-4

NURSING UNIT: 3 ICW #1 | ROOM NO. | BED NO.

DATE OF ORDER / TIME OF ORDER / HOURS

Ancef 1gm IV Q8°

Clindamycin 300mg PO Q8°

Tylox #1 PO Q4°

Motrin 800mg PO TID

Tylenol #3 1gm PO Q6° PRN

Wet to Dry Dakins Solution DSD AS RID to wounds [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

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

B6-2

change Tylox to Tylenol #3 B/C we have no Tylox.

2265

B6-2 B6-2 [redacted]

21JUNE2011

PATIENT IDENTIFICATION: # [redacted] B6-4

TIME OF ORDER / HOURS

1830

D/C to EPW Comp

Keflex 250 QID x10 Days

Same DSD W→D BS QD → BID

Need write Rx

NURSING UNIT: ICW | ROOM NO.: 240/0145 | BED NO.: 220UMN03

B6-2 [redacted] B6-2

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

All B6-2 (except last)

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 19	20	21	22
19	[redacted]	VS: routine	6	/	[redacted]		
			14	/	[redacted]		
			22	[redacted]			
19	[redacted]	AG: ad lib	5	/	[redacted]		
			17	[redacted]			
19	[redacted]	Reg Diet	5	/	[redacted]		
			17	[redacted]			
19	[redacted]	WTD Dakin's solution	6	/	[redacted]		
		DRSG Δ's BID to	18	[redacted]			
		wounds					

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (L) thigh GSW

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION: [redacted]

B6-4

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

A11 B6-2

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
19	[redacted]	admit ortho HCW#1, stable	2330	19	JMM	
6/21	[redacted]	D/C to EPW Camp (saline dsg	6/21		notified	[redacted]
		W→D A's BID/QD				

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

USAPA V1.00

[redacted] All B6-2 (except last) [redacted]

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 19	20	21	22
19	[redacted]	IV: HL	5	/	[redacted]		
	------		17	[redacted]			

19	[redacted]	Ancef 1 gm IV Q8°	08	/	[redacted]		
	------		16	/	[redacted]		
	------		24	[redacted]			

19	[redacted]	Clindamycin 300 mg	08	/	[redacted]		
	------	po Q8°	16	/	[redacted]		
	------		24	[redacted]			

19	[redacted]	MOTRIN 800 mg po TID	8	/	[redacted]		
	------	NIO: c̄ food	14	/	[redacted]		
	------		22	[redacted]			

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (L) thigh GSW

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

CIV # [redacted] B6-4

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 B6-2

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
6/21	[redacted]	Keflex 250 QID x 10 days (D/C to EPW Camp)	6/21	noted		[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
19	[redacted]	Tylox #i po Q4° prn	N/A													
-----	-----															
19	[redacted]	Tylenol #gm po Q6° prn														
19	[redacted]	Tylenol #3 + #i po Q4° prn	2014 2345 [redacted]	2014 1500 [redacted]	22 0001 [redacted]											
-----	-----															
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USAPA V1.00

[redacted] MEDCOM - 11544 [redacted]

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A L L D	I Z	B6-4 [redacted]	B6-4 EPW [redacted]		M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
	35y	Z	9	NONE

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
	N/A	99 B6-4	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
N/A	U	2239	N/A

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K79	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø	ICW1	
		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] 62-2		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
5 Ø 05		Ø3 06 21

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
A B A *		Ø3 06 19

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

FOR LOCAL USE

Dx: GSW ⊖ thigh

B6-2

ADMITTING OFFICER (Signature [redacted] B6-2 Do[redacted]

SIGNATURE OF ADMITTING CLERK B6-2 [redacted] B6-2 [redacted] SPC, S/[redacted]

DA FORM 2085, MAR 80

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER [redacted] B6-4			2. NAME (Last, First, MI) UNK EPW 331		3. GRADE EPW	ADMISSION REMARKS
4. SEX M	5. AGE 35	6. RACE X	7. RELIGION MUSLIM	8. LENGTH OF SVC —	9. ETS —	10. PREVIOUS ADMISSION NO
11. FMP 99 B6-4	12. SSN [redacted]		13. ORGANIZATION —			14. WARD ICW2
15. FLYING STATUS —	16. RATING/DSG —	17. DEPT/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 1715	23. CLINIC SERVICE	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE —			25. TYPE DISPOSITION XFER TO EPW Camp		26. DATE OF DISPOSITION 24 JUN 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) —			27b. TELEPHONE NO. —		28. DATE OF THIS ADMISSION 22 JUN 03	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] B2-2					30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA [redacted]

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

SHOT IN LEG 1 WEEK AGO.

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

(1) GSW to leg leg s/p BKA @ FST
(2) GTOH withdrawal

Procedures: Thoughtlekree amputat
Stump revision + washout

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	2	2

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
[redacted]	[redacted] B6-2		[redacted]		

PAD OR MEDICAL RECORDS OFFICER

DA FO[redacted]

USAPPC V1.00

B6-2 B6-2

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

35 YO SIDE IN (L) LEG / WEDGE
ACD. RX'D AT FST, RX'D WAS PRESCRIBING by
DC SUPERVISOR. REVISED TO BKA 21 Mar 03
LEFT DPW.
(-) ROS
(+) POSITIVE HISTORY

NKDA (+) TOBACCO

PHYSICAL EXAMINATION

10.1 / 7.7
32.8

IN NAD
AFEBRILE - VS/NL
WALK SUPPORT
STUMP CAST / SPLINTS IN PLACE

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

(A) (L) BKA
(P) DISMISS I+D TOMORROW B6-2

[redacted]

[redacted] B6-2

22 Mar 03

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.

CPW [redacted] B6-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
23 Jun 03	Pt returned from OR/PR Recovery in KW#1 via stretcher VSS. A+O x3. HL IV (B)AC patent IV ABX. (B)LS clear (+)BS x4. Dsg to (L) thru knee amputation CDI. JP o/m, w/ has bloody d/c. 45cc @ 2000. Pt rest'd c/o pain [redacted] B6-2 Will cont to mon. Tx. [redacted]
24 Jun 03 0200	Pt care assumed @2100. [redacted] Pt had temp @ 103.6 orally and axillary @0045, 975 mg tylenol per Dr [redacted] B6-2 @0100. Pt placed the tylenol in his mouth for a few minutes, then spit ~~???~~ partially absorbed tablets on the ground. At 0200 temp is 101.7. Lung sounds have expiratory wheezing noted bilaterally. Bowel sounds (+)x4, pulses (+)x4. Dsg on L BKA CDI, no c/o pain. JP draining w/ bloody discharge. Foley site CDI, pt c̄ c/o output. Pt c̄ IV abx @ LFA, pulled needle for ancef out of IV port x2, restraints were tightened, MD was notified ~~for~~ [redacted] 4mg Versed given per MD. When reconnecting IV site, pt spit on ground and @ nurse. Pt has been disruptive and noncompliant all shift. Will continue to monitor. Spc [redacted] B6-2 9KWM6
0400	Foley catheter c̄ 1200 cc dark amber urine, 90cc drained from JP. [redacted] 9KWM6

B6-2

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. ICW2

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1O)
USAPA V1.00

[redacted] B6-4

All B6-2 (except last)

MEDICAL RECORD	PROGRESS NOTES
DATE	
24 Jun 1000	Assumed care of pt @ 0500. Pt has been very agitated. Pt is rational q 6 hrs. Pt has not slept all night of this am shift. VSS. Bandage is dry and intact. JP drain drained 30cc of bloody drainage. Pt was given tylenol 650 mg for temp of 102.8 @ 0900.
1220	IV in (L) ac d/c'd. Started new IV in (R) arm — [redacted] 9WM6, SGT —
24 Jun	Rechock Temp @ 0830 temp ↓ 101. Rechecked Temp @ 1100 Temp ↓ 99. — [redacted] 9WM6, SGT —
24 Jun 03 1400	pt. temp 103.5° ax, pt. given 975 mg tylenol - (L) upper leg hot to touch, inner thigh red - D[redacted] aware of pt's temp, - will recheck [redacted] CB —
24 Jun 03 1500	repeat temp 102.7° ax. will continue to monitor — [redacted] BA —
1850	repeat temp 101.7 ax with SPC [redacted]
1830	assumed care @ 1300 - current temp 102.6° ax,
24 Jun 03	given 975 mg tylenol PO c much encouragement - lungs sounds c (B) wheezes - (+) BS - dsg intact - (L) BKA, JP in place to suction - pt. very uncooperative and verbally abusive to staff - 3 limbs restrained for staff safety and EPW protocol — [redacted] CB —

(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. EW 2

EPW [redacted] B6-4

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE	
24 June 03	Pt vitals taken. BP 108/78, P. 100, R. 16, Temp. 98.4
2130	SPC [redacted] B6-4
2200.	Pt. care assumed @ 2100. USS. Pt. [redacted] operative c̄ nursing staff and translator. Pt. restrained x3 points. Drsng to (L) stump c̄ JP to (L) stump draining bright red bloody drainage. Foley to gravity draining clear yellow urine. IV to (R) UE ∫ s/s infection, infiltration. ~~wit~~ [redacted] B6-2 Pt. refusing to take ativan po. Pills dissolved in water. Pt. taking sips at a time will B6-2 cont. to monitor. [redacted]
0330	700 cc Dark amber urine out, LR reported [redacted] 125cc/hr. [redacted] B6-2
0400	10 cc out by JP, bright red bloody color [redacted] B6-2
0400	200 cc out from foley, dark amber urine [redacted] B6-2
25 June 03	Op Note am Drip Rel Thru knee Amp (R) Procedure was next from Stump [redacted] B6-2 Ebl: 1m Ti: 60m Fy: Clean Stump femur, Calf muscle flap Cord Closure Plan Stump Cast Δ + Dm out in 3 days

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

All B6-2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
25 Jun	Assumed care of pt @ 0500. Pt is asleep. VSS. T-102.8 axil. @ 0545. 0615 temp. @ 101.5 axil. @ 0700 T-99.8. Pt went to OR @ 0800. Pt came back from OR @ 1145. Pt is asleep. Cast on stump. Pt has foley. IV in (L) hand - LR @ 165/hr/kc HL in (R) hand. - patent. — [redacted], SGT 91WM6
25 Jun 03	1530. Assumed care of Pt @ 1300 VSS. Asleep, seems disoriented. (B) LSCHA (+) BS x4, cast to (L) thigh KA CDL, elevated with ice applied. Ø c/o pain. Active/agitated @ time. (L) hand HL PIV, (R) hand HL PIV patent. NABX. Ø N/V 25255 WNL. Will Monitor — [redacted]
26 Jun 03 0100	Pt care assumed @ 2100. VSS, awake without complaint of pain. Lungs sounds ≈ bilateral expiratory wheezing, bs(+)x4 quads. Pt with patent HL, abx. Dsg on lle CDL + com. Pt very obnoxious and noncompliant, will continue to monitor. Spc [redacted] 91WM6 —
0430	JP drain emptied, 50cc bloody output. — foley 91WM6
0440	900cc Dark, foul smelling urine emptied from foley catheter. — [redacted] 91WM6

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

NSN 7540-00-634-4176

600-108

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
22Jun03 2000	pt. admitted to ICW2 from EMT @ ~1900 - VSS, T 100.5 ax as pt. would not hold thermometer in mouth - 18g IV in (L) AC c LR @ 100cc/hr - Foley to gravity draining clear yellow urine, 700cc emptied - (L) BKA dsg. intact, ~~several~~ B6-2 [redacted] ~~small areas of old drainage~~, BKA done 21Jun @ 628 FST - pt. sleeping very soundly, must shake to wake up, interpreter reports pt. is oriented and that pt. told him he drinks a lot of alcohol & smokes hash - pt. has two GSW wounds on (R) shoulder c̄ scabs noted - pt. reported being shot by gang members 14Jun03 - lungs CTA (B) - (+) BS - restrained (B) wrists - (+) 2 pulses in extremeties x3 - [redacted] CPT AW
2145	Pt. care assumed @ 2100. VSS. Pt. sleeping. HR Reg, Lungs CTA, ABD soft + (+) BS. (L) BKA dsg CDI. IV to (L) AC infusing c̄ difficulty. KVO @ 100cc/hr. Pt. NPO p̄ MN for surgery in a.m. Foley to gravity draining clear yellow urine. Will cont. to monitor. B6-2 [redacted] B6-2
23Jun03 0630	Pt. sleeping in bed easily awaused by verbal stimuli. VS: BP 112/68, Sats 97%, P 109. T: 102.6 650mg Tylenol given. Dressing on (L) E is CDI.

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

EPW [redacted]

B6-4

RECORDS MAINTAINED AT: [redacted] B2-2

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

ICW2

CHRONOLOGICAL RECORD OF MEDICAL CARE
MEDCOM - 11552

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
03 June 03 0630	Pt. has LR infusing @ 100cc/hr in (L) AC. S/S of infection or infiltration. Foley draining dark yellow urine. All other assessment findings WNL. Pt's been NPO since MN, on call to OR this AM. Pt. has no apparent complaints @ this time. [redacted] /4N B6-2

ORTHO OP Note
PreOp Dx: GP BKA
procedure: I&D Conversion to thru knee Amputation level
Surg: [redacted] B6-2
B6-2
EBL: 100cc
TT: 40 hr
To PACU stable
Findings: Dead muscle & knee
Clotted off pop Art/vein
poor closure prior BKA
level shown
Revised to Thru Knee Level 2°
Inclusion Muscle Belly
all 4 Compartments

[redacted] B6-2

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)*
25 JUN 03	Transfer Summary
	DOA 22 JUNE 03
	DOT 26 JUN 03 B6-2
	COL [redacted] MD
	REASON FOR ADMISSION:
	35yo Iraqi male shot in (L) leg. Underwent BKA (L) leg at FST. Transferred to CSH & additional Care.
	Hospital Course:
	Patient taken to OR on 23 JUN 03 for wash out. Converted to through knee amputation level 2. Wound closed and stump cast c̄ drains applied. Stump revised 25 JUN 03. Now ready for transfer.
	Final Dx: (1) GSW to leg c̄ Amputation level 2 through knee of (L) leg. (2) Withdrawal symptoms on Ativan
	Procedure:
	Wound washout c̄ conversion to through knee amputation
	Stump closure
	Plan - Ancef 1 gm q 8° x 48° / Ativan PRN
	Tylox PRN

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
	transfer to Iraqi Hospital		
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR [redacted]	B6-2

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

B6-2 [redacted]

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Patient)*	LOG NUMBER	TREATMENT FACILITY [redacted] B2-2
		RECORDS MAINTAINED AT	

PATIENT'S HOME ADDRESS OR DUTY STATION			ARRIVAL	
STREET ADDRESS EPW # [redacted] B6-4			DATE *(Day, Month, Year)* 22/06/03	TIME 1725
CITY	STATE	ZIP CODE	TRANSPORTATI[redacted] B2-2	

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

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

CHIEF COMPLAINT GSW to LLE amputation

CATEGORY OF TREATMENT		VITAL SIGNS					
☐ EMERGENT	TIME 1710	TIME 1710					
☐ URGENT	INITIALS [redacted]	BP 108/58					
		PULSE 118					
☐ NON-URGENT		RESP 22					
		TEMP 102.8					
		WT					

LAB ORDERS						X-RAY ORDERS		
☑ CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT			CXR PA & LAT/PORTABLE		C-SPINE
URINE C&S	UA MSCC/CATH		CHEM:			ACUTE ABDOMEN		LS SPINE
BLOOD C&S X						SINUS		HEAD CT
			66-2			ANKLE R/L		

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
17:20	Tylenol 1gr ~~supp~~ [redacted]				

DISPOSITION	DISPOSITION QUARTERS /OFF DUTY	PATIENT/DISCHARGE INSTRUCTIONS
☐ HOME ☐ FULL DUTY	☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.	
MODIFIED DUTY UNTIL	RETURN TO DUTY	

CONDITION UPON RELEASE	ADMIT TO UNIT/SERVICE	REFERRED ▶	TO	WHEN
☐ IMPROVED ☐ UNCHANGED		I have received and understand these instructions.		
☐ DETERIORATED	TIME OF RELEASE	PATIENT'S SIGNATURE		

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

[redacted] B6-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

NSN 7540-01-075-3786

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

TEST RESULTS

CBC		SMAC	ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
WBC 7.7			SUP O2	PH	PO2	RESULTS	
H/H 13.1/32.0			PCO2	SAT	OTHER		
PLT 210							
PT			U/A	DIP		EKG INTERPRETATION	
APTT	BHCG	ETOH / GLU		MICRO			

PROVIDER HISTORY/PHYSICAL GSW to LLE x 6 days ago - above ankle amp of LLE. Transferred from FST team c̄ dressing + splint in place. No other injuries noted. Hot to touch. Red streaks noted coming up LLE. [redacted]

B6-2

Pm 62 yo BF transfer

See Ortho HPI

Foley inserted 16F foley using aspetic tech - 800cc dark yellow urine

CONSULT WITH	TIME	ACTION
Ortho	upon arrival	

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP [redacted]

PR[redacted]AND STAMP

B6-2

DIAGNOSIS

① foot amputation

CODES

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

A[redacted]

B6-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

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

10. OR NURSING INTERVE[redacted]OMPLETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted] CPT/AN 23 Jun 03 DATE

11. POSTOPERATIVE EVALUATION: B6-2

B6-2

12. PREOPERTIVE [redacted]ED BY (Signature and Title) [redacted] CPT/AN DATE: 23 Jun 03 TIME: 0840	13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title) DATE: TIME:

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

MEDICAL RECORD	**PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT** For use of this form, see AR 40-66; the proponent agency is The Office of the Surgeon General.
1. AGE: 35 HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): NKDA 3. PREVIOUS SURGERY [ ] NO [✓] YES (type): Lt leg B knee Amputation.

4. PROPOSED SURGICAL PROCEDURE:
(Lt) Stump I & D and Revision.

5. ADDITIONAL INFORMATION: Last PO: 12 MN Medical Hx: Ø Implants: Ø Medications: Ø
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)

EPW #1 [redacted] B6-4

35 Yrs.

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: 35
HEIGHT: ?
WEIGHT: 80 Kg

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

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

4. PROPOSED SURGICAL PROCEDURE: Revision Left AKA stump

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition WNL
Tobacco ? ppd X ? yrs. Body Piercing Ø Diabetes (Y) (N) ROM WNL X LLE ASA/Motrin w/72 hrs (Y) (N)
ETOH Ø Implants Ø Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures Ø Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS: Ancef, Unasyn Gent, Acivan

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	✓ Pt. verbalizes any specific anxiety. ✓ Pt. Exhibits relaxed body posture.	✓ Allow pt. to verbalize freely. ✓ Explain OR environment and answer questions regarding surgery. ✓ Offer comfort measures. (e.g., warm blanket, touch). ✓ Explain all nursing procedures before they are done. ✓ Remain with pt. whenever possible. ✓ Maintain family interface. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: ✓ 1) Positioning ✓ 2) Effects of Anesthesia ✓ 3) Medical/Smoking History	✓ Pt. will be able to breathe without difficulty during immediate intraoperative phase .	✓ Offer to elevate head of litter or offer pillow. ✓ Observe pt. while awaiting surgery for signs of distress. ✓ Assist anesthesia during intubation and extubation.
C. INTEGUMENT ✓ Potential impairment of skin integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement ✓ 3) Positional Aids 4) Prosthesis ✓ 5) Pooling of Prep Solutions	✓ Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	✓ Utilize pressure preventing devices on OR table and accessories. ✓ Check for proper positioning and support to maintain good body alignment. ✓ Pad pressure points. ✓ Place ESU ground pad on non compromised skin surface area. ✓ Keep prep fluids from pooling.

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

EPW #[redacted] B6-4

VERIFICATIONS AT HOLDING AREA:
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since MN ! 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: Ø

A11 B6-2

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	✓ Pt. will exhibit signs of adequate tissue perfusion (e.g.. color, warmth, pedal pulse.	✓ Check for support stockings or ace wraps. If none, check with doctors. ✓ Check that safety straps are correctly applied. ✓ Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. ✓ Check that rings 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	✓ Pt. will be transferred to OR table without difficulty. ✓ Pt. will not experience unnecessary physical discomfort.	✓ Have sufficient people available for transfer. ✓ Insure proper body alignment. ✓ Allow patient to lie in position of comfort while waiting for surgery. ✓ Offer support (i.e.. pillows. 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	✓ Pt. will be made aware of surroundings prior to anesthesia induction. ✓ Pt. will be transferred safely to OR table. ✓ Pt. will be able to understand instructions. ✓ Minimize danger of injury during intraop period.	✓ Introduce self. Keep pt. informed as to where he. she is and what is happening. ✓ Inform pt. in which direction to move and assist if necessary. ✓ Speak clearly and slowly. ✓ Address pt. from _____ side. ✓ Validate pt.'s understanding of verbal communication. ✓ 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

I [redacted] OMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTION S NOTED.

[redacted] T/AN 25 JUN 03 DATE

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

12. PREOPERAT[redacted] PREPARED BY (Signature and Titl[redacted] RN
DATE: 25 JUN 03 TIME: 0730

13. POSTOPERATIVE EVAL[redacted] PREPARED BY (Signature and Titl[redacted] N/N
DATE: 25 JUN 03 TIME: 0957

All B6-2 (except last)

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: Amor Staff

2. PATIENT [redacted] WED AND PROCEDURE VERIFIED BY [redacted] CPT/AN

3. DATE: 23 Jun 03 TIME PATIENT ARRIVED IN SUITE: 1(Cu-) OR

4. PATIENT IN ROOM TIME: 1215 NUMBER: 1-1/3

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKDA, NPO p MN.

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] (91D)	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] (66G)	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

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

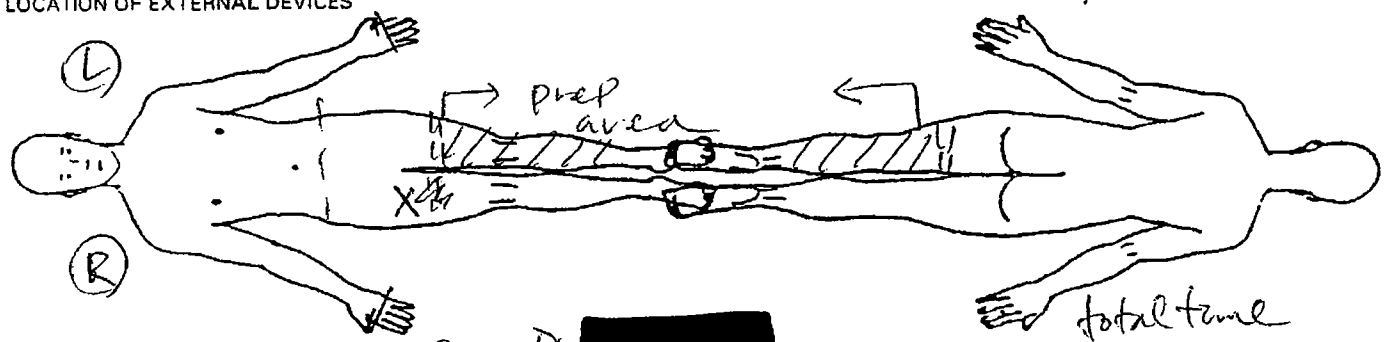
COMMENTS: Bil arms to padded arm board <90°. Body alignment maintained during the procedure.

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Betadine S/Sol
SITE: Lt. leg BY WHOM: CPT. [redacted] AN
SITE: ~ BY WHOM: ~
COMMENTS: Ø pooling of sol.

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad up -- Safety Strap up = = = [redacted] Dr [redacted] @ 300mmHg

10. COUNTS

			C = Correct I = Incorrect			
		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes ☐ No		C	C	SPC [redacted]	CPT [redacted]
Needle Sharp	☑ Yes ☐ No					
Instrument	☐ Yes ☑ No					
Other	☐ Yes ☑ No					

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

EPW # [redacted] B6-4
35 yrs.

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

☑ ESU NO: Valleylab #1
GROUND PAD: BRAND: polytesue
LOT NO: 69652

☐ ESU NO:
GROUND PAD: BRAND:
LOT NO:

☐ BIPOLAR NO:
Cut 230 Coag 230

MEDCOM - 11561

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

All B6-2

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):
0-9% Nacl

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE [redacted]

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

	1.	2.	3.
TYPE/SIZE	10mm JP		
SITE	Knee		

18. DRESSING/IMMOBILIZATION *(Specify)*
Zeroform
Sponges
Webril
Kerlex
Ace & Tape

19. ADDITIONAL INFORMATION
Surgeon: Dr. [redacted] / Dr [redacted]
Anes: LTC [redacted] (CRNA)

20. OPERATION(S) PERFORMED
Lt. leg I & D and conversion thru Knee Amputation.

21. PATIENT TRANSFERRED TO ICU TIME See Anes. Record METHOD Litter

22. [redacted] PT. AW

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

MEDCOM - 11562

All - B6-2 (except last)

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 ILT [redacted]

3. DATE 25 Jun 03 TIME PATIENT ARRIVED IN SUITE 0805

4. PATIENT IN ROOM TIME 0805 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: AKA Stump revision
NKDA, NPO PMN

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	ILT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) Supine on padded OR table. BUE on padded arm boards <90° Safety strap across abdomen. Tourniquet site protected c̄ Webril.

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

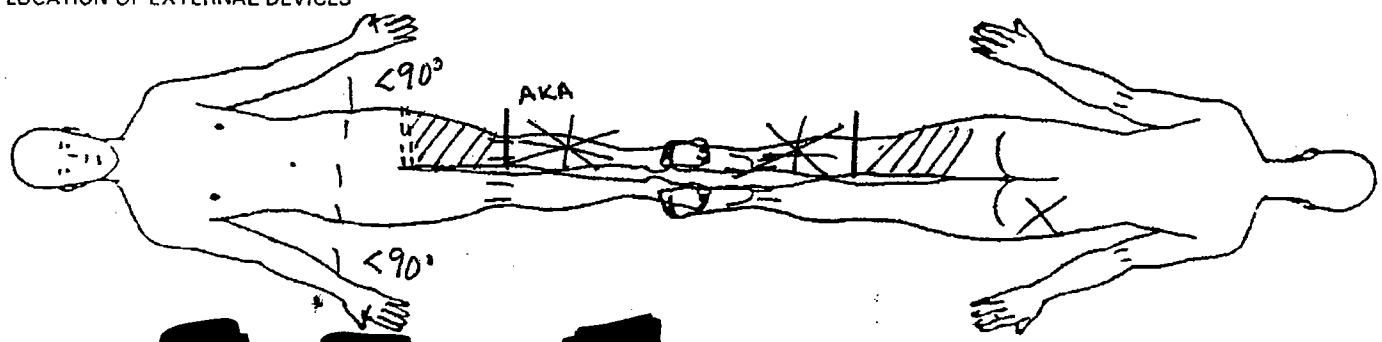
COMMENTS: Normal anatomic body alignment maintained.

8. SKIN PREPARATION

HAIR REMOVAL [ ] YES [X] NO
DONE BY: [ ] OR [ ] NURSING UNIT
METHOD: [ ] DEPILATORY [ ] RAZOR [ ] CLIP
COMMENTS: N/A

PREP SOLUTION (Specify) Betadine / Betadine
SITE: Left leg BY WHOM: ILT [redacted]
SITE: BY WHOM:
COMMENTS: No pooling or adverse reaction.

9. LOCATION OF EXTERNAL DEVICES



LEGEND X [redacted] [redacted] Strap = = [redacted] Tourniquet

Tourniquet @ 250 mmHg x 60 min

Initial: SPC [redacted] ILT

C = Correct / I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	[X] Yes	[ ] No	/	C	C	SPC [redacted]	ILT [redacted]
Needle Sharp	[X] Yes	[ ] No					
Instrument	[ ] Yes	[X] No					
Other	[ ] Yes	[X] No					

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

EPW # [redacted] B6-4

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

[X] ESU NO: #1 cut 30 coag 30
GROUND PAD: BRAND VL REM PolyHesive II
LOT NO: 69652 - Exp 2005.04

[ ] ESU NO:
GROUND PAD: BRAND
LOT NO:

[ ] BIPOLAR NO:

MEDCOM - 11563

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

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

A11 B6-2

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
N/A					

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NaCl - Q.S.

OTHER ORDERS	TIME	CARRIED OUT BY
N/A		

PHYSICIAN'S SIGNATURE [redacted]

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	# 10 JP drain		
SITE	Left AKA stump		

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs, kerlix, xeroform [redacted] wedge'l splint. ~~ACE~~

19. ADDITIONAL INFORMATION

Surgeon: Dr. [redacted]
Anesthesia: CPT [redacted]

Pt. arrived in OR c̄ Foley cath.

DA 5179 Initiated

20. OPERATION(S) PERFORMED

Left AKA stump revision

21. PATIENT TRANSFERRED TO ICU TIME 0957 METHOD LITTER c̄ O2

22. REGISTERED NURSE SIGNATU[redacted] RN

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

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY		1									
POST-OP DAY		DOS									
MONTH-YEAR June 19 2003	DAY	22		23		24		25		26	
	HOUR	6	12	6	12	6	12	6	12		

PULSE (0) / TEMP. F (°) / TEMP. C (Centigrade Equivalents, for Reference only)

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

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

RESPIRATION RECORD

RESPIRATION RECORD		16						18	16		
BLOOD PRESSURE		120/70		112/66	110/72		120/70	120/62			
		120/76		110/80			126/80	120/72			
HEIGHT:	WEIGHT [redacted]										
[redacted]		99%		97%			98%	95%			
	B6-2										

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. ICW 2

SPW [redacted] B6-4

VITAL SIGNS RECORDS

Medical Record

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

Ward Section	K.	ANC PHYSICIAN	LAB	TORY RESULT FORM (Subject to the Privacy Act of 1974)
EM7		[redacted] B6-2		
LAST, FIRST		DATE	TIME	SSN/PSEUDO
[redacted] B6-4		22 Jun	1710	[redacted] B6-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	7.7	4.8-10.8 x 10^3
RBC	3.521	4.2-6.1 x 10^6
Hgb	10.1	14-18 g/dl (M) 12-16 g/dl (F)
Hct	32.8	42-52% (M) 37-47% (F)
MCV	92.7	80-94 fl (M) 81-99 fl (F)
Plt	218	130-500 x 10^3 verified
Lymph %	26.1	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	Amber	N/A
App	Clear	N/A
Glu	Neg	Negative
Bili	Neg	Negative
Ket	40	Negative
SG	1.010	N/A
Bld	Large	Negative
pH	8.0	N/A
Prot	300	Negative
Urob	8	0.2-1.0
Nit	Neg	Negative
Leuk	Neg	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

SSA = H
0-2 RBCs

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: B6-2

REPORTED BY:	DATE:	LAB ID NO.:
[redacted]	22 Jun 03	

Ward/Section: EMT	Rm: [redacted]	[redacted] B6-2	CHE[redacted]TRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FI[redacted] #[redacted] B6-4		DATE 22 JUN	TIME 1720	SSN/PSEUDO SSN:

[redacted]T)			(Piccolo) Chemistry 12			(Piccolo) Metabolic Panel		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Na		138-146 mmol/L	ALB	2.0	3.5-5.5 g/dl	GLU		73-118 mg/dl
K		3.5-4.9 mmol/L	ALP	180	26-84 u/l	BUN		7-22 mg/dl
Cl		98-109 mmol/L	ALT	110	10-47 u/l	CA^{++}		8.0-10.3 mg/dl
pH		7.31-7.45	AMY	52	14-97 u/l	CRE		0.6-1.2 mg/dl
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)	AST	194	11-38 u/l	NA^+		128-145 mmol/l
PO2		80-105 mmHg (art) N/A (ven)	TBIL	1.3	0.2-1.6 mg/dl	K^+		3.3-4.7 mmol/l
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)	BUN	9	7-22 mg/dl	CL^-		98-108 mmol/l
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)	CA^{++}	8.2	8.0-10.3mg/dl	tCO_2		18-33 mmol/l
sO2		95-98%	CHOL	159	100-200 mg/dl	(Piccolo) Liver Panel Plus		
BEecf		(-2) - (+3) mmol/L	CRE	1.0	0.6-1.2 mg/dl	TEST	RESULT	REF. RANGE
AnGap		10-20 mmol/L	GLU	103	73-118 mg/dl	ALB		3.3-5.5 g/dl
Ca		1.12-1.32 mmol/L	TP	6.4	6.4-8.1 g/dl	ALP		26-84 u/l
BUN		8-26 mg/dl	(Piccolo) Metlyte 8			ALT		10-47 u/l
GLU		70-105 mg/dl	TEST	RESULT	REF. RANGE	AMY		14-97 u/l
Creat		0.7-1.5 mg/dl	GLU		73-118 mg/dl	AST		11-38 u/l
Hct		38-51% PCV	BUN		7-22 mg/dl	TBIL		0.2-1.6 mg/dl
Hgb		12-17 g/dl	CRE		0.6-1.2 mg/dl	GGT		5-65 u/l
Misc. Chemistry			CK		39-380 u/l (M) 30-190 u/l (F)	TP		6.4-8.1 g/dl
TEST	RESULT	REF. RANGE	NA^+		128-145 mmol/l	(Piccolo) Electrolyte		
Troponin-I		Negative	K^+		3.3-4.7 mmol/l	TEST	RESULT	REF. RANGE
Drug of Abuse		Negative	CL^-		98-108 mmol/l	NA^+		128-145 mmol/l
		Negative	tCO_2		18-33 mmol/l	K^+		3.3-4.7 mmol/l
		Negative				CL^-		98-108 mmol/l
		Negative				tCO_2		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

CBC C n8 1C 12

[redacted] B6-2

[redacted] B6-4

LABORATORY RESULT FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI.	STATUS	DATE	SSN
		24 Jun	

Chemistry (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
PCO_2		35-45 mmHg (art) 41-51 mmHg (ven)
PO_2		80-105 mmHg (art) N/A (ven)
TCO_2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO_3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO_2		95-98%
BEecf		(-2) – (+3) mmol/L
AGap		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

Blood Bank

ABO/Rh		IAT	
Unit	Type	Crossmatch	

Misc. Chemistry

CKMB		
Troponin		
DOA		
Alcohol		

Microscopic Urinalysis

Chemistry (Piccolo Analyzer)

TEST	RESULT	REF. RANGE
ALT		10-47 U/L
AST		11-38 U/L
GGT		5-56 U/L
ALB		3.3-5.5 g/dl
ALP		26-84 U/L
Amylase		14-97 U/L
Ca		8-10.3 mg/dl
Chol		<200 mg/dl
Creat	0.6	0.6-1.2 mg/dl
BUN	11	7-22 mg/dl
GLU	98	73-118 mg/dl
Tbili		0.21.6 mg/dl
TP		6.4-8.1 g/dl
UA		2.2-6.6 mg/dl (F) 3.6-8.0 mg/dl (M)
Na^+	134	128-145 mmol/L
K^+	4.5	3.3-4.7 mmol/L
Cl^-	99	98-108 mmol/L
$^+CO_2$	21	18-33 mmol/L
CK	3471	39-380 u/L

Urinalysis

TEST	RESULT	REF. RANGE
Gluc		Negative
Bili		Negative
Ketone		Negative
SG		N/A
Blood		Negative
pH		N/A
Protein		Negative
Urob		0.2-1.0
Nitrite		Negative

Hematology

TEST	RESULT	REF. RANGE
WBC	9.0	4.8-10.8 x 10^3
RBC	2.92	4.7-6.1 x 10^3
Hgb	8.7	14-18 g/dl (M) 12-16 g/dl (F)
Hct	27.2	42-52% (M) 37-47% (F)
MCV	92.9	80-94 fl (M) 81-99 fl (F)
Plt	289	130-500 x 10^3 verified
Lymph%	18.2	20.5-51.1%
Retic		0.5-1.5% (adult)
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml
Segs		Mono
Bands		Eos
Lymph		Baso
Atyp		Imm
RBC Morph		
Other		
Spun Crit		42-52% (M) 37-47% (F)
Man WBC		4.8-10.8 x 10^3
Manual Plt		130-500 x 10^3 verified

Microbiology

Source	
Gram Stain	
Culture	
KOH/WP	
O&P	
Occ Bld	Malaria
Other	

MET 8

24 Jun 03

IW#2 24 June 03 c 0415 #[redacted] B6-4 Dr. [redacted] B6-2

(Hematology) CBC

TEST	RESULT	REF RANGE
WBC	5.7	4.8-10.8 x 10³
RBC	5.27	4.2-6.1 x 10⁶
Hgb	14.3	14-18 g/dl (M) 12-16 g/dl (F)
Hct	45.6	42-52% (M) 37-47% (F)
MCV	86.5	80-94 fl (M) 81-99 fl (F)
Plt	321	150-500 x 10³ verified
Lymph %	34.3	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		21-33 secs
D-dimer		20 ng/ml
FDP		10 ng/ml

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] B6-2

DATE: 24 Jun 03

LAB ID NO.:

Section: 1CW2 | REQUESTING PHYSICIAN: [redacted] B6-2 | **CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)

FIRST NAME: [redacted] B6-4 | DATE: 26 Jun | TIME: 0300 | SSN/PSEUDO SSN:

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

(Piccolo) Chemistry

TEST	RESULT	REF. RANGE
ALB	2.0 *	3.5-5.5 g/dl
ALP	250 *	26-84 u/l
ALT	79 *	10-47 u/l
AMY	154 *	14-97 u/l
AST	100 *	11-38 u/l
TBIL	1.7 *	0.2-1.0 mg/dl
BUN	9	7-22 mg/dl
CA^{++}	8.4	8.0-10.3 mg/dl
CHOL	138	100-200 mg/dl
CRE	1.0	0.6-1.2 mg/dl
GLU	106	73-118 mg/dl
TP	7.1	6.4-8.1 g/dl

(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		0.2-1.0 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

(Piccolo) Liver Panel

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)

MEDICAL CHEMISTRY

ST	RESULT	REF. RANGE
min-1		
of ic		

REMARKS:

REPORTED BY: [redacted] B6-2 | DATE: | LAB ID NO.:

ePW [redacted] B6-4 [redacted] B6-2
KWa
06 Jun 0400

(Hematology) CBC		
TEST	*RESULT*	*REF. RANGE*
WBC	10.4	4.8-10.8 x 10^3
RBC	3.04	4.7-6.1 x 10^6
Hgb	8.9	14-18 g/dl (M) 12-16 g/dl (F)
Hct	28.0	42-52% (M) 37-47% (F)
MCV	92.1	80-94 fl (M) 81-99 fl (F)
Plt	615.	130-500 x 10^3 verified
Lymph %	16.8	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:	**DATE:**	**LAB ID NO.:**

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)	
Versed	( )	2
Fentanyl	( )	100 100 50
Propofol	( )	180
Sux / Zemuron	( )	100 / 50
MOSO	( )	5 5
	( )	
VOLAT AGENT: Forane	% del	1.5 1.0 1.5 1.5 1.5 1.5 1.8
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	10 2 2 2 2 2 2 2 2

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

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

TOTALS	
2mg	
250ug	1000
10 mg	
	TOTAL URINE: 100

FLUIDS – SUMMARY
CRYSTALLOID– 3100
COLLOID–
BLOOD–

FLUIDS — LINE site Lt UE 500 Warmed; Rt Warmed; Warmed; Warmed

LOSSES — EST BLOOD LOSS; URINE –

VITAL STATUS: 1 2 3 4 5 E

BODY WEIGHT: 85 KG LB

HEMATOCRIT: 10 / 32.

INITIAL DATA: BP – 126/67; HR– 82

COMP CHECK: OK?– Y N

PATIENT IDENTITY: OK for PROCEDURE; TIME– 1215

TIME → 1230 1300 30 1400

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

W0018 03 002983 3

VT – ml	900	870	880	870	880	880	880
f – breaths/min	9	9	8	8	8	8	8
Peak inf pres / PEEP	29	28	28	28	28	28	28
MODE– S(pon), A(ssist), C(on)	SU	CV	CV	CV	CV	CV	CV
BP/Auto Cuff / ET CO2 (torr)	37	33	33	33	32	32	31
BP / oth / FIO2 (Frac or %)	.54	.54	.60	.60	.60	.60	.60
ART line / SpO2 (%)	100	100	100	100	100	100	100
Steth- PC/ES / ECG	SR	SR	SR	SR	SR	SR	SR
Gas analyzer / TEMP- site	101.8						
N-M Block (T/4)							
Warming blkt							
Conv warmer							

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

REMARKS – Code drugs with numbers, events with letters

PT DOC chart reviewed
Dock in Lift arm
1225 In Room Monitors on
1230 smooth Induction
Intubate
1306 T O ret 350 mlly
1315 2nd IV 16G R hand
Tx c 44 PRBC
1327 total 21 min
1410 1st unit PRBC
1415 SP. Vent
1420 complete SP vent
1420 Sx extubate
1425 TO PACU on O2

RECOVERY AT 1430
PACU ICU I (Specify) OTHER RR
CONDITION: Stable
RESP– 20 SpO2– 98 SR
BP 119/69 HR– 109

	Start	Room	End
ANES	1215	1225	1435
PROC	Ready	Begin	End
	1235	1250	1420

PROCEDURES and CPT Codes: Revision BKA, Conversion through Knee I + D left lower leg

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA – MAC 4 & O CTT

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Dx x2 – once by student. ETT passed ultrasonic BBS = ETCO2 x6 ETT Received Med Epid

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

EPW - [redacted] B6-4

SURGEON: [redacted] B6-2

[redacted]

PROCEDURE LOCATION 1
DATE 23 Jun 03
PAGE 1 OF 1

ICW 2 B6-2

MEDICAL RECORD — ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 11572

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

(4)

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

35 DAYS MOS YRS Sex (X) MALE ( ) FEMALE 35y.o.

ASA Physical State 1 (2) 3 4 5 E
WT: 85 KG/LB HT: 5'10 IN.
ALLERGIES: NKDA

POSED PROCEDURE: I&D
GICAL SERVICE: ortho
SINCE: GSW → (L) LE 7 DAYS AGO

ITS:
BACCO: 3pk / Dy
ETOH: fifth day
DRUGS: Ø

RENT MEDICATIONS:
ordered as premed

MEDICATIONS:
e (Vec) (@) 100 Hrs) /CC
Acef 1gm mg (V) IM PO 0800
Tylenol 650 mg IV IM PO 2345
mg IV IM PO 0630

ORATORY STUDIES:
HCT: 10.1 / 32.0
IER:

@ one time stated Hx of Hashish use but denies today

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	Chronic cough productive whit
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	(L) BKA
Other Significant Hx:			
	(N)	Y	
	(N)	Y	
Familial HX	(N)	Y	

ASSESSMENT

PAST SURGICAL/ANESTHETIC
None

PHYSICAL EXAMINATION
BP 98/62 HR 102 R 45 T 102.7
Pain Scale 0-10
HEENT - Teeth Ø loose teeth
Trachea
TMJ/Neck 3
Oropharnyx 3
Nares
CHEST: (B) CTA
CARDIAC: S1 S2 HRR
EXTREMITIES: pulses X3
IV Access: (L) AC
Ulnar Filling: WNL
BACK:
OTHER:

NPO Since [redacted] Tylenol / SLPS 0630

ESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): (✓) 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.

B6-2

patient/legal [redacted] and agrees. Questions answered.
ned: [redacted] CRNA Date: 23 Jun 03 Time: 0810 Hrs

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

ned: _____ Date: _____ Time: _____ Hrs

ent Identification: (Ward) EPW # [redacted] ICW-2 ICU-1

B6-4

EPW [redacted] ICW2

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 be necessary.

Tobacco

Ancef 1gm pre-op @ 0800

NKDA

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)	
MSO4	( )	1 - 5 7 2 2 2 1
Marcaine	( )	1 1.5
Lidocaine	( )	50
Propofol	( )	150
Fentanyl	( )	50 - 50 - 50 - 50
	( )	
VOLAT AGENT	% del	1.5 1.5 1.7 1.7 1.7 1.5 1.5 X
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	8 2 2 2 2 2 2 2 2

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

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

LINE site	
18G R AD	Warmed — #1 14G / #2 — 1000
	Warmed
	Warmed
	Warmed

LOSSES	
EST BLOOD LOSS	30
URINE –	100

TOTALS	TOTAL BP
13 / 2.5 / 50 / 150 / 200	30
	TOTAL URINE
	100

FLUIDS – SUMMARY
CRYSTALLOID– 1000LR
COLLOID– Ø
BLOOD– Ø

REMARKS– Code drugs with numbers, events with letters

(1) Pre-op passed airway Resp – CTA (B/L); HR
(2) To Letter to OR, monitors O2
(3) Induced; eyelids taped, Rel airway management C Glycopyrrolate 0.2mg 18G PIV placed (4) Reglan 10mg IV
(5) To Letter O. suctioned airway Removed LMA; C Oral airway placed Tease + BBS; +E ET to ICU report to RN Pt left attended
Tourniquet LLE @ 250mmHg TT @ 0837 TT @ 0937 TT=

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 80 (KG / LB)

HEMATOCRIT: 32.8

INITIAL DATA: BP – 122,62 HR – 102

EQUIP CHECK: OK? – (Y) N

PATIENT REVIEW: OK for PROCEDURES? JP TIME – 0745

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

TIME → 0800 · 30 · 0900 · 30 · 1000 · 30 ·

VT – ml	+	320	320	170	260	230	320	340
f – breaths/min	+	30	28	10	13	13	14	15
Peak inf pres / PEEP								
MODE– S(pon), A(ssist), C(on)	S	S	S	S	S	S	S	S
BP/Auto Cuff – ET CO2 (torr)	40	32	34	45	50	53	54	54
BP/oth – FIO2 (Frac or %)	0.63	0.63	0.63	0.64	0.64	0.64	0.64	0.64
ART line – SpO2 (%)	100	99	100	100	100	100	100	100
Steth- PC/ES – ECG	SR	ST	ST	ST	ST	ST	ST	ST
Gas analyzer – TEMP- site Axillary	98.8							
N-M Block (T/4)	BS		+		+	+		+
Warming blkt – x1 Blanket	x1							
Conv warmer								

Mark with letters & symbols, explain under REMARKS — EVENTS Position → (1) (2) (3) (4) (5)

RECOVERY AT 0957
PACU ICU 7 (Specify)
OTHER
CONDITION: stable, asleep
RESP– 24 SpO2– 99
BP– 100/41 HR– 107

	Start	Room	End
ANES	0750	0805	1010
PROC	Ready 0815	Begin 0830	End 0947

PROCEDURES and CPT Codes: (L) AKA stump revision

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GLMA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: LMA #4; Seated; +BBS; sustained ETCO2

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

EPW# [redacted] B6-4

[redacted] B6-4

SURGEONS [redacted] B6-2

[redacted] RNA/CRT

B6-2 [redacted] RECORD – ANESTHESIA

PROCEDURE LOCATION 7
DATE 25 Jun 03
PAGE 1 OF 1

AMC OP 376 REVISED 1 Jan

MEDCOM - 11574

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

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

35 DAYS MOS (YRS) Sex (✓) MALE ( ) FEMALE

ASA Physical State 1 (2) 3 4 5 E
WT: 80 (KG/LB) HT: ____ IN.
ALLERGIES: NKDA

POSED PROCEDURE: (C) AKA revision
GICAL SERVICE: OR HO
SINCE: NW

ITS:
BACCO: (+)
ETOH: ____
DRUGS: ____

RENT MEDICATIONS:
ordered as premed

Ancef 1gm IVPB 08/16/21
Gentamicin 400mg IVPB
Unasyn 3gm IVq6°
Ativan 2mg PO q6° — 04
LD @ 1400 24hrs

MEDICATIONS:
e Yes (@ ____ Hrs) /CC
___ . ____ mg IV IM PO
___ . ____ mg IV IM PO
___ . ____ mg IV IM PO

ORATORY STUDIES:

ICT: ____/____
IER: ____

22 fine
7.7 | 10.1 / 32.8 | 218

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Unknown

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) Pt. arousable but sedate from ativan
	N	Y
Familial HX	N	Y

ASSESSMENT

PAST SURGICAL/ANESTHETIC

unknown

PHYSICAL EXAMINATION

BP 122/62 HR 102 R 18 T 102.2
Pain Scale 0-10 ____ Tylenol 650 @06:
HEENT - Teeth Intact
Trachea midline
TMJ/Neck ____
Oropharnyx multiple tacuoses
Nares ____
CHEST: ____
CARDIAC: ____
EXTREMITIES:
IV Access: 18G (R) HO
Ulnar Filling: ____
BACK: ____
OTHER: Foley

NPO Since NW

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

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

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

B6-2 [redacted] CRNA/CPT Date: 6-25-03 Time: 0730 Hrs

[redacted] ANESTHESIA EVALUATION AND NOTE (NON ASU)
✓ NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

B6-2 [redacted] CRNA Date: 6-25-03 Time: 1808 Hrs

ient Identification: (Ward) ____

[redacted] — B6-4

EPW # [redacted]

SEDATION KEY:

1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is n necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may

518-123 All B6-2 (except last) NSN 7540-00-634-4158

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [x] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)* 1 unit ML

REMARKS: Pt in OR

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [x] TYPE AND SCREEN
- [x] CROSSMATCH 1315

DATE REQUESTED 23 June 2003

DATE AND HOUR REQUIRED ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* Dr. [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE Ct Bone Amputation (GSW)

I have collected a blood specimen on the below named patient, verified the name and ID No. of the pa[redacted] B6-2

DATE VERIFIED 23 June 03

TIME VERIFIED 1315

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. 002083

TRANSFUSION NO.

PATIENT NO.

DONOR ABO O Rh POS

RECIPIENT ABO O Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN: NA

CROSSMATCH: Comp

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

SIGNATURE OF PERSON PERFORMING TEST [redacted]

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 23 June

REMARKS: EXP 25 Jun 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

[redacted]

AT *(Hour)* 1410 ON *(Date)* 23 Jun 03

IDENTIFICATION

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

1st VERIFIER *(Signature)* [redacted] MTC CMM

2nd VERIFIER *(Signature)* [redacted]

PRE-TRANSFU[redacted]

TEMP. PULSE 104 BP 107/59

DATE OF TRANSFUSION 23 Jun 03 TIME STARTED 1410

POST-TRANSFUSION DATA

AMOUNT GIVEN 250 ML

TIME/DATE COMPLETED/INTERRUPTED 1420

REACTION
- [x] NONE
- [ ] SUSPECTED

TEMPERATURE

PULSE 105

BLOOD PRESSURE 114/76

If reaction is suspected—IMMEDIATELY:

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

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

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

[redacted]

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—La[redacted] rate; hospital or medical facility)

WARD

EPW # [redacted] B6-4

35 yrs

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

All B6-2 (except last)

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

- [x] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of ____ units)*
- [ ] CRYOPRECIPITATE *(Pool of ____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* ____

VOLUME REQUESTED *(If applicable)*: 1 unit ML

REMARKS: Pt in OR

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [x] TYPE AND SCREEN 1315
- [x] CROSSMATCH

DATE REQUESTED: 23 Jun 2003

DATE AND HOUR REQUIRED: ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: ____

HEMOLYTIC DISEASE OF NEWBORN? ____

REQUESTING PHYSICIAN *(Print)*: [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE: (L) Knee Amputation

I have collected a blood specimen on the below na[redacted] verified the name and ID No. of th[redacted] specimen tube label to be [redacted]

SIG[redacted]

DATE VERIFIED: 23 Jun 03

TIME VERIFIED: 1315

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: G489830

TRANSFUSION NO.:

PATIENT NO.:

DONOR ABO: O Rh: POS

RECIPIENT ABO: O Rh: POS

TEST INTERPRETATION

ANTIBODY SCREEN: NA

CROSSMATCH: Comp

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [x] NO RECORD

[redacted]

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED | DATE 23 Jun 03

REMARKS: EXP 6/25/03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

[redacted]

AT *(Hour)* 1409 ON *(Date)* 23 June 03

IDENTIFICATION

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

1st VERIFIER *(Signature)*: [redacted]

PRE-T[redacted]

TEMP. 95.6 PULSE 102 BP 109/72

DATE OF TRANSFUSION: 23 Jun 03

TIME STARTED: 1435

POST-TRANSFUSION DATA

AMOUNT GIVEN: 250 ML

TIME DATE COMPLETED: 1510 23 Jun 03

INTERRUPTED:

REACTION

- [x] NONE
- [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:

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

DESCRIPTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER ____

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

- [x] NO
- [ ] YES *(Specify)*

[redacted]

WARD: ICW #1

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries [redacted] NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

EPW # [redacted]

B6-4

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

CLINICAL RECORD - DOCTOR'S ORDERS

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

E 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	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
EPW [redacted] B6-4	ICW2		16	22 JUN 83	1720 HOURS	
				1. TO ICW 2 2. DX - (L) BKA 3. CONDITION STABLE 4. VS - ROUTINE 5. ODS TO CLEAR IND 6. REGULAR DIET, NPO AFTER MIDNIGHT		
EPW [redacted] 8/100/24 B6-4	ICW2		16	1. N - LR AT 100 CC/HR 2. ANCEF + GAZA NPB Q 8 HRS 3. TYLENOL 650 MG P.O. Q 4 HRS PRN 4. DILAUDID, 1-2 P.O Q 4-6 HRS PRN 5. MSO4 2-6 MG IVP Q 2 HRS PRN 6. TO OR TOMORROW [redacted]		B6-2
EPW [redacted] B6-4	ICW2		16	7. BLEED TO GRAVITY [redacted] B6-2 ~~8. VS QTRLY FOR AUG 23 DS OOO~~		noted [redacted] B6-2
EPW [redacted] B6-4	ICW2		16	2 JUN 83 1. RESUME PREVIOUS ORDERS 2. ADVANCE TO REGULAR DIET 3. BED REST 4. ANCEF + GAZA IVPB Q 8 HRS 5. GENTAMYCIN 400 MG IVPB Q DAY 6. N - LR AT 125 CC/HR. HEPLOCK WHEN PO. 7. CBC, MAINTAIN 8 IN ALL [redacted]	1420 HOURS	[redacted]

DA FORM 1 APR 79 4256 RE ... EDITION OF 1 JUL 77, WHICH MAY BE [redacted]

MEDCOM - 11578

B6-2

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.

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER / HOURS	LIST TIME ORDER NOTED AND SIGN
EPW# [redacted] B6-4	23 JUN 03 2200	U.O. Dr. [redacted] / Lt [redacted] (1) 2mg Ativan IVP Q6° [redacted]	B6-2
	23 JUN 2200	U.O. Dr. [redacted] (1) 1 Ativan to PO [redacted]	
NURSING UNIT / ROOM NO. / BED NO.		[redacted]	

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER / HOURS	
EPW [redacted] B6-4	[redacted] 24 Jun 03 0975 ~~mg~~ p.o or pr Tylenol now @ ~~40 mg~~ 2 mg vered IV [redacted]	B6-2	
NURSING UNIT / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER / HOURS	
EPW [redacted] B6-4	24 Jun 03 [redacted] B6-2		
NURSING UNIT / ROOM NO. / BED NO.	24 Vs 0300		

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER / HOURS	
EPW [redacted] B6-4	24 Jun 03	1000	Noted [redacted] 24 Jun 03 1055
	DC Gent	B6-2	
	Unasyn 3gm IV Q6°		
	NPO 8 MN		
	for washout Return 25 Jun 03		
NURSING UNIT / ROOM NO. / BED NO.	ICW II / 24 6 Vs		

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
[redacted]	[redacted]		
		B6-2	
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

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.

PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER / HOURS	LIST TIME ORDER NOTED AND SIGN
			25 JUN 03 0930 Transfer ICU → ICW2 S/P Transhut TAN Knee Amputation Stable VS Q1 x 24 Aero Bed	
NURSING UNIT	ROOM NO.	BED NO.		

PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER / HOURS	
			Ice/Elevate Stump Foley to Gravity To OR To Pain to Such Rule Record pm & am Alb Rep Drt N-PO 100 cc/hr HCW w/ TOL Rule	
NURSING UNIT	ROOM NO.	BED NO.		

PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER / HOURS	
			meds Unasyn 3gm IV Q6 Ancef 1gm IV Q8 MSO4 2-10mg IV/PO Q4 Atbm 2mg IV/PO Q4 Tylenol 650mg PO Q Percocet 1-2 PO Q4 prn B6-2	Noted [redacted] 25 JUN 03 1315
NURSING UNIT	ROOM NO.	BED NO.		

PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER / HOURS	
			CBC, Chem 12 in AM [redacted] B6-2	
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]

B6-4

NURSING UNIT	ROOM NO.	BED NO.
	24°/s	26 Jun 03

DATE OF ORDER: 25 Jun 03 TIME OF ORDER: 2400 HOURS

LIST TIME ORDER NOTED AND SIGN

OK for transfer to Iraqi hospital

B6-2 [redacted]

CHCO [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER [redacted] 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.

All B6-2 (except last)

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 22	23	24	25	26
22	[redacted]	VS ROUTINE	5	/	[redacted]			
			13	[redacted]				
			21	[redacted]				
22	[redacted]	OOB TO chair TID	5	/	[redacted]			
			13	[redacted]				
			21	[redacted]				
22	[redacted]	REG DIET	5	/	[redacted]			
23	[redacted]		11	/	[redacted]			
			17	/	[redacted]			
22	[redacted]	Foley to GRAVITY	5	/	[redacted]			
			13	[redacted]				
			21	[redacted]				
23	[redacted]	Bed Rest	5	/	[redacted]			
			13	/	[redacted]			
			21	[redacted]				
25	[redacted]	ICE/ELEVATE stump	5	/	/	/	[redacted]	
			13	/	/	/	[redacted]	
			21	/	/	/		
25	[redacted]	JP Drain to suction	5	—	/	/	[redacted]	
		record prn + q shift	13	—	/	[redacted]		
			21	—	/	[redacted]		

See below 23 Jun 03

ALLERGIES: ☐ YES ☐ NO ?

PRIMARY DIAGNOSIS: (L) BK A

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

SPW

[redacted] B6-4

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

A11 B6-2

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
22	[redacted]	TO ICW 2: COND. STABLE	22		1900	[redacted]
22	[redacted]	NPO PMID	22	23 00		[redacted]
22	[redacted]	TO OR TOMORROW	23	done		[redacted]
23	[redacted]	resume previous orders	23		1530	[redacted]
23	[redacted]	CBC, metlytes in AM	24	04	04	[redacted]
24	[redacted]	NPO p mid	24	2400		[redacted]
25	[redacted]	CBC, Chem 12 in am	26	0400	0400	[redacted]

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

USAPA V1.00

All B6-2 (except last)

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 22	23	24	25	26
22	[redacted]	~~IV LR @ 100cc/hr~~	5	/	[redacted]			
23	[redacted]	LR @ 125cc/hr - HL	13	[redacted]				
		when taking PO	21	[redacted]				
22	[redacted]	Ancef 1 gram IVPB	8	/	[redacted]			
23	[redacted]	Q8 hrs	16	[redacted]				
			24	[redacted]				
			/					
23	[redacted]	Gentamycin 400mg	18	/	[redacted]			
		IVPB QD						
23 June	[redacted]	2mg Ativan IVP Q6°	04	/	X	D		
			10	/	X			
			16	/	X			
			20	/				
			22					
23 June	[redacted]	Ativan 2mg PO Q6°	04	/	X	[redacted]		
			10	/	X			
			16	/	X			
			22	/	[redacted]			
24 Jun	[redacted]	Unasyn 3gm IV q 6°	06	/	/	/	[redacted]	
			12	[redacted]	/	[redacted]		
			18	/	/	[redacted]		
			24	/	/	[redacted]		

DC'd on night shift

DC'd @ 24 June 03

ALLERGIES: ☐ YES ☐ NO ?

PRIMARY DIAGNOSIS: Dx (L) BKA

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

EPW [redacted] B6-4

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 B6-2

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
24Jun	[redacted]	975 mg Tylenol PO or PR now &	24Jun	0100	0100	[redacted]
	-----	4 mg Versed IV	24Jun	0100	0100	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
22	[redacted]	Tylenol 650 mg	22Jun 03 0630 TT PO [redacted] temp 102.6	23June 1130 TT PO [redacted] temp 102.2		24JUN 0900 TT PO [redacted]	24JUN 24Jun 1345 TT [redacted]									
-----	-----	P.O. Q4hrs prn														
-----	-----															
22	[redacted]	Percocet 1-2 P.O.														
-----	-----	Q4-6° PRN														
-----	-----															
22	[redacted]	MSO4 2-6mg IVP	24Jun 1900 [redacted]	24June 2230 [redacted]							DC'd					
-----	-----	Q2Hrs PRN														
25	[redacted]	MSO4 2-10 mg IVP q 2 hrs														
-----	-----															
-----	-----															
-----	-----															
-----	-----															

USAPA V1.00

All B6-2 (except last)

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 25	26												
25	[redacted]	IV LR @ 100 cc/hr -	5	/	[redacted]												
		HL when tolerating PO	13	[redacted]													
			21	[redacted]													

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Dx (L) BKA

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

PATIENT IDENTIFICATION:
EPW [redacted]
B6-4

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

yut only

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM _____ HOURS TO _____ HOURS | TOTAL HOURS COVERED | DATE 23 June

INT

~~ORAL~~ Output

TIME	TYPE	AMOUNT	ACCUM TOTAL
1930	Bloody	45	45cc
24 June		03	
0430	Bloody	90	90cc
1200	Bloody	30cc	120cc
1930	bloody	50	170cc

INTRAVENOUS

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

urine

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
1200	Amber urine	450	450cc

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] B6-4

INTAKE EQUIVALENTS (Serving levels cc)

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

DD FORM 1 JAN 74 792

ITION OF 1 SEP 54 IS OBSOLETE. REPLACE UL 72 WHICH MAY BE USED.

ORM 3630(TEMP)

*U.S.GPO:1996-404-613/30343

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: 23 JUN 03 Anesthesia Type (Circle)): General Spinal Epidural MBAII
Time In: 1470 IV Sedation Nerve Block
Allergies: 0 OR Intake: Crystalloid 3100 Colloid 250 Int
Pre-op V/S: 93/62, 102 102 OR Output: UOP 700 EBL 1000
Procedures: Revision/BKA & I&D Meds/Times: Ancef Fent/MS04.

Pre Op Meds History fever

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Time	1450	1455	1460	1455	1510	1515						
SaO2	100	100	100	100								
FiO2 100MA												
Methods												
240												
220												
200												
180												
160												
140												
120												
100												
80												
60												
40												
20												
RR	20	26	26	28	24	24						
T 95.6		95.7		96.0	96.0							

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

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1510	PRBC	250	D/ne	[redacted]	250 cc
1515	NS	700	D/ne	[redacted]	700
				66-2	

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	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.	11	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

(Continue on reverse)

PR[redacted] DEPARTMENT/SERVICE/CL[redacted] 66-2 DATE 23 Jun 3

PATIENT'S IDENTIFICATION (For typed [redacted] B6-2 Name – last, first, middle; grade; date; hospital or me[redacted]

#[redacted] B6-4

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete
USAPPC V2.00

A11 R6-2

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1500	NA	MSO4 4mg	IV	—	—	[redacted]

NEUROVASCULAR

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

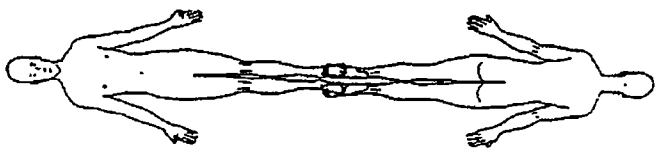
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 1428	LLE	Bulky	Min JP
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1518	Foley	yellow/clear	100

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1500	SR	Ø	Ø

WAMC OP 173-E

NURSING NOTES

1437: pt received from OR via litter; pt somnolent but arousable; MAE, LLE c bulky dressing; no hemorrhage observed; JP intact; chest [redacted] PRBC #2 brought over by [redacted] OR; int chorkel c OR stay + started in ICU #1; q5 vitals per M3-E; no S/S of reperfusion as of yet x 15min; [redacted] 1518; pt tolerated PRBC; report given to ~~not~~ ICU 2; pt

Discharge Criteria:
Date: 23 JUN 97 **Time:** 1520 **PARS:** 12
BP: 120/64 **T:** 96.2 **HR:** 89 **RR:** 20 **Sa02:** 100
Pain Level at D/C (0-10): Unable to assess
Intake: 950 **Output:** 100
Additional Data: PRBC #2 infusing
Transferred To: ICU 2
Report Given To: [redacted]
Transferred Via: W/C [redacted] Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Recovery Room Standards: [redacted]
Charge Nurse Signature: [redacted]

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: 6/25/03
Time In: 1550 HRS
Allergies: NKDA
Pre-op V/S: 127/62 HR 102
Procedures: Resection OAKA stump.

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

OR Intake: Crystalloid 1000 Colloid
OR Output: UOP 100 EBL 30cc
Meds/Times: OR 3mg Mid IV, 250mg midazolam, 200mcg fent

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

Airway: Nasal, (Oral), ETT, Trach, Other

Pre Op Meds

History

Time																		
SaO2	99	97	98	98	98	98	99	98										
FIO2	45	45	45	45	45	45	45	45										
Methods																		
240																		
220																		
200																		
180																		
160																		
140																		
120																		
100																		
80																		
60																		
40																		
20																		
RR	24	24	24	22	24	24	22											
T	97																	
Time																		
Pain (0-10)																		
LOS																		

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	0		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	1		2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2		2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	N/A	N/A	N/A
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C,	8/5		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)

B6-2 [redacted] CPT

PREPAR[redacted]

DEPARTMENT/SERVICE/CLINIC: ICU I

DATE: 6/25/03

PATIENT [redacted]
first, middle, grade, date, hospital or medical [redacted]

Name – last.

EPW [redacted] B6-4

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

A11 B6-2

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							

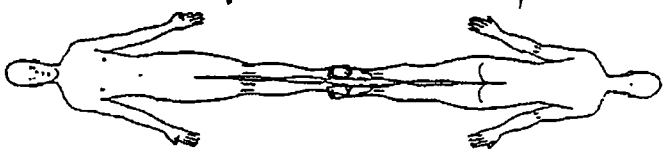
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	Okay	Cast	Ø
30'			
60'			
D/C	Okay	Cast	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

Pt VSS. Pt still drowsy from anesthesia. Awakes when aroused. Moves extremities. O2 Sats 96-99% 45% FIO2. No c/o pain at this time. Pt tries to reach for O2 Mask. Trial restarts tightly. [redacted] LPN 1130. Pt Alert, (R) Cast to Stump Dry + Intact BP 138/61. HR 107 O2 Sat RA 95%. JP draining minimal.
2+ palpable pulse
Soft Sli-Cy
Pt trying to sit self upon bitter
Recovery 1.5hr.
[redacted] Sli-Cy MD

PACU OUTPUT

Discharge Criteria:
Date: 25Jun03 **Time:** 1114 **PARS:**
BP: 120/57 **T:** 97.6 **HR:** 103 **RR:** 24 **SaO2:** 98%
Pain Level at D/C (0-10): 0
Intake: 100cc **Output:**
Additional Data:
Transferred To: ICW2
Report Given To:
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: [redacted]
Cleared IAW [redacted]
Charge Nurse Signature:

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	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A L L D L	I Z	B6-4 [redacted]	UNR EPW [redacted] B6-4	EPW	M

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

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
—	—	99 B6-4	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—	4	1715	—

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		X

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0 B2-2	ICU2	—

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
[redacted]	—

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
—

21. [redacted]	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
03	—	030624

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
		030622

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

FOR LOCAL USE

Dx: (L) BKA

T: 9 Dx: 8990 [illegible] 446
Inj: 569 E990

84.16
86.22
86.28
84.3

891.1
E965.4
303.90

B6-2

[redacted] required)

[redacted] on UL MC [redacted]

DR. [redacted] B6-2

DA FORM 2095, MAR 80

MED [redacted] 592 B6-2

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTRAR NUMBER: 13594	2. NAME (Last, First, MI): EPW #[redacted] B6-4			3. GRADE: EPW	ADMISSION REMARKS
4. SEX: M	5. AGE: 25	6. RACE: X	7. RELIGION: UNK	8. LENGTH OF SVC: —	9. ETS: —
10. PREVIOUS ADMISSION: N					
11. FMP: 99	12. SSN: [redacted]	13. ORGANIZATION: B6-4		14. WARD: ICW2	
15. FLYING STATUS: —	16. RATING/DSG: —	17. DEPT/BEN: K78	18. BRANCH/CORPS: —	19. UIC/ZIP: —	20. TYPE CASE: WIA
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: direct from E.R.			22. HOURS OF ADMISSION: 1047	23. CLINIC SERVICE: ABFA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: UNK		25. TYPE DISPOSITION: 50		26. DATE OF DISPOSITION: 25JUL03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK		27b. TELEPHONE NO.: UNK		28. DATE OF THIS ADMISSION: 23JAN03	ADMITTING OFFICER: B6-2 [redacted]
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] B2-2				30. DATE OF INITIAL 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

mandible fracture

DX: 802.35
802.38
873.73
873.72
E968.9

Proc: 23.19
76.76
76.92
24.5

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	33	33

36. Total Days All Facilities

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
	B6-2			B6-2	

SIGNATURE [redacted] SIGNATURE [redacted]

MEDCOM

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

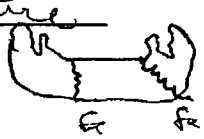
32 y/o IM was robbing a taxi driver and was attacked & sustained a mandible fracture.

PMH: neg
PSH: Right abdominal scar
meds: none
aller: NKDA

per interpreter

PHYSICAL EXAMINATION

Afebrile NC/AT PERRL EOMI.
Ø otorrhea Ø rhinorrhea
maxilla stable
mand fx Left angle, Right body
multiple non restorable teeth
Left foot wound wrapped in kerlex.
Plain films show: Left mand [redacted] B6-2 angle fracture
Right mand body fx.



PROGRESS (Enter date of discharge and final diagnosis)

A/P 32 yo ♂ mand fx
① Plan to take to OR for reduction of mand fx.

SIGNATURE OF PHYSICIAN	DATE	IDENTIFICATION NO.	ORGANIZATION

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

REGISTER NO.	WARD NO.

EPW # [redacted] B6-4

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

All B6-2 (except last)

MEDICAL RECORD	PROGRESS NOTES
DATE	
1800 23 June	Pt CAOX3. C/o PN @ jaw. Pt ambulatory. S assistance. C/o jaw flx x 6 days. V/S 120/70 P93 Reg T99.4 R. R Rh wheezing in all 4 Lobes. Pt is a smoker. [redacted] Bowel sounds x4. Pt has ① AC IV LR 125cc/hr [redacted]
23 Jun 03 1900	pt. admitted to ICW 2 ambulatory in stable conditions VSS - 20g IV started in ① AC, LR @ [redacted] 125cc/hr - abx given as ordered - pt. medicated for pain c̄ Percocet tabs crushed - tolerated CL dinner - ambulated S assistance - ⊕ BS - lungs c̄ wheezes heard throughout - bandage on ① foot - pt. oriented to ward and plan of care through interpreter - pt. is NPO pm, o/c to OR in AM [redacted]
2205	Pt. care assumed @ 2100. VSS. HR Reg, lungs CTA. ABD rotund, c̄ ⊕ BS x4. Pt. NPO p MN for surgery. will cont. to monitor. — [redacted]
24 Jun 03	0630 VSS. ∅ c/o pain or discomfort. Pt awake and alert. HOB 45°. stable & present. [redacted] 0700. DSG to ① foot removed. Bacitracin to open area on foot. DSG reapplied. M.D. notified. —
0500 T97.7 P85 R14 BP 120/81 91% - 95% RA	[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

PROGRESS NOTES
Medical Record

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

EPW [redacted] B6-4

A11 B6-2

PROGRESS NOTES

DATE	
24 June 03 1430	Rec'd pt back from ICU 1 @ 1305. VSS. O2 sats 91% on RA. HOB ↑ 30°. lung sounds c̄ wheezing heard throughout. abd round soft hyporactive BS. ↓ et ↑ c̄ full rom ⊕ pulses. ⊕ foot c̄ drsing CDI. pt's jaw wired shut, wire cutters @ bs per orders. IV ⊕ AC LR @ 125 cc/hr ⊖ s/sx of infiltration. New orders rec'd et noted. pt resting quietly @ this time. Will cont to monitor [redacted] 91WMC
	suction @ bs per orders [redacted] 91WMC
24 JUN 03 1842	Pt awake jaw swollen. lungs ⊕ wheezing & coarse throughout SpO_2 92 on RA, HR 97, RR 22. UD Alb given. Post tx HR-140s RR-30, SpO_2 - 93%. CPT done Pt c̄ productive cough ∅ suctioned. [redacted] Sgt [redacted] 91V20
24 JUN 03 2200	Pt. vitals taken. BP 120/80, P. 86, R. 16, Temp. 97.6 [redacted]
24 JUN 03 0300	Rec'd pt @ 21:00. Awake + alert in bed. VS WNL. Skin W/D. LCA ⊕ 8cm x 4 ⊕ PPP ⊕. Wires in mouth intact. PIV ⊕ AC LR @ 125cc/hr patent. Will cont. to mon [redacted]
25 JUN 03 0020	Pt awake. Pre tx - HR - 80, RR - 20, SpO_2 93 on RA. UD Alb tx given c̄ CPT. Post HR - 92, RR - 22, SpO_2 95 on RA. ∅ cough. Pt tol tx well. [redacted] Sgt [redacted] 91V20
25 Jun 03 0500 T 97.3 P 110 R 22 BP 130/74 90%	0300 - Pt Alert in bed resting. ODB x 1. lungs diminished in bases. Cough productive ⊖ neb tx. SATS 99% RA. HR reg, BS ⊕. Jaws wired shut c̄ cutters at bedside. IV LR @ 100 cc/hr into ⊕ AC. Voicing ∅ complaints. Will cont to monitor [redacted] 24 AN

All B6-2 (except last)

MEDICAL RECORD	PROGRESS NOTES
DATE	
25 Jun03	0850 - Feet cleaned. DSG reapplied c̄ bacitracin to wound on (L) foot. — [redacted] JLT/AN
25 June03 1500	assumed pt care @ 1300 VSS. pt awake & alert. lung sounds CTA, diminished in lower lobes, abd soft round nontender, BS(+). V/E↑ ext c̄ full rom (+) pulses. IV (L) AC infusing LR @ 100cc/hr. 5 diff. (D 5/5x of infiltration jaw wired shut, wire cutters @ DS. Pt c/o pain, given 1 Tylenol #3 per orders. RT c̄ pt giving neb tx, pt tol well, will cont to monitor — [redacted] /WMG SGT
25 Jun03 23:16	Pt. rec'd @ 21:00. c/o pain in jaw area. II Percocet given. PERRLA(+). Skin W/D. Wires intact. LS insp wheeze (R) mid lobe. Otherwise CTA throughout (B). BS(+)x4. I.V (L) AC intact + patent c̄ LR @ 125 cc/hr. (+) PPP (B). Will cont to mon. [redacted] RT/AN
23:20	Pt c/o pain in jaw area 2mg MSO4 given will monitor [redacted] RT/AN
25 June 2346	UD Alb 1x given HR 76 RR 16 SpO2 98% on RA BS Diminished Post tx ~~HR 96%~~ HR 80 SpO2 95% BS No change CPT Done PE coughed not able to suction secretions — Sat [redacted] RT
26 Jun 0337	c/o pain in jaw area. II Percocet given. will mon [redacted] AN

(Continue on reverse side)

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

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PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
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EPW #[redacted] B6-4

A11 B6-2

PROGRESS NOTES

DATE	
26 Jun 03	0600 Pt awake & alert. c/o not sleeping d/t noise from suction machine. VSS. NAD. SL. IV site ō redness or edema. Resting quietly & present. [redacted]
0500 T 95.6	1030 c/o pain in mouth. Percocet ii given as
P 84	ordered. [redacted]
R 20	26 June 03 1600 - Assumed pt care @ 1300. pt awake &
BP 112/80	alert. jaw wired shut, wire cutters @ bs per orders.
89% - 85%	lung sounds diminished in bases. abd soft round nontender, BS⊕ x 4 quads. ↓ & ↑ Ext. ō full rom ⊕ pulses. IV (L) AC infusing 5 diff. pt c/o pain to jaw, ii Tylenol #3 given per prn orders. Will cont to monitor. — [redacted]
26 JUN 03 2030	RT note: Pre tx SpO_2 97% on RA, HR 83, RR 16. BS ↓. UD Alb neb given. Post tx HR 85, RR 20, SpO_2 97%. CPT Done stopped c̄ pain. Pt otherwise fel well. BS no ∆'s ⊕ cough NP. — [redacted]
2205	Pt. care assumed @ 2100. VSS. Pt. guided in using IS, using well. Pt. cooperative. Oral hygiene performed. Bacitracin applied to lips. Jaws wired shut, wire cutters @ BS. Pt. given ii crushed percocet for pain. Prsng to (L) ft. ∆'d. wound cleaned ō hibiclense and bacitracin applied. HR Reg, lungs CTA. ABD rotund but soft ō BS⊕ x4. IV to (L) AC infusing ↓ difficulty. IV drsng reinforced. Pt. ambulated to BR. Will cont. to monitor. — [redacted]
27 Jun 03	0145 - Pt alert & ⊕ x1. VSS, Lungs CTA, HR reg, BS⊕, Encouraged IS. SATS 96% on RA. Gave ii Percocets for pain. HL to (L) AC ⇒ patent. Jaws wired shut ō cutters at bedside. Will cont to monitor. — [redacted]

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

All B6-2 (except last)

MEDICAL RECORD	PROGRESS NOTES
DATE	
27JUN03	1600 Assumed care of Pt @ 1300. VSS. A+Ox3. Pain controlled with percocet (B) LS CTA. TOL NPBS well. (L) AC HL patent, IV ABX. Drsg to (L) foot c̄ Bacitracin CDI. Jaw wired shut, wires intact. OPW assess. WNL. Will monitor [redacted]
27June03	Pt doing well S/P reduction of mandible fx. Continue current care. [redacted]
27Jun03 22:23	Rec'd pt @ 21:00. Skin W/D VS WNL according to flow sheet. Restraints x2. PERRLA (+). LS diminished throughout. Pt. in apparent distress @ this time. (+) PPP (B). PIV (D) & A intact + patent. Wires intact. c/o pain 4mg MSO4. Will cont. tomor [redacted]
28Jun03	0348 - Pt alert OOBx1. VSS, lungs CTA, HR reg, BS (+). Adequate fluid intake. Jaws wired shut & cutters at bedside. HL to (L) AC patent. Will cont to monitor [redacted]
24 jun03	Pt doing well S/P reduction of mand fx. 24 jun 03. continue current care. [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)

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WARD NO. ICU

EPW # [redacted] B6-2

PROGRESS NOTES
Medical Record

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PROGRESS NOTES

DATE	
28Jun03 2045	Rec'd pt @ 21:00. Restraints x2 (L) wrist (R) ankle. Awake + alert in bed. LCA (R). PERRLA (+). Wires intact. BS (+) x4 (+) PPP (R). PIV (L) FA patent. c/o pain x1 ti Percocet given will cont. to mon [redacted]
29 June 03 0410	Assume pt care @ 0500. Awake and Aller. Jaw wired shut. c/o pain to (L) side of jaw. T#3 ~~ti~~ adm. VSS HR regular Lungs CTA. BS x4 active (L) foot open to air. IV to (R) ~~[illegible]~~ FA. [illegible] well. Will continue to monitor. Wire cutters @ BS [redacted]
1600.	Assumed care @ 1300. VSS AO x 3. wired shut jaw/intact. (B) LS CTA. D/C (L) AC IV cath intact. Start 18g PIV (R) ACC IV ABX. Ordo pain. [redacted]
30 June	Assumed care of pt @ 0500. Pt is awake and alert. Lungs CTA. Bowel sounds x 4 quads. Pt tolerated breakfast. HL in (L) arm - patent and flushed. Ø c/o pain/discomfort @ this time. Wire cutters @ bedside. Will continue to monitor. [redacted], LPN, SGT
30jun03	Pt doing well s/p reduction of mandible fracture. 24 June 03 ~~pt doing~~ [redacted] VSS AF ~~tolerating~~ PO BTS diet. continue current care [redacted]
30Jun03 2030	assumed care @ 1300 - VSS - no c/o pain @ this time - (L) AC HL patent - ambulated this shift - [redacted]

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

OPW [redacted] B6-4

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EDICAL RECORD | All B6-2 (except last) PROGRESS NOTES | AUTHORIZED FOR FOOD

DATE	NOTES
30Jun03 2100	Pt care assumed @ 2100. VSS, a+o x3, no complaints at this time. Lung sounds CTA, pulses palpable x4, bs⊕ x4 quads. HL @ LFA intact. Pt c̄ wire cutters @ bedside, will continue to monitor. [redacted] 9LWM6
1 July 03 0500	1030 - Pt alert OOB x 1 this Am. AM care completed. VSS, lungs CTA, HR regular, BS⊕. Cont on liquid diet. Jaws wired shut c̄ cutters at bedside. New HL placed in ⓡ forearm.
963	
72	Voicing no complaints. Will cont to monitor [redacted]
18	
108/74	
95%	
1 Jul 03	~~OMFS~~ Pt doing well s/p ~~[redacted]~~ Open [redacted] reduction of mandible fx. 24 Jun 03. ⊕ clothing Am tolerating PO. VSS, AF CN ~~PR~~ R lungs CTA ⊕ abd soft NT ND ⊕ BS. A/P s/p reduction of mand fx. ① continue current care [redacted]

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

SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS 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. | RECORD No. TCW 2

CPW [redacted] B6-4

PROGRESS NOTES
Medical Record
STANDARD FORM 50

MEDICAL RECORD — PROGRESS NOTES — AUTHORIZED FOR LOG

DATE	NOTES
	ALL B6-2 (except last)
1 Jul 03 1900	assumed care @ 1300 - VSS - no c/o pain @ this time - IV abx d'c'd & SL removed from (R) FA, no S/S of infection at site - pt. talking to other EPWs and delaying getting in bed & using toilet, interpreter explained rules of talking and restraints to pt. he stated understanding — [redacted]
1 July 03 @ 2330	Pt awake & alert, VSS, LCTA (B), (+) BS all qds. c/o pain: given T3 II for pain control, abd: soft, ND, (-) TTP. wire cutters @ bedside. will cont to monitor — [redacted]
2 Jul 03	Assumed pt care @ 0500. Pt. resting but awake easily on verbal command. A to x3. (+) Pulses x4, lung: CTA. (+) BS x4. c/o pain to (R) side of mouth. will continue to monitor. [redacted]
0800 96.1 118/84 63 96% 16	OMFS POD#8 (24 jun 03)
2 jul 03 @ 0907	Pt doing well S/P wire fixation of mandible fracture. (-) c/o pain. alert & stable. VSS AF CN PRR wnl. CTA (B) Abd soft NTND. continue current care. [redacted]

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

BRANCH OF SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

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EPW [redacted] B6-4

PROGRESS NOTES
Medical Record
STANDARD FORM 50

ALL B6-2 (except last)

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:AL RECORD | PROGRESS NOTES

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2July03 assumed pt care @ 1300. pt awake & alert. VSS.
1425 assessment fengings WNL. pts jaw wired shut, wire cutters @ bs. c/o pain varied @ this time. Will cont to monitor — [redacted] 9 Wm6 SBT

2Jul03 Rec'd pt @ 21:00 awake and alert in bed. Skin w/D. PERRLA
0006 LCA(B). BS(+)x4. (+) PPP(B). c/o much pain in jaw will cont. tomor [redacted] 2LT/AN

3 July03 Rec'd pt @ 0500: 11. resting. Awake easily. 870 r5
0650 lungs CTA. (+) BS. (+) pulses x4. Wire cutters @ bedside. ∅ complaints @ this time. Will
0000 96.3 Continue to monitor — [redacted] 9 Wm6.
57
14 3 Jul 03 OMTS POD #9
102/76 @1019 S/P wire fixation of mand fx.
93% doing well. no c/o this Am.
CV. RRR lung CTA(B) abd soft NTND(+)BS
VSS / AF
A/P S/P wire fixation mand fx
(1) continue current care [redacted]

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

RVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

DENTIFICATION: (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] B6-4

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV 5/1
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b

ME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

ATE	NOTES
3July03 1440	assumed pt care @ 1300. VSS. pt sleeping. jaw wired shut, wire cutters @ BS. assessment finds WNL. ① S/Sx of distress noted @ this time. Will cont to monitor — B6-2 [redacted] 91WM6 SGT
03Jul 2330	Received pt resting in bed, pt USO, see SF 513, jaw wired shut, wire cutters @ BS. Intermittently sleeping. LSWAB HLE BBS4 SNT ADD. Will cont to monitor [redacted]
4Jul03 0820	Progress Note [redacted] B6-2 S: Pt Dx fro, s/p wire fixation for Mandibular fracture. Pt c̄ new complaints. To cont liquid diet. O: Alert + normotensive A/P: Mandible fx s/p wire fixation ① Continue routine care [redacted] B6-2

MEDICAL RECORD | PROGRESS NOTES | AUTHORIZED FOR LOCAL RE

DATE	NOTES
4 July 03	1000 - Pt alert OOB x1. Performed AM care. Jaws wired shut c cutters at bedside. Medicated c Percocet x1. VSS, HR reg, B6-2 BS ⊕. Will cont. to monitor. [redacted]
4 July 03 1300	Pt awake et alert, working a crossword puzzle book. assessment findings WNL. jaw wired shut, wire cutters @ bs. ⊖ c/o pain/discomfort @ this time. Will cont to monitor [redacted] B6-2 [redacted] 9 Wmx 3GT
4 Jul 03 20:10	Rec'd pt @ 2100. Awake + alert in bed. VS WNL per flow sheet. Skin PWD PERRLA ⊕ LCTA ⊖. BS ⊕ x4. ⊕ PPP ⊖. B6-2 Jaw wires in place. Will cont. to mon [redacted] /AW
23:40	c/o pain ii Percocet given will mon [redacted] /AD
5 Jul 03 0700-1200	OMFS POD #11 S/P wire fixation manad fx. Pt doing well c̄ c/o VSS AF ~~xlmf~~ stable Continue current care [redacted] B6-2

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR'S ID NO (SSN or Other)

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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] B6-4

PROGRESS NOTES
Medical Record
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All B6-2

FIRST NAME	MIDDLE INITIAL	ID NUMBER

NOTES

5 July 03 0800 Assume pt care @ 0700. Pt awake and alert. Jaw wired shut. (R) side jaw swelling noted. C/o sm amt of pain. VSS. HR Reg. Lungs CTA Abd soft. BS x 4. pt tolerating BTS diet well. Wire cutters @ BS. Will continue to monitor — [redacted]
0815 ~~00~~ 11 tylenol #3 PO for pain — [redacted]
1330 - Assumed care of Pt @ 1300. VSS. A+O x 3. pain controlled with PO meds. Jaw wireds shut. Cutters @ bedside. TOL BTS diet well. O/W Assessment WNL. Will Monitor — [redacted]

5 Jul 03 - 21:14 Assumed c/o pt @ 21:00. Awake and alert in bed. VS WNL per flow sheet. Skin W/D. LCA (R). BS (+) x 4. (+) PPP (R) Jaw wires intact. (R) side of jaw remains slightly edematous $\bar{s}$ pitting. Q c/o pain @ this time. Will cont. to mon [redacted]
6 July 03 - Pt. asleep in bed easily awaned by verbal stimulus. Pt's IV access. VSS. HR regular, lungsounds clear bilat, bowel sounds (+) x 4 quads. Pt. $\bar{s}$ complaints @ this time. Wires in gums $\bar{s}$ s/s of infection. All other assessment findings WNL. Will continue to monitor [redacted]
0700
1330 - Assumed care of Pt @ 1300. VSS. A+O x 3. Amb $\bar{s}$ assistance. Q c/o pain. Jaws wired shut, slight lateral mvt, MD Aware. Pt Knows not to move jaw around. TOL BTS $\bar{s}$ Ensure diet. O/W Assessment WNL. Will Monitor — [redacted]

A11 B6-2

DATE	NOTES
Jul 03 2210	Assumed pt. care @ 2100: Pt. sitting up in bed. AFOX3 lungs CTA. ⊕ Pulses x4. ⊕ BS x4. Wire cutters @ bed side. C/o pain to ⊖ side of Jaw. Will Continue to monitor — [redacted] 91WM6
8 Jul 03 0907	OMFS POD #14 Pt doing well. S/P wire fixation of mand fx. Pt tolerating PO diet. Pt c̄ C/O loose wire. ant & MF wire loose. right intra oral wound breaking down most likely 2° to over zealous brushing. VSS AF A/P S/P wire fixation of mand fx ① will DO daily wash outs of tissue breakdown ② tighten wires. [redacted]
8 July 03 1007	Pt alert sitting in bed. VSS, lungs CTA, BS ⊕. C/o pain x1 → Gave percocet x II. ⊖ procedures this AM. Cutters at bedside. Will cont. to monitor — [redacted] 2WAM

All B6-2

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DICAL RECORD | PROGRESS NOTES

DATE	NOTES
6 Jul 03	Pt rec'd @ 2100. Awake + alert in bed. PERRLA ⊕
22:10	EOMI ⊕. BS ⊕ x4 ⊕ PPP ⊕. Jaw wires in place & c/o
	pain @ this time. Will cont. to mon [redacted] RIT/MD
0103	c/o pain ii T3s given @ this time. Pt pointed out
	to me that ⊕ jaw is moving. ~~[illegible]~~ EMB will mon.
	[redacted] DLT/AW
7 July 03	POD #13 OMFS
@0715	S/P wire fixation of mand fx
	doing well. tol. liq diet
0600 96.0	VSS AF
58	Continue current care
12	
114/76	[redacted]
95%	1030 - Pt alert OOB x2 this AM. VSS, lungs
	CTA, BS ⊕. Jaws cont. to be wired
	shut c cutters @ bedside. Pt concerned
	about movement of jaws. Voicing no
	complaints at this time. Will cont. to
	monitor [redacted] DLT/AW
1330	assumed care @ 1300. VSS. A+O x3. Ø c/o pain. Pt concerned
	about jaw mvt, MD aware. O/W assessment WNL. Will Monitor
	[redacted]

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

T./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

T'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509
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All B6-2 (except last)

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DICAL RECORD | PROGRESS NOTES

DATE	NOTES
8 July 03	Assumed pt care @ 1300. pt resting quietly. VSS
1450	jaw wired shut c̄ wire cutters @ bs. Lungs CTA, BSP
	x4. ↓ & ↑ ext c̄ full ROM ⊕ pulses x4. ⊖ c/o discomfort/
	pain voiced. Will cont to monitor — [redacted] 91WMC SGT
2140.	Pt. care assumed @ 2100. VSS. Oral care done, pt.
	using IS Q1°. HR Reg Lungs CTA, ABD soft c̄ BS⊕
	x4. Will cont. to monitor — [redacted] 91WAN
2240.	Jaw s wired shut. Wire cutters @ B.S. Will
	cont. to monitor — [redacted] 91WAN
9 July 03	
	On PS POD #15
	Pt doing well S/P C/R of mandible.
0600 97.6	Open wounds granulating in. still
64	c̄ piece of exposed bone on ridge
16	of post right.
122/90	
98%	VSS AF
	Continue current care
	1100 - Pt alert. VSS, HR reg, Lungs [redacted]
	wired shut c̄ cutters at bedside. Voiding
	⊘ complaints at this time. Will cont to
	monitor — [redacted] 21WAN

IONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NO. (SSN or Other)
	LAST	FIRST	MI	

T./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

T'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] B6-4

PROGRESS NOTES
Medical Record
STANDARD FORM 509
Prescribed by GSA/ICMR FPMR (41CFR) 101-

All B6-2 (except last)

AUTHORIZED FOR LOCAL REPR

MEDICAL RECORD | PROGRESS NOTES

DATE | NOTES

9 Jul 03 1430 Assumed care of Pt @ 1300. VSS. A+O x3. Ø c/o pain WIRES INTACT IN JAW. DRSG/ACE to ® lower gum in mouth intact. O/W assessment WNL. will cont monitor [redacted]

2200 Pt. care assumed @ 2100. VSS. Pt. sleeping, easily arousable. HK Reg, lungs CTA, BS ⊕ X4. Pt C/O Ø pain. will cont. to monitor. — [redacted]

10 July 03 0530 Assume pt care @ 0500. Alert and awake. C/o small amt of pain to ® side of jaw. Wire cutters @ BS. VSS. Assessment WNL. Will continue to monitor — [redacted] 91WM6

0540 gauze to ® lower gum — [redacted] 91WM6

10 July 03 1400 assumed pt care @ 1300. pt awake et alert. VSS. assessment findings WNL. jaw wired shut, wire cutters @ BS. Ø complaints voiced. Will cont to monitor — [redacted] 91WM6 —

10 Jul 03 OMFS. POD #16
Pt doing well S/P wire fixation Ob unaid fx. Pt still c̄ unpaced bone
VSS AF
A/P (1) Plan to take to OR to close tissue tomorrow

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

CURRENT 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]

PROGRESS NOTES
Medical Record
STANDARD FORM 509
Prescribed by GSA/ICMR FPMR (41CFR) 101

A11 B6-2

TE	NOTES
10Jul03 21:54	Rec'd pt @ 21:00. Awake and alert in bed, restraints x2 (D) wrist and ankle. PERRLA (+) WNL. Skin WNL. Jaw wires intact, c/o pain x1 ii Percocet given will mon [redacted] RT/AN
Addendum	2CA (D). BS (+) x4 (+) APH (B) [redacted] RT/AN
11 July 03	1030 - Pt alert sitting up in bed. VSS, lungs CTA, BS (+), O/C to OR. NPO. Voiding Ø complaints now. Will cont to monitor - [redacted] 2HW
0630 96.7 53 16 96/58 93%	1900. Pt return from OR/Recovery on ICU #2. VSS. A+O x 3. (B) CS CTA. (+) BS x4. Ø c/o pain. Jaw wires (shut wires intact. O/W assessment WNL. Will Monitor [redacted]
2130	Pt. care assumed @ 2100. Pt. c/o sleep; inability to sleep. Percocet & Benadryl given. HR Reg, Lungs CTA, BS (+) x4. Jaws wired shut, wire cutters @ BS. Bacitracin applied to lips. Will cont. to monitor. [redacted] TTAN
12July03	0840 - Pt alert sitting in bed. VSS, lungs CTA, BS (+), Pulses equal & strong bilat to ↑ & ↓ extremities. Jaws wired shut c cutters at bedside. Gave percocet for pain this AM. Will cont to monitor [redacted] 2HW
12Jul03 1330	Assumed care of Pt @ 1300. VSS. A+O x 3. Ø c/o pain. Jaws wired intact. IDL BRS diet. Pt request an aid to have a BM. (+) BS x4 hypo Abd firm/Ø distention. O/W Assessment WNL. Will Monitor [redacted]

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CAL RECORD | PROGRESS NOTES

NOTES

11 Jul 03 @1223

OMFS Brief OP NOTE

Pre op dx: Mand fracture (R) Body left angle c̄ open wound and exposed bone

Post op dx: Same

Procedure: Arthroplasty c̄ repair of soft tissue and placement back into OMF

Surg: [redacted]

Assist: [redacted] B6-2

Anesth: NETA

fluids: 1000 cc LR

EBL: 50cc

Comp: none

Cond: Stable extubated & breathing spontaneously and transferred to recovery.

[redacted]

B6-2

SHIP TO SPONSOR | SPONSOR'S NAME LAST | FIRST | MI | SPONSOR'S ID (SSN or Other)

SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS 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

#[redacted]

PROGRESS NOTES
Medical Record
STANDARD FORM 509
Prescribed by GSA/ICMR FPMR (41CFR) 101

All B6-2 (except last)

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
12 Jul 03	OMFS POD #17 /1 Pt doing well s/p wire fixation of mand fx. intra oral wounds 1° closed c̄ no active bleeding. clinically stable VSS, AF ① continue current care [redacted]
2220	Pt. care assumed @ 2100. VSS. Pt. assisted c̄ doing oral care & applying bacitracin to lips. HR reg, Lungs CTA. ABD soft, rotund c̄ BS @ x4. Jaws wired shut, wire cutters @ B.S. Will cont. to monitor. — [redacted] TAN
7/13 0200	Pt. has had ØBM since 1st dose MOM. Pt given ½ tbs MOM PO for cont. constipation. — [redacted] TAN
0400.	Pt. c/o cont. constipation. Dulcolax supp. given c̄ results.
13 July 03	0534 - Pt alert sitting up in bed. VSS, HR reg, lungs CTA, ABD. Jaws wired shut c̄ cutters @ bedside. Voiding no complaints at this time. Will cont to monitor — [redacted] JLP

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.
EDW [redacted] B6-4		

PROGRESS NOTES
Medical Record

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

A11 B6-2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	OMFS POD 18/2
13 jul 03 @ 0713	Pt slp wire seed of mand fx c/o constipation. vsmf stable VSS AF continue current care dulcolax supp [redacted]
0615 97.1 73 110/84 98%	1415 Assumed care of Pt @ 1300. VSS. A+Ox3. Ø c/o pain. Pt resting now, but was OOB → chair all morning. ⊕ BM this am. Jaws wired shut. Wounds intact. O/w Assessment WNL. Will Monitor [redacted]
13 JUL 2354	Rec'd c/o pt @ 21:00. Restraints x2 ⊕ wrist ⊕ ankle. Pt awake and alert in bed. Skin color WNL. PERRLA ⊕ LCN(B) BS ⊕ x4. ⊕ PPP(B) Jaw wires intact. Ø c/o pain @ this time. will cont. to mon. [redacted] BT/AN
	OMFS POD #19/3
14 jul 03 @ 0710	pt doing well Ø c/o. vsmf stable VSS AF Continue current care [redacted]
1400	Assumed care of Pt @ 1300. VSS. A+Ox3. Ø c/o pain. Wired jaw intact. TOL BTS diet. Resting Comfortably. O/w Assess. WNL. Will Monitor [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

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A11 B6-2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
15 July 03	2240 Assume pt care @ 2100. VSS. Mouth wired shut. Wire cutters @ BS. No c/o pain to jaw @ this time. HR NCS. Lungs CTA. Abd soft tender to palpate. pt worried about not having BM. Supp. given @ 2000. Will cont. to monito — [redacted] 9/4 MC
16 Jul	Assumed care of pt @ 0500. VSS. Lungs CTA. Bowel sounds x4 quads. Abd. soft and tender. Wires still intact inside of mouth. Ø c/o pain/discomfort. Will continue to monitor — [redacted] LPN SGT
1320	Assumed care of Pt @ 1300. VSS. A+O x3. Ø c/o pain. Jaw wired shut. JA BTS DIET. Awaiting D/C to ASMC. O/W assess. WNL. Will cont to monitor — [redacted]
16 JUL 03 21:15	Rec'd c/o pt @ 21:00. Awake and alert in bed. Restraints x2 (R) wrist and ankle. Skin color WNL. PERRLA (R) WNL. Jaw wires intact. LCA (R) BSO (R) x4. (+) PPP (R). Ø c/o pain @ this time. Will cont. to mon [redacted] /AD
17 Jul 03	Assumed care of pt @ 0500. VSS. Lungs CTA. Bowel sounds x4 quads. Abd. soft and tender. Jaw wires intact. Ø c/o pain/discomfort @ this time. [redacted] LPN, SGT
17 July 03 RHO	assumed pt care @ 1300. VSS. pt awake et alert, looking @ magazine. Assessment findings WNL. Jaw wired shut c̄ cutters @ bS. Ø c/o pain voiced @ this time. Will cont to monitor — [redacted] 9 Wmie

All B6-2 (except last)

AUTHORIZED FOR LOCAL REPRO

DICAL RECORD | PROGRESS NOTES

DATE	NOTES
7-14-03 2230	Pt. care assumed @ 2100 - VSS. Pt. c/o nausea and dizziness. 25mg Phenegan given IM. HR Reg, Lungs CTA, BS @ X4. Jaws wired shut, wire cutters @ BS. Will cont. to monitor. — [redacted]
15 Jul 03 @ 0210	OMPS POD # 2014 Pt doing well no c/o VSS, AF continue current care [redacted]
15 Jul	Assumed care of pt @ 0500. Pt asleep. VSS. Lungs CTA. Bowel sounds x4 quads. Abd. soft and tender. Pt has dc orders to ASMC. Suture removable kit readily available for Pt when she leaves. Will continue to monitor. [redacted] LPN, SGT
15 July 1315	Assumed Pt care, Received Pt Alert to verbal stimuli, VSS. Lungs are clear B/Ltural. BS x4. Abdomen soft tender. Pt has good Pulse motor function on All extremity, Pt does not c/o Pain to jaw. Pt is still awaiting transfer to ASMC. Will continue to monitor [redacted] LPN

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

T./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.

#[redacted] B6-4

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (RE
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All B6-2 (except last)

[redacted] [redacted]

AUTHORIZED FOR LOCAL REPRO

CAL RECORD | PROGRESS NOTES

NOTES

18Jul 03 0037 Rec'd c/o pt. @ 21:00. VS WNL. Awake and alert in bed. PERRLA WNL LCA BS x 4 PPP. Jaw wires intact. c/o pain @ this time will cont. to mon.
[redacted] DAT/AD

18 Jul Assumed care of pt @ 0000. Pt asleep. VSS. Lungs CTA, Bowel sounds x4 quads. Abd soft and tender. Wire cutters next to bed. Wires in mouth still intact. Awaiting transportation to ASMC. [redacted] LPN, SGT

18 Jul 03 @1213 OMFS POD #2317
Pt doing well S/P C/R OG mand fx
c̄ c/o pain
VSS AF
continue current care
[redacted]

18 Jul 03 1330 Assumed care 0/300 - VSS - pt. not going to ASMC, pt. acting unhappy and uncooperative as a result - no c/o pain at this time [redacted]

SHIP TO SPONSOR | SPONSOR'S NAME [redacted] | SPONSOR'S ID (SSN or Other)
LAST | FIRST | MI

SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS 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. TCW2

[redacted] B6-4

PROGRESS NOTES
Medical Record
STANDARD FORM 509
Prescribed by GSA/ICMR FPMR (41 CFR) 101

A11 B6-2

TE	NOTES
19JUL03 0050	Rec'd c/o pt @ 01:00. VS WNL per flowsheet. Jaw wires intact assessment unremarkable. ~~&~~ c/o's will cont. to mon [redacted] /AN
	omts pro 24/8
19 jul 03	Pt once again able to move right body segment. will take to OR on tuesday for ORIF [redacted]
19 Jul	Assumed care of pt. Asleep. VSS. Lungs CTA. Bowel sounds x 4 quads. Ø c/o pain / discomfort. Will continue to monitor. [redacted] LPN, SGT
19 Jul 03 2020	assumed care @ 1300 - pt. c/o constipation given 30cc mom as last night's results poor - small result c this dose of mom, small BM, pt. given dulcolax supp. - [redacted]
19 July 03 2130	Assume pt care @ 2100. ~~Assume~~ pt awake and alert. No complaints @ this time. VSS. Wires intact ~~c~~ Non. HR reg. Lungs CTA Abd soft BSX4 will continue to monitor - [redacted]

All B6-2 (except first)

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
[redacted] B6-4			

DATE	NOTES
20 July 03	0700 - Pt alert, lying in bed. VSS, lungs CTA, BS⊕. Jaws wired shut c̄ cutters @ bedside. Pulses ⊕ & strong bilat to ↑ & ↓ extremities. Will cont to monitor — [redacted] 24hr
	OMTS 25/9
20 jul 03	Pt S/P wire fixation of mand fx. Pt continues to manipulate (R) body fx. plan to return to OR on Tues for ORIF [redacted]
20 Jul 03 1340	assumed care @ 1300 - VSS - no c/o pain - pt. aware he is going to OR on Tuesday - restrained on (L) wrist and (L) ankle [redacted]
21 Jul 03 00:10	Rec'd c/o pt. @ 21:00. VSWNL. ⊖ c/o pain. Jaw wires intact. c/o nausea. Some Phenergan given x1 IM (L) Deltoid. ⊖ further complaints. All other assessment findings unremarkable/WNL will cont to mon [redacted] 25/AO
21 jul 03	OMTS POD 26/10
@0900	Pt doing well ⊖ c/o
	plan for OR in AM
21 Jul	Assumed care of pt @ 0500 [redacted] Pt asleep. Lungs CTA. Bowel sounds x4 quads. On call for OR in am. NPO p midnight [redacted] 9 Nomle, SGT

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All B6-2 (except last)

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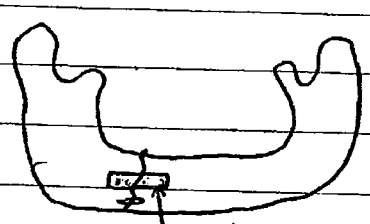
DICAL RECORD

PROGRESS NOTES

ATE	NOTES
21 JUL 03	Assumed care of pt @ 1300. VSS. A+Ox3. Ø c/o pain.
1310	Jaw wired shut, wires intact. TOL BTS diet. O/C for CBC in AM, NPO p MN. O/W assessment WNL. Ø IV access. Will mon. for [redacted]
2150	Pt care assumed @2100, VSS, a+Ox3, no c/o pain. Pt & wires intact, cutters @ bedside. Pt O/C for CBC in am, NPO past midnight. Will continue to monitor [redacted]
2345	Pt c/o nausea, 25mg phenergan given im. [redacted]
21 Jul 03 @ 1000	OMFS Brief OP NOTE pre op dx: mandible fx (R) Body; left ✓. Post op dx: same procedure: ORIF (R) mand body fx Surg: [redacted] Assist: [redacted] Anesth: NETA EBL: min 50cc fluids: 1L LR Comp: Ø Cond: Stable extubated + transferred to recovery on mask O2 3 event.



osteomed 4 hole plate 12mm screws x4

D SPONSOR | SPONSOR'S NAME | LAST | FIRST | [redacted] SOR'S ID NUMBER

L | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT [redacted]

FICATION (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade) | REGISTER NO. | WARD NO. ICW 2

Pt [redacted] B6-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.10

All B6-2

22 July 03 | 1200 - Pt received from ICU II s/p ORIF (R) mand body fx. VSS, lungs CTA, HR reg, BS(+), Pulses (=) & strong bilat to ↑ & ↓ extremities. Wires intact to jaws. Cutters @ bedside. Some bleeding noted in mouth. NS @ 125 into (R) AC, patent. Voiding ∅ complaints at this time. Will cont to monitor. [redacted] 2Lt Am

22 July 03 1345 | assumed pt care @ 1300. pt awake & alert. Pt c̄ ice bag to (R) side of jaw. assessment findings WNL pt c/o pain given 30mg Toradol per prn orders. Will cont to monitor [redacted] 91 WMC

1500 | pt c/o nausea given 25mg Phenergan, suction hooked up & given to pt. pt spitting up blood. Will cont to monitor [redacted] 91 WMC

22 Jul 03 21:21 | Recd c/o pt @ 21:00. Restraints x2 (L) wrist/(R) ankle. VS WNL per flowsheets. Awake and alert in bed. Skin Color WNL. PERRLA (+) WNL. LCA (R). BS (+) x4. (+) PPP (B). Jaw Wires intact. (R) aspect of mandible c̄ moderate amt edema & c/o pain @ this time. Will cont to mon [redacted] 2Lt/AN

All B6-2 (except last)

AUTHORIZED FOR LOCAL REPRODUCTION

DICAL RECORD | PROGRESS NOTES

ATE | NOTES

230530 July 03 Nursing Assessment: Pt asleep but arousable. Airway intact, breathing even and unlabored, LS clear to all fields. Abd soft, nondistended, ∓ tenderness. BS⊕x4. GU/U. Flow and neurovascularly intact to all extremities ⓑ. IV to ⊖ hand HL and flushes well, ∓ s/s infection/infiltration. Pt tolerating liquid/pureed diet. Encouraged fluid intake. Will monitor to ensure no solid food/candy taken in [redacted] AW

230545 July 03 Wire cutters at bedside. Oral mucosa has some dry bloody drainage & under blood noted. [redacted] AW

23 Jul 03 @0800 Omns POD 28/12/1

Pt s/p ORIF of ⓡ mand body fx.
wounds closed 1° ⊼ min amt of pain on examination.
DSS, AF
A/P continue current care
plan to DC to MA custody in 3-4 days then return for dent removal
[redacted]

23 July 03 1320 Assumed pt care @ 1300. pt awake & alert. Assessment finding WNL. ~~wire wired~~ jaw wired shut, wire cutters @bs. ⓘ c/o pain/discomfort voiced @ this time. Will cont to monitor [redacted] 91Wmk

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

E | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

TICATION. (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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV 5
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.20

[redacted] B6-4

All B6-2 (except last)

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DICAL RECORD

PROGRESS NOTES

ATE | NOTES

23 Jul 03 Rec'd c/o patient @ 21:00. Restraints x2 (R) wrist (L)
21:14 ankle. VS WNL per flowsheet. Skin W/D. PERRLA (+) WNL
(CA (B). BS (+) x4. (+) PPP (B). HL patent (L) hand. Jaw wires intact.
c/o pain x1 30mg toradol given will cont. to mon [redacted] /AN
24 July 03 0415 Assume pt care @ 0500. Pt awake and
Alert. VSS. HR reg Lungs CTA. Abd Soft no TRD
noted. Jaw wired shut - wires intact wire cutters @
bedside. Swelling noted to (R) side of jaw. pt c/o
sm amt of pain @ this time. HL to (L) wrist no
S/S redness/infiltration c̄ flush. Will D/C IV
after breakfast. Will continue to monitor [redacted] /WMC
0935 HL DC'd. Tordal given IM due
to instructions on VIAL will get order changed
to IM [redacted] /WMC
1430 Pt stable at this time AAOx3. PERRLA. Plate to mouth
intact, no bleeding or open areas noted. Performs
self care to mouth. Pureed diet, tolerating
well. Lungs CTA bilat, Ø resp distress. NSR.
Abd soft, non-tender, bowel sounds active
x4 quads. Strong pulses and brisk cap refill
x4 extremities. Ø complaints [redacted] /LT/AN

O SPONSOR | SPONSOR'S NAME | LAST | FIRST | MI | SPONSOR'S ID NUMBER (SSN or Other)

E | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

TICATION (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] B6-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV 5
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.20

AUTHORIZED MEDICAL REPRODUCTION

NOTES

14 jul 03 Discharge / Transfer Summary
@ 1136

Admit Dx: mandible fracture
Left mandibular angle
Right mandibular body

Discharge Dx: Same

D/C condition: Stable

D/C Diet: Blended thru straw or powder Carnation Instant Breakfast
Ensure 1-2 cans per meal

D/C meds: none needed @ this time
OTC Pain meds crushed

Plate

Procedures ① Wire fixation of left mandibular angle & right mandibular body fracture on 24 jun 03
② exploration of right mandibular body fx and closure of wound on 11 jul 03.

Pt has archbars & wires and is
* wired shut. *

③ ORIF C Plate ® mand Body fx on 22 jul 03.

SPONSOR'S NAME | LAST | FIRST | MI | SPONSOR'S ID NUMBER

GRADE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

IDENTIFICATION (or patient's written entries: name - last, first, middle; service or SSN; date of birth; rank/grade) | REGISTER NO.

Pw # [redacted]

B6-4

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. ...)
Prescribed by SSA-DMF FPMR 41 CFR 101-11.206

DATE NOTES

Plan ① Please stress oral hygiene with toothbrush TID.

* ② Pt should be returned to B2-2 the [redacted] on August 7, 2003 for evaluation and removal of archbars and wires.

③ Wire cutters near pt @ all times. Please DO NOT Allow Pt to cut his own wires.

[redacted] B6-2
MAJOR, DC MAS/DC
ORAL & MAXILLOFACIAL SURGERY Oral & maxillofacial Sx.

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

OMFS Brief OP NOTE

24 jun03
@1030 Pre op dx: (L) mand angle fx
(R) mand body fx
NRT # 2, 12, 15, 18, 19, 29

Post op dx: Same

Procedure: Ext of teeth # 2, 12, 15, 18, 19, 29
Open reduction of (L) ∡ + (R) body fx
and placement of archbars + ∅ MF

Surg: [redacted] B6-2

Assist: [redacted], [redacted]

Anesth: NETA

EBL: 200 cc

fluids: 700 cc LR

Comp: ∅

Condition: Stable, extubated and transferred to recovery on mask O2.

[redacted] MAJ/DC
B6-2

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.

2Plus # [redacted] B6-4

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
25 jun03	Pt doing well S/P OR of mand fx.
@0426	Oral hygiene fair. Oral wounds
	closed 10 ℃ no active bleeding noted.
	Pt tolerating blended thru straw diet.
	CVRRR
	lungs ↓
	Abd obese soft NT ND (+)BS
	ext (L) foot wound
	A/P pt doing well S/P OR of mand fx.
	(1) Plan to continue current care.
	[redacted]
	B6-2

STANDARD FORM 509 (REV. 5/1999) BACK

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
24Jun03	Pt. given UDA1B via face mask @ 8Lpm x10min
	P 102-110 RR 15-19
	BBS w coarse rhonchi throughout.
	Pt. has productive cough with minimal amounts of
	bloody sputum. CRM [redacted]
	B6-2

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

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

[redacted] B6-4

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

ALL B6-2 (except last)

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
24 July 03 1500	Pt c episode of emesis. Given 25 mg Phenergan IM for nausea — [redacted] LCT/AN
24 Jul 03 21:33	Rec'd c/o pt @ 21:00. Restraints x2 @ wrist/ankle. VS WNL per flowsheet. Skin color WNL. Jaw wires intact LCA (B). BS (+) x4. (+) PP (B). HR Reg. Will cont. to mon. & c/o nausea @ this time. Will mon [redacted] DZT/AN
2350	Pt emesis x1. Suctioned scant amt emesis. 25 mg ~~IMG~~ Phenergan given 20cc mom given will cont. to mon. [redacted] DZT/AN
25 0600 July 03	Nursing Assessment: Assumed care of pt. Airway intact. Breathing even and unlabored, LS clear to all fields. Abd soft, nontender, + distention. Ø N/V. BS (+) x4. Fr Foley in place, urine clear, intact to all extremities. Jaw continues to be wired shut. Wire cutters are at bedside. (−) bleeding or swelling to oral mucosa. Ø IV access — [redacted]
25 0840 July 03	Nursing ~~Ass~~ Note: Pt c/o nausea, c̄ ~~vom~~ small amount of emesis. Suctioned at bedside. — [redacted]
25 July 03 1320	pt care assumed @ 1300. VSS. pt awake & alert. jaw wired shut, wire cutters @ bs. lungs CTA, abd soft round nontender BS (+) x4 quads. ↓ & ↑ ext c̄ full ROM strong (+) pulses. Ø c/o pain/discomfort voiced @ this time. Will cont to monitor — [redacted] 91WM
25 July 03 1320	- pt care reassumed by SGT [redacted]. will cont to monitor pt. [redacted] LPN
25 Jul 03 2340	Rec'd c/o pt @ 21:00. Restraints x2 @ wrist (B) ankle. VS WNL per flow sheet. Skin WD. PERRLA (+). LCA (B). BS (+) x4. (+) PP (B). Jaw wires intact. Ø c/o pain @ this time will cont. to mon. [redacted] DZT/AN

GPW# [redacted] B6-4

STANDARD FORM 509 (REV. 5/1999) BACK
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MEDICAL RECORD

PROGRESS NOTES

DATE	NOTES
26 July 03	0815 - Pt alert OOB this AM x1. VSS, lungs CTA, BS⊕. Jaws wired shut. Tolerated breakfast; D/C orders written, Pt ready to leave - [redacted]

SHIP TO SPONSOR

SPONSOR'S NAME

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

SERVICE

HOSPITAL OR MEDICAL FACILITY

RECORDS 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.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (R

Prescribed by SGA/DCMP FDMP (AAFDFL 101-1

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

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp): [redacted] B2-2

LOG NUMBER

ARRIVAL			
DATE			TIME
DAY	MONTH	YR.	
23	06	03	1519

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

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): Jaw Fracture & 6 days / (L) Toe Injury

SEX: M AGE: 32

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER

VITAL SIGNS			
TIME	1523		
BP	117/81		
PULSE	109		
RESP.	20		
TEMP.	99.1		
WT. (Child)			

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)

32 yr ♂ tried to rob Taxi. Was hit by driver

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

ORDERS	INITS.	TIME

ASSESSMENT/DIAGNOSIS

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).

EPW

[redacted] B6-4.

SIGNATURE OF PROVIDER AND ID STAMP

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

EMERGENCY CARE AND TREATMENT
MEDCOM - 11631 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 40-407; the proponent agency is The Office of the Surgeon General.

1. AGE: 32

HEIGHT: Unknown
WEIGHT: Unknown

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

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

4. PROPOSED SURGICAL PROCEDURE: Pt does not speak English
Mandible Fx History unknown

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition
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/Contact (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 interface. Parents to stay with pt.
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] B6-4

VERIFICATIONS AT HOLDING AREA:
66-2 [redacted] Allergy Band [redacted]ntures Removed
[redacted] P [redacted]ntacts Removed
! NPO Since 5PM [redacted]welry Removed
! ~~UHCG/LMP~~ [redacted] [redacted]dy Pierce Removed
[redacted]nsent/Blood Transfusion
[redacted]ned/Witnessed/Dated
[redacted]rgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) (N)
! Family/Friend: None

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. 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 [redacted] 4) Caps ____ 2) Lower [redacted] 5) Crowns ____ 3) Bridges [redacted]	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 [illegible] 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

A11 B6-2

[redacted] D/ADDITIONAL INTRAOPERATIVE INTERVENTIONS NOTED.

24 Jun 03 DATE

[redacted] KIN INTEGRITY: Bovie Pad Site: ✓ Clean and Dry ☐ Red ☐ N/A DRESSING DRY & INTACT: (Y) (N)

LEVEL OF CONSCIOUSNESS: ☐ A&O ☐ Drowsy ☒ Sleepy ☐ Intubated BREATHING EASY: (Y) (N)

LEVEL OF ACTIVITY: [redacted] ☐ Moves Upper Extremities

[redacted] d to liner with roller due to spinal

12. PREOPERA[redacted] 13. POSTOPERATI[redacted]

(Signature and Ti[redacted] BY (Signature and Title[redacted]

DATE: 24 [redacted] TIME: 0815 DATE: 24 Jun 03 TIME: 24 Jun 03 1100

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: 35

HEIGHT:

WEIGHT:

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

3. PREVIOUS SURGERY [ ] NO [X] YES (type):
See H+P

4. PROPOSED SURGICAL PROCEDURE:
Repair of Soft tissue

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition_____
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/Contact (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	○ Pt. verbalizes any specific anxiety. ○ Pt. Exhibits relaxed body posture. See H+P for Previous Surgical Hx + Medical Hx	○ Allow pt. to verbalize freely. ○ Explain OR environment and answer questions regarding surgery. ○ Offer comfort measures. (e.g., warm blanket, touch). ○ Explain all nursing procedures before they are done. ○ Remain with pt. whenever possible. ○ Maintain family interface. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: 1) Positioning 2) Effects of Anesthesia 3) Medical/Smoking History	○ Pt. will be able to breathe without difficulty during immediate intraoperative phase.	○ Offer to elevate head of litter or offer pillow. ○ Observe pt. while awaiting surgery for signs of distress. ○ Assist anesthesia during intubation and extubation.
C. INTEGUMENT ✓ Potential impairment of skin integrity due to: 1) Intraoperative Immobility 2) ESU Pad Placement 3) Positional Aids 4) Prosthesis 5) Pooling of Prep Solutions	○ Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	○ Utilize pressure preventing devices on OR table and accessories. ○ Check for proper positioning and support to maintain good body alignment. ○ Pad pressure points. ○ Place ESU ground pad on non compromised skin surface area. ○ Keep prep fluids from pooling.

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

#[redacted]

B6-4

[redacted]IFICATIONS A[redacted]OLDING AREA:
[redacted]/Allergy Band [redacted]ntures Removed
[redacted]& P [redacted]ntacts Removed
[redacted] NPO Since [redacted] [redacted]welry Removed
[redacted] LHCG/LMP [redacted]dy Pierce Removed
[redacted]sent/Blood Transfusion
[redacted]d/Witnessed/Dated
[redacted]rgical Site/Consent verified by
[redacted]./Anesthesia/Surgeon
! Contact Precautions (Y) (N)
! Family/Friend: NME

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. 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 [redacted] 4) Caps 2) Lower [redacted] 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 Rt 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. A11	OTHER NURSING INTERVENTIONS Or continuation of above interventions B6-2

10. OR NURS[redacted] D/ADDITIONAL INTRAOPERATIVE INTERVENTION S NOTED.

[redacted] 11 Jul 03 DATE

11. POS[redacted]ION: SKIN INTEGRITY: Bovie Pad Site: ☑ Clean and Dry ☐ Red ☐ N/A DRESSING DRY & INTACT: (Y) (N)

LEVEL O[redacted] ☑ Drowsy ☐ Sleepy ☐ Intubated

LEVEL OF AC[redacted] All Extremities ☐ Moves Upper Extremities BREATHING EASY: [redacted]

[redacted] ansferred to liter with roller due to spinal

12. PREOP[redacted] (Signature a[redacted]

DATE: [redacted] 11 Jul 03 TIME: 1135

13. POSTOPERATIV[redacted] ED BY (Signature and Title) [redacted]

DATE: 11 Jun 03 TIME: [redacted]

All B6-2 (except last)

[redacted] [redacted]

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 CPT [redacted]

3. DATE 22 July 03 TIME PATIENT ARRIVED IN SUITE 0730

4. PATIENT IN ROOM TIME 0730 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Pt awake, up ad-lib. Ambulatory to OR, escorted by anesthesia

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted], OR3	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted], AN 0840	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) Pt transferred to OR table, anatomically aligned for surgical procedure & padding under head (R) arm tucked @ side (L) arm placed on padded arm board. Pillow under knees

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

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

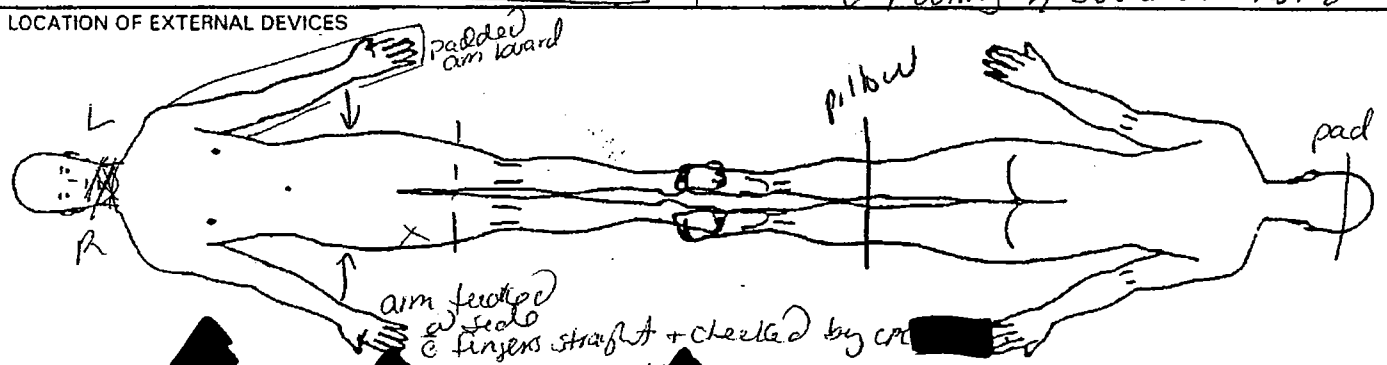
PREP SOLUTION (Specify) Nibbler (betadine)

SITE: FACE BY WHOM: CPT [redacted]

SITE: ~~XX~~ See #9 BY WHOM:

COMMENTS: @ pooling of solution noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Grou[redacted] Pad -- Sa[redacted] Strap = = = Tourniqu[redacted]

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
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;)

#EPW [redacted]

ICW-2 B6-4

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

☐ ESU NO: #4

GROUND PAD: BRAND Valleylab

LOT NO: 65706 Exp 2004-11

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

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

Osteomed M3 Total Rigid Fixation System
2.0 4 hole plate (straight)
c̄ 4 2.0 mm screws

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
1% Xylocaine c̄ epi 1:100,000	3cc	Intra-op	INJ	[redacted]	Dr. [redacted]
					B6-2

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGN[redacted] B6-2

15. X-RAY IN O[redacted]OM 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)*
X

19. ADDITIONAL INFORMATION

Surgeon: [redacted]
Anesthesia: [redacted]/[redacted] b6-2

20. OPERATION(S) PERFORMED

ORIF mandible Fracture
B6-2 0455

21. PATIENT TRANSFERRED [redacted] TIME see DA7389 METHOD Litter c̄ O2
ICU 2

22. REGISTE[redacted] CPT/AN [redacted]

REVERSE OF D[redacted] USAPA V1.01

MEDCOM - 11637

All B6-2 (except last)

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 IDENTIFICATION VERIFIED BY: [redacted] PROCEDURE: OPT/Ar
3. DATE: 11 Jul 03 TIME PATIENT ARRIVED IN SUITE: 1050
4. PATIENT IN [redacted] TIME: 1050 NUMBER: 1-5

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Pt awake and looking around

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] OCT	RELIEF SCRUB	
ASSIGNED CIRCULATOR	OPT [redacted] Ar	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) Pt transferred to OR table, anatomically aligned for surgical procedure (B) arms tucked at pt side c fingers straight + checked by [redacted]

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

COMMENTS:

8. SKIN PREPARATION

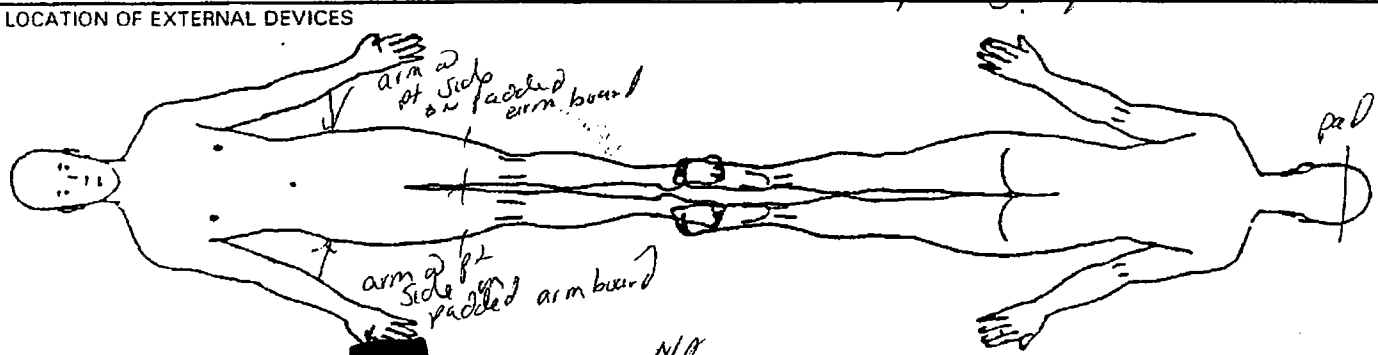
HAIR REMOVAL: ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION (Specify): Betadine
SITE: FACE BY WHOM: OPT [redacted]
SITE: BY WHOM:

COMMENTS: & pooling of solution noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap ≡≡≡ Tourniquet N/A

10. COUNTS (C = Correct I = Incorrect)

		Initial Count	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
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;)*

#[redacted]

B6-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO 30/30

☒ ESU NO: #4
GROUND PAD: BRAND Valley Lab
LOT NO: 63706 Exp 2004-11

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
1% Xylocaine c̄ epi 1:100,000	3cc	Intra-op	INJ	[redacted]	[redacted] B6-2

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S [redacted] B6-2

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)*

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

19. ADDITIONAL INFORMATION

Surgeon [redacted] B6-2

Anesthesia [redacted] B6-2

Throat pack in @ 1030 out @

20. OPERATION(S) PERFORMED

Repaired soft tissue
Smooth irregular Bone / Added Wire

21. PATIENT TRANSFERRED TO ICU2-RR B6-2 TIME 1225 METHOD litter c̄ O2

22. REGISTERED [redacted] CPT/AN [redacted]

REVERSE OF DA FORM 5179-1, OCT 82 [redacted] USAPA V1.01

All B6-2 (except last)

[redacted]

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 [redacted]

2. PATIENT [redacted] ED AND PROCEDURE VERIFIED B [redacted] THR

3. DATE: 24 Jun 03 TIME PATIENT ARRIVED IN SUITE: 0730

4. PATIENT [redacted] TIME: 0730 NUMBER: 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Pt awake, transferred from litter to OR table, 5 difficulties

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] ORT	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] AR	RELIEF CIRCULATOR	MAJ [redacted] 1025 - EOC

7. POSITION AND POSITIONAL AIDS (Specify) Pt anatomically aligned on OR table c̄ pad.

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

COMMENTS: Under head (B) arms placed on padded arm board less 90° arms removed from armboards + tucked @ pt side c̄ fingers straight + checked

8. SKIN PREPARATION See #19

HAIR REMOVAL: ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION (Specify): Hibclen

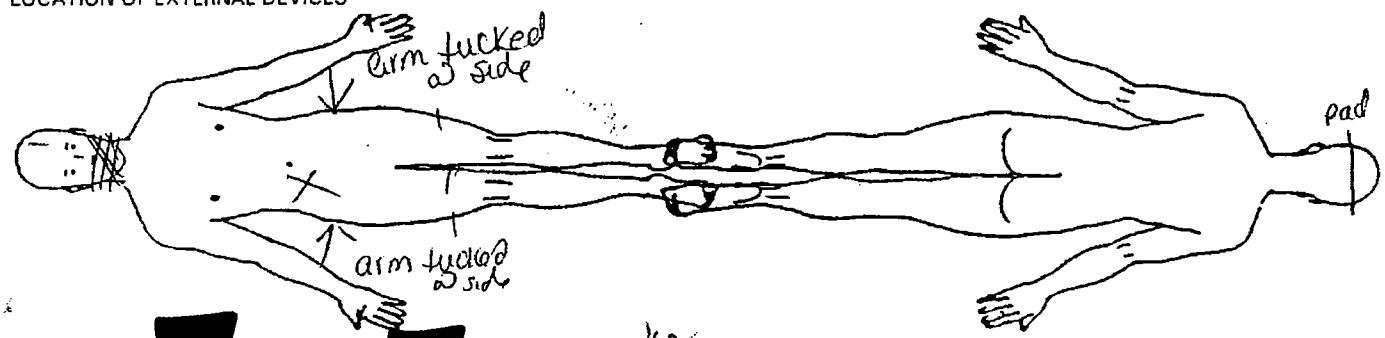
SITE: FACE BY WHOM: CPT [redacted] AR

SITE: BY WHOM:

~~See #9~~

COMMENTS: @ pooling of solution noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X [redacted] Pad -- Safe[redacted]p = = = Tourniquet N/A

C = Correct I = Incorrect

10. COUNTS			Initial Count	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
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;)

EPW # [redacted]

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO 25/25

☒ ESU NO: #1

GROUND PAD: BRAND Valleylab

LOT NO: 69652 Exp 2005-04

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

MEDCOM - 11640

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

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