DATE | DX | HOSPITAL DAY

VITAL SIGNS	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21
BP Arterial Line	123/54	118/53	145/54						140/56	125/59	130/53	127/52	101/49	105/52	118/52	—
BP Cuff	117/53	111/51	117/52						117/53	124/53	123/56	123/56	105/51	119/53		
Temperature	98.3	99.7							98.7	98.9	99.3	99.9		99.8		
Pulse	76	86	78						82	81	98	109	104	117	100	
Respiratory Rate	16	12	14						13	14	12	17	20	14	12	
O2 Sat	95%	96%	97%						97%	98%	98%	98%	98%	100%	100%	
FiO2	3L	3L	3L						RA	RA	RA	RA	RA	RA	RA	
Methacut	NC humid	Humi	Humi													
TS		140/140								120cc	120cc	120				
Pulse: Dorsalis Ped.		⊕ doq							⊕ doq	⊕ doq	⊕ doq	⊕ doq	⊕ doq			
Post Tib		⊕ doq							⊕ doq	⊕ doq	⊕ doq	⊕ doq	⊕ doq			
Pain									Sleeping	Sleeping	Minimal	HA Minimal				

INTAKE	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
LR TOTAL	125	350	496	1480			1200		2250	2350	2450	2550	2650	2750	2850	2850	2850	
LR	125	125	415	415						100	100	100	100	100	100	hold	hold	
IVPB	Ø	Ø			100	140			200	Ø	Ø	100	200	Ø				
Heparin										20	20	20	20	20	20	24	24	
										20	40	60	80	100	124	148	172	
PRBC																200	200	
																200	400	
PO	NPO	NPO	NPO	— OR —						Ø	Ø			1320		230	250	
TOTALS																1570	1820	

OUTPUT		06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
URINE	HOUR	175	150	200					1100	1625	150	150	150	200	200	350	300	300	
	TOTAL	175	325	525					1625		1750	1900	2050	2250	2450	2800	3100	3400	
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

POST-OP DAY

V	22	23	24	01	02	03	04	05
BP			102/45	115/55	112/44	112/48	100/46	106/45
			115/49	107/47	102/46	111/49	114/52	115/50
Temp			99.6	99.3		98.9		97.2
HR			78	86	82	78	92	86
RR			20	14	20	18	17	19
O2 sat			97	99	97	98	100%	99
O2 method			R/A	R/A	R/A	R/A	R/A	R/A
			R/A					

	22	23	24	01	02	03	04	05	8° T
IV	100 2850	100 2850	100 2950	100 3050	100 3150	100 3250	100 3350	100 3450	3450
UPB	100 600						100 600		600
	24 190	24 220	24 244	24 268	28 290	28 324	28 352	28 380	380
	200 600	200 800							800
									1800
	250 3650	200 3850	200 4050	300 4350	200 4550	200 4750	200 4950	150 5100	7050 5100

ACUITY LEVEL CLASSIFICATION

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

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

ACTIVITIES OF DAILY LIVING	TIME				TURN	TIME				
	MOUTH CARE	1600								
	BATH	0900								
	SKIN CARE	0800	1600							
	FOLEY CARE	0800			SUCTION					
	TRACH CARE									
	ROM EXERCISES									

24 I&O TOTALS		NURSE'S SIGNATURE	INITIALS
wt Yesterday	wt Today	(b)(6)-2	(b)(6)-2
INTAKE	OUTPUT	(b)(6)-2	(b)(6)-2
IV	Urine:		
po			
TOTAL 7050	TOTAL 5100		
	950		

NEUROLOGICAL ASSESSMENT

HOURS: 18 19 20 21 22 23 24 01 02 03 04 05

COMA SCALE

EYES OPEN	SPONTANEOUSLY	4
	TO SPEECH	3
	TO PAIN	2
	NO EYE OPENING	1
BEST VERBAL RESPONSE	ORIENTED	5
	CONFUSED	4
	VERBALIZES	3
	VOCALIZES	2
	NO VOCALIZATION	1
BEST MOTOR RESPONSE	OBEYS COMMANDS	6
	LOCALIZES PAIN	5
	FLEXION WITHDRAWAL	4
	ABNORMAL FLEXION	3
	EXTENSION TO PAIN	2
	NO MOTOR RESPONSE	1

LIMB MOVEMENT

ARMS	NORMAL POWER
	MILD WEAKNESS
	SEVERE WEAKNESS
	ABNORMAL FLEXION
	ABNORMAL EXTENSION
	NO RESPONSE
LEGS	NORMAL POWER
	MILD WEAKNESS
	SEVERE WEAKNESS
	ABNORMAL FLEXION
	ABNORMAL EXTENSION
	NO RESPONSE

PUPILS

RIGHT	SIZE	
	REACTION	
LEFT	SIZE	
	REACTION	

PUPIL SCALE: 2 3 4 5 6 7 mm

CP

CEREBRAL PERFUSION PRESSURE

LEGEND

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

VASCULAR ASSESSMENT

HOURS: 18 20 22 24 02 04

		18	20	22	24	02	04
Pulses	R	D	D	D	D	D	D
Dorsalis Pedal	L	++	++	++	++	++	++
Post. Tib.	R	D	D	D	D	D	D
	L	++	++	++	++	++	++
	R						
	L						
	R						
	L						

LEGEND

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

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

NEURO	TIME	0615	INITIALS (b)(6)-2		INITIALS	1900	INITIALS (b)(6)-2
	PUPILS	3mm & PERLA				3mm brisk ellist	
	SENSORIUM	alert, oriented (language barrier), follows commands, moves extremities				circumstantial appropriate. moves ext x4. follows commands.	
RESPIRATORY	RESPIRATORY PATTERN	even & unlabored				even unlabored equall	
	BREATH SOUNDS	CTA bilaterally				full chest expansion.	
	SECRETIONS	Ø noted				lung sounds CTA x4 lobes ~~&~~ cough	
SKIN	COLOR	normal for race				warm dry to touch	
	INTEGRITY	dressings to (R) groin, (R) leg ex fix, (L) lower leg - CDE				clean to (L) groin leg CDD (R) leg ex fix. Dressing to groin CDE.	
IV SITE	LOCATION	(R) FA infusing Heparin,				(L) wrist infusing heparin	
	CONDITION	Ø signs infiltration, (R) SC cordis infusing LR @ 100 cc/hr				Ø s/s of infiltration (R) cordis infusing LR @ 100 cc/hr no s/s of infection A-line (R) wrist patent	
GASTRO	ABDOMEN	soft, non-tender				soft non-tender	
	BOWEL SOUNDS	(+) x 4 quads, regular diet				BS (+) x4 quads regular diet	
GU	URINE:	Foley to gravity				Foley → gravity	
	COLOR/CLARITY	clear, yellow				clear yellow urine	
CARDIOVASCULAR	CARDIAC RHYTHM	NSR pulses palpable x3, (R) LE pulses heard on Doppler, Ø edema noted, A-line to (R) radial				NSR 60-70 bpm pulses palpable equal. (R) LE pulses unavailable doppler. Ø Edema	

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

(Continue on reverse)

PREPARED BY (b)(6)-2 LCTAN

DEPARTMENT/SERVICE/CLINIC ICU

DATE 16 Sep 03

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

(b)(6)-4

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21
BP Arterial Line	114/46	125/53	133/54	110/46	119/51	113/51	120/50	122/45	115/50							
BP Cuff	105/41	112/53	107/51	109/46	111/49	101/53	109/50	101/45	114/46	107/49	108/41	111/48	108/58	110/60	104/34	111/49
Temperature	97.3						97.6				98.2					
Pulse	67	70	83	70	69	88	81	93	68	92	63	71	103	78	62	76
Respiratory Rate	13	17	19	14	16	20	13	24	19	10	15	19	21	22	15	21
O2 Sat	98%	99	99	98	98	100	100	100	99	100	100	99	100	100	97	100
Oxygen	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA

INTAKE

TIME	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
LR	100	100	100	100	100	100	100	100		100	100	100	100	100	100	100	100	
Heparin 50,000 IU/mL	28	28	28	30	30	30	30	30		30	30	30	30	30	30	30	30	
Units/hr Heparin	1460	1400	1400	1500	1500	1500	1500	1500		1500	1500	1500	1500	1500	1500	1500	1500	
IVPB					1500							30						
TOTALS																		

OUTPUT

			06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
URINE	HOUR	TOTAL	250/250	150/400	450/850	150/900	150/1050	250/1300	150/1450	450/1900		100/2000	300/2300	375/2675	100/2775	200/2975	250	250	200	
	30 gr																			
	S/A																			
NG	OUTPUT																			
	pH																			
	GUIAC																			
EMESIS																				
STOOL																				
DRAINS																				
TOTALS																				

POST-OP DAY

VITALS	22	23	24	01	02	03	04	05
							104/75	104/48
	112/75	114/41	117/51	114/43	112/75	110/48	104/43	104/49
	98							
	60	65	62	60	55	64	59	63
	15	18	15	14	13	17	15	15
	98%	99%	98	100	99	98	100	99
	RA	RA	RA	RA	RA	RA	RA	RA

	22	23	24	01	02	03	04	05	8° T
	100	100	100	100	100	100	100	100	3400
	30	50	30	50	30	20	30	50	714
	150	150	150	150	150	150	150	150	
	50								150
								10	25
									344
	200	100	100	200	100	100	200	100	5175

ACUITY LEVEL CLASSIFICATION

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

LABORATORY	TIME	0800									
	GLUCOSE										
	Na/K										
	Cl/CO_2										
	BUN/Cr										
	WBC/PLATELET	7.1/141									
	Hct/Hgb	29.5/9.9									
	PT	12.7									
	PTT	45.2									

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

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

	INTAKE	OUTPUT
IV		Urine:
po		
TOTAL	3464	TOTAL 5175

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

NEUROLOGICAL ASSESSMENT

COMA SCALE		HOURS	LEGEND
EYES OPEN	SPONTANEOUSLY 4		C Closed by swelling
	TO SPEECH 3		
	TO PAIN 2		
	NO EYE OPENING 1		
BEST VERBAL RESPONSE	ORIENTED 5		T Trach/Endo
	CONFUSED 4		S Slurring
	VERBALIZES 3		D Dysphasia
	VOCALIZES 2		R Receptive
	NO VOCALIZATION 1		E Expressive
BEST MOTOR RESPONSE	OBEYS COMMANDS 6		
	LOCALIZES PAIN 5		
	FLEXION WITHDRAWAL 4		
	ABNORMAL FLEXION 3		
	EXTENSION TO PAIN 2		
	NO MOTOR RESPONSE 1		
LIMB MOVEMENT — ARMS	NORMAL POWER		R Right
	MILD WEAKNESS		L Left
	SEVERE WEAKNESS		Record separately if there is a difference between the two sides.
	ABNORMAL FLEXION		
	ABNORMAL EXTENSION		
	NO RESPONSE		
LEGS	NORMAL POWER		
	MILD WEAKNESS		
	SEVERE WEAKNESS		
	ABNORMAL FLEXION		
	ABNORMAL EXTENSION		
	NO RESPONSE		
PUPILS — RIGHT	SIZE		+ + Brisk
	REACTION		+ Slow
LEFT	SIZE		- No Response
	REACTION		
PUPIL SCALE		2 3 4 5 6 7 mm	
CP			+ Intact
CEREBRAL PERFUSION PRESSURE			- Abnormal

VASCULAR ASSESSMENT

		HOURS 06	LEGEND
Dorsalis Pedis	R	D/	+ + Normal
	L	H	
Post. Tib	R	D/	+ Weak
	L	H	
	R		- Absent
	L		
	R		D Doppler
	L		
	R		R Right
	L		L Left

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0615	INITIALS (b)(6)-2	1900	INITIALS (b)(6)-2		INITIALS
NEURO	PUPILS		3mm & PERLA		PERRLA			
	SENSORIUM		awake, alert; follows commands, moves all extremities		A+O x3, (P) commands MAE's.			
RESPIRATORY	RESPIRATORY PATTERN		even & unlabored		easy, nonlabored			
	BREATH SOUNDS		clear, bilaterally		clear bilat			
	SECRETIONS		Ø noted		O2 sat 98% on R/m.			
SKIN	COLOR		normal for race		WNL.			
	INTEGRITY		dressings to (R) LE ex fix, (R) fem, (L) LE COI		Drsg to (R) groin, BLE's, external fixator to RLE.			
IV SITE	LOCATION		(L) FA infusing		(L) FA PIV	(L) SC cordis		
	CONDITION		Heparin @ 750u/° (L) SC cordis infusing LR @ 100cc/° - both patent		site + drsg intact, Heparin (L) 30cc/hr (1500 units/hr) infusing	site + drsg intact, LR @ 100cc/hr infusing		
GASTRO	ABDOMEN		soft, non-tender		Soft, flat, nontender			
	BOWEL SOUNDS		(+) x4 quads, regular diet c̄ supplement shakes		(+) BS x4 quads			
GU	URINE:		Foley to gravity		Foley → gravity			
	COLOR/CLARITY		clear, yellow		clear yellow c̄ good output.			
CARDIOVASCULAR	CARDIAC RHYTHM		NSR, pulses palpable x3, (R) LE heard on doppler, mild edema noted to (R) foot Brad A-line patent		NSR. 3 extremity (R) post tib pulse inaudible to check due to drsg over area. see vascular assessment pg 4.			

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

(Continue on reverse)

PREPARED BY (Signature & Title) (b)(6)-2 RN BSN

DEPARTMENT/SERVICE/CLINIC ICU

DATE 1 Sept 89

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility) (b)(6)-4 (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21
BP Arterial Line	117/50	119/62	120/54	119/48	119/51	120/50	124/45	108/54	127/58	117/47	125/53	112/54	125/54	139/58	129/48	127/58
BP Cuff	109/47	100/47	111/53	112/41	100/54	123/47	119/48	114/50	124/53	100/51	100/52	113/48	104/55	116/60	107/42	123/51
Temperature	98.6													98.1		
Pulse	75	88	76	62	70	69	65	77	75	95	85	84	78	70	65	102
Respiratory Rate	12	16	10	14	18	15	16	17	21	12	17	19	21	16	16	14
O2 Sat	100	98	100	99	99	100	99	100	99	100	99	98	98	98	98%	100%
Method	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA

INTAKE

TIME	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
LR	100	100	100	100 / 400	100	100	100	100 / 800		100	100	100	100 / 1200	100 / 1300	100 / 1400	100 / 1500	100 / 1600	
Heparin Units	30	30	30	30 / 120	30	30	30	30 / 240		30	30	30 / 300	30 / 360	30 / 390	30 / 420	30 / 450	30 / 480	
	150														1500			
IVPB	50 / 50			50 / 100	100 / 200							100 / 300		300				
TOTALS																		

OUTPUT

	HOUR / TOTAL	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21
URINE		50	275	150	300 / 775	200	450 / 1475	250 / 1675	400 / 2075	350 / 2425	200 / 2625	300 / 2925	200 / 3125	200 / 3325	300 / 3625	300 / 3925	200 / 4125
	sp gr																
	S/A																
NG	OUTPUT																
	pH																
	GUIAC																
EMESIS																	
STOOL																	
DRAINS																	
TOTALS																	

POST-OP DAY

	22	23	24	01	02	03	04	05	
Time	111/47	102/43	96/45	96/37	94/39	104/40	102/39		
BP	109/48	95/39	106/38	102/44	106/40	108/42	108/39		
Temp				97.3					
Pulse	80	60	68	57	55	57	58		
RR	20	15	16	12	13	13	12		
O2 Sat	100	99%	99%	100%	99%	99%	98%		
Method	R/A	R/A	R/A	R/A	R/A	R/A	R/A	R/A	

	22	23	24	01	02	03	04	05	8° T
IV	100 / 1700	100 / 800	100 / 1900	100 / 2000	100 / 2100	100 / 2200	100 / 2300	100 / 2400	2400
Drip	30 / 510	30 / 510	36 / 510	36 / 612	36 / 648	36 / 684	36 / 720	36 / 756	756
Units	1500	1500	1500						
PRB	100 / 400						100 / 500		500

	275 / 4400		100 / 4500		200 / 4700		325 / 5025	100 / 5125	5125

ACUITY LEVEL CLASSIFICATION

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

LABORATORY DATA	TIME	0600	1515	2200
	GLUCOSE	146		
	Na/K	137/3.8		
	Cl/CO_2	105/24		
	BUN/Cr	5/0.6		
	WBC/PLATELET	4.7/44		
	Hct/Hgb	28.3/9.3		
	PT	13.8	13.3	13.4
	PTT	45.2	45.9	35.9

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

TURN	TIME				
SUCTION					

24 I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE

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

NEUROLOGICAL ASSESSMENT

		HOURS	
COMA SCALE	EYES OPEN	SPONTANEOUSLY	4
		TO SPEECH	3
		TO PAIN	2
		NO EYE OPENING	1
	BEST VERBAL RESPONSE	ORIENTED	5
		CONFUSED	4
		VERBALIZES	3
		VOCALIZES	2
		NO VOCALIZATION	1
	BEST MOTOR RESPONSE	OBEYS COMMANDS	6
		LOCALIZES PAIN	5
		FLEXION WITHDRAWAL	4
		ABNORMAL FLEXION	3
		EXTENSION TO PAIN	2
		NO MOTOR RESPONSE	1
LIMB MOVEMENT	ARMS	NORMAL POWER	
		MILD WEAKNESS	
		SEVERE WEAKNESS	
		ABNORMAL FLEXION	
		ABNORMAL EXTENSION	
		NO RESPONSE	
	LEGS	NORMAL POWER	
		MILD WEAKNESS	
		SEVERE WEAKNESS	
		ABNORMAL FLEXION	
		ABNORMAL EXTENSION	
		NO RESPONSE	
PUPILS	RIGHT	SIZE	
		REACTION	
	LEFT	SIZE	
		REACTION	
PUPIL SCALE		2 3 4 5 6 7 mm	
CP			
CEREBRAL PERFUSION PRESSURE			

LEGEND

C Closed by swelling

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

R Right
L Left

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

++ Brisk
+ Slow
- No Response

+ Intact
- Abnormal

VASCULAR ASSESSMENT

HOURS		19	20	21	22	23	00	01	02	03	04	05
Dorsalis Pedis	R	D		D		D		D			D	
	L	++		++		++		++			++	
Post. Tib	R	Doppler		Doppler		Doppler		Doppler			Doppler	
	L	++		++		++		++			++	
	R											
	L											
	R											
	L											

LEGEND

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

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0615	INITIALS (b)(6)-2	1900	INITIALS (b)(6)-2		INITIALS
NEURO	PUPILS		3mm & PERLA		PERRL			
	SENSORIUM		alert, oriented, follows		A+OX3			
			commands, moves		(R) commands, MAE.			
			all extremities		w/g/e toes + (R) foot			
					c external fixator			
RESPIRATORY	RESPIRATORY PATTERN		even & unlabored		easy, nonlabored			
	BREATH SOUNDS		CTA bilaterally		clear, bilat			
	SECRETIONS		Ø noted		uses incentive spirometer			
			IS used q1°		well			
SKIN	COLOR		normal for race		WNL			
	INTEGRITY		dressing to (R) ex fix,		Dressing to BLE + (R) groin			
			(L) LE, (R) fem incision		ex fix c to RLE			
IV SITE	LOCATION		(L) SC cath, infusing		18G Peripheral IV c fondis			
	CONDITION		LR @ 100cc/hr and		Dress + site site + dry			
			Heparin @ 1800u/°		intact.			
			patent, dressing Ud		Flushes easily, Heparin @ 10cc/hr			
			Ø s/sx infection		2000 units/hr			
					LR @ 100cc/hr.			
GASTRO	ABDOMEN		soft, non-tender		soft nontender			
	BOWEL SOUNDS		hyperactive x 4 quads,		(+) BS x 4 quads			
			regular diet c		ate 30% dinner.			
			supplement		tol well.			
GU	URINE:		Foley + tegracunty		Foley → gravity			
	COLOR/CLARITY		clear, yellow		clear yellow urine			
CARDIOVASCULAR	CARDIAC RHYTHM		NSR, pulses palpable		NSR.			
			x3, (R) pedal auscultated		See vascular assessment			
			c doppler, mild edema		for pulses.			
			noted to (R) foot		(R) radial + line c			
					good waveform.			

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

(Continue on reverse)

PREPARED BY (b)(6)-2 LSA

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 18 Sep 03

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

(b)(6)-4

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21
BP Arterial Line	128/74	109/65	118/47	108/49	113/50	124/45	109/46	120/47	119/50	120/45	115/43	114/45	120/46	125/53	108/41	130/86
BP Cuff	109/46	110/45	102/46	109/48	114/45	116/53	115/45	110/39	109/46	120/64	108/43	110/40				
Temperature	97°				96.2				97.3					97.3		
Pulse	71	57	65	74	76	67	73	66	76	67	61	62	65	94	69	60
Respiratory Rate	12	11	14	11	17	16	19	10	19	14	13	17	19	26	14	15
O2 Sat	100%	100	99	100	100	100	100	99	98	98	99	99	100	100	98	98
Oxygen	N/A	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA

INTAKE

TIME	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
LR	100	160	100	100	100	100	100	100		100	100	100	100	100	100	100	100	
Heparin	36	36	36	40	40	40	40	40		40	40	40	40	40	40	40	40	
IVPB	50				50	100								300				
PO	500	500					500			50					250			
TOTALS																		

OUTPUT

	HOUR / TOTAL	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21
URINE	HOUR	275	150	150	200	150	300	200	400	400	250	175	300	200	250	200	175
	TOTAL	275		575	775	925	1325	1525	1925	2325	2575	2750	3050	3250	3500	3700	3875
	SP GR																
	S/A																
NG	OUTPUT																
	pH																
	GUIAC																
EMESIS																	
STOOL																	
DRAINS																	
TOTALS																	

POST-OP DAY

	22	23	24	01	02	03	04	05
SBP	103/42	118/46						
NBP	103/46	114/49	113/48	93/43	93/43	97/43	95/45	105/49
T	98.8		97.3					
HR	60	61	65	91	58	58	62	58
RR	14	15	16	27	13	14	12	13
Sat	92 RA	93%	100%	98%	98%	98%	99%	100%
O2	RA	RA	RA	RA	RA	RA	RA	RA

	22	23	24	01	02	03	04	05	8° T
	100	100	100	100	100	100	100	100	
500	1600	1700	1800	1900	2000	2100	2200	2300	2300
20	40	40	40	40	40	40	40	40	
	680	720	760	800	840	880	920	960	960
		100					100		
		400					500		500

	22	23	24	01	02	03	04	05	
	200	200	200	200	50	50	50	50	
	3975	4175	4375	4575	4625	4675	4725	4775	4775

ACUITY LEVEL CLASSIFICATION

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

LABORATORY	TIME	0600	1400	2250								
	GLUCOSE	96										
	Na/K	131/3.7										
	Cl/CO_2	101/23										
	BUN/Cr	7/0.5										
	WBC/PLATELET	12										
	Hct/Hgb	26.6/8.4										
	PT	12.8	12.9	15.1								
	PTT	43.1	56.6	57.3								

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

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
PO			
		L	

BALANCE

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

MEDCOM - 7387

NEUROLOGICAL ASSESSMENT

COMA SCALE	HOURS		12/01	02	03	04	05
EYES OPEN	SPONTANEOUSLY	4					
	TO SPEECH	3					
	TO PAIN	2					
	NO EYE OPENING	1					
BEST VERBAL RESPONSE	ORIENTED	5					
	CONFUSED	4					
	VERBALIZES	3					
	VOCALIZES	2					
	NO VOCALIZATION	1					
BEST MOTOR RESPONSE	OBEYS COMMANDS	6					
	LOCALIZES PAIN	5					
	FLEXION WITHDRAWAL	4					
	ABNORMAL FLEXION	3					
	EXTENSION TO PAIN	2					
	NO MOTOR RESPONSE	1					
LIMB MOVEMENT: ARMS	NORMAL POWER						
	MILD WEAKNESS						
	SEVERE WEAKNESS						
	ABNORMAL FLEXION						
	ABNORMAL EXTENSION						
	NO RESPONSE						
LEGS	NORMAL POWER						
	MILD WEAKNESS						
	SEVERE WEAKNESS						
	ABNORMAL FLEXION						
	ABNORMAL EXTENSION						
	NO RESPONSE						
PUPILS: RIGHT	SIZE						
	REACTION						
LEFT	SIZE						
	REACTION						
PUPIL SCALE			2	3	4	5	6 7 mm
CP							
CEREBRAL PERFUSION PRESSURE							

LEGEND

C Closed by swelling

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

R Right
L Left

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

++ Brisk
+ Slow
- No Response

+ Intact
- Abnormal

VASCULAR ASSESSMENT

	HOURS		18	19	20	21	22	23	24	01	02	03	04	05
Dorsalis Pedis		R		D										
		L												
Post tib		R												
		L												
		R												
		L												
		R												
		L												
		R												
		L												

LEGEND

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

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0600	INITIALS (b)(6)-2	1900	INITIALS (b)(6)-2		INITIALS
NEURO	PUPILS	Pupils 3mm Brisk		PERRLA			
	SENSORIUM	AT0 x3, MAE x4, denies pain or pressure		AT0 x3 MAE denies pain			
RESPIRATORY	RESPIRATORY PATTERN	Even & unlabored		easy, non labored,			
	BREATH SOUNDS	Lungs CTA in all fields		clear, bilat			
	SECRETIONS	O2 sat 100% on RA		⊘ SOB, O2 sat 99% on RA			
SKIN	COLOR	Normal for race		WNL			
	INTEGRITY	No evidence of skin breakdown		Area to BLE & exit to BLE dsg intact & ⊕ gauze			
I.V. SITE	LOCATION	LSC Cardio J, 16 G		⊕ hand left, ⊕ SC Cardio			
	CONDITION	Infection. Hyperemia ⊕ swelling ⊕ drainage ⊕ IV c/ H. 18 G to ⊕ forearm D/C'd, was alert to leave		dsg & site dsg & site intact. intact. IV @ 100cc/hr + flushes easily heparin @ 40cc/hr patent. (2,000 units/hr) Infusing.			
GASTRO	ABDOMEN	BS x4. Appetite poor		soft, flat.			
	BOWEL SOUNDS	Eating ½ of tray offered		⊕ BS x4 quads good appetite, ate 40% of dinner. Tol well.			
GU	URINE:	~~Voiding freely~~		foley → gravity			
	COLOR/CLARITY	Foley draining, clear yellow urine		clear yellow c good out put.			
CARDIOVASCULAR	CARDIAC RHYTHM	SB Sectopy, PR, 16 BVS. BS: Pulses ⊕ to all extremities. ⊕ edema. ⊕ bilat doppler pulses to DP & PT		NSR Sectopy. pulses ⊕ to bilat radial and ⊕ pedal. ⊕ doppled to ⊕ pedal.			

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

(Continue on reverse)

(b)(6)-2

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

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 19 Sep 03

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

(b)(6)-4

(b)(6)-4

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21
BP Arterial Line																
BP Cuff	109/48	100/50	108/53	116/58	108/53	108/53	107/50	114/50	116/50	108/47	119/60	108/53	116/49	106/45	122/50	130/72
Temperature	97.4	96.4					98.7				98.5		97.9			
Pulse	58	77	59	61	55	61	62	62	76	61	65	59	58	65	62	86
Respiratory Rate	12	16	11	14	13	16	15	18	23	15	14	15	17	12	14	22
O2 Sat	99%	99%	98%	98%	99%	97%	97%	100%	99%	100%	100%	98%	100%	99%	99%	99%
Oxygen Method	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA

INTAKE

TIME	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
Heparin units	40 / 8000	40 / 8000	40 / 8000	40 / 8000	40 / 8000	40 / 8000	40 / 8000	40 / 8000		40 / 8000	40 / 8000	40 / 8000	40 / 8000	40 / 8000	40 / 8000	40 / 8000	40 / 8000	
LR	100 / 100	100 / 200	100 / 300 / 480	100 / 400	100 / 500	100 / 600	100 / 700 / 500	100 / 800		100 / 900	100 / 1000	100 / 1100	100 / 1200	100 / 1300	100 / 1400 / 500 / 1480	100 / 1500	100 / 1600	
IVPB					100 / 100				980			100 / 200						1480

OUTPUT

		TIME	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21
URINE		HOUR / TOTAL	400 / 400	100 / 500	150 / 650	200 / 850	150 / 1000	150 / 1150	100 / 1250	185 / 1435	140 / 1575	140 / 1715	150 / 1865	50 / 1915	200 / 1975	—	475 / 2450	400 / 2850
		sp gr																
		S/A																
NG		OUTPUT																
		pH																
		GUIAC																
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

OST-OP DAY

	22	23	24	01	02	03	04	05
BP	115/86	111/82	117/53	114/50	115/58	119/55	117/80	110/53
T			98²				97⁶	
Pulse	61	56	60	56	62	62	55	57
RR	13	12	13	13	13	15	13	13
Sat	99%	99%	98%	98%	99%	97%	99%	98%
O2	R/A	R/A	R/A	R/A	R/A	R/A	R/A	R/A

	22	23	24	01	02	03	04	05	8° T
	40 / 680 / 2000	40 / 720	40 / 760	40 / 850	40 / 840	40 / 880	40 / 920	40 / 960	960
	100 / 1700 / 100	100 / 1800	100 / 1900	100 / 2000	100 / 2100	100 / 2200	100 / 2300	100 / 2400	2400
							100 / 1480		1480
	100 / 300						100 / 400		400
	500 / 3350	500 / 3850	100 / 3950	150 / 4100	150 / 4100	100 / 4300	150 / 4450	100 / 4550	5240 / 2550

ACUITY LEVEL CLASSIFICATION

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

LABORATORY	TIME	Yesterday 0600									
	GLUCOSE	98									
	Na/K	133 / 3.9									
	Cl/CO_2	102 / 26									
	BUN/Cr	8 / 0.7									
	WBC/PLATELET	513 / 222									
	Hct/Hgb	9.4 / 28.2									
	PT	13.4									
	PTT	66.1									
	CK	559									

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

24 HR TOTALS

NURSE'S SIGNATURE | INITIALS

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

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL	5240	TOTAL	2550

90

NEUROLOGICAL ASSESSMENT

COMA SCALE		HOURS
EYES OPEN	SPONTANEOUSLY	4
	TO SPEECH	3
	TO PAIN	2
	NO EYE OPENING	1
BEST VERBAL RESPONSE	ORIENTED	5
	CONFUSED	4
	VERBALIZES	3
	VOCALIZES	2
	NO VOCALIZATION	1
BEST MOTOR RESPONSE	OBEYS COMMANDS	6
	LOCALIZES PAIN	5
	FLEXION WITHDRAWAL	4
	ABNORMAL FLEXION	3
	EXTENSION TO PAIN	2
	NO MOTOR RESPONSE	1
LIMB MOVEMENT: ARMS	NORMAL POWER	
	MILD WEAKNESS	
	SEVERE WEAKNESS	
	ABNORMAL FLEXION	
	ABNORMAL EXTENSION	
	NO RESPONSE	
LIMB MOVEMENT: LEGS	NORMAL POWER	
	MILD WEAKNESS	
	SEVERE WEAKNESS	
	ABNORMAL FLEXION	
	ABNORMAL EXTENSION	
	NO RESPONSE	
PUPILS: RIGHT	SIZE	
	REACTION	
PUPILS: LEFT	SIZE	
	REACTION	
PUPIL SCALE		2 3 4 5 6 7 mm
CP		
CEREBRAL PERFUSION PRESSURE		

LEGEND

C Closed by swelling

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

R Right
L Left

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

++ Brisk
+ Slow
- No Response

+ Intact
- Abnormal

VASCULAR ASSESSMENT

HOURS		18	19	20	21	22	23	24	01	02	03	04	05
Dorsalis Pedis	R	D						D				D	
	L	H						H				H	
	R												
	L												
	R												
	L												
	R												
	L												
	R												
	L												

LEGEND

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

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) _ QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0630	INITIALS (b)(6)-2	1900	INITIALS (b)(6)-2		INITIALS
NEURO	PUPILS	Pupils 4mm Reactive. Eyes PERRLA		4mm PERRLA			
	SENSORIUM	MAEX4. Clear		A&OX3 MAEX4			
		Alert & Oriented x3 Maintained		IV MSO4 for Pain			
RESPIRATORY	RESPIRATORY PATTERN	Even & Unlabored - Lungs		Even, Unlabored			
	BREATH SOUNDS	CTA - Well Aerated.		CTA Bilat			
	SECRETIONS	Absence of productive		⊖ Sputum			
		Cough or Deep Breath					
		Ventilator Settings					
SKIN	COLOR	Normal for Race. Pink		NFR			
	INTEGRITY	Abrasions Fusion c slight		External Fix (R) Leg			
		redness		⊖ + Edema			
IV SITE	LOCATION	18G to (R) forearm		18g RFA ⊖ Sx Sx infex			
	CONDITION	Site ⊖ redness or swelling		Cordis (R) Subcl			
		(C) Subclavian Site Clean		⊖ Sx Sx infection			
		⊖ redness or infection					
		LR @ 100cc/hr, Heparin					
		@ 40 cc/hr					
GASTRO	ABDOMEN	BS x4 Quadrants		BSX4, Soft Non Tender			
	BOWEL SOUNDS	No Distension Upon					
		palpation. Soft to					
		touch. BM one day ago					
GU	URINE:	Foley to gravity		Foley to gravity			
	COLOR/CLARITY	Clear Yellow Urine		Clear / Yellow			
CARDIOVASCULAR	CARDIAC RHYTHM	Sinus Brady Rate on		SR			
		50's. No ectopy PR. 1°		+ 2 Palpable Bil DP +			
		AHA. OP S1S2 auscultated		bilE, (R)LE			
		Pulses to (R) Lower extremity		by doppler			
		1st by doppler					

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

(Continue on reverse)

(b)(6)-2

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

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 20 Sep 03

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

(b)(6)-4

(b)(6)-4

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21
BP Arterial Line																
BP Cuff	114/54		159/72	157/64	138/57	128/65	132/67	120/69	135/64	139/60	137/69	132/80	126/64	114/52	127/63	122/54
Temperature	97.6	97		96.6				97			98.2					
Pulse	54	59	56	60	62	62	81	69	78	86	80	73	73	96	74	69
Respiratory Rate	12	13	11	13	11	18	15	16	16	17	18	16	16	14	13	15
O2 sat	98%	99%	99%	99%	100%	100%	99%	99%	97%	97%	97%	97%	97%	98	97	100
Oxygen	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA

INTAKE

TIME	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
LR	100/100	60/200	60/300	60/400	60/500	60/600	60/700	40/800		100/900	100/1000	100/1100	100/1200	100/1300	100/1300	100/1400	100/1500	
IVPB																		
Heparin units	40/40/2000	80/80/2400																
po				240/240											340			
PO																		
TOTALS																		

OUTPUT

			06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21
URINE	HOUR	TOTAL	50/50	200/300	400/800	500/1300	100/1400	100/1500	150/1650	150/1800	100/1900	100/2000	100/2100			300/2400		400/2800
	sp gr																	
	S/A																	
NG	OUTPUT																	
	pH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

	22	23	24	01	02	03	04	05
B/P	121/48	117/53	125/51	126/51	108/40	113/43	100/N	106/53
T	98.2							
P	71	78	64	62	56	57	102	88
R	15	20	13	18	18	19	20	20
SPO2	99	100	99	98	99	100	99	99
	RA	RA	RA	RA	RA	RA	RA	RA

	22	23	24	01	02	03	04	05	8° T
IV	100 1400 100	100 1700	100 1800	100 1400	100 300	100 900	100 200	100 300	2300
PO	300								80 940
U		500 3875			800 3625			450 4075	4075

RESPIRATORY DATA

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

LABORATORY DATA

TIME											
GLUCOSE											
Na/K											
Cl/CO_2											
BUN/Cr											
WBC/PLATELET	7.1/450										
Hct/Hgb	30/10.8										

ACTIVITIES OF DAILY LIVING

TIME											
MOUTH CARE											
BATH											
SKIN CARE											
FOLEY CARE											
TRACH CARE											
ROM EXERCISES											

TURN / SUCTION — TIME

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	2300	Urine:	4075
po	60		
	940		
TOTAL	3320	TOTAL	655

NURSE'S SIGNATURE — INITIALS

(b)(6)-2

MEDCOM - 7395

NEUROLOGICAL ASSESSMENT

COMA SCALE		HOURS
EYES OPEN	SPONTANEOUSLY	4
	TO SPEECH	3
	TO PAIN	2
	NO EYE OPENING	1
BEST VERBAL RESPONSE	ORIENTED	5
	CONFUSED	4
	VERBALIZES	3
	VOCALIZES	2
	NO VOCALIZATION	1
BEST MOTOR RESPONSE	OBEYS COMMANDS	6
	LOCALIZES PAIN	5
	FLEXION WITHDRAWAL	4
	ABNORMAL FLEXION	3
	EXTENSION TO PAIN	2
	NO MOTOR RESPONSE	1
LIMB MOVEMENT: ARMS	NORMAL POWER	
	MILD WEAKNESS	
	SEVERE WEAKNESS	
	ABNORMAL FLEXION	
	ABNORMAL EXTENSION	
	NO RESPONSE	
LIMB MOVEMENT: LEGS	NORMAL POWER	
	MILD WEAKNESS	
	SEVERE WEAKNESS	
	ABNORMAL FLEXION	
	ABNORMAL EXTENSION	
	NO RESPONSE	
PUPILS: RIGHT	SIZE	
	REACTION	
PUPILS: LEFT	SIZE	
	REACTION	
PUPIL SCALE		2 3 4 5 6 7 mm
CP		
CEREBRAL PERFUSION PRESSURE		

LEGEND

C Closed by swelling

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

R Right
L Left

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

++ Brisk
+ Slow
- No Response

+ Intact
- Abnormal

VASCULAR ASSESSMENT

		HOURS	06	08	09	10	11	12	13	14	15	16	17	18
Posterior Tib	R					D				D				D
	L													
Dorsalis Pedis	R					D				D				D
	L													
	R													
	L													
	R													
	L													

LEGEND

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

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)_ QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0620 INITIAL (b)(6)-2	INITIALS	INITIALS
NEURO	PUPILS	2mm & PERLA	2mm & PERLA	No Sig Δs
	SENSORIUM	alert, awake, follows commands, moves all extremities language barrier	alert - cooperative able to move all ext.	
RESPIRATORY	RESPIRATORY PATTERN	even & unlabored	RRR - lungs CTA	
	BREATH SOUNDS	CTA throughout	bilat ϕ crackles, ϕ secretions	No sig Δs
	SECRETIONS	ϕ noted		
SKIN	COLOR	normal for race	normal for race	
	INTEGRITY	dressings to (R) LE, groin, saturated c̄ blood - reinforced	Dss, Arc wrap (R) LE ↑ ϕ drainage	No Sig Δs
IV SITE	LOCATION	(L) SC cath infusing	- ϕ sub cath Dlcd	
	CONDITION	LR @ 100cc/° (R) hand heplock, flushed & patent	now 20 c IV cath (L) FA	
GASTRO	ABDOMEN	soft, non-tender	(+) BS x 4 quads	No Sig Δs
	BOWEL SOUNDS	(+) x4 quads, regular diet #1	soft - nondistended res diet - JM this shift	
GU	URINE:	Foley to gravity	Foley dlcd	
	COLOR/CLARITY	clear, yellow		
CARDIOVASCULAR	CARDIAC RHYTHM	NSR, all pulse palpable, (R) LE heard on doppler mild edema noted to (R) foot	NSR - (+) radial and (L) LE pulse pins in way of (R) LE pulses	No Sig Δs

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

(Continue on reverse)

PREPARED BY (b)(6)-2 [signature] DEPARTMENT/SERVICE/CLINIC ICU DATE 21 Sept 03

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

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21
BP Arterial Line																
BP Cuff	111/46	109/46	113/51	119/46	112/48	110/41	110/46	124/46	111/48	110/51	110/45	124/58				
Temperature									98.0							
Pulse	61	80	72	68	84	81	69	83	61	78	65	67	66			
Respiratory Rate	15	19	16	18	22	15	13	18	14	20	17	21	15			
SpO2	98	100	100	99	100	100	99	99	99	99	99	100	99			
O2	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA			

INTAKE

TIME	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21	8°T
IVF	100	100	100	100	100	100	Ø	Ø		Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	
PRBCs								400			500	200	Ø					
IVPB												100	Ø					
PO												400						
TOTALS																		

OUTPUT

		TIME	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21	8°T
URINE		HOUR / TOTAL	200	200	200	250	350	350	Ø	Ø		100	Ø	Ø	Ø	Ø			600	
		sp gr																		
		S/A																		
NG		OUTPUT																		
		pH																		
		GUIAC																		
EMESIS																				
STOOL																				
DRAINS																				
TOTALS																				

1050

POST-OP DAY

	22	23	24	01	02	03	04	05
	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø
	50							102/52
	109/46			110/62				62
	70			68				14
	17			14				97%
	98%			99%				RA
	RA			RA				

	22	23	24	01	02	03	04	05	8° T
	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	
	50								1,600
								700	1300

ACUITY LEVEL CLASSIFICATION

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

LABORATORY	TIME	0500									
	GLUCOSE	103									
	Na/K	121/4.5									
	Cl/CO_2	98/24									
	BUN/Cr	8/1.3									
	WBC/PLATELET	6.6/158									
	Hct/Hgb	35.7/14									

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

24 HR I&O TOTALS		NURSE'S SIGNATURE	INITIALS
wt Yesterday	wt Today		
INTAKE	OUTPUT		
IV ~~[illegible]~~	Urine: ~~1900~~		
po 1600 ~~1000~~	3350		
TOTAL 2600	TOTAL 3350		
	1750		

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	INITIALS		INITIALS		INITIALS
		0615	(b)(6)-2				
NEURO	PUPILS	3mm & PERLA					
	SENSORIUM	awake, alert; follows commands, moves all extremities					
RESPIRATORY	RESPIRATORY PATTERN	even & unlabored					
	BREATH SOUNDS	CTA bilaterally					
	SECRETIONS	Ø noted, sats 98-99% on RA					
SKIN	COLOR	normal for race					
	INTEGRITY	dsg to R inguinal Ad, dsg to R LE CDL					
IV SITE	LOCATION	DFA, heplock					
	CONDITION	flushed, patent Ø s/sx infection					
GASTRO	ABDOMEN	soft, non-tender					
	BOWEL SOUNDS	Ø x4 quads, regular diet					
GU	URINE:	urinal @ bedside					
	COLOR/CLARITY	clear, yellow					
CARDIOVASCULAR	CARDIAC RHYTHM	NSR, pulses palpable, R dorsalis ped. heard on doppler, mild edema to R foot					

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

(Continue on reverse)

PREPARED BY (Signature & Title) (b)(6)-2 SGT/LPN

DEPARTMENT/SERVICE/CLINIC ICU

DATE 22Sep03

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

(b)(6)-4

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	06	07	08	09	10	11	12	13	/	14	15	16	17	18	19	20	21	/
BP Arterial Line																		
BP Cuff	114/45	120/50	117/55	120/52	117/45	121/53	119/61											
Temperature	97.8																	
Pulse	76	75	83	57	63	57.	69											
Respiratory Rate	12	28	27	16	18	20	18											
	99	97	98	96	99	99	99											

INTAKE

TIME	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
IVPB	Ø	Ø	50	Ø	Ø	Ø	Ø											
PO		250		Ø	Ø													
TOTALS																		

OUTPUT

		HOUR / TOTAL	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
URINE			400	Ø	Ø	Ø	Ø	Ø	600											
		sp gr																		
		S/A																		
NG		OUTPUT																		
		pH																		
		GUIAC																		
EMESIS																				
STOOL																				
DRAINS																				
TOTALS																				

POST-OP DAY

VITALS SIGNS

22	23	24	01	02	03	04	05	

22	23	24	01	02	03	04	05	8° T

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

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

LABORATORY DATA

TIME	0600
GLUCOSE	108
Na/K	136/4.5
Cl/CO_2	97/22
BUN/Cr	10/1.0
WBC/PLATELET	7.1/344
Hct/Hgb	30.6/10

ACTIVITIES OF DAILY LIVING

TIME	
MOUTH CARE	
BATH	
SKIN CARE	
FOLEY CARE	
TRACH CARE	
ROM EXERCISES	

TURN

SUCTION

TIME

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE ______

NURSE'S SIGNATURE	INITIALS

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 6 Oct 03
Time In: 1205
Allergies: NKDA
Pre-op V/S: 136/60 – 76-18
Procedures: Remove ex fix

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 700 Colloid 0
OR Output: UOP 0 EBL 0 min
Meds/Times: Duraf 150mg, Versed 3mg propofol 150mg

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

Pre Op Meds History

Time	1200	1205	1210	1220	1230
SaO2	98	100	99	100	100
FiO2					
Methods	RA	NC	RA	RA	RA
240					
220					
200					
180					
160					
140					
120			V		
100		V		V	V
80					
60					
40					
20					
RR	12	20		10	16
T	98			96	97

Time	1205	1215
Pain (0-10)	0	0
LOS		0

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	[redacted]	Infused
1200	NS	200cc	20g OFA		200cc
				(b)(6)-2	

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	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	2	2	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,	12	12	12

Codes

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

V/S
X = A-line BP
˙ = Cuff BP
= Pulse

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

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

PREPARED BY (b)(6)-2 SGT USA 91WM6

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 6 Oct 03

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

[redacted] (b)(6)-4

(b)(6)-4

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

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

USAPPC V2.00

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

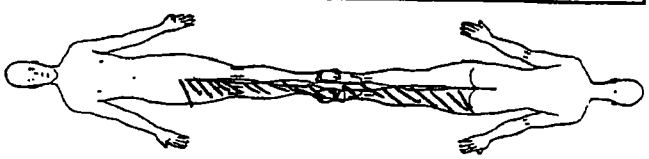
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

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



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

1210 Pt transfer to ICU from OR via litter for recovery s/p ex-fix removal. Pt awake, alert, pleasant, monitor on. VS noted on reverse side. Cast to (R) leg able to put two finger in cast. (+) sensation to leg, PT c/o HA 650mg tylenol give PO. PT tolerated well. PT Had 240cc Milk & nausea, & vomiting noted. [redacted] (b)(6)-2

1230 HR 45 pt awake oriented & complaints of pain at this time / [redacted] (b)(6)-2

1235 - T. 97.5 Ax, Report given to SGT [redacted] PN pt ready for transport [redacted] (b)(6)-2

Pt transfer to ICW 7 bed 5 complications / [redacted] (b)(6)-2

Discharge Criteria:
Date: 6 Oct **Time:** 1240 **PARS:** 12
BP: 111/64 **T:** 97.3 Ax **HR:** 51 **RR:** 15 **Sa02:** 100
Pain Level at D/C (0-10):
Intake: 200cc / 360 PO **Output:** 0
Additional Data:
Transferred To: ICW
Report Given To: SGT [redacted] (b)(6)-2
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: SGT [redacted] (b)(6)-2
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: [redacted] (b)(6)-2

ADMISSION AND CODING INFORMATION

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

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

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19 19		X	9	UNK

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
		9 9	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
		0800	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K 7 8 PO W/INT	[redacted]

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION	(b)(6)-4
I Z		BC	YEAR	☑ NO

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

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYYYMMDD)
		2003108

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
NEA		20030913

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

FOR LOCAL USE

(R) Leg gr3 open tibia Fx 2ND to GSW (R) Leg
823.92 891.1

IRRIGATION + Debridement of (R) Leg Fx External Fixation tibia Fx Vascular Repair

86.28 36.10 38.00

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK

ADMISSION AND CODING INFORMATION

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

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

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

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36	37 38 39 40 41 42 43 44 45

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

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

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

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

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
73 74	75 76 77 78 79 80	81 82 83 84 85 86

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

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

FOR LOCAL USE

PX
82392
88089
8911
2859

Proc
7817
8628
3800
3956

T I
1 450

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK
E9912	

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

Admission and Coding Information

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

1. Reporting MTF (b)(2)-2	2. MTF Location IZ			
3. Register Number (b)(6)-4	Name (Last, First, MI) (b)(6)-4		4. Pay Grade CIV	5. Sex M
6. DoB (YYYYMMDD)	7. Age at Admission	8. Race X	9. Ethnicity 9	Religion UNKNOWN
10. Length of Service	ETS	11. FMP 99	12. Social Security Number (b)(6)-4	
Organization (Active Duty Only)		13. Marital Status Z	Hour of Admission 08:00	Branch / Corps:
14. Flying Status	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES		16. Zip Code of Residence:	
17. Unit Location	18. MOS	19. Trauma BC	Prev. Admission NO	
20. Source of Admission Direct from ER	Ward: ICW	Name / Relationship of Emergency Addressee		
		Address of Emergency Addressee		
Name and Location of Medical Treatment Facility: (b)(2)-2		Telephone Number of Emergency Addressee		
21. Type of Disposition TRF-OTH	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2003-10-08		
24. Clinic Svc - Admitting AEA - ORTHOPEDICS	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-09-13		
27. Location of Occurrence IZ	28. MTF of Initial Admission	29. Date of Initial Admission 2003-09-13		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: RIGHT LEG GRADE 3 OPEN TIBIA FRACTURE, 2ND TO GSW RIGHT LEG

823.92 891.1

Procedure Narrative(s): IRRIGATION AND DEBRIDEMENT OF RIGHT LEG FRACTURE, EXTERNAL FIXATION TIBIA FRACTURE, VASCULAR REPAIR

86.28 36.10 38.00

Cause of Injury Narrative: TRYING TO STEAL AMMO

(b)(6)-2

Admitting Officer (Signature, as requ

Signature of Admitting Clerk

DR (b)(6)-2

Admission and Coding Information

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

1. Reporting MTF (b)(2)-2	2. MTF Location IZ			
3. Register Number (b)(6)-4	Name (b)(6)-4		4. Pay Grade CIV	5. Sex M
6. DoB (YYYYMMDD)	7. Age at Admission	8. Race X	9. Ethnicity 9	Religion UNKNOWN
10. Length of Service	ETS	11. FMP 99	12. Social Security Number (b)(6)-4	
Organization (Active Duty Only)		13. Marital Status Z	Hour of Admission 08:00	Branch / Corps:
14. Flying Status	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES		16. Zip Code of Residence:	
17. Unit Location	18. MOS	19. Trauma BC	Prev. Admission NO	
20. Source of Admission Direct from ER	Ward: ICW	Name / Relationship of Emergency Addressee Address of Emergency Addressee		
Name and Location of Medical Treatment Facility: (b)(2)-2		Telephone Number of Emergency Addressee		
21. Type of Disposition TRF-OTH	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2003-10-08		
24. Clinic Svc - Admitting AEA - ORTHOPEDICS	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-09-13		
27. Location of Occurrence IZ	28. MTF of Initial Admission	29. Date of Initial Admission 2003-09-13		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: RIGHT LEG GRADE 3 OPEN TIBIA FRACTURE, 2ND TO GSW RIGHT LEG

823.92 891.1

Procedure Narrative(s): IRRIGATION AND DEBRIDEMENT OF RIGHT LEG FRACTURE, EXTERNAL FIXATION TIBIA FRACTURE, VASCULAR REPAIR

86.28 36.10 38.00

Cause of Injury Narrative: TRYING TO STEAL AMMO

(b)(6)-2

Admitting Officer (Signature, as requir

DR (b)(6)-2

Signature of Admitting Clerk

(b)(2)-2

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

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

1. Register Nbr	2. Name					3. Grade	Admission Remarks
(b)(6)-4	(b)(6)-4					CIV	
4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm	
M		X	UNKNOWN			NO	
11. FMP	12. SSN	13. Organization				14. Ward	
99	(b)(6)-4					ICW	
15. FlyStatus	17. Dept / Ben		18. BranchCorps	19. UIC / ZIP		20. Type Case	
	K78-PRISONER OF WAR/INTER					BC	
21. Source of Admission			22. Hour Of Adm:	23. Clinic Service			
Direct from ER			00:20	ABA - GENERAL SURGERY			
24. Name/Relation of Emergency Addressee			25. Type Disp	26. Date of Disp			
			TRF-OTH	2003-09-28			
27a. Address of Emergency Addressee			27b. Telephone No	28. Date This Adm:		AdmittingOfficer:	
				2003-09-16		DR (b)(6)-2	
29. ReportingMTF				30. Date Init Adm		32. Units Blood Components	
(b)(2)-2				2003-09-16			

31. Selected Administrative Data

Marital Status: Z DoB:

In/Out Patient: Inpatient MOS:

33. Cause Of Injury: TRYING TO STEAL AMMO

34. Diagnosis / Operations and Special Procedures:

GSW LEFT BUTTOCK

877.0

IRRIGATIONA AND DEBRIDEMENT LEFT BUTTOCK

35. Total Days This Facility

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

35. Total Days This Facility

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

Signature of Attending Medical Officer

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

Signature of PAD or Medical Records Officer

(b)(6)-2 SSG, PAD NCOIC

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

20 y/o ♂ EPW SHOT 5-56 2000 STEALING AMMO.

PMH ⊖
PSH ⊖
ALL - "ALL SHOTS"
MED - ∅
HABITS - SMOKES
ROS - N/C

PHYSICAL EXAMINATION

NAD
PERRLL EOMI NANCY & OP CLEAR
CHEST CTA CVR RRR ⊖ MRG - FST
SOFT NT ⊖ NABS
EXT (L) BUTTOCK ENTRY NO EXIT
NVI DISTALLY
AN - LARGE FRAG POST TO SC

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

A - (L) BUTTOCK GSW
P - ADMIT TO OR

S	(b)(6)-2	DATE 16 SEP 03	IDENTIFICATION NO.	ORGANIZATION
PATIENT'S IDENTIFICATION *(For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)*			REGISTER NO.	WARD NO.

(b)(6)-4

(b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
16Sep03	PT arrives at 0215
Time 0221	
BP 122/57	IV right arm 0225
Pulse 109	Foley 0229
PO2 100	1g antibiotic IV 0230
Rectal Temp 99.1	.5cc Tetanus
	pos hem 0234
	(b)(6)-4 No Allergies
	PT claims problem with stomach

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

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

(b)(6)-4

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

AUTHORIZED FOR LOCAL REPRODUCTI

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
16 SEP 03	ORTHO OP NOTE
	(1) SURGEON: (b)(6)-2 , 1ST ASS. (b)(6)-2
	(2) DX: (L) BUTTOCK GSW
	(3) SVC: ORTHO ~~PA~~
	(4) INDICATION: 20 y.o. IRAQI MALE, SHOT IN (L) BUTTOCK WHILE RAIDING AMMO DUMP. 16 SEP 03. ENTRY WOUND ONLY INF/LAT (L) BUTTOCK. FRAGMENT ON X-RAY; EXTRA ARTICULAR
	(5) PROCEDURE: DEBRIDEMENT (L) BUTTOCK WOUND.
	(6) DESCRIPTION: ENTRANCE WOUND SKIN EXCISED; MINIMAL CONTAMINATION. WOUND TRACKS CEPHALAD, POSTERIOR TO JOINT. NO FRAGMENT ENCOUNTERED. NO INDICATION TO EXPLORE TO FIND.
	(7) EBL: MINIMAL. UOP 500 cc. FLUID: 1000 cc. ANESTHESIA: GEN.
	(8) COMPLICATIONS: Ø.
	(b)(6)-2 (b)(6)-2 MAJ USA

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

(b)(6)-4

EPW

(b)(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

LAST NAME | FIRST NAME

NOTES

DATE	NOTES
14 Sep 2003 1120	Nursing Post-Op: Pt received from ICU via stretcher. Pt move self from stretcher to bed. Ø c/o pain at present. Lungs CTA, pt c/o difficulty coughing & SOB. O2 Sats 98% on RA. Place pt [redacted] in high fowlers for comfort. HR 76, reg. IV to (R) AC patent. Ø edema noted. Abd soft, nontender, hypoactive BS (+). Drsg to (L) buttock CDI — ICU (b)(6)-2
16 Sep 2003 1200	Nursing: Diet: Pt lunch arrive from DFAC, Pt refuse to eat any food. Pt taking sips of water — (b)(6)-2
15 Sep 03 1850	Nursing Notes: Assumed care of Pt [illegible] regular diet Ø N/V. Pt's breathing [illegible] Labored breathing. able to move [illegible] S obstruction or complain. dr[illegible] dry clean and intact. Abd soft [illegible] W fluids infusing Ø S/S of [illegible] site. will continue to monitor [illegible] (b)(6)-2
2234	Gave Incentive Spromiter. Pt's breath [illegible] instructed Pt on use. Pt comply OK [illegible] to monitor. Vitals Stable — (b)(6)-2
0500	Total Recorded output = 3150 cc Total Recorded input = 1500 cc (b)(6)-2 [illegible]
15 Sep03	Nursing Shift note Pt bright + alert Ø signs of resp. distress. Denied pain. Tolerating po well. Hydrating by mouth. Performed ADL's C assist. Dressing clean, changed [illegible]

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

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17Sep03 (Cont.)	Nursing: Cont Physicians. Pt able to ambulate w/assist of holding other items. Void 300cc at 1500. Concentrated. ↑ PO intake. (1) edema in lower extremities. Cont. to monitor — (b)(6)-2 CPM
17Sep03 1977	Nurses Notes: Assumed care of Pt A+O x3 Breathing intact ∅ SOB or Labored breathing ∅ c/o pain this shift at this time Pt able to move legs ∃ pain or complication. Cap refill brisk in both legs able to wiggle toes and ambulate to Bath Room. Urinates Spontaneously. ∅ drainage or obvious bleeding noted on (1) buttock dressing will continue to monitor status — (b)(6)-2 IDA
0027	Pt c/o nausea. New order for Phenergan 25mg IV given. will Continue to monitor Pt status — (b)(6)-2 (b)(6)-2 Lane
18Sep2003 0950	Nursing: Assessment: Pt sleeping, easily aroused. Pt c/o pain, Tylenol given. Pt alert, lungs CTA, 2L 90% HR NSR, reg, ↓ edema noted, ↑ pulses x4 extremities. Abd soft, nontender. (1) BS x4. Pt consume small portion of reg diet for breakfast. Interpreter in to talk c̄ pt, pt was

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

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

EPW

(b)(6)-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18Sep2003 0850 (cont'd)	not eating because feared he was receiving pork. Interpreter explain to pt. that he would not receive pork, pt agreed to eat meals. ↑ OOB to latrine, Ø c/o difficulty voiding. Drsg to (L) buttock CDT ——— LST (b)(6)-2
18Sep2003 1030	Nursing: MD in, removed penrose drain & tied sutures ——— LST (b)(6)-2
18Sep03 19:17	Received care of patient @ 18:00. Pt. resting comfortably in bed. Awake and alert. Dry cough/non-productive noted x 1. Tylenol given. Dry cough subsided. VS WNL per flowsheet. Skin warm/dry/intact. PERRLA (+) WNL. EOM (+) WNL. Buccal mucosa pink/moist. Lung sounds clear to auscultate throughout (B). Heart rate reg. S1S2 WNL. Bowel sounds (+) x4 quadrants. Abdomen soft/non-tender x4 quadrants. Dressing to (L) Buttocks clean/dry/intact. (+) pedal pulses (B) (4). 5 strength. HL to (R) AC patent/intact. Small dime sized abrasion noted to forehead. Healing tissue/"scabbing". Small abrasion noted to (L) hip "scabbing" noted. c/o pain @ this time. Will continue to monitor ——— (b)(6)-2
19 Sep 03 1035	ORTHO ~~of~~ PN (S) Pt Doing well. (-) complaints (O) AF, VSS INCISION S EPITH INDURATION, CENTERL MOIST AREA S FRANK PUS OR DRAINAGE (b)(6)-2 A/P (1) UNCOMPLICATED (L) BUTTOCK (HT) (2) Cont ⊖ SUTURES 4-5 DAYS → D/C

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-600/60618

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19 Sep 2003 1340	Nursing: Pt awake, ∅ c/o pain. Alert, lungs CTA, O2 Sats 98% on RA, ∅ SOB. HR 68, reg. ∅ edema noted. HL to (R) ac, patent. Pt c/o pain to HL site, will restart HL. Abd soft, nontender, (+) BS x4. Interpreter in to assist, pt reports BM of normal stool this morning. Pt ↑ to latrines outside, voiding well. Drsg to (L) buttock CDI ——— 1LT (b)(6)-2 ANC
20 Sep 03 ~~19 Sep 03~~ 03:36	Received c/o patient @ 18:00 19 Sep 03. Pt @ 1800 A+O x3 PERRLA (+) WNL. (+) EOM WNL. Skin warm/dry/intact. Buccal mucosa pink/moist. Lungsounds clear to auscultate (B) throughout. ~~Bowels~~ Error (b)(6)-2 Heart rate regular S1S2 WNL. Bowel sounds (+) x4. Abdomen soft - non-tender x 4 quadrants. Dressing to (L) buttocks clean/dry/intact. HL to (R) fore arm, patent intact. NVV's to (L) lower extremity WNL. ∅ c/o pain @ this time or throughout shift will continue to monitor ——— (b)(6)-2 SGA
20 Sep 2003 0905	Nursing Assessment: Pt sleeping, easily aroused. ∅ c/o pain. Pt alert, lungs CTA, non-productive cough, O2 sats 98% on RA. HR 92, reg. ∅ edema to extremities, HL to [redacted] patent. Abd soft, nontender, (+) BS x4. Pt ↑ OOB, amb well. Drsg to (L) buttock CDI ——— 1LT (b)(6)-2 ANC
20 Sep 03 1900	Nursing Note: Assumed care of Pt A+O. ∅ c/o pain at this time. Breathing intact ∅ SOB or labored breathing. Dressing to Buttock clean dry and intact. Pt able to move all extremities ∃ complication. Abd soft and non tender. Pt ambulatory to BR, Voids spontaneously. IVSL flushes well, will continue to monitor status ——— (b)(6)-2 SGA

EPW (b)(6)-4

STANDARD FORM 600 (REV. 6-97) BACK

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
21 Sep 03 21/05	Ancef IV to SL. Pt c/o burning. redness around area of IV SL. New IV site started (R) AC. flushes OK — (b)(6)-2 [redacted]
21 SEP 03	ASSESSMENT - 1049 - A&O x3, PERRLA, LEWIS CARDIAC, S, S2 STRONG + REG, (+) BS x4 DRSG Ad. C.D.I. GUS & CATHETER ASST. TREATMENTS REC DIET & COMPLAIN. CONTINUES IV ANTIBIOTICS. THERAPY WILL CONTINUE TO MONITOR THROUGHOUT — (b)(6)-2 [redacted] SGT, USA
21 SEP 03	DRESS PN POD #5 S/P HD (L) BUTTOCK GSW (S) Pt DENIES WELL, & DENIES SIGNIFICANT PAIN. (O) INCISION WELL APPROX C ≈ 1" DRY DRAINAGE ON 4x4
	A/P (1) UNCOMPLICATED BUTTOCK GSW (2) CONT. DSG D'S UNTIL DRY → D/C TO MP CONTAINMENT. (b)(6)-2 [redacted] (b)(6)-2 [redacted]
21 SEP 03	
21 Sep 03 20:30	Received care of pt. @ 1800. Pt. A+O x3. Consumed 100% of dinner. PERRLA (+) WNL EOM (+) WNL. Skin warm/dry/intact. Buccal mucosa pink/moist. Lung sounds clear to auscultate (B) throughout. Bowel sounds (+) x4 quadrants. Abdomen soft/nontender x4 quadrants. (+) Radial pulses (B) (+)2 strength. Dressing to (L) Buttocks intact c̄ scant amt. serous drainage noted. H/L to (R) AC patent/intact. & c/o pain

STANDARD FORM 600 (REV. 6-97) BACK

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
21 Sep 03 20:30	will continue to monitor — [redacted]
22 Sep 03	ORTHO PN: (5) SIP GSW (L) BUTTOCK, DENIES SIGNIFICANT PAIN (0) AF, VSS CONTINUED DRAINAGE FROM BUTTOCK WOUND (A/P) (1) CONTINUED CENTRAL INCISIONAL DRAINAGE (2) TO OR TOMORROW FOR I+D, CLOSURE [redacted]
23 Sep 03	ORTHO OP NOTE SURGEON: [redacted] ASSIST NONE SVC: ORTHO DX: GSW (L) BUTTOCK 16 Sep 03 PROCEDURE: I+D (L) BUTTOCK INDICATION: CONTINUED DRAINAGE (L) BUTTOCK FINDINGS: MODERATE NECROTIC MATERIAL → DEBRIDED / IRRIGATED DRAINS: WOUND PACKED C̄ VERSUS FLUID: 300CC FEBL 200CC COND: STABLE TO RR, COMPLICATION: NONE

[redacted] NDARD FORM 600 (REV. 6-97) BACK

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

MEDCOM - 7418

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
0950 23 Sep 2003	Nursing: Pt received from ICU post-op. Pt drowsy, pain is tolerable. Lungs CTA, O2 sats 98% on RA. HR 60, reg, ∅ edema. IV NS @ ~~200~~ 100 cc/hr to (R) fa. Abd soft, nontender, (+) BS x4. Pt DTV by 1500. Drsg to (L) buttock CDI. ——— LT (b)(6)-2 AN
23 Sep 2003 1215	Nursing: Pt tolerated reg diet for lunch, will ↑ PO void. ——— LT (b)(6)-2 AN
23 Sep 2003 1510	Nursing: Pt void 275 cc clr, amber urine. HL IV. ——— LT (b)(6)-2 AN
23 Sep 03 19:21	Received care of pt. @ 18:00. Pt. awake/alert in bed. PERRLA (+) iris (+) conjunc. Buccal mucosa pink/moist. Skin warm/dry/intact. Lung sounds clear to auscultate (B) throughout. HR regular S1S2 present. Bowel sounds (+) x4 quadrants. Abdomen soft/nontender x4 quadrants. Radial pulses (+) 2 strength (3). Dressing to (L) buttocks intact c̄ scant amount bloody drainage noted & c/o pain @ this time will continue to monitor (b)(6)-2 [illegible]
24 Sep 2003 1320	Nursing: Pt awake & alert, ∅ c/o pain. Lungs CTA, ∅ SOB O2 sats 98% on RA. HR 80, reg. ∅ edema, new IV site to (R) fa of 18g catheter, patent. Abd soft, nontender, (+) BS x4. Pt reports to interpreter last BM 23 Sep of normal stool. Pt voiding well. ↑ OOB amb to bathroom s̄ assist. Drsg to (L) buttock c̄ lrg area shadowing of serous & bloody drainage across 2 4x4s. Area circled. ——— LT (b)(6)-2 AN

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
29 Sep 03	(S) Pt Doing well.
	(O) AFVSS
	Dressing CDI
	(A/P)
	(1) GSW (L) Buttock
	(2) To OR tomorrow for
	D/C Packing, Delayed Closure
	(b)(6)-2 (b)(6)-2
24 Sep 03 1815	Nurses Notes: Assumed care of Pt A&O sitting up in bed breathing intact & SOB or Labored breathing. Vitals Stable dressing to (L) buttock clean dry and intact. Pt able to move all extremities without complication. Marked area on dressing & New drainage or bleeding noted. Abd soft and non tender. Pt ambulate to Rest room Voids Spontaneously IV S.L flushes well. will continue to monitor Status (b)(6)-2
25 Sep 03 1915	Nurses Notes: Assumed care of Pt A&O c/o pain or discomfort, breathing intact & SOB or Labored breathing. dressing to (L) buttocks clean and intact with noticed small area of bleeding or leade. will continue to monitor for ↑ flow IV SL flushes well. Pt ambulate to Rest Room without Complain assist x 2 nurses (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
25 SEP 03	OPTAO OP NOTE
	SURGEON: (b)(6)-2 ASSIST: Ø
	DX: (L) BUTTOCK GSW
	PROCEDURE: (L) BUTTOCK I&D
	FINDINGS: CLEAN WOUND, NO NECROTIC MATERIAL. CLOSED IN LAYERS.
	EBL: 15 cc
	FLUID: 500 NS
	COMPLICATION: NON
	CONDITION: STABLE TO RR.
	(b)(6)-2 (b)(6)-2
25Sep03 1738	Post-OP/Nursing: Pt. received from recovery team able to transfer self to bed. Alert, Ø c/o pain. Dressing DRY. VSS, using IS, tolerating po intake. Voiding w/o difficulty. Cont to assist (b)(6)-2
25Sep03 2210	Pt. complained of pain to (L) buttocks. 1 Percocet given. Will reevaluate Pt 1° for effectiveness (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
26 Sep 2003 0825	Nursing: Pt awake, ∅ c/o pain. Lungs CTA, O2 sats 99% on RA. HR 108, reg. ∅ edema noted. HL to (R) fa patent. Abd soft, nontender, (+) BS x4. ∅ N/V. Pt ↑ OOB c̄ crutches to latrines to void. Drsg to (L) buttock c̄ quarter size area of sero-sang drainage. Drsg intact. ——— LT (b)(6)-2
26 Sep 2003 1020	Nursing. Pt c/o pain to IV site. D/C HL to (L) fa. Start 18g cath to (R) fa, flush well. ——— LT (b)(6)-2
26 Sep 03 20:30	Received care of pt @ 1800. Pt. A+Ox3. PERRLA DWN. (E) Conjunct. Buccal mucosa pink/moist. Skin warm dry intact. Lung sounds clear to auscultate (B) throughout. HR regular S1S2 present. Bowel sounds (+) x4 quadrants. Abdomen soft/non-tender x 4 quadrants. Dressing to (L) Buttocks intact c̄ scant ~~amount~~ error (b)(6)-2 amount bloody drainage noted from 3 days ago/unchanged. drainage exceeding (b)(6)-2 border drawn. (+) NV ✓'s (B). HL to (R) forearm patent. New HL/IV initiated. no complaint @ this time will continue to monitor (b)(6)-2
2045.	Pt complained of itching to (L) buttocks. 50mg Benadryl IV given c̄ (+) results will continue to monitor ——— (b)(6)-2
27 Sep 2003 1355	Nursing: Pt awake, ∅ c/o pain. Pt alert & oriented. Lungs CTA, O2 sats 98% on RA, ∅ SOB. HR 80, reg, ∅ edema noted. HL to (R) ac. patent. ±2 pulses x4. Abd soft, flat, nontender (+) BS x4. Pt reports voiding well through interpreter. Pt ↑ OOB, amb c̄ crutch assistance. Drsg to (R) flank. A'd, old drsg c̄ small amt dried serous drainage. Drsg to (L) buttock c̄ small amt bloody drainage. Sutures in tact. New 4x4 applied ——— LT (b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
27Sep03 21:29	Received care of pt @ 1800. A+O x3. Restraints x2 (R) wrist/ankle. PERRLA (+) EOMI. Buccal mucosa pink/moist. Lung sounds clear to auscultate (B) throughout. Bowel sounds (+) x4 quadrants. Abdomen soft/non-tender x4 quadrants. (+) Radial pulses (B) (+) 2 strength. Dressing to (L) buttocks intact c scant amount old bloody drainage noted. c/o complaint of pain @ this time will continue to monitor — (b)(6)-2
28Sep03 0530	Nursing: Shift note Pt. c/o not sleepy. Given benadryl as ordered. Slept throughout the night — (b)(6)-2
28Sep2003 0930	Nursing: Pt awake, ∅ c/o pain. Alert, gesturing when will he leave here. Lungs CTA, O2 sats 98% on RA, ∅ SOB. HR 76, reg. ∅ edema noted. HL to (R) ac, patent. Abd soft, nontender, (+) BS x4. Pt ↑ OOB to BR c crutches. Amb. well. Drsg to (R) flank D/I. Old drsg c pen tip size of serous drainage. Drsg to (L) buttock: old drsg c scant serous drainage. Stitches intact ∅ active drainage noted. Wound well approximated, ∅ S/S infection present. 2x2 applied to site. — (b)(6)-2
28Sep03 1601	Received care of pt @ 1400. Pt resting in bed comfortably. Awake/alert x3. Ambulating to BR. Restraints x2 (R) wrist (R) ankle. Awaiting MP to take to detention center. Will continue to monitor — (b)(6)-2

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28 Sep 03 0011	Nurses Notes: Assumed care of Pt AAO2 c/o itching at site. Benadryl given PO breathing intact Ø SOB or labored breathing. Denies pain at this time dressing clean dry and intact Ø drainage bleeding. Pt ambulates to rest room Ø complication. Will continue to monitor status. (b)(6)-2
29 Sep 03 2400	Nurses Notes: Assumed care of Pt AAO X3 breathing intact Ø SOB or labored breathing Ø c/o pain or itching at this time. Pt moves all extremities OK. Vitals stable Ø S/S of distress. Will continue to monitor status (b)(6)-2
30 Sep 03 0115	Nursing: MPs in to return RPW to prison. Narrative Summary, & x-ray, & Pt clothes given to MP (b)(6)-2

(b)(6)-4

STANDARD FORM 600 (REV. 6-97) BACK

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
29 SEP 03	ORTHO NARRATIVE SUMMARY
	DOA: 16 SEP 03 DOD: 28 SEP 03
	Dx: LEFT BUTTOCK GUNSHOT WOUND.
	PROCEDURES: I+D (L) BUTTOCK 16 SEP 03; REPEAT I+D, DPC (L) BUTTOCK 23 SEP 03.
	HOSP COURSE: N/V INTACT (L) BUTTOCK GSW. I+D 16 SEP 03, SUPRA RETAINED FRAGMENT, EXTRA ARTICULAR INITIAL DPC 19 SEP 03 CONTINUED DRAINAGE, REPEAT I+D 23 SEP 03. WOUND DRT & SUTURES IN PLACE @ TIME OF D/C 28 SEP 03
	CONDITION: STABLE
	COMPLICATIONS: NONE
	DISPOSITION: D/C TO MP CUSTODY. DETENTION MED PERSONNEL REMOVE SUTURES IN 5-7 DAYS.
	MEDS: NONE

(b)(6)-2

(b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERV	ED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

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

REGISTER NO.	WARD NO.

(b)(6)-4

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

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp) (b)(2)-2

LOG NUMBER

ARRIVAL — DATE: DAY 16, MONTH Sep, YR. 03 — TIME: 0219

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

CURRENT MEDICATION (Include immunization or other): Nt Leprox

HISTORY OBTAINED FROM: ☒ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

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

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

CHIEF COMPLAINT(S) (Include symptom(s), duration): GSW to left buttock

SEX: M AGE: 20

POSSIBLE THIRD PARTY PAYER: ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 0215

VITAL SIGNS

TIME	0220		
BP	122/57		
PULSE	107		
RESP.	30		
TEMP.	99.1		
O2 SAT. (Circle)	99.8		

CATEGORY (See reverse)

- [X] EMERGENT
- [ ] URGENT
- [ ] NON-URGENT

ORDERS	INITS.	TIME
An of 1g 0220 MSO4 10 MCG	(b)(6)-2	0220
Fentanyl 0220 IV LR		0220
Fem Stick		0220
xray 0309 Foley		0230
X ray		0230
O2		0220

ASSESSMENT/DIAGNOSIS: GSW @ L buttox

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)

Pt was shaky. Vs fine in Tikrit AXP

S - 20 y/o ♂ c̄ gsw @ L butt Pt walked was steady Ambu

AXO times 3. PT denies pain. ⊖ radiation. Nothing done to relieve pain. Dressing applied in field.

O - VSS. HEmocult ⊕

FAST ⊖

distal pulse ⊕ c̄ doppler

Heent - clear

neck - WNL

Chest - LS CTA = ⊕ RRR

ABD - ⊕ BS x 4 q ⊖ TLD

pelvis - stable stable / abrasion on hip

ext - WNL

back - GSW @ L buttox

mino bleeding - entry wound, ⊖ exit wound found

PHMX ⊘

PSHX L ARM

FMHX ⊘

Tabbo yes

ETOH ⊘

LOI 2300 Last meal

TOI 2400

16.2 | 16.8 | 281 | 50.4

132 | 104 | 9 | .7 | 113 | 3.9 | 24

Urine - Bld - Neg
Prot - Neg
SG 1.026

XRay: L hip medial fragment

DISPOSITION (Check all that apply)

- [ ] HOME
- [ ] FULL DUTY
- QUARTERS: [ ] 24 Hrs. [ ] 48 Hrs. [ ] 72 Hrs.
- MODIFIED DUTY UNTIL: DAY / MONTH / YEAR
- REFERRED TO (Indicate clinic): ortho
- [ ] EMERGENCY [ ] TODAY
- [ ] 72 HOURS [ ] ROUTINE
- ADMIT. TO HOSP. UNIT/SERVICE: ICW → OR

CONDITION UPON RELEASE

- [X] IMPROVED
- [ ] UNCHANGED
- [ ] DETERIORATED

TIME OF RELEASE: 0330

(CONTINUE ON SF 507, IF NEEDED)

(b)(6)-2

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

(b)(6)-4

SIGNATURE OF PROVIDER AND ID STAMP: (b)(6)-2 SPC 91B

TREATMENT (Include medications and plans)

To ICW then OR.

EMERGENCY CARE AND TREATMENT
Medical Record Copy

STANDARD FORM 558 (Rev.
Prescribed by GSA and ICMR

510-112 NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
11 Sep 03	0413		Received care of pt @ 0400. Pt. transferred from EMT via litter. able to transfer self from litter to bed w/ difficulty. Awake and alert. ⊕ PERRLA ⊕ EOM WNL. Skin warm/dry/intact. Buccal mucosa dry, lips chapped. Moist membranes. Lung sounds clear to auscultation throughout ⓑ. Heart Rate regular S1S2. Bowel sounds ⊕ x 4 quadrants. Abdomen soft/∅ tender. Dressing to (R) Buttock clean/dry/intact. Dressing to (L) hip clean/dry/intact c̄ op-site over it. ⊕ Radial pulses ⓑ. ⊕ 2 strength ⊕ NV ✓5 to (L) leg/foot. PIV ⊕ (R) AC infusing LR @ 75cc/hr. ∅ c/o pain @ this time. Will continue to monitor. (b)(6)-2 VS WNL per flow sheet. (b)(6)-2
Addendum 11 SEP 2003	0755		Nursing Assessment: Pt sleeping, easily aroused. ∅ c/o pain. Pt alert. Lung CTA, O2 sats 99% on RA. HR 84, reg. ∅ edema noted. IV to (R) ac c̄ LR @ 75. Abd soft, nontender, ⊕ BS x 4. Pt NPO/On-call to OR. Drsg to (L) buttock c̄ 12in diameter area bloody drainage. Area marked & timed. —LT (b)(6)-2

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility) (b)(6)-4

REGISTER NO.

WARD NO.

NURSING NOTES
Medical Record

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

MEDICAL RECORD — **INTRAOPERATI[illegible] CUMENT**

For use of this form, see AR 40-66, the propon[illegible]cy is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA litter BY Staff - OR
2. PATIENT VERIFIED BY (b)(6)-2 [illegible]VED AND PROCEDURE CCP, [illegible]
3. DATE 16 Sept 03 TIME PATIENT ARRIVED IN SUITE
4. PATIENT TIME 0820 NUMBER 1-1 #2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT (b)(6)-2	RELIEF CIRCULATOR	SFC (b)(6)-2 66E

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

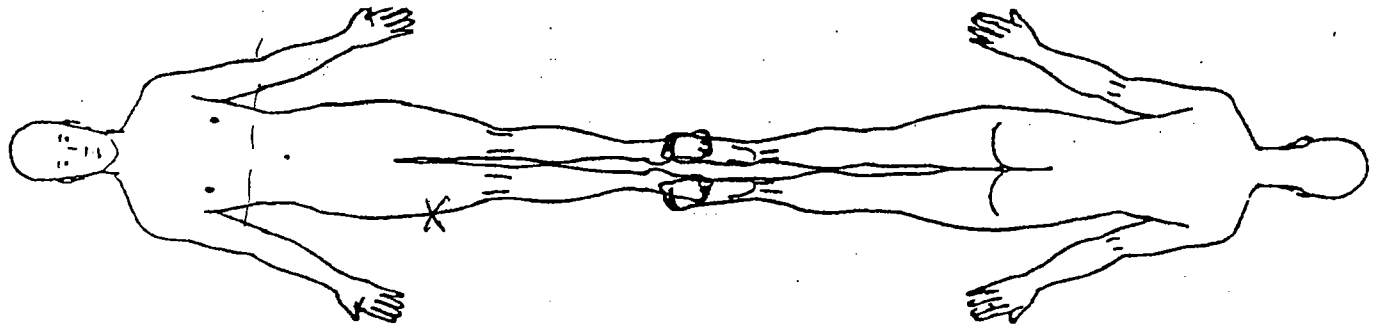
COMMENTS: Bean bag Pillow - bye Ax pad (R)

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine / Betadine
SITE (L) Buttocks BY WHOM: (b)(6)-2
SITE: BY WHOM:
COMMENTS: Ø poolg ability

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

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

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

(b)(6)-4

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

☑ ESU NO: 1-1 30/30
GROUND PAD: BRAND Valleylab
LOT NO: 69263 2005-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

Equipment site Clean Post op

13. PROSTHESIS, IMPLANTS ☐ ☑ 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
Ø		

(b)(6)-2

(b)(6)-2

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM IF YES, SITE

YES ☐ NO ☑

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

TYPE/SIZE	1. 16 Fr Foley	2. 18 Penrose	3.
SITE	1. Medial	2. Buttocks	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs 4x8
Cover All

19. ADDITIONAL INFORMATION

Foley from EMT clear yellow draining

20. OPERATION(S) PERFORMED

Debridement left Buttocks

21. PATIENT TRANSFERRED TO ICU TIME 0940 METHOD

22. REGISTERED NURSE SIGNATURE (b)(6)-2 RN, BSN

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

MEDICAL RECORD — **INTRAOPERATI[illegible] [illegible]CUMENT**

For use of this form, see AR 40-66, the propon[illegible] [illegible]s the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATIN[illegible] VIA litter BY CPT (b)(6)-2 CRNA

2. PATIENT IDENTIFIED, R[illegible] REVIEWED AND PROCEDURE VERIFIED BY (b)(6)-2 MAJ, AN

3. DATE 23SEP 03 TIME PATIENT ~~ARRIVED IN SUITE~~ 0808

4. PATIENT ~~IN ROOM~~ TIME 0808 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Alert.

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG (b)(6)-2 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ (b)(6)-2 AN/66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* Axillary Roll under right axilla, Bean bag deflated to maintain position. (B) arms extended in front of body. Rt dependent arm resting on padded armboard. Lt arm resting on top of pillow.

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

COMMENTS: Arms secured with safety strap to board. Rt dependent leg flexed resting on egg-crate. Lt leg straight resting on pillow. Genitals free from pressure.

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

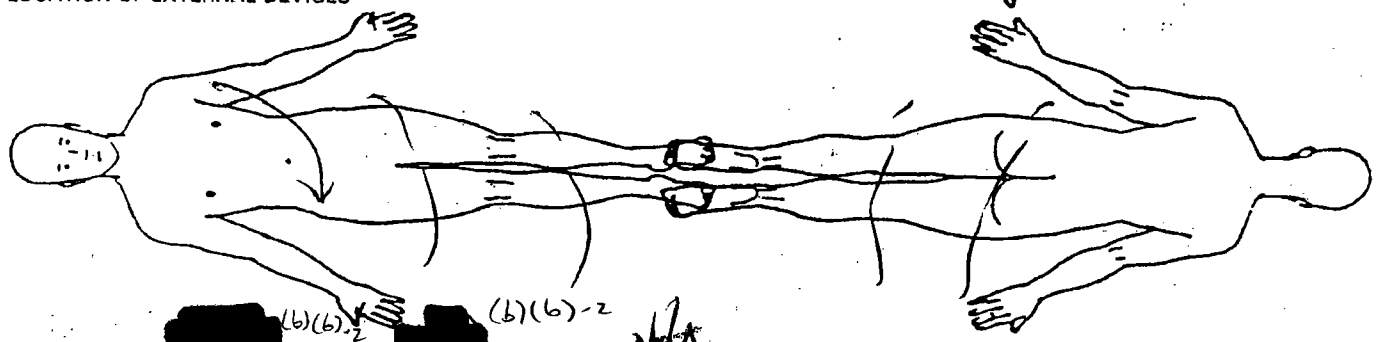
PREP SOLUTION *(Specify)* ~~Betadine~~ Betadine

SITE: Lt buttocks BY WHOM (b)(6)-2

SITE: region BY WHOM:

COMMENTS: No pooling noted. Chux used.

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad [redacted] (b)(6)-2 – Safety Strap [redacted] (b)(6)-2 = = = Tourniquet N/A

10. COUNTS C = Correct I = Incorrect Init by: (b)(6)-2 (b)(6)-2

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

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

(b)(6)-4

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

☒ ESU NO: 000442 VL FORCETT

GROUND PAD: BRAND VL Polyhesive

LOT NO: Not used

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

13. PROSTHESIS, IMPLANTS ☐ ☒ NO IF YES NAME: ID NUM ANUFACTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

(b)(6)-2

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. fluffs	2.	3.
SITE	1. Lt buttocks wound	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs
ABD Pad
Coverall

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

20. OPERATION(S) PERFORMED
D+I, Lt buttocks wound.

21. PATIENT TRANSFERRED TO ICU TIME 0855 METHOD litter

22. REGISTERED NURSE SIGNATURE (b)(6)-2 MAJ, AN

REVERSE OF DA FORM 5173-1, OCT 87 USAPA V1.01

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 Ambulatory BY Staff
2. PATIENT IDENTIFIED VERIFIED BY (b)(6)-2 PROCEDURE R
3. DATE 25 Sept 03 TIME PATIENT ARRIVED IN SUITE
4. PATIENT IN ROOM TIME 0800 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT (b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

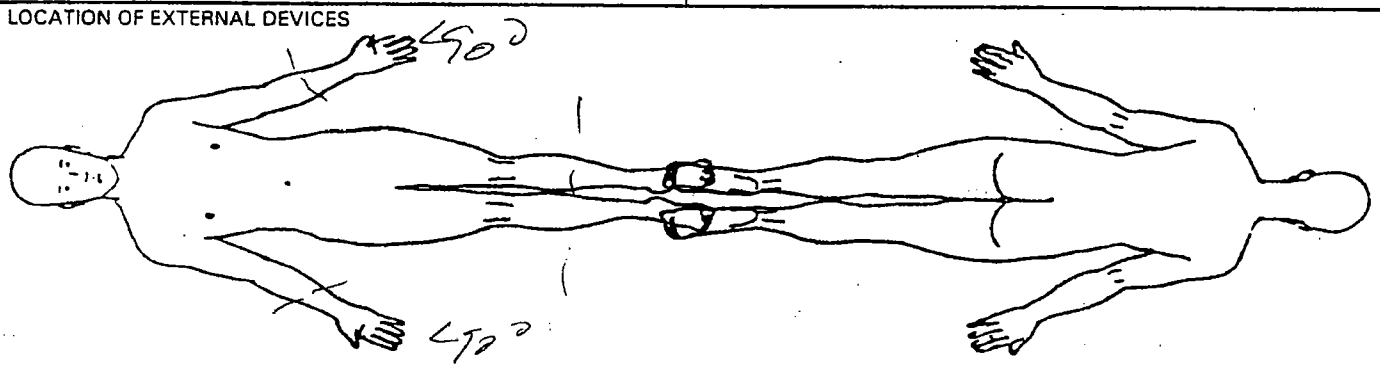
COMMENTS: Gen Sag Axroll (R), Pillow (L) arm between Lgs.

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* [redacted] (b)(6)-2
SITE: (L) Buttocks BY WHOM: CLAG
SITE: BY WHOM:
COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

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

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

(b)(6)-4

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

☑ ESU NO: V 1-1 30/20
GROUND PAD: BRAND Valleylab
LOT NO: 69263

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

Pad site clean prep-off

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

13. PROSTHESIS, IMPLANTS ☐ NO IF YES NAME: ID NUMB NUFACTURER

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

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☑

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

18. DRESSING/IMMOBILIZATION *(Specify)*

fluffs
Abd
Gauzeall

19. ADDITIONAL INFORMATION

20. OPERATION(S) PERFORMED

I & D (L) Buttocks GSW c closure

21. PATIENT TRANSFERRED TO ICU TIME 0955 METHOD

22. REGISTERED NURSE SIGNATURE (b)(6)-2

REVERSE OF DA FORM 5179-1, OCT 87

MEDCOM - 7433

USAPA V1.01

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM _____ HOURS
TO _____ HOURS

TOTAL HOURS COVERED

DATE 16 Sep 2003

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0600	NPO		Ø
1200	reg diet/pt refuse		Ø

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0L	500	LR	500	1330	500
1330	500	LR	500	1915	1000
1915	500	LR	500	0311	1500
0311	500	LR	500		

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

OUTPUT

URINE

	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
Foley	0900	400	400			
	1340	550	950			
	2100	1200	2150			
VN	2330	1000	3150			
	[illegible]	500	500			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL
GRAND TOTAL OUTPUT			

REMARKS

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

(b)(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 792, JAN 74

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

USAPPC V1.00

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY		1				2						3			4				5			6	
POST- DAY		POD				1						2			3								
MONTH-YEAR	DAY	16				16						19			17				20			21	
19	HOUR	0	0			3		12				0			8				0			0	
PULSE (O)	TEMP. F (•)	99				99		99				98			98				99			98	
	105°																						
180	104°																						
170	103°																						
160	102°																						
150	101°																						
140	100°																						
130	99°																						
	98.6°																						
120	98°																						
110	97°																						
100	96°																						
90	95°																						
80																							
70																							
60																							
50																							
40																							

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)

ESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

(b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY	7	8	9	10	11			
POST- DAY	6							
MONTH-YEAR Sep								
DAY	22	23	24	25	26	27	28	
19/2003 HOUR								

PULSE (O) — TEMP. F (°) — TEMP. C

105° — 40.6°
180 — 104° — 40.0°
170 — 103° — 39.4°
160 — 102° — 38.9°
150 — 101° — 38.3°
140 — 100° — 37.8°
130 — 99° 98.6° — 37.2° 37.0°
120 — 98° — 36.7°
110 — 97° — 36.1°
100 — 96° — 35.6°
90 — 95° — 35.0°
80
70
60
50
40

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

SpO2

Record special data only when so ordered

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

(b)(6)-4

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY		121													
POST-	DAY														
MONTH-YEAR	DAY	29		30											
19	HOUR	0		0											
PULSE (0)	TEMP. F (°)	6		6											
	105°	8		8											
180	104°														
170	103°														
160	102°														
150	101°														
140	100°														
130	99°														
	98.6°														
120	98°														
110	97°														
100	96°														
90	95°														
80															
70															
60															
50															
40															

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)

ESPIRATION RECORD		16													
Record special data only when so ordered	BLOOD PRESSURE	116/56		86/48											
	HEIGHT: WEIGHT →														
	Spo2	98		98											

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

(b)(6)-4

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

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

Ward/Section: EMT

Requesting Physican: (b)(6)-2

LABORATORY RESULT FORM

(ect to the Privacy Act of 1974)

Name: (b)(6)-4

Date: 16 SEP 03

Time:

Patient #

Chemistry 7

Test	Result	Ref. Range
GLU	113	73 - 118 mg/dL
BUN	9	7 - 22 mg/dL
Creat	0.7	0.6 - 1.2 mg/dL
Na	132	128 - 125 mmol/L
K	3.9	3.3 - 4.7 mmol/L
Cl	104	98 - 108 mmol/L
tCO2	24	18 - 33 mmol/L

Chemistry 12/LFT

ALB		3.5 - 5.5 g/dL
ALP		26 - 84 µg/dL
ALT		10 - 47 µg/dL
AMY		14 - 97 µg/dL
AST		11 - 38 µg/dL
Tbili		0.2 - 1.6 mg/dL
TP		6.4 - 8.1 g/dL
Ca		8.0 - 10.3 mg/dL
Chol		100 - 200 mg/dL
Creat		0.6 - 1.2 mg/dL
BUN		7 - 22 mg/dL
GLU		73 - 118 mg/dL

Other Chem

Troponin		Negative
GLU Only		73 - 118 mg/dL
CK		39 - 380 µg/L - Male
		30 - 190 µg/L - Female

Urinalysis

Test	Result	Ref.Range
Color	Yellow	N/A
App	Clear	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	neg	Negative
SGav.	1.020	N/A
Bld	neg	Negative
pH	5.0	N/A
Prot	neg	Negative
Urob	Norm	0.2 - 1.0
Nit	neg	Negative
Leuk	neg	Negative
Micro UA		

Blood Gas

ph	7.412	7.31 - 7.45
PCO2	41.5	35 - 45: Art
PO2	228	80 - 105
HCO3	26	22 - 26
TCO2	28	23 - 27
BE	2	(-2) - 3
sO2	100	95 - 100%

Hematology(CBC)

Test	Result	Ref. Range
WBC	16.2	4.8 - 10.8 x 1E3
RBC	5.39	4.7 - 6.1 x 1E6
Hgb	16.8	14 - 18 g/dL (M); 12-16 (F
Hct	50.4	45 - 52% (M); 37 - 47% (F
MCV	93.4	80 - 99 fL
Plt	281	130 - 500 1E3
Lymph%	14.2	20.5 - 51.1 %

Hematology Manual Diff

Segs	Lymph
Bands	Atyp
Mono	Imm
Eos	RBC Morph
Baso	Plt. Est

Coagulation

PT		9.8 - 13.6 sec
aPTT		21 - 34 sec
INR		N/A

MISC

Malaria		Negative
Gram Stain		N/A
UA Tox:		Negative
HCG		Negative

Additional Instructions:

(b)(6)-2

Date: 16 Sept 03

Lab ID #: (b)(6)-2

Ward/Section: Requesting Physician:

LAST FIRST MI | DATE | TIME

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

SSN/PSEUDO SSN:

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%
BaseE		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
iCa		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

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

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
tCO2		18-33 mmol/l

LIVER PANEL

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

MISC.

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

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.:

ASA II (b)(6)-2
NKDA

MEDICAL RECORD - ANESTHESIA

For use o[illegible] form, see AR 40-66; the proponent agency is t[illegible] SG

CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "/" = CONSTANT INFUSION																	
DRUGS	(Units)																
Midazolam	(mg)	2															
Fentanyl	(mcg)	100		50													
Propofol	(mg)	150															
Succ / Zem	(mg)	100 /	40	10													
Neostigmine/glycopyrrolate	(mg)					5/0.8											
	( )																
VOLATILE AGENT	150 % del		1.0	0.4	0.8	.6 X											
	% e.t.																
AIR	L/Min																
N2O	L/Min																
O2	L/Min	8	2	2	2	2	4	8									
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS																	
FLUIDS LINE	LR (cc) 20g PIV (R) Warmed					800		1000									
	Warmed																
Ancef 1gm 4cc IVPB	Warmed	✓		X													
	Warmed																
LOSSES	EST BLOOD LOSS																
	URINE -					300											

TOTALS	TOTAL EBL
2mg	Min cc
150mcg	
150mg	TOTAL URINE
100 /	
5/0.8	300 cc

FLUIDS SUMMARY
CRYSTALLOID- LR = 1000cc
COLLOID-
BLOOD- X

PHYSIOLOGIC MONITORING

1 2 3 4 5 E

BODY WEIGHT: ~65 KG LB

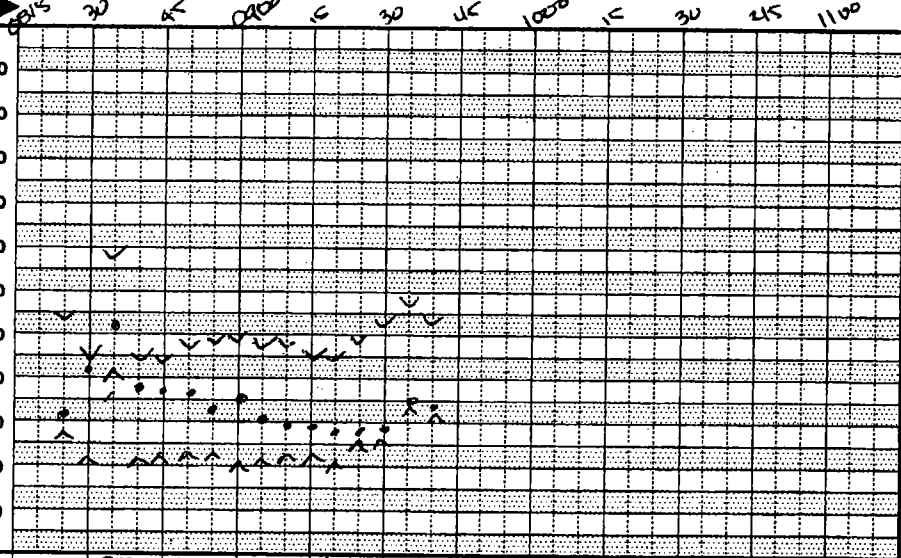
HEMATOCRIT: 50.4

INITIAL DATA: BP- 109/55 HR- 62

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? Y/N TIME- 0800

SYMBOLS: BP by cuff V (L arm Reg Adult) ∧; Heart rate ●; Resp rate ✓; BR (transduced) ✚; TOURNIQUET T—T; ANES- X-X; PROC- ⊙-⊙



VENTILATION							
I:E = 1:2	VT - ml	–	800	770	820	800	300
	f - breaths/min	18	10	8	8	6	14 11
	Peak inf pres / PEEP		22	21	22	20	–
	MODE - S(pon), A(ssist), C(on)	S	C	C	C	C	S
✓ BP/Auto Cuff	✓ ET CO2 (torr)	⊕	34	28	30	35	40
BP/oth	✓ FIO2 (Frac or %)	.85	.85	.85	.85	.85	.85 RA
ART line	✓ SpO2 (%)	100	100	100	100	100	100 99
Steth- PC/ES	✓ ECG	SR	SR	SR	SR	SR	SR
Gas analyzer	✓ TEMP-site (Axil)						
	✓ N-M Block (T/4)	4/4	0/1	4/4	1/4	4/4	4/4 55
Warming blkt		✓	✓				
Cover warmer							

Mark with letters & symbols, explain under REMARKS

EVENTS Position → @arm secured <90° on padded armboard. @arm secured over pillow across @arm. Supine → RLD c beanbag. →

REMARKS

Code drugs with numbers, events with letters

0745 → IProp complete via chart et interpretation Plan GETA. 20g IV patent RAC. ⊕ ID. NPO confirmed.

0820 In OR 1-1 via lifter. Positions self on bed PreO2. IV induction. RSI. Cricoid pressure. Eyes taped shut. See airway note below.

0830 Position to RLD & beanbag. Axillary roll in place. Ext pressure pts Vel/padded

0938 Resp even/reg. To supine position. IV 300. Airway reflexes intact. Oral suction. Extubated. Spont resp resume.

0940 To PACU. Report to SGT [redacted] VSS. Pt stable. (b)(6)-2

RECOVERY AT 0940

PACU ICU _____ (Specify)

OTHER T = 96.6

CONDITION: Stable

RESP. 11 SpO2 99% RA

BP. 104/66 HR 67

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0740	0820	0950
	Ready	Begin	End
PROC	0828	0858	0955

PROCEDURES and CPT Codes:
Debridement + Irrig (L) buttock (GSW) wound.

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

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA.

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
PreO2. DLX1 c MAC 3 grade I view VC, 8.0 OETT passes easily et secured @23cm @teeth @stylet @sustained ETCO2 @BBS= @soft bite block.

SURGEONS: (b)(6)-2 / (b)(6)-2

ANESTHETISTS: (b)(6)-2 CRNA

PROCEDURE LOCATION: OR 1-1

DATE: 16 SEP 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 MEDCOM - 7441 COPY 1 - PATIENT'S MEDICAL RECORD USAPA V1.00

ASA II

25mcg Fentanyl wasted

MEDICAL RECORD - ANESTHESIA

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

CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION																		
DRUG	(Units)																	
Midazolam	(mg)	2																
Fentanyl	(mg)	100	50	50		25											225	
Propofol	(mg)	150																
Succ	(mg)	100																
	( )																	
	( )																	
MONITOR SETTINGS 150	% del		1.8	1.5		X												
	% e.t.																	
AIR	L/Min		1 —	1 —		X												
N2O	L/Min																	
O2	L/Min	B	1 —	1 —		B												

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

FLUIDS																
LINE site LR(ec) (b)(6)-2	☐ Warmed				300											
	☐ Warmed															
	☐ Warmed															
	☐ Warmed															
LOSS	EST BLOOD LOSS															
	URINE -															

TOTALS	TOTAL EBL
2mg	Min
100mg	TOTAL URINE
150mg	Ø
100mg	
X	

FLUIDS - SUMMARY

CRYSTALLOID- LR 300cc

COLLOID-

BLOOD- X

PATIENT CHARACTERISTICS

1 2 3 4 5 E

BODY WEIGHT: N 65 KG LB

HEMATOCRIT: N/A

INITIAL DATA: BP- 117/57 HR- 76

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE (b)(6)-2 TIME-

TIME → 0800 15 30 45 0900 15 30 45 1000 15 30 45

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

220 200 180 160 140 120 100 80 60 40 20

VENTIL							
VT - ml		720		2200	1400		
f - breaths/min		18	10	12	13	12	11
Peak inf pres / PEEP		16	—	—			
MODE - S(pon), A(ssist), C(on)		S	C	S	S	S	S
MONITORS/ACCESSORIES							
BP/Auto Cuff	ET CO2 (torr)	(E)	36	52	56		
BP/oth	FIO2 (Frac or %)	.88	.62	.62	.88	7.21	
ART line	SpO2 (%)	100	100	100	100	100	
Stath- PC/ES	ECG	SR	SR	SR	SR	SR	
O2 Gas analyzer	TEMP-site Axia						
	N-M Block (T/4)	4/0/4		4/4			
Warming blkt		✓					
Cooy warmer							

Mark with letters & symbols, explain under REMARKS

EVENTS / Position → Max Roll in place. Arms secured on pillow b/l arms. Cannulated OK+RLD — OK

REMARKS

Code drugs with numbers, events with letters

0750 Procep complete. Received Ancef @ 0800. USS. Plan GETA. RAC IV patent

0808 In OR 1-1 via W'lter. Monitors on. Pre O2 IV induction Eyes taped see Airway note below.

0825 RLD by 4. (b)(6)-2

0856 - Resp even and reg. TV >400 opens eyes. Oral Sxn. Extubated c̄ @ pressure breath. Spont resp resume

0900 to ICU for recovery, USS. Report to MAJ (b)(6)-2 RN

RECOVERY AT 0900

PACU ICU ____ (Specify)

OTHER T=97.3

CONDITION: Stable.

RESP- 11 SpO2- 100% @ 6L

BP- 113/69 HR-69

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0730	0808	0910
	Ready	Begin	End
PROC	0815	0833	0840

PROCEDURES and CPT Codes: Debridement + Irrig (L) buttock wound

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

GETA.

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

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

DL x1 c̄ MAC 3 Grade I view VC 8.0 OETT c̄ stylet passes easy ETCO2 @ 23cm @ teeth @ sust. ETCO2 @ B/BS: @ B/L

SURGEONS: (b)(6)-2

ANESTHETISTS: (b)(6)-2 CPT/CRNA

PROCEDURE LOCATION: OR 1-1

DATE: 23 SEP 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 MEDCOM - 7442 COPY 1 - PATIENT'S MEDICAL RECORD USAPA V1.00

ASA II → tols.
NKDA

wanted 50 mg Fentanyl (b)(6)-2

MEDICAL RECORD - ANESTHESIA

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

CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "/" = CONSTANT INFUSION																	
DRUG	(Units)																
Midazolam	(mg)	2															
fentanyl	(mg)	100	50	25 25													
Propofol	(mg)	160	40														
Succ	(mg)	100															
	( )																
	( )																
VOLATILE AGENT	Sevo % del	1.5	2.0	1.8	Ø												
	% e.t.																
AIR	L/Min																
N20	L/Min																
O2	L/Min	B-2-	2—	2	—B-												
SINGLE DOSE DRUGS MARK ON GRID WITH NUMBERS & ENTER IN REMARKS																	
FLUIDS LINE site NS(cc) 18gLA	☐ Warmed			450	500												
	☐ Warmed																
	☐ Warmed																
	☐ Warmed																
LOSSES EST BLOOD LOSS																	
URINE -																	

TOTALS	TOTAL EBL
2mg	MIN
200mcg	
200	TOTAL URINE
100	Ø
X	

FLUIDS - SUMMARY
CRYSTALLOID- NS = 500cc
COLLOID-
BLOOD- X

REMARKS
Code drugs with numbers, events with letters

0730 - Greeted in ICW. ID. NPO verified. Prop unchanged on a 23SEP. Chart review.
0800 Ambulates to OR 1-1 via crutches. Position self on bed. Monitors on. Pre O2 IV induction. Sec airway, note below. Eyes taped shut.
0815 Resp even/Reg, Airway Reflexes intact. Opens eyes to name. MAE. Oral stm. TV > 400 Extubated c̄ pos pressure breath
0850 To ICW via litter. Resp even/reg. Report to Sgt (b)(6)-2 RN/WC Pt Stable

RECOVERY AT 0850
PACU ICU _____ (Specify)
OTHER T = 96.2
CONDITION: Stable
RESP- 10 SpO2- 99% RA
BP- 119/5 HR- 62

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0730	0800	0900
	Ready	Begin	End
PROC	0812	0825	0840

MONITORS/ACCESSORIES						
VENTIL	VT - ml		450	>300	>250	
	f - breaths/min		16 40	9	14	11
	Peak inf pres / PEEP		—	—		
	MODE - S(pon), A(ssist), C(on)		S A	S	S	S
✓ BP/Auto Cuff	✓ ET CO2 (torr)		⊕ 42	50	47	—
✓ BP/oth	✓ FIO2 (Frac or %)		.85	.86	.86	RA
✓ ART line	✓ SpO2 (%)		100	99	100	100
✓ Steth- PC/ES	✓ ECG		SR	SR	SR	SR
✓ Gas analyzer	✓ TEMP-site/Avail					
	✓ N-M Block (T/4)		4/4 0/4	4/4		
Warming blkt			✓			
Cooy warmer						

Mark with letters & symbols, explain under REMARKS — EVENTS / Position → (A) arm secured on padded armboard. (B) arm secured over pillow. (C) Avrall in place OR, RLD →

PROCEDURES and CPT Codes:
Debridement/Irrigation Lt buttock GSW

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA.

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

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
DL x 1 (b)(6)-2 3 by SSG (b)(6)-2 RT. 8.0 OETT placed at secured @ 24cm @ teeth. @ Stylet @ Sustained ETCO2 @ BBS = @ Bite block

SURGEONS: (b)(6)-2

ANESTHETISTS: (b)(6)-2 (b)(6)-2

PROCEDURE LOCATION: OR 1-1
DATE: 25SEP03
PAGE 1 OF 1

DA FORM 7389, FEB 1998 MEDCOM - 7443 COPY OF MEDICAL RECORD USAPA V1.00

PRE-ANESTHESIA AND POST-ANESTHESIA EVALUATION

AGE: 20 HRS DAYS MOS (YRS) SEX: (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: D&I (L) buttocks SURGICAL SERVICE: Ortho

ASA PHYSICAL STAUS 1 (2) 3 4 5 E
WEIGHT: 65 (KG) LB HEIGHT: ____ IN.
ALLERGIES: NKDA

HABITS:

TOBACCO: (+)
ETOH: Ø
DRUGS:

CURRENT MEDICATIONS:

([ ] = ordered as premed)
[ ] Ancef 1g 0230
[ ] Tetanus 0230
[ ]
[ ]
[ ]
[ ]

PREMEDICATION:

None Yes (@ ____ Hrs) /OC
____ mg IV IM PO
____ mg IV IM PO
____ mg IV IM PO

LABORATORY STUDIES:

HB/HCT: ____ / ____
U/A:
OTHER:
16 SEP 0223
16.2 / 16.8 / 50.4 / 281
132 | 104 | 9
3.9 | 24 | 0.7 | 113

PREOPERATIVE ASSESSMENT

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:	Hypertension	N	Y
	Angina	N	Y
	MI	N	Y Neg
	CVA	N	Y
	Other	N	Y VIG
Pulmonary System:	Asthma	N	Y inhaler
	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	N	Y
Endocrine System:	Diabetes	N	Y
	Steroids	N	Y
	Thyroid	N	Y
Neurological:	Seizures	N	Y
	Neuropathy	N	Y
	Other	N	Y
Gynecological:	Pregnancy	N	Y N/A
Other Significant Hx:		(Y)	(L) mother GSW
		N	Y shot @ 2400 2 5.56 while sleeping ammo
Familial HX			

PAST SURGICAL/ANESTHETIC HISTORY

Ø ? Dura.

PHYSICAL EXAMINATION

BP 116/58 HR 90 RESP 18 98% on RA
HEENT - Teeth poor hygiene
Trachea midline
TMJ/Neck FROM
Oropharynx MP II
Nares patent
CHEST: CTA (B)
CARDIAC: S1 S2 RRR
EXTREMITIES:
IV Access: LR 75cc/hr. (b)(6)-2
Ulnar Filling:
BACK:
OTHER:
T&S.

ANESTHETIC PLAN: [ ] Local [ ] MAC - [ ] Regional (Specify): ____ (X) General: Mask Intubation

INFORMED CONSENT/COUNSELLING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed wih the patient/legal guardian. The patient/legal guardian [redacted]. Questions answered.

Signed: (b)(6)-2 CRNA DATE: 16 SEP 03 TIME: 0745 Hrs

CONDITION UPON ARRIVAL TO P.A.R.R. ____

VITAL SIGNS: BP ____ HR ____ RESP ____ SuO_2 ____

RESP STATUS: [ ] Spontaneous [ ] Assisted [ ] Cont'd

MENTAL STATUS: [ ] Awake [ ] Alert [ ] Lethargic [ ] Asleep

[ ] Responsive [ ] Unresponsive Block Level ____

REPORT GIVEN: [ ] Yes [ ] No

POST-ANESTHESIA EVALUATION AND NOTE

(X) NO APPARENT ANESTHETIC COMPLICATIONS [ ] OTHER

[redacted]

Signed: (b)(6)-2 DATE: 17 SEP 03 TIME: 0930 Hrs

PATIENT IDENTIFICATION: (Ward: ____)

(b)(6)-4

ANESTHESIA PLAN OF CARE PR **EDURAL ASSESSMENT (Sedation ... ia)**

Age 20 DAYS MOS (YRS) Sex (X) MALE ( ) FEMALE

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

PROPOSED PROCEDURE: I+D Buttocks wound
SURGICAL SERVICE: Ortho
NPO SINCE: ____

HABITS:
TOBACCO: (+)
ETOH: ∅
DRUGS: ∅

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Ancef 1g q8hr LD 08
( ) ____
( ) ____
( ) ____
( ) ____
( ) ____

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

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

16 SCP 16.2 16.8 / 50.4 / 28

132 | 104 | 9 (113
3.9 | 24 | 0.7

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) → (L) buttock cellu
N Y
Familial HX N Y

NKA

ASSESSMENT
PAST SURGICAL/ANESTHETIC
(L) buttock I+D 9/16

PHYSICAL EXAMINATION
BP 110/68 HR 84 R 19 T 98.4
Pain Scale 0-10 ____
HEENT - Teeth ____
Trachea Midline
TMJ/Neck ~~to~~ FROM
Oropharnyx MMT
Nares patent
CHEST: CTA (B)
CARDIAC: S1S2 RRR
EXTREMITIES:
IV Access: PIC
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since 12M.

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

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

The patient/legal guardian seems to understand and agrees. Questions answered.
Signed: (b)(6)-2 CRNA Date: 23 SEP 03 Time: 0750 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

(b)(6)-4

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

518-124 NSN 7540-00-634-4159

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)* _____ ML

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [x] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED 16 Sept

DATE AND HOUR REQUIRED 16 Sept ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

REQUESTING PHYSICIAN *(Print)* (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE trauma

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER (b)(6)-2

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

DATE VERIFIED 16 Sept 03

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.	TRANSFUSION NO. / PATIENT NO.	TEST INTERPRETATION: ANTIBODY SCREEN	TEST INTERPRETATION: CROSSMATCH	PREVIOUS RECORD CHECK: [ ] RECORD [ ] NO RECORD / SIGNATURE OF PERSON PERFORMING TEST
DONOR	RECIPIENT			
ABO	ABO			
Rh	Rh			

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED — DATE

REMARKS:

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*

AT *(Hour)* ON *(Date)*

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)*

2nd VERIFIER *(Signature)*

PRE-TRANSFUSION

TEMP. PULSE BP

DATE OF TRANSFUSION TIME STARTED

POST-TRANSFUSION DATA

AMOUNT GIVEN ML

TIME/DATE COMPLETED/INTERRUPTED

REACTION [ ] NONE [ ] SUSPECTED

TEMPERATURE PULSE BLOOD PRESSURE

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)*

SIGNATURE OF PERSON NOTING ABOVE

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

SEX WARD

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

RADIOLOGIC CONSULATION REQUEST

PATIENTS NAME: (b)(6)-4

SSN: (b)(6)-4

UNIT: NAP

PROVIDER/ CLINIC: (b)(2)-2

DATE REQUESTED: 16 Sept 03

EXAMINATION REQUESTED:

SPECIFIC REASON(S) FOR REQEST:

RADIOLOGIC REPORT:

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 16 SEP 03 TIME OF ORDER: 0400 HOURS

LIST TIME ORDER NOTED AND SIGN

1. ADMIT ICW C/O McFARLAND
2. Dx: (L) BUTTOCK GSW
3. COND: STABLE
4. NKA
5. LR @ 75cc/hr
6. FOLEY TOUCHAWAY
7. ~~O2 4L NKB~~ MS 2-4mg IV q15 prn

0445 noted 0400 16 Sep 03

NURSING UNIT: R (b)(6)-2

PATIENT IDENTIFICATION: (b)(6)-2

DATE OF ORDER: 16 Sep 03 (b)(6)-2

1. ADMIT ICU (b)(6)-2
2. Dx: (L) BUTTOCK FRAGMENTATION WOUND
3. COND: STABLE
4. VS q ROUTINE
5. ACTIVITY: EPW RESTRAINTS
6. NKA

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

7. DIET: ADV TO REG
8. IVF: LR @ 100 cc/HR, D/C WHEN TOL PO.
9. MSO4 2-4mg q 15' PRN PAIN, NOT EXCEEDING 20mg q
10. O2 VIA NC TITRATE TO >92%
11. FOLEY TO GRAVITY.

NURSING UNIT | ROOM | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

12. DRAINS: PENROSE (L) BUTTOCK
13. TYLENOL 325mg T-III q 6° PRN PAIN/FEVER/HA.
14. LABS: Ø
15. ANCEF 1g IV q 8H

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2 (b)(6)-2 16 SEP 2003

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

16 Sep 03 0 2220 (b)(6)-2

MEDCOM - 7448

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 18 Sep 03 TIME OF ORDER: 0025 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Phenergan 25 mg IV q 4° PRN Nausea

(b)(6)-2

(b)(6)-2 MD

MAJ, MC USA

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 18 Sep 03 TIME OF ORDER: 1730 HOURS

(1) Robitussin DM (or equiv) 2 tsp q6° prn cough

(b)(6)-2

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 22 Sep 03 TIME OF ORDER: ~~1430~~ 1505 HOURS

(1) NPO p MIDNIGHT

(b)(6)-2

(b)(6)-2

(b)(6)-2

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

(b)(6)-4

(b)(6)-4

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

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
23 SEP 03	HOURS	
(1) ADMIT RR → ICW		
(2) DX: (L) BUTTOCK GSW		
(3) COND: STABLE S/P I&D		
(4) VITALS: q RR ROUTINE		
(5) ACT. UP AS TOL W/ EPW RESTRAINTS		
(6) NWDA		

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
(7) ANCEF 1g IV q 8H	HOURS	
(8) MSO4 2-4mg IV q 15' NOT EXCEEDING 20mg q 2°		
(9) BENADRYL 25-50 IV q 6H PRN PRURITUS / INSOM.		
(10) DIET: ADV. TO REG		
(11) IVF: NS @ 100cc/HR HEPLOCK WHEN TOL PO		

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	ORDER
24 SEP 03 16 (b)(6)-2	(b)(6)-2
(1) NPO P [redacted]	
TO OR IN AM.	
(b)(6)-2	(b)(6)-2
24 chart ✓ 24 Sep @ 2215	(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
25 SEP 03	0830 HOURS	
(1) ADMIT RR → ICW		
(2) DX: (L) BUTTOCK GSW S/P I&D		
(3) COND: STABLE		
(4) VITALS Q ROUTINE		
(5) MSO4 2-4mg IV q 15' NOT EXCEED 20mg q 2°		
(6) ANCEF 1g IV q 8H	(b)(6)-2	(b)(6)-2
(7) DIET REG.		

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

DATE OF ORDER: 25 Sep 03 TIME OF ORDER: 2201 HOURS

LIST TIME ORDER NOTED AND SIGN

V.O.
Percocet 1-2 PO q 4-6° PRN pain

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

24° chart / 25 Sep 03 @ 0330

PATIENT IDENTIFICATION

DATE OF ORDER: 26 Sep 03 TIME OF ORDER: 2245 HOURS

50 mg Benadryl IV q 6° PRN

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 28 Sep 03 TIME OF ORDER: 0450 HOURS

1. Cozaar 1 PO BID
2. MOM 60 cc PO q 4° PRN Constipation
3. 2x2's OPSITE TO Buttock wounds
4. D/C MP Custody
5. Flu Detention Medical Personnel FOR Suture Removal in 7 Days

29 Sep 03 0550

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 29 Sep 03 TIME OF ORDER: 0535

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD

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

Mo. Sep Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 23 24 25 26 27 28 29
23Sep	(b)(6)-2	VS: Q8	00	(b)(6)-2
23Sep			4	
			08	(b)(6)-2
23Sep	(b)(6)-2	Act: ↑ ad lib	00	(b)(6)-2
		EPW restraints	18	
23Sep	(b)(6)-2	Diet: Adv to Reg	00	(b)(6)-2
24Sep		NPO @ Midnight	12	
25Sep		Diet Reg	18	
28	(b)(6)-2	2x2's OPSite to Buttock wound	00	

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
(L) BUTTOCK GSW / S/P I&D

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

PATIENT IDENTIFICATION:
(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo Sep Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
23Sep	(b)(6)-2	Admit ICW			1000	(b)(6)-2
23Sep		Cond: stable S/P I&D				
24Sep		TO OR in AM	25Sep			
25Sep		D/C MP Custody				
28Sep		F/u Detention Medical				
		Personnel for Suture removal				
		in 7 days				

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

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CLINICAL RECORD

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

Mo. 9 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 16	17	18											
MeSep	(b)(6)-2	Foley to gravity	06	(b)(6)-2													
			18														

ALLERGIES: ☐ YES ☐ NO
NKA

PRIMARY DIAGNOSIS:
(2) Buttock GSW

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

PATIENT IDENTIFICATION:
(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*					Mo 9 Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS		Date to be Done	Time to be Done	Time Done	Initials
16Sep	(b)(6)-2	Admit to ICW c/o	(b)(6)-2	16Sep	—	—	(b)(6)-2
	- - - - -	Cond: Stable		16Sep			
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Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED													
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CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*
For use of this form, see AR 40-407;
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Mo. Sep Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 16	17	18	19	20	21	22	23
16Sep	(b)(6)-2	VS routine	06	(b)(6)-2							
			14								
			22								
16Sep	(b)(6)-2	Act: EPW restraints	06	(b)(6)-2							
			18								
16Sep 22	(b)(6)-2	Diet: Adv to Reg NPO	06	(b)(6)-2							
			18								
16Sep	(b)(6)-2	Foley to gravity	06	(b)(6)-2							
			18								
16Sep	(b)(6)-2	Drains: Penrose (L) Buttock	06	(b)(6)-2							
			18	(b)(6)-2							

DC DTV 1500

D/C'd 18 Sep 2003

ALLERGIES: ☐ YES ☐ NO
NKA

PRIMARY DIAGNOSIS:
(L) Buttock Fragmentation Wound

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

PATIENT IDENTIFICATION:
(b)(6)-2

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*				Mo Sep Yr 2005
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
9/16	(b)(6)-2	Admit ~~ICU~~ ICW (b)(6)-2			1080	(b)(6)-2
1680		Condition: Stable			1080	
1680		Labs Ø			1080	
2080		NPO Ø MN	22Sep	2400	0000	

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

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CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 9 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 16	17	18	19	20
16Sep	(b)(6)-2	LR @ 75cc/hr	16	(b)(6)-2				
			18					

ALLERGIES: ☐ YES ☐ NO

NKA

PRIMARY DIAGNOSIS:

(2) Buttock GSW

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	Mo. 9 Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
	- - - - -					
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Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
1Sep	(b)(6)-2	MS04 24mg IV														
- - - - -	- - - - -	q 15min PRN pain														
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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. Sep Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 16	17	18	19	20	21	22	23
16 Sep	(b)(6)-2	IVF; LR @ 100cc/hr	06	(b)(6)-2							
		D/C when tol PO	18								
16 Sep	(b)(6)-2	O2 via NC / Titrate	06	(b)(6)-2							
		TO >92%	18								
16 Sep	(b)(6)-2	Ancef 1g IVq	08	(b)(6)-2							
		8H	16	(b)(6)-2							
			24								

ALLERGIES: ☐ YES ☐ NO

NKA

PRIMARY DIAGNOSIS:

(L) Pauftocic Fragmentation Wound

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:
(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	Mo. Sep Yr. 2003

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												
1684	(b)(6)-2	MSO4 2-4mg q15'													
		pm pain, not													
		exceeding 20mg q20													
1684	(b)(6)-2	Tylenol 325mg 1-2													
		q6° pm Pain/fever													
1684	(b)(6)-2	Phenergan 25mg (1)													
		q 4° PRN Nausea													
19560	(b)(6)-2	Robitussin DM 2tsp													
		q 6° PRN cough													

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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. Sep Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 23	24	25	26	27	28	29
23Sep	(b)(6)-2	Ancef 1 g IV q 8 HR	08	(b)(6)-2						
			16	(b)(6)-2						
			24	(b)(6)-2						
23Sep	(b)(6)-2	IVF: NS @ 100 cc/hr	04	(b)(6)-2						
		Heplock when tol. po	12							
28Sep	(b)(6)-2	Colace + PO BID	10							
			22						(b)(6)-2	

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: (L) Buttock GSW / SIP LTD

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION: (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				Mo. 9 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
		PRN				
28	(b)(6)-2	MDM 60cc PO q 4° PRN				
		Constipation				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
23 Sep	(b)(6)-2	NSO4 2-4mg IV	23 Sep 1200													
		Q15' not exceed mg	(b)(6)-2													
		20mg in 2°														
23 Sep	(b)(6)-2	Benadryl 25-50mg														
		IV q 6° pm pruritis/insomnia														
25 Sep	(b)(6)-2	Percocet 1-2 PO q 4°	25 Sep 1200													
		PRN Pain	1 PO													
26 Sep	(b)(6)-2	Benadryl 50mg IV	(b)(6)-2 26 Sep 2011 50mg IV													
		4° PRN	(b)(6)-2													

USAPA V1.00

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DA.

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: 16 Sep 03
Time In: 0940
Allergies: NKA
Pre-op V/S:
Procedures: Debridement FD @Buttock

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

OR Intake: Crystalloid 1000 Colloid Ø
OR Output: UOP 300cc EBL
Meds/Times: 2mg Vrs 150 Fent all other reversed 1Gm Ancef (0850)

Pre Op Meds
History ASA 2 (Smoking)

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

Airway: Nasal, Oral, ETT, Trach, Other

Time	0934	0945	0950	0955	1010	1015	1030
SaO2	98	97	98	99	100	99	99
FiO2							
Methods	RA	RA	RA	RA	RA	RA	RA
240							
220							
200							
180							
160							
140							
120							✓
100	✓	✓	✓	✓	✓		✓
80					o		
60	^ o		o	o		^	
40		^	^	^	^		
20							
RR	25	11	13	10	13	17	12
T	98			98			
Time							
Pain (0-10)							
LOS							

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1020	LR	50cc	BAC		

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	Ø	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	2	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.	9	12	12

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

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

(Continue on reverse)

PREPAR (b)(6)-2 | SGT/LPN | DEPARTMENT/SERVICE/CLINIC: ICU | DATE: 16Sep03

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

(b)(6)-4

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

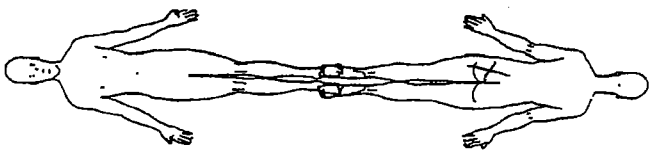
MEDICATIONS						
Allergies:						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

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	Ⓡ buttock	bulky	CDI
30'	"	"	CDI
60'	"	"	"
D/C			



PACU OUTPUT			
Time	Source	Color/Appearance	Amount
1020	Foley	clear, yellow	50cc

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

0940 - Pt arrived from OR via litter - airway patent - connected to monitor, satting 91-99% on RA, pt arousable to voice, but very drowsy. Will monitor & transfer to ICW. [redacted] (b)(6)-2 SGT/LP

1000 - Pt resting comfortably, arousable to voice, still satting 99% on RA. IV Ⓐ KVO to Ⓡ AC 20g PIV [redacted] (b)(6)-2 SGT/LP

1030 - All transfer criteria met, report given to ILT [redacted] (b)(6)-2, pt transferred via litter to ICW [redacted] (b)(6)-2 SGT/LP

Discharge Criteria:
Date: 16 Sep 03 Time: 1030 PARS: 12
BP: T: HR: RR: Sa02:
Pain Level at D/C (0-10): Ø
Intake: 50cc Output: 50cc
Additional Data:
Transferred To: ICW
Report Given To: ILT [redacted] (b)(6)-2
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: SGT [redacted] (b)(6)-2
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DA...

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 Sept 03
Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
Time In: 0900
Allergies: NKDA
OR Intake: Crystalloid 300cc Colloid
Pre-op V/S:
OR Output: UOP ∅ EBL M.D
Procedures: BSW ⊕ Buttocks
Meds/Times: Anti-gram used, Advised, Zoning Policy
Debridement Irrigation ⊕ Buttock
100 mg Propofol
ASA II
Pre Op Meds
History ASA II

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

Time	0900	0905	0915	0920	0930
SaO2	100	100	100		100
FiO2	35	100	35		35
Methods					
240					
220					
200					
180					
160					
140					
120		✓	✓	✓	
100	✓			✓	
80					
60	✓			✓	
40			✓	✓	
20					
RR	11	11	10	8	7
T	97			96	94
Time	1000	0920	0945		
Pain (0-10)	0	3			
LOS					

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

V/S
X = A-line BP
˙ = Cuff BP
= Pulse

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

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

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

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 23 Sept 2003

PATIENT'S IDENTIFICATION (For typed or written entries give: Name — last, first, middle; grade; date; hospital or medical facility) (b)(6)-4

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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
0900	3	25 mg Fentanyl	IV	3	P	[redacted]
0930	3	4 mg MSO4	IV	4	P	

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
	Bilat						
Adm	0900	+	+	+	Brisk	Warm	
15'							
30'							
45'							
60'							
90'							
D/C							

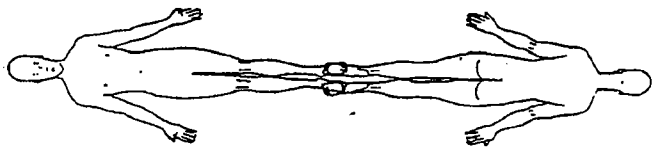
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	0900 (L) Buttock	C ABD	(-)
30'	(L) Buttock	ABD	(-)
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
	Ø		

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0900	NSR	Ø	Ø
1000	NSR	Ø	

WAMC OP 173-E

NURSING NOTES

Received from OR @ 0900. Dressing to (L) Buttock intact, no drainage noted. Pass to (L) leg pedal. Strong CTA in all pulses, O2 NC 2 L/min nonrebreather applied. Gr: Children 3 distention, BS x4, hypoactive. No bowel sounds present. Received 25 mg Fentanyl IVP leg CON [redacted] MAGN

0930 Patient c/o pain to (L) Buttock. Given 4 mg Morphine IVP, O2 at 2 L/min via nasal cannula. Able to move all extremities, coughing and deep breathing c/pain continues [redacted] MAGN

0945 Resting comfortably. denies pain at present. Given 4 mg. MS 100, Patient denies pain at present, MS x4. (L) Buttock Dressing CDI. To PCU via stretcher. [redacted] MAGN

Discharge Criteria:
Date: 03 Sept 03 **Time:** 0900 **PARS:** 7, Smoking
BP: 136/87 **T:** 98.4 **HR:** 76 **RR:** 11 **Sa02:** WNL
Pain Level at D/C (0-10): 3
Intake: 400 **Output:** Ø
Additional Data:
Transferred To: PCU
Report Given To:
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: [redacted] MAGN
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: [redacted] MAGN

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: 25 Sept 03
Time In: 0900
Allergies: NKDA
Pre-op V/S: 125/63 76
Procedures: Debridement of buttock

Anesthesia Type (Circle)): (General) Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 500 NSS Colloid
OR Output: UOP Ø EBL min
Meds/Times: 2mg Vers, 200mcg Fent, 200mg Prop, 100mg Succ

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds

History ASA 2 (smoker) 65k

Time	0900	0905	0910	0915	0920	0925	0930
SaO2	100	99	99	99	99	100	100
FiO2	RA						
Methods							
240							
220							
200							
180							
160							
140							
120							
100	✓	✓	✓	✓	✓	✓	✓
80							
60	0	0	0	0	0	0	0
40	✓	∧	∧	∧	∧	∧	∧
20							
RR	9	10	10	9	12	12	
T	98				98.6		
Time	0900						
Pain (0-10)	0						
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	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	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.	9	11	12

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

V/S
X = A-line BP
• = Cuff BP
= Pulse

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

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

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

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

(Continue on reverse)

PREPARED BY *(Signature & Title)* (b)(6)-2 MAJ

DEPARTMENT/SERVICE/CLINIC: FCU

DATE: 25 Sept 03

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

(b)(6)-4

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

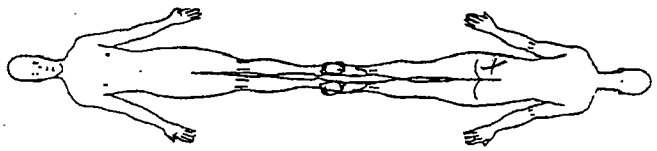
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

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



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

0850 Pt arrived from OR, sleeping but arousable c̄ difficulty, s/p debridement (1) buttock (3rd wash-out), IVF running slowly to (1) wnst 18G PIV. Sat'ing 99% on RA. Will monitor. [redacted] SGT/CRN

0930 - Pt c/o numbness to extremities. explained through interpretor that it was normal from anasthesia. [redacted] SGT/

0945 - Report given to CPT [redacted] SGT/

Discharge Criteria:
Date: 25 Sep 03 **Time:** 0945 **PARS:** 12
BP: 112/61 **T:** 96.5 **HR:** 68 **RR:** 13 **Sa02:** 99%
Pain Level at D/C (0-10): 0
Intake: _____ **Output:** _____
Additional Data: _____
Transferred To: ICW
Report Given To: _____
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: SGT [redacted]
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: _____

Admission and Coding Information

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

1. Reporting MTF (b)(6)-4	2. MTF Location IZ			
3. Register Number (b)(6)-4	Name (Last, First, MI) (b)(6)-4		4. Pay Grade CIV	5. Sex M
6. DoB (YYYYMMDD)	7. Age at Admission	8. Race X	9. Ethnicity 9	Religion UNKNOWN
10. Length of Service	ETS	11. FMP 99	12. Social Security Number (b)(6)-4	
Organization (Active Duty Only)		13. Marital Status Z	Hour of Admission 00:20	Branch / Corps:
14. Flying Status	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES		16. Zip Code of Residence:	
17. Unit Location	18. MOS		19. Trauma BC	Prev. Admission NO
20. Source of Admission Direct from ER	Ward: ICW		Name / Relationship of Emergency Addressee	
			Address of Emergency Addressee	
Name and Location of Medical Treatment Facility: (b)(6)-4			Telephone Number of Emergency Addressee	
21. Type of Disposition TRF-OTH	22. MTF Transferred To		23. Date of Disposition (YYYYMMDD) 2003-09-28	
24. Clinic Svc - Admitting ABA - GENERAL SURGERY	25. MTF Transferred From		26. Date this Admission (YYYYMMDD) 2003-09-16	
27. Location of Occurrence IZ	28. MTF of Initial Admission		29. Date of Initial Admission 2003-09-16	

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: GSW LEFT BUTTOCK
877.0

Procedure Narrative(s): IRRIGATION AND DEBRIDEMENT LEFT BUTTOCK

Cause of Injury Narrative: TRYING TO STEAL AMMO

Admitting Officer (Signature, as required) DR (b)(6)-2	(b)(6)-2	Signature of Admitting Clerk

ADMISSION AND CODING INFORMATION

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

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

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19830101	20Y	X	9	UNKNOWN

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	Z	0020	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K78 POW/INT	[redacted]

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION	
I Z		BC	YEAR	(b)(6)-4 / NO

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

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYYYMMDD)
		20030928

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
		20030916

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

FOR LOCAL USE

GSW (L) Buttock
877.0
I&D (L) Buttock

DX-8770
E9912
Trauma-1
Injury-450 PR-8622

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK

Automated Facsimile (b)(6)-4

INPATIENT TREATMENT RECORD COVER SHEET

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

1. Register Nbr	2. Name					3. Grade	Admission Remarks
(b)(6)-4	(b)(6)-4					CIV	
4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm	
M		X	UNITARIAN			NO	
11. FMP	12. SSN	13. Organization				14. Ward	
99	(b)(6)-4					ICW	
15. FlyStatus	17. Dept / Ben	18. BranchCorps	19. UIC / ZIP	20. Type Case			
	K78-PRISONER OF WAR/INTER			BC			
21. Source of Admission		22. Hour Of Adm:	23. Clinic Service				
Direct from ER		00:20	AEA - ORTHOPEDICS				
24. Name/Relation of Emergency Addressee		25. Type Disp	26. Date of Disp				
		HOME	2003-09-21				
27a. Address of Emergency Addressee		27b. Telephone No	28. Date This Adm:	AdmittingOfficer:			
			2003-09-16	(b)(6)-2			
29. ReportingMTF			30. Date Init Adm	32. Units Blood Components			
(b)(2)-2			2003-09-16				

31. Selected Administrative Data

Marital Status: Z DoB:

In/Out Patient: Inpatient MOS:

33. Cause Of Injury: TRYING TO STEAL AMMO

34. Diagnosis / Operations and Special Procedures:

GSW RIGHT KNEE

981.0 E991.2

I&D I Knee GSW

35. Total Days This Facility

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

35. Total Days This Facility

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

Signature of Attending Medical Officer: (b)(6)-2 MAJ, MC

Signature of PAD or Medical Records Officer: (b)(6)-2

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

23 yo IRAQI EPW WOUNDED 16 SEP 03 STEALING AMMUNITION.

PMH: ∅ PSH: ∅ NKDA / MAYS

PHYSICAL EXAMINATION

HEENT: NC/AT SUPPLE
LUNGS CTA-BL, ABD: SOFT NT/ND, PELVIS: STABLE
EXTREM: BL UE OK, (R) LE OK,
(L) LEG c̄ 2.0 cm ENTRANCE WOUND MEDIAL ASPECT KNEE. ⊖ EFFUSION, ⊖ EDEMA. TTP ONLY OVER ENTRANCE WOUND.

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

(1) ISOLATED PENETRATING TRAUMA (L) KNEE, UNCLEAR INTRA VS EXTRA ARTICULAR
(2) FUNDUS (L).

XRAY
FRAGMENT POST / SUP MEDIAL ASPECT (L) KNEE

SIGNATURE	DATE	IDENTIFICATION NO.	ORGANIZATION
(b)(6)-2 (b)(6)-2 MAY MC	16 SEP 03		

PATIENT'S IDENTIFICATION *(For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)* 0330

REGISTER NO.	WARD NO.

(b)(6)-4

(b)(6)-4

0330

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
16 SEP 03	ORTHO OP NOTE
(1)	SURGEON: (b)(6)-2 1ST: (b)(6)-2
(2)	DX: (L) KNEE GSW
(3)	POST DX: SAME.
(4)	PROCEDURE: (L) KNEE DEBRIDEMENT
(5)	FINDINGS: SMALL JACKET FRAGMENT IN MEDIAL SOFT TISSUE, (-) JOINT VIOLATION, (-) EXTRAVASATION JOINT FLUID / (-) HEMARTHROSIS. WOUND EDGES EXCISED / 2L. IRRIGATION
(6)	EBL: MIN UOP: 200
	TT: BLOOD: Ø
	FLUID: 1000R
(7)	COND: STABLE TO PR
(8)	COMPLICATIONS: Ø
	(b)(6)-2 (b)(6)-2

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

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; [illegible] SSN; Sex; Date of Birth; Rank/Grade)*

REGISTER NO. | WARD NO.

AST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

NOTES

DATE	NOTES
16 Sep 03 1915	Nurses Notes: Assumed care of Pt A+O. Pt breathing intact Ø SOB or labored breathing Ø c/o pain. dressing to (L) knee clean, dry and intact - Pt able to move all toes on affected leg. warm & brisk cap refil to touch. Pt tolerated regular diet ate small portion ate fruit. Pt voids spontaneously clear yellow urine noted. IV SL flushes well will continue to monitor status — (b)(6)-2
17 Sep 03	ASSESSMENT - ICW - ALOB, PERRLA, GIVEN Oxy MORPHINE FOR PAIN WHEN PT TRANSFERRED TO DIFFERENT BED. DRESS TO (L) KNEE C/D/I, GOB TO DIFFERENT BED. TOLERATED REG DIET. IV RESTARTED UNDER GUARD. WILL CONTINUE TO MONITOR THROUGHOUT — (b)(6)-2 SEALEN
17 Sep 03 1915	Nurses Notes: Assumed care of Pt A+O Breathing intact Ø SOB or labored breathing. dressing to (L) knee clean, dry and intact. Pt able to move toes on affected leg Ø pain or complications abd soft and non tender Pt tolerated regular diet Ø N/V. IV SL flushes well Ø S/S of infection at IV site will continue to monitor status. — (b)(6)-2 USA
2040	Pt c/o pain Percocet II Po tabs given. 4 mg MSO4 given for pain. will continue to monitor status — (b)(6)-2 USA
2115	Pt Asleep — (b)(6)-2

STANDARD FORM 509 (REV. 5/1999)
USAP

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

21SEP03 ORTHO NARRATIVE SUMMARY.

DOA: 16 SEP 03 DOD: 21 SEP 03

ADMIT DX: GSW MEDIAL (L) KNEE

PROCEDURES: I&D (L) KNEE GSW 16 SEP 03

HOSPITAL COURSE: SHOT 16 SEP 03 WHILE STACKING AMMO BY REPORT. LARGE JACKET FRAGMENT REMOVED 16 SEP 03. NO JOINT INVOLVEMENT. WOUND DRY & SUTURES IN PLACE AT TIME OF D/C 21 SEP 03.

COMPLICATIONS: NONE

DISPOSITION: D/C TO MP CUSTODY 21 SEP 03

FOLLOW UP: F/U & CONTAINMENT FACILITY MEDICAL PERSONNEL. SUTURES OUT IN ≈ 4 DAYS.

(b)(6)-2

(b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

(b)(6)-4

PROGRESS NOTES
Medical Record

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

USAPA V1.00

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
16 SEP 03	
	Pt arrived 0208 hrs. (A)VPU
	0208 clothing removed. Administer O_2 NRB mask 15LPM
V/S Time: 0208	0210 wound exposed (L) knee entrance wound medial (L) knee
BP: 135/75	0213 I.V. line (L) AC Lactated Ringers Bolus
P: 93	0213 ultrasound (L) lower leg and foot: (-) Pulse dorsalis Pedis
T: 98.1	0215 Cnceph 1 Gram adm. I.V.
R: 24	0215 Tetanus shot administered (L) deltoid.
PO_2: 100%	0219 I.V. flow stopped. ~~(+) Pdorsalis Pedis~~
	0219 Blood draw (L) AC via I.V. Cath (+) Posterior tibial
	0221 I.V. flow ressumed.
	0223 5 mg morphine administered via I.V. line
	0226 wound area cleaned c̄ sterile gauze, sterile H_2O
Allergies: ? PENICILLIN	0227 X-rays shot (L) knee
	0231 Posterior examined. No wounds found.
	0237 Blood draw (R) AC
V/S Time 0253	0241. Urinary Cathada placed
BP 106/56	0243 5 mg morphine administered via I.V. line.
P 58	0250 EKG leads attached to Pt
R 18	0251 Blood draw (R) AC
PO_2: 100%	0255 urine collected from foley bag for lab.

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

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

(b)(6)-4

(b)(6)-4

(b)(6)-4

(+) Smoker

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18 SEP 2003 1810	Nursing: Assessment. Pt sleeping, easily aroused. ∅ c/o pain @ present. Alert, Lungs CTA, O2 Sat 98% on RA, ∅ SOB. HR 74, reg, ∅ edema noted. +2 pulses x4 extremities. Abd soft, nontender, (+) BS x4. Pt voiding clr, yellow urine. Drsg to (R) knee CDI. (L) LE warm, dry, (+) sensation. +2 DP pulse, brisk cap refill — IH (b)(6)-2 A
18 Sep 03 1904	Received care of pt. @ 18:00. Pt resting comfortably in bed. Awake and alert. Breathing unlabored and easily. PERRLA (+) w/L/EOM (+) w/L. Skin warm/dry/intact. VS @ 1745 WNL per flowsheet. Buccal mucosa pink/moist. Lungs clear to auscultate throughout (B). Bowel sounds (+) x4 quadrants. HL to (L) AC patent and intact. ACE wrap dressing to (L) knee clean/dry/intact. NVV's to (L) foot WNL. ROM of (L) foot digits. C/o pain x1 ii Tylenol given. Will continue to monitor — (b)(6)-2
19 Sep 03	SIP 1 D GSW (S) Pt Doing Well. ∅ Complaint (O) AF, VSS INCISION WELL APPROX ∅ SUTURES IN PLACE, ∅ DRAINAGE, MOIST EDGES (AP) (1) UNCOMPLICATED 1 D. (2) PLAN SUTURE D/C 4-5 DAYS → D/C.

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT (b)(6)-2 (b)(6)-2
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

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

REGISTER NO. | WARD NO.

(b)(6)-4

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

MEDCOM - 7478

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19 Sep 2003 1350	Nursing: Pt awake, ∅ c/o pain. Pt alert, asking interpreter when will he go to EPW camp. Lungs CTA, ∅ SOB. HR 58, reg, HL to (L) ac, (−) Homan's sign. Abd soft, nontender, (+) BS x4. Last BM yesterday of normal stool. Pt reports to translator pt voiding ~ difficult. Drsg to (L) Knee CDI. +2 DP pulse, brisk cap refill, skin warm, dry. Pt has (+) sensation to all toes. ↑ OOB, amb c̄ crutches ——— VLT (b)(6)-2 AN
1510	Nursing: D/C HL to (L) ac: Pt c/o pain @ site. Antibiotics complete ——— VLT (b)(6)-2 AN
20 Sep 03 0342	Received care of pt. @ 1800 19 Sep 03. @ 1800 Pt. A+O x3. PERRLA (+) WNL. (+) EOM WNL. Skin warm/dry/intact. Buccal mucosa pink moist. Lung sounds clear to auscultate (B) throughout. HR regular S1 S2 WNL. Bowel sounds (+) x4 quadrants. Abdomen soft/nontender x4 quadrants. (+) Radial pulses (B) (L) 2 strength. ACE wrap dressing to (L) ↓ ext. clean/dry/intact. NV ✓'s to (L) lower extremity WNL. ~~Pt~~ error (b)(6)-2 ∅ complaints of pain throughout shift. Will continue to monitor ——— (b)(6)-2 AN
20 Sep 2003 0850	Nursing Assessment. Pt sleeping, easily aroused c̄ touch to shoulder. ∅ c/o pain. Lungs CTA, O2 sat 98% on RA. HR lat, reg, ∅ edema to extremities. +2 pulses x4 extremities. (−) Homan's sign. Abd soft, nontender (+) BS x4. Pt ↑ OOB, amb to latrine c̄ outside ~ difficulty. Drsg (L) Knee CDI. (L) LE warm, dry, +2 DP pulse, brisk cap refill. ——— VLT (b)(6)-2 AN

(b)(6)-4

STANDARD FORM 600 (REV. 6-97) BACK

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
21 SEP 03 1100	ORTHO POS POD #5 S/P (L) KNEE GSW 1ID
	(S) PT DOING WELL, DENIES SIGNIFICANT PAIN
	(O) AFVSS
	INCISION WELL APPROX DRY.
	(A/P)
	(1) UNCOMPLICATED (L) KNEE GSW 1ID.
	(2) D/C TO MRP CONTAINMENT FACILITY.
	(b)(6)-2 (b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK

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

EMERGENCY CARE AND TREATMENT (Medical Record)

TREATMENT FACILITY

LOG NUMBER

ARRIVAL DATE: DAY 16 MONTH SEP YR 03 TIME 0208

TRANSPORTATION TO HOSPITAL (Attach care provider chart): ☑ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (Include immunization and other data): ~~0~~

HISTORY OBTAINED FROM: ☑ PATIENT ☐ OTH

ALLERGIES: PCN

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

HOME TELE. NO. (Area

CHIEF COMPLAINT (S) (Include symptom(s), duration): GSW to (L) Knee

TOI 0001

SEX: M AGE: 03

POSSIBLE THIRD PARTY: ☐ YES ☐

TIME SEEN BY PROVID: 0250

VITAL SIGNS

TIME	0208	0253	
BP	135/75	106/56	
PULSE	93	58	
RESP.	24	18	
TEMP.	98.1		
O2 (Cutaneous)	100%	100%	

CATEGORY (See reverse)

- EMERGENT
- URGENT
- NON-URGENT

ORDERS	INITS.	TIME
I.V. RL Bolus		0213
Encephalgan		0215
Tetanus		0215
Morphine 5mg		0223
Morphine 5mg		0243

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

S) c/c GSW (L) knee @ 0000 this AM while running in tikrit. Denies pain

O) (L) medial knee Entrance puncture wound (-) exit wound.
Ultrasound: (+) Dorsalis Pedis Pulse, (+) Posterior Tibial Pulse

S: Pt is a 23 yo Iraqi on EPW shot by US Forces while stealing Ammo @ Tikrit ASP

O: Ulcerated mandible 2° to GSW.
HEENT: NCAT PERRL EOMI 5mm
Neck: NT FROM.
Chest: (B) sig CTA
Cardiac: [illegible]
Abd: BBS NT on palp. FAST ⊖
Pelvis stable NT ⊖ crep
~~Rectal NT NL Pros~~
Ext: proximal medial GSW to (L) Knee
Absent DP pulses (B). DPT pulses (B) triphasic Doppler
Neuro intact.

results

16.1		
16.6	49.5	31.0
137/104		
42	23	108

FAST ⊖
DPL ⊖ Knee ⊖ fx fragments in medial posterior knee

ASSESSMENT/DIAGNOSIS: (L) Knee GSW

DISPOSITION (Check all that apply)

- HOME
- FULL DUTY
- QUARTERS
- 24 HRS.
- 48 HRS.
- 72 HRS.
- MODIFIED DUTY UNTIL: DAY / MONTH / YEAR
- REFERRED TO (Indicate clinic): Ortho
- EMERGENCY
- TODAY
- 72 HOURS
- ROUTINE
- ADMIT TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE

- IMPROVED
- UNCHANGED
- DETERIORATED

TIME OF RELEASE: 0345

(CONTINUE ON S

SIGNATURE OF PROVIDER: [redacted] 9/13/01

INSTRUCTIONS TO PATIENT (Follow-up plans): [redacted]

To ICW → To OR

PATIENT'S IDENTIFICATION (Mechanical imprint). IN WRITTEN ENTRIES GIVE: Name - last, first, middle; DOB, service status, name and relation of sponsor; IMPORTANT: Use [illegible] RECORD: [redacted]

EMERGENCY CARE AND TREATMENT
Medical Record Copy

STANDARD FORM 558
Prescribed by GSA and ICS

510-112

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
16 Sep 03	0155		Pt. admitted from EMT via litter. Pt. transferred self from litter to bed ~~s~~ assistance. Awake and alert. VS WNL per flowsheet. Skin warm/dry/intact. PERRLA (+) WNL. EOM (+) WNL. Buccal mucosa dry/pink. Pt. NPO for O/C to OR. Lung sounds clear to auscultate (B) throughout. Bowel sounds (+) x4 quadrants. Abdomen soft/non-tender. (+) Peripheral radial pulse (+)2 strength WNL. PIV to (R) AC patent infusing NS @ 150 cc/hr. Dressing to (L) knee intact ~~c~~ scant amt. bloody drainage noted. Will continue to monitor. (b)(6)-2 NWS to (L) foot cool to touch ~~c~~ doppler pulse. MD. aware. (b)(6)-2
16 SEP 03		1200	A+O×3, PERRLA, LUNGS CTA BILAT, S1-S2 STRONG AND REG. (+) BS×4. DRSG TO (L) LE C, D, I. IV HL TO (L) AC. IV ANCEF CONTINUES. TOLERATED REG DIET. Ø C/O PAIN. WILL CONTINUE TO MONITOR THROUGHOUT. (b)(6)-2 SSZLPN

(Continue on reverse side)

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

(b)(6)-4

(b)(6)-4

REGISTER NO.

WARD NO.

23 yo

NURSING NOTES

Medical Record

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

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: [illegible] BY: OK (b)(6)-2

2. PATIENT ID VERIFIED BY (b)(6)-2 ND PROCEDURE [illegible]

3. DATE: 16 Apr 03 TIME PATIENT ARRIVED IN SUITE:

4. PATIENT IN [illegible] TIME: 1000 NUMBER: 1-1 #3

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	(b)(6)-2 SK	RELIEF SCRUB	
ASSIGNED CIRCULATOR	(b)(6)-2 CPT	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Sheet bump (R) thigh

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☐ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☑ RAZOR ☐ CLIP

COMMENTS: Safety

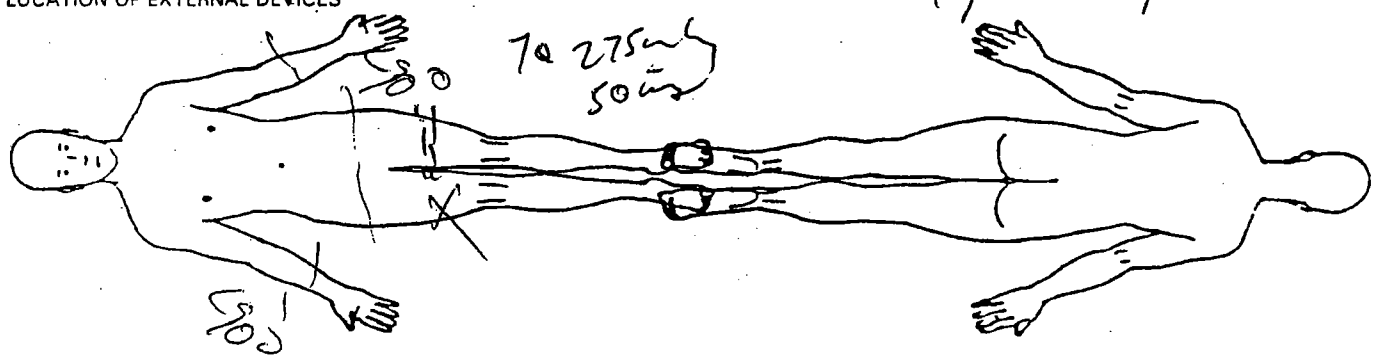
PREP SOLUTION *(Specify)* Betadine/Alcohol

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

SITE: BY WHOM:

COMMENTS: Spoling

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				(b)(6)-2	(b)(6)-2
Needle Sharp	☑ Yes ☐ No			C		
Instrument	☐ Yes ☑ No					
Other	☐ Yes ☑ No					

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

(b)(6)-4

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

☑ ESU NO: 1-1

GROUND PAD: BRAND Valleylab

LOT NO: 69627

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

ESU 1 pad site Clean prep

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

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

PHYSICIAN'S SIGNATURE
May me

15. X-RAY IN OPERATING ROOM YES ☑ NO ☑ (b)(6)-2 IF YES, SITE

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

TYPE/SIZE	1. 16Fr Foley	2. 3/8 (b)(6)-2	3.
SITE	1. rt-Oth	2. (b)(6)-2	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Phillips
Kerlix
ACE
Vaseline

19. ADDITIONAL INFORMATION
EMT

20. OPERATION(S) PERFORMED
Debridement Left Knee GSW

21. PATIENT TRANSFERRED TO IEU. TIME 1130 METHOD

22. REGISTERED NURSE SIGNATU (b)(6)-2

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

MEDCOM - 7484

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY: 1 2 3

POST- DAY: POD 1 2

MONTH-YEAR: Sep 2003 — DAY: 16 17 18 19 20 21

HOUR

PULSE (O) — 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

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

EPW

REGISTER NO.

WARD NO. ICW

(b)(6)-4

(b)(6)-4

[redacted] (b)(6)-4

MEDCOM - 7485

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD - ANESTHE[illegible]

For us[illegible] rm, see AR 40-66; the proponent [illegible] OTSG

ANESTHETIC AGENTS AND DRUGS

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

DRUG (Units)							TOTALS
Versed (mg)	1						1mg
Fent (mcg)	150		50		50		250mcg
Propofol (mg)	150						150mg
Sux// Roc (mg)	100//50						100/50
Neostig (mg)					5		5mg
Glycop (mg)					1		1mg
VOLATILE AGENT 150 % del / % e.t.	X	1.5	1.0	1.0	0.4	X	
AIR L/Min							
N20 L/Min							
O2 L/Min	X - 8	2	2	2	2	8	

TOTAL EBL: min

TOTAL URINE: 200

SINGLE DOSE DRUGS MARK ON GRID WITH NUMBERS & ENTER IN REMARKS: 1000 1Gm Ancef

FLUIDS

LINE site LR ☐ Warmed — 2 (500)

☐ Warmed

☐ Warmed

☐ Warmed

FLUIDS SUMMARY

CRYSTALLOID- 1000

COLLOID- Ø

BLOOD- Ø

LOSSES

EST BLOOD LOSS

URINE - 200

PHYSICAL STATUS: (1)2345(E)

BODY WEIGHT: 60 (KG) LB

HEMATOCRIT:

INITIAL DATA:

BP- 118/48

P-99/R-18

HR- 60

EQUIP CHECK

OK?- (Y) N

PATIENT RECHECK

OK for PROCEDURE? Y

TIME- 1060

TIME ▶ 1000 15 30 45 1100 15

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

Scale: 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20

REMARKS

Code drugs with numbers, events with letters

0950 pt ID'd ! plan of Care Reviewed c̄ pt

1000 In Rm Monitors On

1005-1009 RSI c̄ Cricoid pres

1120 pt s/ regard TV, pt MAED Extubated c̄ pos pres. p̄ suctioning

VENTILATION / MONITORS / ACCESSORIES

VT - ml		850	850	850	850	
f - breaths/min		8	8	8	8	
Peak inf pres / PEEP		18	19	20	20	
MODE - S(pon), A(ssist), C(on)	S/C	C	C	C	C	S
BP/Auto Cuff — ET CO2 (torr)	(+)	32	30	30	30	(+)
BP/oth — FIO2 (Frac or %)	.86	.86	.86	.86	.86	.86
ART line — SpO2 (%)	100	100	100	100	100	100
Steth- PC/ES — ECG	SR	SR	SR	SR	SR	
Gas analyzer — TEMP-site						
N-M Block (T/4)	4/4	4/4	4/4		3/4	3/4

Tourniquet ↑ @ 275 mmHg ↑ —— ↓ Total time 50 mins

Warming blkt

Conv warmer

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

RECOVERY AT 1125

PACU (ICU) (Specify)

OTHER

CONDITION: stable

RESP- 12 SpO2- 100

BP- 112/52 HR- 73

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0950	1000	1140
	Ready	**Begin**	**End**
PROC	1010	1030	1120

PROCEDURES and CPT Codes: I&D (L) Knee (GSW)

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GETA

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

(b)(6)-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* DLx2 c̄ 3 Mil Visualized cords ! Intubated c̄ 8.0 ETT to 21 cm @ lip, BilAT BS ! ETCO2 x5 waves, Eyes taped

SURGEONS: (b)(6)-2 / (b)(6)-2

PROCEDURE LOCATION: 1-1

ANESTHETISTS: MAJ (b)(6)-2 AN, CRNA (b)(6)-2

DATE: 16Sept03

PAGE 1 OF 1

PRE-ANESTHESIA AND POST-ANESTHESIA EVALUATION

AGE: 23 HRS DAYS MOS YRS SEX: (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: I&D (L) Knee SURGICAL SERVICE: ortho

ASA PHYSICAL STAUS (1) 2 3 4 5 (E)
WEIGHT: _____ KG/LB HEIGHT: _____ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: ∅
ETOH: ∅
DRUGS: ∅

CURRENT MEDICATIONS:
([ ]= ordered as premed)
[ ] Ancef 1Gm @ 0215
[ ] Tetanus
[ ]
[ ]
[ ]
[ ]

PREMEDICATION:
None Yes (@ _____ Hrs) /OC
_____ ' _____ mg IV IM PO
_____ ' _____ mg IV IM PO
_____ ' _____ mg IV IM PO

LABORATORY STUDIES:
HB/HCT: _____ / _____
U/A: _____
OTHER:
16.6 / 49.5 < 16.1 / 316
137 / 4.2 / 104 / 23 / 1.7 / 9 / 108

PREOPERATIVE ASSESSMENT

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	N	Y
Endocrine System:	Diabetes	N	Y
	Steroids	N	Y
	Thyroid	N	Y
Neurological:	Seizures	N	Y
	Neuropathy	N	Y
	Other	N	Y
Gynecological:	Pregnancy	N	Y
Other Significant Hx:		N	Y GSW (L) leg
		N	Y (Knee)
Familial HX			

PAST SURGICAL/ANESTHETIC HISTORY
∅

PHYSICAL EXAMINATION T-99.1
BP 118/48 HR 60 RESP 18
HEENT – Teeth: Intact
Trachea: Midline
TMJ/Neck: FROM
Oropharynx: MPI
Nares: _____
CHEST: CTA
CARDIAC: S1S2
EXTREMITIES: MAE ° GSW to (L) leg
IV Access: #18g (L) AC
Urinar Filling: _____
BACK: _____
OTHER: _____

ANESTHETIC PLAN: [ ] Local [ ] MAC – [ ] Regional (Specify): _____ [ ] General: Mask Intubation

INFORMED CONSENT/COUNSELLING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed wih the patient/legal guardian. The patient/legal guardian seems to understand and agrees. Questions answered.

Signed: (b)(6)-2 MAJ/CRNA DATE: 0900 TIME: 16 Sept Hrs

CONDITION UPON ARRIVAL TO P.A.R.R. _____
VITAL SIGNS: BP _____ HR _____ RESP _____ SuO_2 _____
RESP STATUS: [ ] Spontaneous [ ] Assisted [ ] Cont'd
MENTAL STATUS: [ ] Awake [ ] Alert [ ] Lethargic [ ] Asleep
[ ] Responsive [ ] Unresponsive Block Level _____
REPORT GIVEN: [ ] Yes [ ] No

POST-ANESTHESIA EVALUATION AND NOTE
(X) NO APPARENT ANESTHETIC COMPLICATIONS [ ] OTHER

Sign (b)(6)-2 CPT DATE: 17 Sep 03 TIME 0950 Hrs

PATIENT IDENTIFICATION: (Ward: _____)

(b)(6)-4

WAMC Form 2300
1 Aug 92 (HSXC-SU)

PREVIOUS EDITION IS OBSOLETE
MEDCOM - 7487

☆ U.S. GPO: 1994-628-533/00102

PATIENT RECORD COPY

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER: 16 Sep 03 TIME OF ORDER: 0400. HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit to ICW preop.
2. D/ GSW to (L) knee.
3. Cond. Stable.
4. NPO
5. BR
6. IV NS @ 150 cc/hr
7. MSO4 5-10mg IV q 2-4° pm.

Noted 0400 16 Sep 03

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 16 Sep 03 TIME OF ORDER: HOURS

1. ADMIT ICU → ICW
2. D/ (L) KNEE GSW
3. COND: STABLE
4. VITALS: q ROUTINE
5. ACT: EPW RESTRAINT PRN
6. ALLERGY: NKA
7. DIET: ADV. TO REG

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: TIME OF ORDER: HOURS

8. IVF: LR @ 100 cc/HR b/c WHEN TOL PO
9. MSO4 2-4mg IV q 15' PRN PAIN (SEVERE)
10. PERCOCET I-II PO, 4-6H PRN PAIN (MODERATE) VICODIN I-II PO, 4-6H

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

EPW

DATE OF ORDER: TIME OF ORDER: HOURS

TOXS: PAIN, FEVER. (MILD PAIN)

11. ANCEF I g IV q 8H x 3 DOSES
12. LABS: Ø
13. AP/LAT (L) KNEE
14. D/C FOLEY

(b)(6)-4

(b)(6)-4

23 Sep

BED NO.

(b)(6)-2

(b)(6)-2

(b)(6)-2

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

MEDCOM - 7488

e 23 Sep

(b)(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

(b)(6)-4

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 17 SEP 03 TIME OF ORDER 2100 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) CONTINUE ANCEF
IV q 8H ANTIBIOTICS
48 HRS.

(b)(6)-2

(b)(6)-2

Top chart 18 Sep 03 0800

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 21 SEP 03 TIME OF ORDER 1400 HOURS

(b)(6)-2

(1) DISCHARGE TO MY CUSTODY
(2) SUTURES OUT IN 4 DAYS
BY CONTAINMENT MEDICAL
PERSONNEL → F/U & CONTAINMENT
PERSONNEL
(3) NO MEDS.

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

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

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

CLINICAL RECORD

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

Mo. ____ Yr. ____

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 16	17	18	19	20	21	22	23	24
16Sep	(b)(6)-2	NPO	06	(b)(6)-2								
			18									
16Sep		BR	06	(b)(6)-2								
			18	(b)(6)-2								
16Sep		VS q SHIFT	06	(b)(6)-2								
			14									
			22									
16Sep		ACT - RESTRAINT CPW	06									
			18									
16Sep		DIET RCR	06	(b)(6)-2								
			14									
			18									

ALLERGIES: ☐ YES ☐ NO
NKA

PRIMARY DIAGNOSIS:
GSW (L) Knee

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

PATIENT IDENTIFICATION:
(b)(6)-4

(b)(6)-2

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)			Mo 9 Yr 03	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
16Sep	(b)(6)-2	Admit to ICW cond: Stable	16Sep	0400	0400	(b)(6)-2
16Sep		Pre-op	16Sep	0400	0400	
16Sep		ADMIT TO ICU → ICW	16SEP		1220	
21Sep		DISCHARGE TO MP CUSTODY	21Sep	1100		–
21Sep		SUTURES OUT IN 4 DAYS BY COMPANYMENT	21Sep	1100		
		MEDICAL PERSONNEL → FLW W/ 17H MEDICAL	–			
		COMPANYMENT PERSONNEL PRN				
21Sep		PO Mon S	21Sep	1100		
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					

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

USAPA V1.00

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 9 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 16	17	18	19
16Sep	(b)(6)-2	IV NS @ 50cc/hr	06	(b)(6)-2			D/C TKO 16Sep03
			18				
16Sep		IV NS 100cc/hr	06	(b)(6)-2		NO ACCESS	
		DIC when PO TOL	18				
16Sep		Ancef IV 1gm q8H	06	(b)(6)-2			
		x3 doses	14				
			22				
17Sep		Ancef IV 1gm q8H x48H	6	(b)(6)-2			
			14				
			22				

ALLERGIES: ☐ YES ☐ NO

NKA

PRIMARY DIAGNOSIS: GSW (L) Knee

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

(b)(6)-4

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

2340

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

MEDCOM - 7492

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	Mo._____ Yr._____

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
16Sep	(b)(6)-2	MSO4 5-10mg IV														
- - - - -		q2-4° PRN														
16 Sep		MSO4 2-4mg IV q15'	1530 4mg	1732 4mg 2040												
- - - - -		PRN Pain (severe)	(b)(6)-2													
16Sep		Percocet 1-2 po q4-6H	1732 2 Tab 2040													
- - - - -		PRN Pain (moderate)	(b)(6)-2													
16Sep		Tylenol 1-2 PO q4-6	1530 1 PO	1902 1 PO												
- - - - -	- - - - -	PRN Pain, fever	(b)(6)-2													
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															

D/C 16 Sep 03

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: 16 Sep 03
Time In: 1130
Allergies: NKA
Pre-op V/S:
Procedures: ED of (L) Knee

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

OR Intake: Crystalloid 1000cc LR Colloid 0
OR Output: UOP 200cc EBL min
Meds/Times: Inj Vers 2.50 Fent 1gm Ancef (1000)

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

Pre Op Meds

History ASA 1E

Time	1130	1135	1140	1145	1200	1215	1230
SaO2	100	100	99	100	100	100	100
FiO2	100	100	100	100			
Methods	NC	NC	NC	NC	RA	RA	RA
240							
220							
200							
180							
160							
140				✓			
120	✓				✓	✓	
100		✓	✓				✓
80							
60	o	o	o	o	o	o	
40		^	^	^	^	^	o ^
20							
RR	16	19	10	8	12	13	12
T	98.6					98.6	
Time							
Pain (0-10)							
LOS							

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

PREPARED (b)(6)-2 SGT/LPN

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 16 Sep 03

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

(b)(6)-4

(b)(6)-4

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

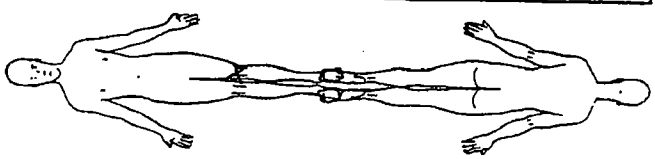
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) Knee	ACE	CDT
30'	"	"	"
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

1130-Pt arrived from CR via litter-hooked to monitor, satting 100% on 10lpm O_2 via NRB, Pt arousable to touch, dressing to (L) knee CDT (+) pulses, will monitor — [redacted] SGT/LPN

1200-Pt tolerating RA-satting 100%, pt awake & asking about friends. Ø% pain — [redacted] SGT/LPN

1220-Transfer criteria met-will give report to ICW — [redacted] SGT/LPN

Discharge Criteria:
Date: 16Sep03 **Time:** 1220 **PARS:** 12
BP: 107/49 **T:** 96.4 **HR:** 55 **RR:** 15 **Sa02:** 100
Pain Level at D/C (0-10): Ø
Intake: _____ **Output:** _____
Additional Data: _____
Transferred To: ICW
Report Given To: _____
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: SGT [redacted]
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: _____

ADMISSION AN. .ODING INFORMATION

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

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

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

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46: 2		

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52: K 2 8 POW/INT	53 54 55 56 57 58 59 60 61: 0 9 3 2 3 0 0 0 0

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
62 63: I Z	64 65 66 67 68 69 70	71: 9	YEAR ☐ NO

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

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYYYMMDD)
73 74: 0 5	75 76 77 78 79 80	81 82 83 84 85 86 87 88: 2 0 0 3 0 9 2 1

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
89 90 91 92: A E A B	93 94 95 96 97 98	99 100 101 102 103 104 105 106: 2 0 0 3 0 9 1 6

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYYYMMDD)
107 108: I Z	109 110 111 112 113 114	115 116 117 118 119 120 121 122

FOR LOCAL USE

GSW (R) KNEE
981.0 E991.2
I&D (L) Knee GSW

DX-8910
E9912
PR-8622
Trauma-1
Injury-450

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK

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

Admission and Coding Information

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

1. Reporting MTF (b)(2)-2	2. MTF Loca IZ			
3. Register Number (b)(6)-4	Name (Last, First, MI) (b)(6)-4		4. Pay Grade CIV	5. Sex M
6. DoB (YYYYMMDD)	7. Age at Admission	8. Race X	9. Ethnicity 9	Religion UNITARIAN
10. Length of Service	ETS	11. FMP 99	12. Social Security Number (b)(6)-4	
Organization (Active Duty Only)		13. Marital Status Z	Hour of Admission 00:20	Branch / Corps:
14. Flying Status	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES		16. Zip Code of Residence:	
17. Unit Location	18. MOS	19. Trauma BC	Prev. Admission NO	
20. Source of Admission Direct from ER	Ward: ICW	Name / Relationship of Emergency Addressee		
		Address of Emergency Addressee		
Name and Location of Medical Treatment Facility: (b)(2)-2		Telephone Number of Emergency Addressee		
21. Type of Disposition HOME	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2003-09-21		
24. Clinic Svc - Admitting AEA - ORTHOPEDICS	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-09-16		
27. Location of Occurrence IZ	28. MTF of Initial Admission	29. Date of Initial Admission 2003-09-16		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: GSW RIGHT KNEE

981.0 E991.2

Procedure Narrative(s): I&D I Knee GSW

Cause of Injury Narrative: TRYING TO STEAL AMMO

Admitting Officer (Signature, as required) (b)(6)-2 LTC, MC	Signature of Admitting Clerk (b)(6)-2

Automated Facsimile - DA FORM 2985, MAR 2000

MEDCOM - 7497

Automated Facsimile

INP...ENT TREATMENT RECORD COVER SHEET

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

(b)(2)-2

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

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

11. FMP	12. SSN	13. Organization	14. Ward
99	(b)(6)-4		ICW

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

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER		AAA - INTERNAL MEDICINE

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	TRF-OTH	2003-09-23

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-09-22	(b)(6)-2

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
(b)(2)-2	2003-09-22	

31. Selected Administrative Data

Marital Status: Z DoB:

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

LEFT PECTORAL MUSCLE STRAIN

35. Total Days This Facility

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

35. Total Days This Facility

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

Signature of Attending Medical Officer (b)(6)-2 (b)(6)-2 LTC, MC

Signature of PAD... Officer (b)(6)-2

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

See SF 558

PHYSICAL EXAMINATION

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

Imp: 1) Non-cardiac CP.
No evidence MI/Ischemia Hx, exam, Labs, ECG.
No further testing needed.
Advised to D/C smoking.

(b)(6)-2

SI		DATE	IDENTIFICATION NO.	ORGANIZATION
	M.C.	23 Sep 03		

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

REGISTER NO.	WARD NO.

(b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
22Sep03	
P- 68	38 Year old Male Complaining of chest pain wich radiates to Neck and left side of thorax
R- 20	pt states he has pn when his side is
Temp. 98°F	palpated. pt states 8 mos ago he had a heart
BP: 140/90	attack ⊖ surgery. pt states he has pn in chest
	for 3 hrs. (b)(6)-2
All: None	1745- Nitro given
	1747- Aspirin
Med: Lopressor	1750- 2nd dose of Nitro
	1810- 3rd Nitro
PSH: Surgery due to gunshot in Left Leg.	
PMH:	S- pt is 38 YO ♂ EPW who speaks no english; per translator, pt had MI 8 mos ago, and was told that he needed surgery, ⊖ surgery due to fear by patient. ⊖ was due to ⊖ money situation by patient. pt now presents w/ (L) arm and chest pain that radiates to (L) side neck, and down (L) arm; pt NAD, ⊖ diaphoresis. Only takes Lopressor for BP.
Tob: yes 2 ppd x 1987	pt has tobacco usage - 2 ppd x 87.
Alc: Yes	

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

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

(b)(6)-4

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

Cont.

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

(b)(2)-2 [redacted]

O- Heart - RRR
lungs - CTA A/P
musk - ⊕ pain (mild) on palp (L) ant chest, and pain not on palp. ⊕ pain on palp (L) ant shoulder and hip noted. ⊖ C spine tenderness, ⊕ chin to chest
neuro - strength 5/5, pulses wnl

A - Chest pain c̄ probable MI (pert)?

P - 1) 3 NTG's 0.4mg given @ 5 min intervals c̄ little ↓ in pain
2) 1 ASA 325mg given
3) 1 L Lx given
4) No pulse Ox avail @ this time (O2 later, P later)
5) EKG, CXR → sent by medevac to (b)(2)-2 [redacted] CASH.
Flu after CASH (pt accepted by Dr, (b)(6)-2 [redacted]
He was called and case discussed w/ him.)

(b)(6)-2 [redacted]

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
23 Sep 03	Narrative Summary
1400	38 YM Iraqi EPW admitted w/ chest pain.
	Admit 22 Sep 03
	D/C 23 Sep 03
	Admit dx: chest pain/muscle pain
	D/C Dx: 1) Non-cardiac chest pain
	2) Musculoskeletal pain.
	Pt brought from BAS. CP started yesterday and was not relieved w/ SLNTG. Only relieved ~~p~~ several hours, w/ MSO4. No evidence MI by EKG, Hx, labs.
	Pain is clearly musculo-skeletal.
	Disp: 1) Return to custody. No further testing needed.
	- Motrin 800 mg tid x 5d given.
	(b)(6)-2 (b)(6)-2 M.C.
	LTC MC

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

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

(b)(6)-4

REGISTER NO.	WARD NO.

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
2100	Nurses Notes: Admitted Pt from EMT to ICW via Stretcher. Vitals Stable Pt A+O breathing intact Ø SOB or Laboreal breathing. Ø O_2 needed. Pt able to transfer self from Stretcher to bed. Interpreter on hand to translate for Patient. IV NS to gravity Ø S/S of infiltration. Abd slightly distended normal for Obesity. Ø wounds Ø Signs of deformity. Will continue to monitor Status. — (b)(6)-2
2122	Pt changed into Scrubs. Offered and Pt ate MRE. Foley to gravity yellow urine draining Ø blood or particles noted in bag. WN continue to monitor Status — (b)(6)-2
03SEP2005 1420	Nursing: D/C Hx. Narrative Summary & D/C meds given to guard. — ILTR (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

(b)(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

EMERGENCY CARE AND TREATMENT

DATE: DAY 22 MONTH 9 YR. 03 TIME 1911

TRANSPORTATION TO HOSPITAL: ☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify) Air

CARRIER: Ø Lopressor per BAS note.

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER

ALLERGIES: NKDA

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

HOME TELE. NO.

CHIEF COMPLAINT (Include location(s), duration): Chest pains

SEX: M AGE: 38

POSSIBLE THIRD PARTY PAYER: ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 1905

VITAL SIGNS			
TIME	1912		
BP	117/71		
PULSE	66		
RESP.	20		
TEMP.	97.2 ⊕		
PS (Pulse Ox)	95		

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

ORDERS	INITS.	TIME
NC 6L/min		1912
IV		1930
EKG		1935
CBC/Chem 8, Chem 12, Trop		1932
ABCs, Foley, O2		
MSO4 2mg IV.		

ASSESSMENT/DIAGNOSIS: ⓛ Pectoralis muscle pain.

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

S: Pt is a 38yo Iraqi or EPW who was just brought to EPW camp today & c/o ⓛ CP → ⓛ Arm. Sent by Helo from [redacted] (b)(2)-2 for eval. Pt had been R ō ASA & NTG x3 over an hour ō appreciable benefit. CP was 8/10 @ onset while pt at rest riding in a truck from another EPW Camp to Tikrit Camp. ⊖ Assoc ō exertion. Denies any Trauma, arm use. ⊖ Diaphor, N/V, SOB. Previous eval for CP was 8mo from another "Camp" up North. Onset of CP @ 1200 today. ⊖ Acid Brash, ⊖ Indigestion. Unprocessed @ 1600 from Kirkuk, seen there 3d ago for HTN & ? Started on meds.

O: NAD min NAD A&O x3 Ambulated ō diff off Helo. ⊖ Diaphor ⊖ Respir dist. Non Toxic appearing. Good Color.

HEENT: NC/AT PERRLEOMI mmm.

Chest: ⊕ Reproducible tend to ⓛ Pectoralis insertion to humerus & ant axilla reprod C/c. ⊖ Crep. ⊖ sq emphy.

Lungs: ⊕ CTA.

Cor RRR ⊖ ⊖

Abd: ⊕ BS. S NT NO ⊕ Rlb.

Rectal: NT NL Pros. Brn stool guaiac ⊖.

Ext: ⊖ C/C/E.

EKG: SB ō Sinus Arrhythmia. No ischemic Δ's.

MSO4 2mg IV @ 1920

EPC: minimal CP p̄ MS 2mg IV. Pn relieved p̄ 2nd dose of 2mg MS.

ISB
2pck/day
PSHx
ⓛ leg GSW
PMHx
Ø
Reports MI
US Narrowed "Crown" art.
8mg ō reid.
⊖ Cath.
⊕ Echo
⊖ GXT

CRF
⊕ Tob. 30pk yr. ? Prior Dz.
⊕ ↑
? Chol.
⊕ Fam Hx
⊕ HTN by PA report but not by Pt. PA reported Lopressor

9.2 > 7/50 < 257 | 131/4.2 | 104/26 < 9/1.2 | 92
Chem 12 NL. CK. 102
UA: Hyal, Cir Chol 181
1.015, 5.0 g/l ⊖ Trop. Neg

7.49/36/112/27/4/99%

DISPOSITION (Check all that apply): HOME | FULL DUTY

QUARTERS: 24 Hrs. | 48 Hrs. | 72 Hrs.

MODIFIED DUTY UNTIL: DAY | MONTH | YEAR

REFERRED TO (Appropriate clinic): Dr (b)(6)-2

- EMERGENCY | TODAY
- ☒ 72 HOURS | ROUTINE

ADMIT. TO HOSP. UNIT/SERVICE: ICW.

CONDITION UPON RELEASE
- ☒ IMPROVED | UNCHANGED
- DETERIORATED

TIME OF RELEASE: 2000

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

(b)(6)-4

9/1965

(CONTINUE ON SF 507, IF NEEDED)

SIGN: (b)(6)-2

AND ID STAMP: 91W (b)(6)-2

TO ICW

EMERGENCY CARE AND TREATMENT

Medical Record Copy

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY				2													
POST- DAY																	
MONTH-YEAR	DAY			23 Sep													
19	HOUR	2 3		0 1													
PULSE (0)	TEMP. F (°)	1 5		6 4													
		6 8		8 8													
	105°																TEMP. C
																	40.6°
180	104°																
																	40.0°
170	103°																
																	39.4°
160	102°																
																	38.9°
150	101°																
																	38.3°
140	100°																
																	37.8°
130	99°																
	98.6°																37.2°
120	98°																37.0°
																	36.7°
110	97°																
																	36.1°
100	96°																
																	35.6°
90	95°																
																	35.0°
80																	
70																	
60																	
50																	
40																	
RESPIRATION RECORD				35													
BLOOD PRESSURE		138/84		118/74													
		126/62		120/76													
HEIGHT:	WEIGHT →	95%		94													
		95%		95													

(Centigrade Equivalents, for Reference only)

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

(b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

Ward/Section: EMT

Requesting Physican: (b)(6)-2

LABORATORY RESULT FORM

(Pursuant to the Privacy Act of 1974)

(b)(6)-4

Date: 22 Sept 03

Time: 1934

Patient # (b)(6)-4

Chemistry 7

Test	Result	Ref. Range
GLU		73 - 118 mg/dL
BUN		7 - 22 mg/dL
Creat		0.6 - 1.2 mg/dL
Na		128 - 125 mmol/L
K		3.3 - 4.7 mmol/L
Cl		98 - 108 mmol/L
tCO2		18 - 33 mmol/L

Chemistry 12/LFT

ALB		3.5 - 5.5 g/dL
ALP		26 - 84 µg/dL
ALT		10 - 47 µg/dL
AMY		14 - 97 µg/dL
AST		11 - 38 µg/dL
Tbili		0.2 - 1.6 mg/dL
TP		6.4 - 8.1 g/dL
Ca		8.0 - 10.3 mg/dL
Chol		100 - 200 mg/dL
Creat		0.6 - 1.2 mg/dL
BUN		7 - 22 mg/dL
GLU		73 - 118 mg/dL

Other Chem

Troponin		Negative
GLU Only		73 - 118 mg/dL
CK		39 - 380 µg/L - Male
		30 - 190 µg/L - Female

Urinalysis

Test	Result	Ref.Range
Color	Lt Yellow	N/A
App	Clear	N/A
Glu	NEG	Negative
Bili	NEG	Negative
Ket	NEG	Negative
SGav.	1.015	N/A
Bld	NEG	Negative
pH	5.0	N/A
Prot	NEG	Negative
Urob	0.2	0.2 - 1.0
Nit	NEG	Negative
Leuk	NEG	Negative

Micro UA

Blood Gas @ 2030

ph	7.399	7.31 - 7.45
PCO2	45.4	35 - 45: Art
PO2	124	80 - 105
HCO3	28	22 - 26
TCO2	29	23 - 27
BE	3	(-2) - 3
sO2	99	95 - 100%

Hematology (CBC)

Test	Result	Ref. Range
WBC	9.2	4.8 - 10.8 x 1E3
RBC	5.30	4.7 - 6.1 x 1E6
Hgb	16.6	14 - 18 g/dL (M); 12-16 (F)
Hct	49.1	45 - 52% (M); 37 - 47% (F)
MCV	92.6	80 - 99 fL
Plt	251	130 - 500 1E3
Lymph%	47.0	20.5 - 51.1 %

Hematology Manual Diff

Segs	Lymph
Bands	Atyp
Mono	Imm
Eos	RBC Morph
Baso	Plt. Est

Coagulation

PT		9.8 - 13.6 sec
aPTT		21 - 34 sec
INR		N/A

MISC

Malaria		Negative
Gram Stain		N/A
UA Tox:		Negative
HCG		Negative

Additional Instructions: Chem 8

(b)(6)-2

Date 22 Sept

Lab ID # (b)(6)-2

Ward/Section: EMT

Requesting Physician: (b)(6)-2

ORATORY RESULT FORM

(b)(6)-4

ct to the Privacy Act of 1974)

Date: 22 Sept 03

Time: 1943

Patient # (b)(6)-2

Chemistry 7

Test	Result	Ref. Range
GLU	92	73 - 118 mg/dL
BUN	9	7 - 22 mg/dL
Creat	1.2	0.6 - 1.2 mg/dL
Na	131	128 - 125 mmol/L
K	4.2	3.3 - 4.7 mmol/L
Cl	104	98 - 108 mmol/L
tCO2	26	18 - 33 mmol/L

Chemistry 12/LFT

ALB	3.6	3.5 - 5.5 g/dL
ALP	83	26 - 84 µg/dL
ALT	76	10 - 47 µg/dL
AMY	33	14 - 97 µg/dL
AST	63	11 - 38 µg/dL
Tbili	0.8	0.2 - 1.6 mg/dL
TP	7.3	6.4 - 8.1 g/dL
Ca	9.9	8.0 - 10.3 mg/dL
Chol	181	100 - 200 mg/dL
Creat	1.1	0.6 - 1.2 mg/dL
BUN	8	7 - 22 mg/dL
GLU	97	73 - 118 mg/dL

Other Chem

Troponin	NEG	Negative
GLU Only		73 - 118 mg/dL
CK	102	39 - 380 µg/L - Male
		30 - 190 µg/L - Female

Urinalysis

Test	Result	Ref.Range
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SGav.		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2 - 1.0
Nit		Negative
Leuk		Negative
Micro UA		

Blood Gas

ph	7.493	7.31 - 7.45
PCO2	35.8	35 - 45: Art
PO2	112	80 - 105
HCO3	25.7	22 - 26
TCO2	29	23 - 27
BE	4	(-2) - 3
sO2	99	95 - 100%

Hematology (CBC)

Test	Result	Ref. Range
WBC		4.8 - 10.8 x 1E3
RBC		4.7 - 6.1 x 1E6
Hgb		14 - 18 g/dL (M); 12-16 (F)
Hct		45 - 52% (M); 37 - 47% (F)
MCV		80 - 99 fL
Plt		130 - 500 1E3
Lymph%		20.5 - 51.1 %

Hematology Manual Diff

Segs	Lymph
Bands	Atyp
Mono	Imm
Eos	RBC Morph
Baso	Plt. Est

Coagulation

PT		9.8 - 13.6 sec
aPTT		21 - 34 sec
INR		N/A

MISC

Malaria		Negative
Gram Stain		N/A
UA Tox:		Negative
HCG		Negative

Additional Instructions:

Reported By	Date	Lab ID #

3x4 Simultaneous Report

Name: (b)(6)-4
Number: (b)(6)-4
Sex: Male
Date of Birth: 9/23/1965 (38 years)
Height/Weight: 71in / NA

Recorded: 9/23/2003 2:34:50 AM
Device: CL 131127

Measurements

Heart Rate:	59 bpm
P Duration:	102 ms
PR Interval:	160 ms
QRS Duration:	86 ms
QT Interval:	392 ms
QTc Interval:	387 ms
P,QRS,T Axis:	28°, 28°, 20°

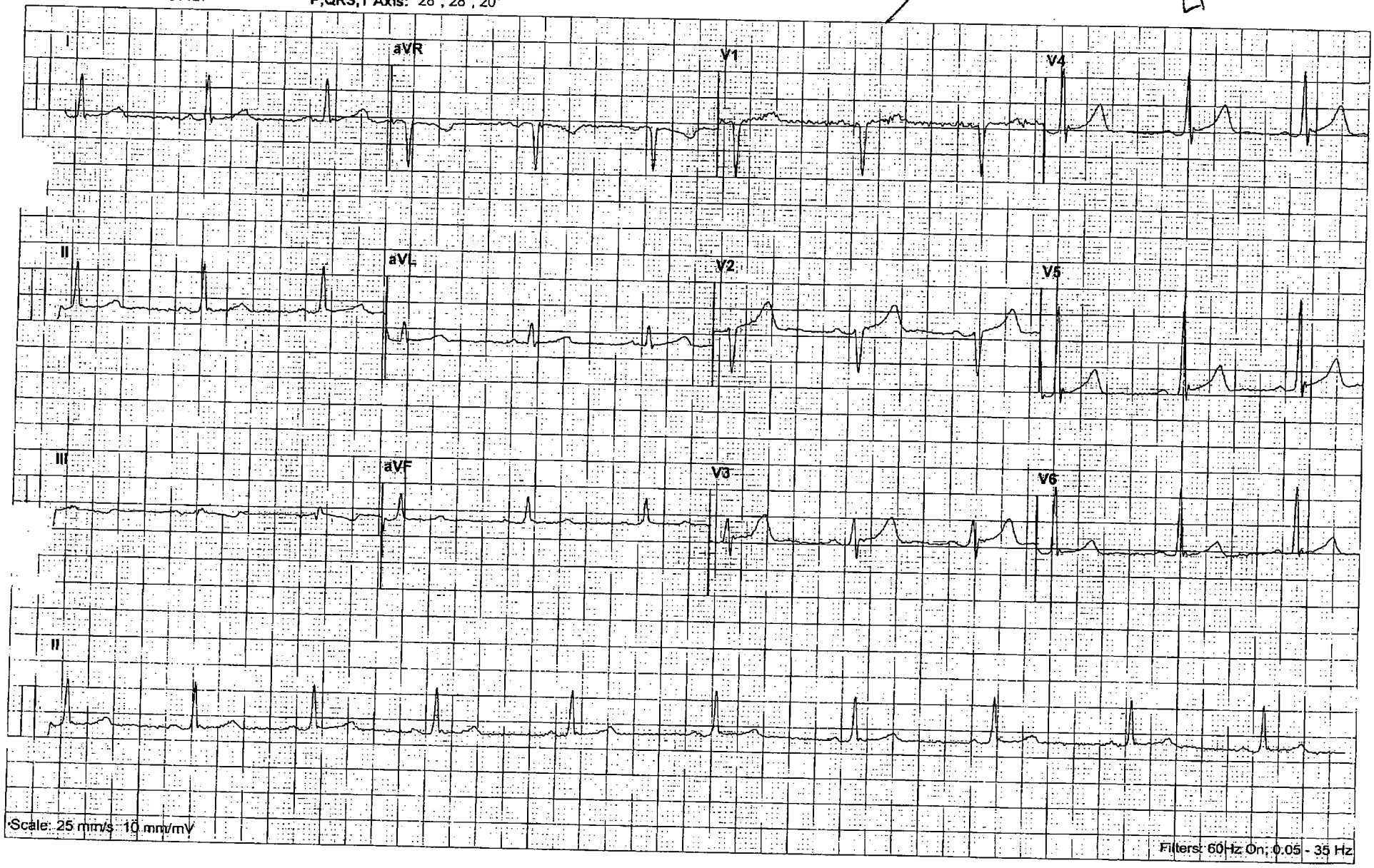
Interpretation (Unconfirmed)
Sinus bradycardia
Sinus arrhythmia
Normal morphology

NL

(b)(6)-2

(b)(6)-2

LTC M.C



MEDCOM 7508

(Data must be reviewed by a qualified physician)

Confirmed by:

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

(b)(6)-4

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 22 Sep 03. TIME OF ORDER: 2030 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit to ICW
2. Dx ① Pectoralis muscle Pain
3. Card Stable.
4. VS q Shift.
5. Reg Diet
6. IV NS @ 125 cc/hr.
7. D/c Foley in AM.

Mod 1/1 22 Sep 03 2300

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

8. Motrin 600 mg I po q 6°
9. Msoy 2 mg IV q 2° prn.
10. ASA 325 mg I po q d.

(b)(6)-2

24° Chart ✓ 22 Sep 03 @ 2300

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 23 Sep 03 TIME OF ORDER: 1400 HOURS

1. D/c IV & D/c to EPW camp when ride available.

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

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.

U.S. GOVERNMENT

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. 9 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 22	23
22	(b)(6)-2	VS q Shift	6	/	/
			14	/	/
			22	(b)(6)-2	
22	(b)(6)-2	Regular diet	7	/	(b)(6)-2
			12	✓	
			17	/	

ALLERGIES: ☐ YES ☑ NO

NKDA

PRIMARY DIAGNOSIS:

(L) Pectoralis Muscle Pain

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 9 Yr 03

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
22	(b)(6)-2	Admit to ICW				
22		Condition: Stable		Done		
22		D/C Foley in Am	23 Sep		0740	(b)(6)-2
23 Sep		D/C TO EPW Camp when ride available			1555	
	- - - - -					
	- - - - -					
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Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
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USAPA V1.00

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

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

Mo. 9 Yr. 9

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 2023
22	(b)(6)-2	IV NS @ 125 ml/hr	6	✓
			14	✓
			22	(b)(6)-2
22	(b)(6)-2	ASA 325mg ÷ PO q d	10	(b)(6)-2
22	(b)(6)-2	Motrin 600mg ÷ PO q 6°	6	✓ (b)(6)-2
			12	✓
			18	✓
			24	(b)(6)-2

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS:

(L) Pectoralis Muscle Pain

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

(b)(6)-4

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	Mo. 9 Yr. 8

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
23 Sep	(b)(6)-2	D/C IV			1400	(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED													
22	(b)(6)-2	M-SO4 2mg IV														
		q 2° PRN														

USAPA V1.00

ADMISSION AND CODING INFORMATION

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

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

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

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

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

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52: K 7 8	53 54 55 56 57 58 59 60 61: 0 9 3 2 3 0 0 0 0

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
62 63: I Z	64 65 66 67 68 69 70	71: 9 Dis	YEAR ☐ NO

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

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYYYMMDD)
73 74: 0 5	75 76 77 78 79 80	81 82 83 84 85 86 87 88: 2 0 0 3 0 9 2 3

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
89 90 91 92: A A B A	93 94 95 96 97 98	99 100 101 102 103 104 105 106: 2 0 0 3 0 9 2 2

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYYYMMDD)
107 108: I Z	109 110 111 112 113 114	115 116 117 118 119 120 121 122

FOR LOCAL USE

(2) pectoral muscle strain
Dx: 84849
9927
Pr: 9929

Inj Trauma
949 8

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK

Admission and Coding Information

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

1. Reporting MTF (b)(2)-2	2. MTF Loc: IZ			
3. Register Number (b)(6)-4	Name (Last, First, MI) (b)(6)-4		4. Pay Grade CIV	5. Sex M
6. DoB (YYYYMMDD)	7. Age at Admission	8. Race X	9. Ethnicity 9	Religion MUSLIM
10. Length of Service	ETS	11. FMP 99	12. Social Security Number (b)(6)-4	
Organization (Active Duty Only)		13. Marital Status Z	Hour of Admission	Branch / Corps:
14. Flying Status	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES		16. Zip Code of Residence:	
17. Unit Location	18. MOS	19. Trauma DIS	Prev. Admission NO	
20. Source of Admission Direct from ER	Ward: ICW	Name / Relationship of Emergency Addressee		
Name and Location of Medical Treatment Facility: (b)(2)-2		Address of Emergency Addressee		
		Telephone Number of Emergency Addressee		
21. Type of Disposition ~~TRF-OTH~~ 05	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2003-09-23		
24. Clinic Svc - Admitting AAA - INTERNAL MEDICINE	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-09-22		
27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission 2003-09-22		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: LEFT PECTORAL MUSCLE STRAIN

Procedure Narrative(s):

Cause of Injury Narrative:

Admitting Officer (Signature, as required) (b)(6)-2 (b)(6)-2 LTC, MC

Signature of Admittin (b)(6)-2

Automated Facsimile - DA FORM 2985, MAR 2000

MEDCOM - 7515

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

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

(b)(3)-1

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

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

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

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

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	14:05	ABA - GENERAL SURGERY

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	HOME	2003-10-04

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-09-23	DR (b)(6)-2

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
~~(b)(3)-1~~ (b)(2)-2	2003-09-23	

31. Selected Administrative Data

Marital Status: Z DoB:

In/Out Patient: Inpatient MOS:

33. Cause Of Injury: PT RAN A CHECKPOINT WITH A WEAPON IN HIS VEHICLE.

34. Diagnosis / Operations and Special Procedures:

GSW ABDOMEN, FRAGMENTATION WOUND LEFT ELBOW

879.2 54.72

EX LAP, BOWEL RESECTION AND REPAIR, LEFT ELBOW DEBRIDEMENT

35. Total Days This Facility

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

35. Total Days This Facility

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

Signatur (b)(6)-2 (b)(6)-2 MAJ, Signature of PAD or Medi (b)(6)-2 (b)(6)-2 SSG, PAD NCOIC

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

65 yo IRAQI Male who was shot today
at 1300 when he ran a check pt,

Ø730 last meal

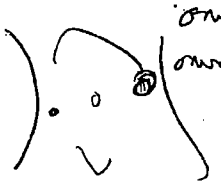
NKDA | MMS | PMH | PSH
TOB - Quit 1991 | Orthostatic Hypotension | MI Bypass x3 - DM. | Ø

Bleeding

RVS - Stum (-)

PHYSICAL EXAMINATION VS P 88 BP 136/86 98.7 78 kg

Gen - Elderly Male in AD,
HEENT Ø NECK - No distended neck veins,
CHEST - Ø HEART - RRR & (M) ABDomen - Flat - ØBS
omental eviscerated
omentum



Rectal (-)
MS - (L) Deltoid
Oriented x3
Neuro - Grossly intact

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

A: GSW to ABDomen
P: To OR for exploratory Laparotomy / ITD bullets

(b)(6)-2 MD
MC USA

(b)(6)-2

	DATE	IDENTIFICATION NO.	ORGANIZATION
	23 Ø8 03		

n entries give Name last, first, middle; hospital or medical facility)

REGISTER NO.	WARD NO.

(b)(6)-2

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
23 Sept 03	Arrival: 1405 64y/o O_2 NRB mask 15LPM
TOI	arrived c̄ I.V. access NaCl 9% (L) Arm (pm tx.)
78kg est	1406: wounds exposed. Entrance/exit wounds,
	(L) ABD and (R) ABD c̄ evisceration from (psh tx)
V/S 1405	(C) ABD 1405
BP: 136/91	Guaic (-) 1408
P: 93	14:09 Blood drawn, I.V. started (R) ACTHO LR (Allergies)
R: 30	LOI: 730 Hrs A.M. (meds)
T: 98.7 (R)	Lungs: CTA
PSO2: 92% Room Air	1415 Foley in place.
hx diabetes,	1415 Fast Exam, AAS, PCXr, UA
heart condition	Pt states 'alot of pain'
(-) Surgeries	ultra sound @ 14:15
orders	1415 Morphine 5mg MSO4 via I.V.
Foley, ABG	1416 Tetanus IM (L) Deltoid
xray	1416 Blood draw from femoral artery
Allergies	1417 unasyn 3gm via I.V.
NKDA	VS 1415 BP 147/85 P81 R26 O_2 98% on NRM 100% 1420: 12 Lead EKG. Wounds covered c̄ sterile
	Gauze.
Meds	ABG
hx for diabetes	FAS MFI Back clear
(-) Smoker	1433 morphine 5mg via I.V. <OVER

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

SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* REGISTER (b)(6)-2 WARD NO.

(b)(6)-4

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

V/S 1447

BP 122/83
P 85
SpO_2 98%

Depart: to O.R via litter
@ 1450

SPT - (b)(6)-2 91320

AUTHORIZED FOR LOCAL REPRODUCTIC

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
23SEP03	OP NOTE
1600	PRE-OP DX – GSW ABDOMEN, L-SCT (ECOBON)
	POST-OP DX – Transverse Colitis, Soft tissue injury, Abdom wall (L) colon
	PROCEDURE – EXPLORATORY LAP, Transverse colectomy, hand I+D
	SURGEONS – Dr [redacted] (b)(6)-2, [redacted] (b)(6)-2, [redacted] (b)(6)-2 – Gr [redacted] (b)(6)-2
	FINDINGS – Transverse colon entering Abdominal wall injury, (L) Abdom injury
	DESCRIPTION – GSW – Propelling Retroperitoneal hematoma in area from below Xiphoid to midline pelvis / Pubic – ~400cc
IV Fluids in	blood encountered upon entry into peritoneal cavity, 4 Quadrants packing
1700 ILLR	injury Found transverse colon w/ 1 colotomy and 1 deep serosal injury
1 in PRBC	plus bruising of colon x 3cm. Omentum devitalized ~10 cm diameter
1892 – 400 cc	1 cm laceration tear of spleen – Not Bleeding. Liver Ø Stomach Ø –
	Small Bowel seen Ø – Colon/Rectum other than Nl – ~3-4 cm Jejunal
WS – 700 cc	injury and AAA seen – No bleeding. Transverse colectomy –
	w/ primary stapled anastomosis. Staples entry closed in 2 layers.
DRAINS: NGT	Abdomen irrigated w/ 6L NS until clear, Dry minimal spillage
FOLEY	Entry site RLQ and exits LLQ – skin excision, (L) – Subcutaneous flap
CMP: Ø	raised by Abdo injury (5.5cm) wound, Anterior Rectus sheath
	torn and bruised to (L) rectus M. ⇒ Repaired w/ int. Figure of 8 sutures
Antibiotic therapy	w/ O Vicryl. Fascia was then opened to closed obtained w/
UNASYN 3	interrupted Figure of 8 sutures #1, Wound is packed w/ Pulse

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

LAST NAME | FIRST NAME

DATE	NOTES
	Lavage was performed w/ Saline Sterile gauze / Amp. Left elbow - prepped / Prepped - Skin edges eversed - interrupted w/ 3-0 Silk - Pulse lavage, wound packed w/ Saline Sterile gauze, Flaff, Roll Kerlix Acc. Pt tol procedure well - Stabilized / Evacuated and transported to FRU in Stable condition

(b)(6)-2 MD

(b)(6)-2

MAJ, MC USA
CHIEF, DOS

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.0

MEDICAL RECORD	PROGRESS NOTES
DATE	
23 Sept 03 1830	Pt From OR, Transfered to bed, O2 via Mask @ 15L/min, LR to IV in RFA & IRD, A-line to (R) wrist with damped Wave Form, HR >100 given metroprolol 5mg IV, (b)(6)-2 CPT/AN
1940	Given 4mg IV MSO4 for Pain (b)(6)-2 CPT/AN
2000	Bs 257 given 9u Reg Insulin per sliding scale Dr Notified of K 6.3 No additional Orders Recieved (b)(6)-2 CPT/AN
2140	Given 4mg IV MSO4 for Pain (b)(6)-2 CPT/AN
2304	W/o ↓ 20 cc/hr Dr Notified Orders Received (b)(6)-2 CPT/AN
2400	BS 105 No insulin coverage required (b)(6)-2 CPT/AN
24 Sept 03 0130	Pt given MSO4 5mg IV for Pain (b)(6)-2 CPT/AN
0306	SBP 92 per Orders Dr Notified Orders Received (b)(6)-2
0440	AM Labs drawn (b)(6)-2 CPT/AN
0500	24° I+O IV in 5125 w/o 1000 cc BL 400 Balance + 3685 (b)(6)-2 Dr Notified of ↓ SBP 86 + Shown Labs, Orders Received
0630	Report received from CPT (b)(6)-2. Pt BP 83/53, will notify MD, assessment performed (see DA 4700) pt resting in bed. will monitor (b)(6)-2 SGT/LAN
0700	Pt receiving Hespan bolus per Dr order. BP 78/49 - will monitor (b)(6)-2 SGT/LAN
0800	CPT (b)(6)-2 in to start new A-line in (R) radial - correlating c NI cuff, FS done, BG - 121, Ø insulin given. New PIV started in (R) FA 2° infiltration of bolus. Will notify MD. (b)(6)-2 SGT/LAN

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE	
1000	Pt comfortable, LR infusing to TLC (distal), PIV heplocked. O2 ↓d to 2lpm, Pt still satting 99%. Will monitor. (b)(6)-2 SGT/LPN
1130	Pt bathed & shaved, given 4mg MSO4 for c/o pain to abd incision site. Dressings reinforced for serous fluid saturation. Will monitor. (b)(6)-2 SGT/LPN
1330	Pt resting, HOB ↑ 45°, pt c/o pain to abd incision site. 2mg MSO4 given. (b)(6)-2 SGT/LPN
1530	Pt sleeping ∓ c/o pain. (b)(6)-2 SGT/LPN
1730	NG tube flushed - occlusion present. 100cc fluid aspirated. HR ↑d to 125-130, Lopressor given & 1,000cc LR bolus started per MD. Pt c/o hiccups earlier. 25mg Thorazine given. Pt now sleeping. (b)(6)-2 SGT/LPN
1820	Pt extremely agitated - pulled out NG tube, very restless - wants to move self - temp 101.4, MD notified. Ordered not to re-insert NG. 4mg MSO4 given. Report given to oncoming shift. (b)(6)-2 SGT/LPN

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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

PROCEDURE NOTE

9/24/03 (2) SC TLC inserted c̄ sterile technique; ~~attempt~~ x 3.

0915 PROCEDURE - Central venous access

INDICATION - loss of peripheral access

SURGEON [redacted] (b)(6)-2 CORAD ASSIST (b)(6)-2 M.D

DESCRIPTION - Left chest prepped w/ Betadine thru 5-c LA w/ 1% LIDOCAINE. Modified Seldinger technique used for access. Left subclav v. TLC advanced to 15 cm and suture secured. All 3 ports c̄ good blood return and easy flush. CXR ordered. (b)(6)-2 (b)(6)-2 CCR

1215 CXR w/ Catheter tip c̄ good placement

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

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

(b)(6)-4

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
25 SEP 03	OP NOTE
(1)	SURGEON: (b)(6)-2 (2) ASSIST (b)(6)-2
(3)	DX: ABDOMEN GSW, (L) ELBOW GSW
(4)	PROCEDURE: EXTRA FASCIAL I+D C̄ DPC LAPAROTOMY; I+D (L) ELBOW, TRICEPS TENDON REPAIR, DPC.
(5)	FINDINGS: CLEAN LAPAROTOMY INCISION SITE; SOME NECROTIC MATERIAL @ ENTRANCE/EXIT WOUNDS → PACKED OPEN; LAPAROTOMY INCISION CLOSED; INTRA ARTICULAR GSW IRRIGATED / CLEAN WOUNDS; 50% TEAR (PARTIAL THICKNESS) TRICEPS LACERATION REPAIRED C̄ FIG 8 3-0 PROLENE. TRAUMATIC LAC + EXTENSIONS CLOSED.
(6)	EBL: MIN; FLUID 500 NS; UOP 400 cc
(7)	COMPLICATIONS: NONE
(8)	CONDITION: STABLE TO ICU.
	(b)(6)-2 (b)(6)-2

STANDARD FORM 509 (REV. 6/1999) BACK

USAPA V1.0

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

24Sep03
1030

Cardiology

Day 1 post-op from ex-lap and bowel repair 2° GSW.
No angina today. (last angina by Hx was several MOS ago)
No dyspnea. Has abd pain - post-op.
His PMH includes MI (ASCAD) ~ 10 yrs ago. Was on meds for 5-6 yrs but D/C meds x 4 yrs. No cardiac procedures, no routine F/U. Also DM II on oral Rx (unknown name).

Neuro: Alert, no issues.
CV: 80's-100's / 50-60's, 90-110; on metoprolol 5mg IV q6°.
- No Δs - BP is appropriate range. Would like HR slightly lower, but we should allow that to occur gradually. Will discuss use of ASA w/ 1° surgeon.
[Repeat echo today: Grossly NL LV/LA size - LV lower-limits NL fxn, ∅ obvious WMA, sclerotic AoV - ∅ obvious AS.]
Pulm: Lungs CTA, good sats w/ 2L NC. No issues.
Renal: Adequate UOP for wt. Agree w/ volume challenges to maintain BP/UOP. Cardiac status should tolerate extra volume. May need judicious Lasix in next 24-48° as 3rd space volume returns intra-vascular.

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME		(b)(6)-2	SOR'S ID NUMBER (b)(6)-2
	LAST	FIRST		MC
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORD		LTC MC
ATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)		REGISTER NO.		WARD NO.

(b)(6)-4

PROGRESS NOTES
Medical Record

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

AME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
25 Sep 03	Pt cooperative the last hour - Sa.02 99% on 3LNC -
	Labs drawn - Pt NPO, extremities warm, cap refill
0515	brisk < 3 seconds - Foley still draining QS urine
	Dsg's intact & S/Sx of bleeding or dehiscence of
	wounds - will continue to monitor - (b)(6)-2

(b)(6)-4

STANDARD FORM 509 (REV. 5/1999) BA
USAPA

AME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
1830	Report recieved from dayshift - Pt sitting up in bed - Eyes open somewhat agitated - responding to interpreter questions - Vital Signs Stable - See flowchart SpO2 99% 2L NC - Triple lumen (R) subclavian central line LR infusing @ DSaline into medial port, Distal port used for arterial line, proximal port unused, Ø other IV access - Dsg to abd covering abd incision - Dsg CDI I (R) arm Dsg CDI I ace wrap to elbow + Foley to gravity draining clear yellow urine QS - BP cuff to (L) calves - Lungs CTA bilat ↓ in bases shallow inhalation - Pt afebrile 100 (T) - (Map average 72-76) (CVP 6-9) (HR 96-11[illegible]
	(b)(6)-2
1900	Pt somewhat agitated - trying to get out of bed, pulling @ lines - Benadryl 50mg IVP per Dr (b)(6)-2 repeat x 1 if needed - Vital Signs Stable SpO2 97% 2L NC - talking c interpreter (b)(6)-2 Pt benadryl calm - sleepy
1930	Pt trying to pull out lines, foley and attempting to get out of bed repeat benadryl 50mg IVP Pt seems alert and attempting to communicate interpreter states pt angry - unsure of issues being communicated ? Dr [redacted] (b)(6)-2 aware of problem
	(b)(6)-2
2000	IV antibiotic infused - Temp 100° - Pt NPO for surgery tomorrow per Dr. [redacted] (b)(6)-2 - Foley draining QS urine > 50 cc/hr < 100 - Pt moving all extremities - 4mg MSO4 for abd pain though interpreter (Neb)

STANDARD FORM 509 (REV. 5/1988) B/
USAPA

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
2230	Pt. uncooperative - pulling at lines - 5mg Ambien P.O. c̄ small sip per Dr [redacted] (b)(6)-2
	Pt. required holding down in bed by guard and myself - Vital Signs Stable Sa02 99%
2320	5mg IV valium x 1 now (Dr Hodges) - Pt pulled out
2100	(R) arterial line - pressure to control bleeding
	Pt continues to be uncooperative - Restraints
2400-FS 94 Ø insulin	to bilat hands and (R) foot - Vital Signs
	@ 0100 133/55 P-106 R-24 Sa02 99% SL NC
0200	Pt sleeping, calm, restraints in place - neurochecks
	to hands and feet WNL - (b)(6)-2
0300	Pt screaming, attempting to get out of bed - held
	down by staff and guard - Pt pulled
	Nasal Cannula off - Sats dr 80 % -
	NRB placed to increase sats - Pt held until
	4mg Imsom and NRB in place, Sats 100%
	Pt still uncooperative - restraints in place and secu
0315	Pt still talking, but calm - Vital Signs Stable
	3 lumen central line still in place LL @ 125 c/hr.
	Foley to gravity draining ⊘S urine - NC @ 4L
	Sa02 96%

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

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

REGISTER NO. | WARD NO.

(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV.
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.2
USA

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
25 Sep 03	1826 Pt Care Assumed, Physical Assessment Completed (b)(6)-2 CPT/AN
1859	Pt reports via interpetor that Vision is Foggy (b)(6)-2 CPT/AN
1930	Pt ↑ Ambulate x 50 ft (b)(6)-2 CPT/AN
2000	BS by Finger stick 105 No Insulin ~~Dose~~ Given, MSO4 3mg IV For Pain [redacted] CPT/AN (b)(6)-2
2100	Pt Requesting Sleep Aid, Given Ambien 5mg PO (b)(6)-2 CPT/AN
2300	Pt Agitated given Haldol 5mg IM (b)(6)-2 CPT/AN
0100 26 Sep 03	Pt given 3mg MSO4 For Pain (b)(6)-2 CPT/AN
0300	Pt given 5mg MSO4 For Pain (b)(6)-2 CPT/AN
0400	AM Labs drawn, BS 86 (b)(6)-2 CPT/AN
0500	24° I+O IV 4100 U/O 3720 Balance + 380 (b)(6)-2
0630	Report received from CPT Cline, assessment performed (see DA4700), pt restless & confused, in & out of sleep, not connected to cardiac monitor 2° anxiety, pt tried to get out of bed, was calmed by staff & encouraged to lay down & will monitor closely (b)(6)-2 SGT/LAN
0740	Pt ate jello & drank tang per Dr. order for clear liquids, so far tolerating well. Pt bathed and is now sitting up in bed. (b)(6)-2 SGT/LAN
0830	Pt up ambulating - reconnected to O2 after desatting to 76%, now sitting in chair. (b)(6)-2 SGT/LAN

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

(b)(6)-4

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV.
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.2(
USA

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
25Sep03 0630	Report received, assessment performed (see DA4700), pt now appears somewhat restless & agitated, rolling around in bed, pulling at Foley. Cannot find interpretor - Will monitor & notify MD. (b)(6)-2 SGT/L
0745	Pt agitated, now has hiccups - Pharmacy not around for Thorazine. sats staying around 96%, O2 turned up to 6lpm awaiting surgery. (b)(6)-2 SGT/LP
0800	FS done, BS - 33, serum drawn for verification, Pt resting in bed, Unasyn & Zantac given. Serum glucose - 78 (b)(6)-2 SGT/LP
0915	Pt taken to OR via litter c̄ NRB @ 10lpm (b)(6)-2 SGT/LPN
1130	Pt returned from OR sedated, very difficult to arouse on 8L O2 per minute via NRB, satting 99%. BS hyperactive in lower quadrants, VS: 113/76, 111, 21, 97%. (b)(6)-2 VS (1140: 111/73, 110, 20) SGT/LP 1200 VS: 112/69, 107, 17, 1215 VS: 115/72, 107, 15, 1230 VS: 109/66, 106, 15
1330	Pt extremely agitated, climbed out of bed. Pulled at triple lumen, staff sat him in chair, began telling interpretor he was at his farm - was not oriented to place or time at all. 5mg Haldol given. Pt now sleeping in bed. VSS - still agitated whenever aroused. Will monitor & allow to sleep. (b)(6)-2 SGT/LP
1530	Pt still sleeping - Ø % pain. VSS, 2 pt. restraints in place (b)(6)-2 SGT/LPN
1700	Pt woke up - is now oriented - told interpretor he remembers staff from yesterday. Very calm. (b)(6)-2 SGT/LPN

STANDARD FORM 509 (REV. 5/1999) BA

USAPA V

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
26Sep03 0910	5mg MSO4 given for c/o pain to abd incision site — (b)(6)-2 SGT/CP
1120	Dressings to abd Ad (wet to dry), pt resting comfortable in bed — (b)(6)-2 SGT/CP
1300	Pt OOB for 30 minutes into chair. Now back in bed resting - was given 5mg Haldol for agitation/restlessness. Will monitor. — (b)(6)-2 SGT/CP
1500	Pt wanted to walk upon getting up, pt had fecal incontinence x approx 300cc, pt cleaned & bed Ad, feces was dark brown loose (liquid), pt returned to bed & reconnected to monitor. Still appears restless - 25mg Thorazine given for hiccups — (b)(6)-2 SGT/CP
1700	Pt agitated & restless. Continues to pull O2 off - moving around in bed - IVF dc'd, 5mg Haldol given IM - will monitor — (b)(6)-2 SGT/CP
1800	Report from day shift SGT Sale, client in bed, awake, very agitated, attempting to get out of bed and pulling at lines. Restraint to RLE, four fingers able to reach into restraint around foot - neurovascular deficits noted. — (b)(6)-2 LT HN
1830	Assessment done, see DA form 4700. — (b)(6)-2 LT HN

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

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

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; SSN or Service/Grade) (b)(6)-4 | REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1)
USAPA V1.01

LAST NAME (b)(6)-4	FIRST NAME	MIDDLE INITIAL	ID NUMBER (b)(6)-4

DATE	NOTES
26 Sep 03 1900	Client extremely agitated, attempting to pull out (R)SCTLC, BUE placed in restraints, medicated c̄ sedation cocktail per MD of 10mg Haldol IVP, 50mg Benadryl IVP and 2mg Lorazapam PO at this time — SG.
1930	client asleep, resting quietly. — (b)(6)-2
2100	Client asleep in NAD, Oxygen @ 3L via NC, O2 sat 98%. RR 20. — (b)(6)-2 ILT AN.
2215	Client awake, C/O pain, medicated c̄ 5mg Morphine IV — SG.
2300	Client very agitated, Dr (b)(6)-2 [redacted] @ bedside, medicated c̄ 2mg Ativan PO, crushed and mixed c̄ jello, 10mg Haldol IVP. will continue to monitor — (b)(6)-2
27 Sep 03 0030	Client very agitated pulling at lines and lashing at staff, medicated c̄ 1mg versed by CRT (b)(6)-2 (b)(6)-2
0050	Client awake, C/O pain, continue to be agitated, medicated c̄ 4mg morphine for pain. — (b)(6)-2
0115	client asleep, on 3L NC at this time — (b)(6)-2
0300	client asleep in NAD — (b)(6)-2
0400	labs drawn from (R)SCTLC, middle port, flushed, proximal port unable to flush, distal flushed c̄ no blood return — (b)(6)-2
0630	Report given to CPT (b)(6)-2, client in bed on 3L NC, foley intact + patent, client in restraints to BUE and RLE. — (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.0

LAST NAME (b)(6)-4	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
27 Sep 03 1815	Report from CPT (b)(6)-2 - Fabroni, client laying on floor on cushion c̄ pillow resting quietly. IVF infusing via (R) SCTLC via medial port @ 125cc/hr, foley patent and draining clear yellow urine. Drsg to abdomen D+I, ~~left~~ right (b)(6)-2 c/d/o c̄ some bruising noted. Left hand c̄ drsg D+I. — (b)(6)-2
1830	client agitated, pulling at foley and TLC, client up to chair c̄ nursing personnel at side. — (b)(6)-2
1900	client c̄ continued agitation, nursing personnel continue to be at patient's side for close monitoring, client in and out of chair, pulling at foley at times. — (b)(6)-2
1945	c/o pain to abdomen and client c̄ continued agitation medicated c̄ 3mg morphine IV [redacted] (b)(6)-2 for pain and 1mg versed for agitation, client placed in bed on floor c̄ pillow and blankets. FSG done results 91, nothing to be given for results. will continue to monitor client — (b)(6)-2
2005	client resting [redacted] (b)(6)-2 at this time with occasional repositioning of self. — (b)(6)-2
2005	late entry @ 1900 IVF increased from 125 c/hr to 200 cc/hr per Dr (b)(6)-2 — (b)(6)-2
2200	assessment done, client agitated but follow some commands. lungs clear, O2 sat 99% on RA, attempted to assess abdomen client refused by pushing nurses hands away, pulses palpable to all extremities, sedation cocktail given at this time client ~~on~~ floor on bed. — (b)(6)-2
2230	client very agitated pulling at foley and TLC, medicated c̄ 1mg versed for agitation and 4mg Morphine IV for pain, sat c̄ client until calm, ~~on bed~~ nothing on floor at present. — (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.01

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MEDICAL RECORD	PROGRESS NOTES

DATE (27 Sept 03 NSG Notes) NOTES

1330: distention MSO4 4mg administered Eval quality Gif

1430: Pt cont complains of abd pain. Dr. (b)(6)-2 notified

-1600 KUB ordered. 1500 - Pt ambulates w/ O2 sat, assistive per staff x3/4 to radiology. (error) (b)(6)-2 Pt ambulates outside s/p KUB and through PLX x 1. Series ordered per Dr. (b)(6)-2 Toradol 30 mg IV administered per VO Dr SO4 use to ↓ r/t possible ileus. Pt returned toward to chair x 1/2 hr. Bed placed on floor s/p washing, complete cleaning of area. Pt → floor to sleep c̄ out problem or complaint. Pt rest quietly and comfortably x 1.5 hrs — (b)(6)-2

1730 VS remain stable O2 per RA SaO2 @ 95-96% RR - 17 - 22 BPM. Pt up OOB to chair x 1, easily reassured back to floor/bed. Pt appears comfortable and unlikely on floor. Close one-to-one monitoring continues. MP on duty x 2. — (b)(6)-2

1815: Report passed to W Garrick. Pt care transferred Pt resting quietly VS cont. Stable — (b)(6)-2 —

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST 27 Sept 03	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

(b)(6)-4

REGISTER NO.

WARD NO. ICU

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
27 Sept 03	(cont.) offered H_2O PO & consumed 60 cc w/o problem.
0730:	Complete Bedbath & shave provided. Restraints remain apy. VS remain stable. (b)(6)-2
0830:	Pt cont. to be agitated. Translator not available - Versed 1mg IV administered. Pt sleeping quiet x 1 hr. (+) Dressing Δ to abd wnds. (+) midline incision agg. c̄ staples, simple dry, clean dressing (Ø) evidence of drainage. (L) lateral aspect wnd ~1.5cm red deep, Ø evidence infection, Ø drainage, pink color. wnd packed c̄ wet-to-dry - saline utilized. (R) wnd red agg 2.5 cm in diz. (+) wet-to dry, saline applied for wet. (+) pink color, deep, Ø drainage. All abd wnds covered/dressed c̄ gauze. (L) elbow incision approximated c̄ stitches, (+) old drainage dry and brownish red. Ø evidence infection, Ø discharge. Simple dry dressing applied & secured. - Pt cont. resting VS STABLE (b)(6)-2
0900:	Pt c/o abd pain MSO4 3mg administered eval pending (b)(6)-2
1000:	Pt continues moving about on bed, moving up/down side-to-side sitting on edge. Pt [redacted] reassured, allowed to move about 1-to-1 assistance @ BS @ all times. (b)(6)-2
1130:	VS stable 1-to-1 cont. Pt status unchanged (b)(6)-2
1200:	Versed 1mg IV administered for cont. agitation. Eval pending. (b)(6)-2
1330:	Pt c/o ABD pain, states tape too tight. Tape dry/ureapplie (+) RLQ BS hyperactive, Ø UQ AS x2. (P) abd.

STANDARD FORM 509 (REV. 5/1999) BACI

USAPA V1.00

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

27 Sept 2003 0615: Received report from ILT (b)(6)-2 [redacted]. Assumed care of pt. Pt sleeping awakens momentarily, spontaneously speaking in Arabic short phrases. Returns to sleep w/in seconds of awaking. O_2 per NC @ 3L/min. Ø evidence distress SaO_2 @ 100% RR: BP 101/58 HR 92. Ø IVF's infusing. 3-L ⓛ subclavian HL'd. ⊕ foley to gravity, clear yellow ug. Complete physical assessment noted on form DA 4700. Plan: monitor cognitive state, ensure safety, diminish aggressive, agitated episodes via reassurance, calm voice, reassuring touch, lighting, music (if possible); maintain line of site vision, one-to-one care @ all times. Use restraints as per MO orders. Cont cardiac, resp monitoring. WND dressing Δ's x 1 wet-to-dry for bullet wounds, single dry for approximated incision. Monitor I/O's. Comfort & pain management per (b)(6)-2 [redacted]

0730: Pt awake, appears disoriented, attempts to get out of bed, turn in bed, pull at restraints. ⊕ restraint leather - to Ⓡ wrist Ⓡ ankle & Ⓛ wrist. Ⓡ wrist restraint D/C'd. Pt's level of agitation ↓'d. VS remain stable. Monitoring to cont (b)(6)-2 [redacted]

0745: Pt appears anxious sitting up to sitting back in bed. All restraints removed, pulses ✓'d 2+ radial, pedal bilat. Good cap refill @ ≤3 sec; ⊕ movement & sensation. Ot

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

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

(b)(6)-4 [redacted]

REGISTER NO.

WARD NO. ICU

PROGRESS NOTES
Medical Record

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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
27 Sep 03 2300	Client very agitated at this time and very combative, struck nursing personnel, client placed back up in bed and restraints applied to BUEs. guard at bedside. (b)(6)-2 LT
2400	Client c̄ continued agitation, 1mg versed given IVP. (b)(6)-2 LT
28 Sep 03 0110	Client c̄ continued agitation, kicking at staff and attempting to climb out of bed, sedation cocktail repeated per order (b)(6)-2 LT
0200	client asleep, VSS, will provide decreased stimulus in surround for client. (b)(6)-2 LT
0400	FSG done, results [redacted] 99, no insulin given, blood drawn and sent to lab for analysis. (b)(6)-2 (b)(6)-2 LT
0430	Drsg change done to (D) SCTLC c̄ sterile procedure, new dressing applied and secured c̄ tape. (b)(6)-2 LT
0600	VS done, client awake and agitated at times (b)(6)-2 LT
0640	Report given to CPT (b)(6)-2 (b)(6)-2 LT
0655:	Received report 0630. Assumed care of patient. Pt awakening - (+) agitation, appears [illegible] confused. (+) Pulling @ restraints, yelling, screaming out. Attempts to console, reassure; Orient not c̄ aggressive behavior to include kicking, pulling at arms, squeezing fingers/hands tightly and pushing away. Pt attempts to get out of bed, met c̄ (error [redacted]) (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

ATIENT'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

(b)(6)-4

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	repositioning and realignment of body. 2pt restraints to bilateral wrists = leather, secured. 1-to-1 close monitoring per staff and guard provided. IVF LR infusing @ 200 cc hr to Ch. Abd incision, wds dressed, secured & tape ∅ drainage (error)
1340:	Plan = close monitoring of mental status and treatment ~~[illegible]~~ (b)(6)
107/57	Cont. Maintenance fluids, maintain NPO status and prep
80	for OR later in AM. Cont. Cardiac/resp monitoring, provide
99	comfort, reassurance, reorientation and pain management.
16	(b)(6)-2
1345:	0830: Complete Bed bath. Pt cont. to be agitated, 1-to-1
105/55	assistance provided. (b)(6)-2
81	1000: Restraints removed, pt oob, amb. outside with
16	assistance x 3. Unsteady, unbalanced, uneven gait.
99%	shuffling ↓ strength to R side. Pt guarded 1-to-1, emotional support
1400:	per Major Walker while outside, resting in chair. (b)(6)-2
	1100: Pt back in ward sleeping quietly on floor w/intermittent
	bouts of waking, tossing around returning to sleep. IVF's
	cont at 200 cc/hr. O_2 RA c̄ SaO_2 @ 98%. (b)(6)-2
	1145: Pt taken to OR on stretcher secured c̄ strap —
	O_2 @ RA, LR @ TKO. Assist per OR staff x 2. (b)(6)-2
	1330: Pt returns to ward O_2 per NC RB, SaO_2 @ 100% RR 17-20 BPM
	∅ evidence distress. LR @ (~~200 cc/hr~~ 100 cc/hr, error) to medial port ∅ evidence
	infiltration @ site. (b)(6)-2
	1430 Pt sleeping quietly VS stable @ NC @ 4L SaO_2 @ 99%
	RR-14-16 BPM.
	1530: O_2 ↓ 2L SaO_2 @ 96-97% RR 19-20 all other VS
	90's systolically 50's diastolically HR 90's, T. 99.0. (b)(6)-2

STANDARD FORM 509 (REV. 5/1999)

USAPA V1.01

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
28 Sept 2003	—	1615	Pt awake, combative, kicking, punching, pushing, yelling attempting to get out of bed. Reassurance - verbally and via hands to shoulder unsuccessful. (+) pulling at foley catheter. Restraints x 3 places Blat Vs used to (L) LE. Pt cont agitated. Translator, NEBO, states (+) disorientation, i.e. "pt doesn't make sense." One-to-one constant monitoring in place. VS Remain stable. O2 @ 2L Humidified SaO2 @ 97%. LR infusing @ 100cc/hr. (b)(6)-2
		1620	LATE note: Dulcolax suppository PR administered per MD order. Results pending (b)(6)-2
		1715:	100p over past 3° = 30-35cc concentrated urine. LR Bolus 500cc started. Fleet enema pending administration result of 1600° admin of Dulcolax. Pt continues c̄ intermittent bouts of agitation interspersed c̄ episodes of short naps. Monitoring 1-to-1 continues. (b)(6)-2
		1800	Pt. sitting up in bed - appears to be sleeping and relaxed - report recieved. 500cc NS Bolus almost complete. SaO2 99% on 2LNC. Pt in restraints, foley to gravity, open to air. Midline incision c̄ staples - ∅ dehiscence noted well approx w/o s/sx of infx - 2x2 Dsg's also on abd x2 CD&I - will continue to monitor. Foley tube checked for proper placement (+) return upon advancement of catheter

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility) REGISTER NO. (b)(6)-2 WARD NO. SICU

NURSING NOTES
Medical Record

(b)(6)-4

MEDCOM - 7540

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

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
2000			Triple lumen central line @ R subclavian artery all ports patent per report medial port infusing LR @ 200 cc/hr ~ bolus Distal and Proximal port's patent flushed ~ c heparin solution 3ml per port
2120			Pt OOB to commode given one fleets enema @ 1 hour small pieces of stool ~ c enema in bowel - maybe 10 cc worth of stool - soft and brown - ambulated pt ~ c assist in ward very weak and ~ c shuffling gait - pt assisted to bed very cooperative no restraints in bed needed (b)(6)-2
2145			Pt sleeping, V.S. Signs Stable See Flow sheet - still unrestrained FS 99 ∅ insulin coverage needed Dsg to elbow CD:I - pt afebrile Temp 98.8 @ - Foley draining 40-50 cc dark yellow urine (b)(6)-2
2300			Pt resting occasionally sits up in bed calm - LR still infusing 200cc/hr into patent port (triple lumen)
2330			Sedation Cocktail given to induce sleep throughout the night Pt still unrestrained (b)(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
28 Sep 03 1330	BRIEF OPERATIVE REPORT

PRE-OP DIAGNOSIS: OPEN WOUNDS

POST-OP DIAGNOSIS: WASHOUT / DPC abdomen

PROCEDURE: Wound Washout / DPC

SURGEON: Dr. (b)(6)-2 ASSISTANT: Ø

ANESTHESIA: GETA OPERATIVE ANTIBOITIC:

FLUIDS: 400 cc LR BLOOD PRODUCT USAGE: None

EBL: Ø URINE OUTPUT: 125 cc

TOURNIQUET TIME: NA

DRAINS: Foley

SPECIMENS: None (b)(6)-2

FINDINGS: Wound clean

DESCRIPTION OF PROCEDURE: - Washout of GSWs (2) - Skin undermined and elliptical excised - Skin edges approx w/ 3-0 Vicryl. Staples

COMPLICATIONS: Ø

CONDITION: Stable

(b)(6)-2

(b)(6)-2 MD
MAJ, MC USA
CHIEF, DOS

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

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

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

(b)(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
28 Sep 03	Surg SVC
1359	S: Dr Dramm saw pt and does not realize his situation
	O: Afeb, VS stable
	Alert: Sl disorientation, ⊕ 3/3 [redacted] b6-2
	No neurological sym. Color gun 3 [illegible]
	Abnl clinic.
	A: DPOD 5 [illegible] days/[illegible] coloring injury
	(2) Dementia - ? Baseline
	P: (1) will place on clin lyrics po
	(2) Infectious Supp.
	(3) off on [illegible], DC [illegible] time.

(b)(6)-2

MAJ, MC USA
CHIEF, DOS

(b)(6)-2

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
0200	Pt. sleeping, $S_{a}O_2$ 99% 2L NC — Ø difficulties
29 SEPT 03	c̄ patients attitude this shift — no
	restraints needed — UO >40 cc/hr
0230	Pt awake trying to climb out of bed - 4mg IV MSO4
	Given Δd — Chux placed under bottom
	small amt of stool on sheets — liquid
	stool — bottom cleaned — Pt positioned
	back in bed somewhat agitated, but
	very drowsy — uncooperative and speaking
	loudly, 1 mg versed po ET (b)(6)-2
	will continue to monitor — (b)(6)-2
0240	1 mg IV versed for sedation had +
	effect, Pt calm, eyes closed, talking
	intermittently — (b)(6)-2
0415	1 mg IV versed administered to patient
	for sedation — Pt moving continuously
	can't seem to get comfortable — VSS, $S_{a}O_2$
	99% 2L NC will continue to monitor
	Pt is risk for falling out of bed
	cannot leave pt alone — So (b)(6)-2
0500	am labs redrawn H&H both critically
	low 8 and 27 — new sample CBC
	sent to lab @ 0515 — Pt still up
	in bed talking to himself — (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
29 Sept 03 0630	Assumed care of pt fwd report from SGT (b)(6)-2; LPN. Pt in bed awake moving @ bed. T.C central-line (b) clavical LR 200cc/hr infusing midial port distal, proximal ports flushed c̄ NS ~~5~~ difficulty. ~~Foley~~ → gravity draining yellow urine. Initial Assessment done, noted on DA 4700. Will monitor/ (b)(6)-2 SGT US 9WM
0800	Pt OOB → Am Care done at bedside pt BTB reposition, pt agitated, pt got OOB → Chair. Will monitor (b)(6)-2 SGT US 9WM
0830	Pt ambulated 50ft c̄ assist x2 pt 9o pain 4mg MSO4 given IVP pt in bed appears to be sleeping will continue to monitor/ (b)(6)-2 SGT US 9WM
0945	Pt in bed sleeping NAD noted will monitor/ (b)(6)-2 SGT US 9WM
1010	Pt awake, agitated, getting OOB, translator state that pt is not making sense, want to go →

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1(
USAPA V1.0

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

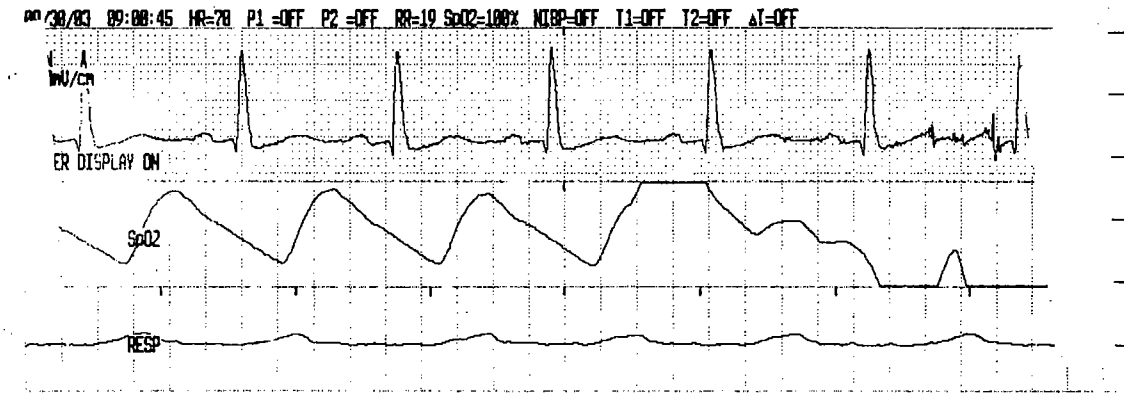
DATE	NOTES
	~~home to farm.~~
29 Sept 1010	home to farm. Atenolol give PO Pt spit pill out x2. Medication administered c̄ Yellow Pt appeared to be in pain MSO4 4mg given IVP Pt BTB, awake moving @ bed. will monitor for safety and changes in status / (b)(6)-2 SGT 91WM6
1130	Pt OOB ambulated outside → chair sat for 10min ~~SpO2~~ pt state he was dizzy ambulated BTB SpO2 ↓ 92% O2 4L via NC applied. SpO2 ↑ 98-100%. Pt in Bed c̄ HOB ↑ 30° angle NAD noted at this time. Pt sleeping at present time will monitor (b)(6)-2 SGT USA 91WM6
1230	proximal & distal port → TLC central line flushed c̄ 10cc NS s̄ difficulty/pt sleeping at present time (b)(6)-2 SGT USA 91WM6
1430	Pt OOB ambulate → toilet flushes enema given brown liquid expelled. soap sud enema 700mL; 400mL infused pt able to hold. Ø BM brown liquid. Pt ambulated BTB. Pt refused any food state his stomach hurts he can't eat via translator. 1530 Pt c/o pain MSO4 4mg IVP given. Pt in bed calm resting c̄ eye open NAD at this time will monitor / (b)(6)-2 SGT USA 91WM6

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.0

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
30 Sep 03 0100	Client OOB to commode, ⊕ flatus, ⊖ bm, back to bed, fell asleep quickly. — (b)(6)-2 [redacted]
0200	Client asleep, will not do vital signs @ this time due to decreased stimulation status being maintained — Sin
0400	no changes at this time. — (b)(6)-2 [redacted]
0600	VSS. blood drawn from TLC site, sent to lab, medicated c̄ IV Toradol for pain management. — (b)(6)-2 [redacted]
0630	Report given to MAJ (b)(6)-2 [redacted], client in bed asleep, connected to 3L O2 via NC. LR @ 200 cc/hr. — (b)(6)-2 [redacted]
0700	Patient totally cooperative. assisted OOB to chair. MAE x 4. Completed assessment as per DA Form 4700. Patient alert & oriented & person answering all questions appropriately. Lungs c̄ bilateral crackles O2 @ 10 L on 3L N/C. TLC used c̄ NSS infusing to (R) Dorsalis Pedis. Dressing changed c̄ S/S of infection. Breakfast given c̄ patient eating 1/2 egg and piece of toast crumbs. Will assist to ambulate prompt for confusion — (b)(6)-2 [redacted]



1100	KCL refused PO intake, Dr (b)(6)-2 [redacted] ordered c̄ run infusion at 25 cc/hr over 2 hours. Foley discontinued c̄ 1100 cc returning. Patient resting at present — (b)(6)-2 [redacted]
1200	C/O nausea, given Phenergan 25 mg IV — (b)(6)-2 [redacted]

09 (REV. 5/1999) BACK

USAPA V1.01

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
29 Sep 03 1800	Report received from SGT (b)(6)-2, client in bed connected to cardiac monitor, on 3LNC c̄ humidity. client asleep at this time. (b)(6)-2 ICTA
1900	Client awake, assessment done see DA form 4700. Brsg to Q arm DTI. Refused dinner, client getting agitated, moving around, attempting to get out of bed, will sit c̄ client (b)(6)-2 USA
1945	c/o pain, Dr (b)(6)-2 notified orders to increase dose for toradol and hold morphine. 15mg toradol given IV in addition to the 15mg given @ 1800 for total of 30mg. (b)(6)-2 USA
2000	c/o nausea, medicated c̄ 25mg Phenergan IV. (b)(6)-2
2100	client c/o pain to abdomen, (+) BS auscultated in all four quads. Dr (b)(6)-2 notified, tylenol 1000mg po given for pain. (b)(6)-2 ICTA
2200	VS, medicated per order. ambulated twice in last hour, fair gait, somewhat unsteady, c̄ two assists. ~~of 2nd~~ (b)(6)-2. Back to bed, FSG 167, 3 units regular insulin given SQ. (b)(6)-2
2230	OOB → commode, moderate amt loose brown stool, back to bed 3LNC c̄ humidity, LR @ 200 cc/hr, foley patent draining. SA
2300	Client asleep, at this time. (b)(6)-2 ICTA

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

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

(b)(6)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
30 Sept 05 1300	Up ambulatory to Bedside commode. Voided 300cc clear yellow urine. (b)(6)-2
1430	Urosign infusing as ordered. Resting quietly. LR @ 200cc/hr. Up ambulatory on RA. Given Tylenol 650 for c/o abdominal pain to (D) Inp (b)(6)-2
1600	Pt resting, Chem, drawn K. 4.3 results given to Dr [redacted]
1700	Pt reports given to PT [redacted]. Abdominal pain resolved. [redacted]
1830	Pt Vomitted ≈ 300cc, given phenergan 25mg IV (b)(6)-2
2130	Pt requested Med for Sleep, given Benadryl 50mg PO (b)(6)-2
2230	Pt c/o Abd Pain, Tylenol 1000mg PO Given, Dr [redacted] (b)(6)-2
	Orders Received (b)(6)-2
1 October 05 0040	Pt ↑ bathroom, Small solid stool & 200cc Urine (b)(6)-2
0500	24° I+O W/N 3925 U/O 3650 Balance -525, AM Foley Collected
0550	AM Foley Collected (b)(6)-2 (b)(6)-2
0700	Report received, assessment performed (see DA4700), pt ambulated to back to urinate - now resting in bed. Will continue to monitor. (b)(6)-2
0900	TLC d/c'd by MAJ [redacted]. Walked to back to clean up - c/o nausea & dizziness but refuses medication. Will continue to monitor. (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.01

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
1 Oct 03-	Pt comfortable-resting in bed — (b)(6)-2 — SGT/LPN
1100	
1300	Pt ate all of lunch - 0 % nausea — (b)(6)-2 — SGT/LPN
1500	Pt eating granola bar. Stood up and ambulated to empty ileostomy — (b)(6)-2 — SGT/LPN
	recopied to 509

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.0

LAST NAME (b)(6)-4	FIRST NAME	MIDDLE INITIAL	ID NUMBER (b)(6)-4

DATE	NOTES
20 Oct 03 0600	Report given to MAJ (b)(6)-2 (b)(6)-2 (b)(6)-2
20 Oct 03 0700	Pt assessment as per flow sheet. Pt ambulated in hallway after breakfast. Given 25 mg Demerol IV. Slept for 2 hours and ambulating w/ difficulty (b)(6)-2
1000	Up to sink, completed hygiene and dressing (b)(6)-2
1015	Ate ½ of lunch. Worried about family members and his "car". Pt (b)(6)-2 notified and patient instructed that interpreter will help contact family thru LT (b)(6)-2 (b)(6)-2
1700	Doctor at bedside explaining to patient he can not be discharged until paperwork approved. Patient showed understanding (b)(6)-2
1800	Pt transferred to ICW, VSS. Ambulating w/ difficulty. Report given to CPT (b)(6)-2 (b)(6)-2 (b)(6)-2
20 OCT 03 21:34	Received care of pt @ 1800. Pt. awake and alert. In no apparent distress. VS WNL per flow sheet. Dressings to abdomen R/L quadrants clean/dry/intact. Bowel sounds hypo-active x4 quadrants. Staples to midline abdomen intact, OTA c no apparent s/s infection. Complained of pain x/ Tylenol given will continue to monitor (b)(6)-2
20 Oct 03 2300	Nurses NOTES: Assumed care of Pt @ 2300. Lying in bed. Breathing intact Ø SOB or Labored breathing Ø S/S of distress vitals stable. Pt denies pain at this time. Ambulates w/ assistance. IV SL flushes OK Ø S/S of infection at IV site. will continue to monitor status (b)(6)-2

(b)(6)-4

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
10Oct03 1230	Pt only ate apple for dinner - drank half of water - ambulating around ward. — (b)(6)-2 SGT/USN
1430	Pt resting - sitting up in bed — (b)(6)-2 SGT/USN
1630	Pt ambulating around ward then sitting in chair beside bed. Pt s/o pain or discomfort. (b)(6)-2 SGT/USN
~~17~~	
1830	Report received from SGT [redacted], client in bed awake + alert, calm at this time, assessment done see DS form 4700. — (b)(6)-2 LCPL
2000	Client OOB ambulated to commode, gait steady, had small formed brown BM and voided 500 cc clear dark yellow urine. — (b)(6)-2 LCPL
2200	Medicated per order, assessment done c̄ no changes from prior assessment. BS done, results 126, no insulin given. — (b)(6)-2 LCPL
2400	Client in bed asleep. — (b)(6)-2 LCPL
20Oct03 0200	VSS, client OOB ⇒ commode, voided 400cc urine and had small brown formed BM, no changes from previous assessment. — (b)(6)-2 LCPL
0400	Client in bed asleep — (b)(6)-2 LCPL
0500	blood drawn and sent to lab. — (b)(6)-2 LCPL

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
30OCT 2003 0705	Nursing: Pt awake, alert. Ø c/o pain. Lungs CTA, O2 sat's 96% on RA, Ø SOB. HR72, reg, Ø edema noted. Ø IV access Abd soft, nontender, (+)BS x4. Pt tol. regular diet. ↑OOB, amb well ⅋ assist. Drsg Δ's: Wound sites x3 to abd/chest. Sites intact, Ø active drainage noted. Reapplied gauze & tape. Drsg to Elbow ⅋ sm. amount old serous drainage. Applied 4x4, Kerlix & ace wrap. ML abd incision ⅋ staples intact. Ø drainage, Ø S/S infection, wound well approximated. (b)(6)-2
30OCT03 1500.	Received care of pt. @ 14:00. Pt. resting in bed. Awake and alert. PERRLA(+)IUM. EOM(+)IUM. Skin warm/dry/intact. Lung sounds clear to auscultate (B) throughout. Bowel sounds (+)x4 quadrants. Abdomen soft/tender to touch d/t abdominal wounds. Staples to midline abdomen CTA ⅋ S/S infection. Dressings to (R) and (L) mid-quadrants clean/dry/intact. (+) radial pulses (B) (+)2 strength. HL to (R) fore arm patent/intact. complained of "small amount" of pain to abdomen. Too early for dose of Tylenol. will reevaluate for pain level throughout shift will continue to monitor (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
30Oct 03 2300	Nurses Notes: Assumed care of Pt ATO. Pt sitting up in bed. Ø c/o pain or discomfort. Staples to midline clean dry and intact so no dressings. Pt ambulates Ø complication (b) SL pushes IV. will continue to monitor status — (b)(6)-2 — 1902
2220	Pt c/o inability to sleep. per interpreter. advised Pt no orders for sleep aid is written. will continue to monitor status (b)(6)-2 — Conr 1905
0600	Labs drawn and sent. Results pending — (b)(6)-2 — 1000
4 Oct 2003 0005	Nursing: Pt awake, alert. Ø c/o pain. Lungs CTA, O2 sats 98% on RA. HR 66, reg, Ø edema noted. HR to (R) fa, pokint. Abd soft, nontender. BBS x4. Tol reg diet, ↑ OOB, amb well. MC incision CTA, Ø active drainage noted. Ø redness, Ø swelling @ site. Drsg to (R) shoulder Ø drainage, new 2x2 placed. Drsg x2 to abd CDI, Ø drainage, replaced staples — (b)(6)-2 — AM
4 Oct 2003 1448	Nursing: D/C'd. Pt to return to ~~EAA~~ MP auxiliary — (b)(6)-2 — AM

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
04OCT03	Department of the Army
1100	(b)(3)-1

NARRATIVE SUMMARY

INFO DIAGNOSIS: [illegible] 15M - 3.5 cm - 4 cm

PROCEDURES: [illegible] 25 SEPT 03 TRANSVERSE COLON INJURY

HISTORY OF PRESENT ILLNESS: 64 yo Iraqi male who was shot while driving thru a check point. He had a GSW to left elbow. Left elbow fracture. Well injury.

GSW to left tuna of Left elbow.

Pt underwent exploratory laparotomy w/ repair of transverse colon and stoma on 23 Sept 03.

HOSPITAL COURSE: He then went back to the OR for DPC of abdomen and wound elbow 25 Sept 03. He was very sensitive post op and eventually has serosum closed. He currently is ambulating 5 [illegible] and tolerating regular diet.

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

(b)(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	HOSPITAL COURSE (CONTINUED):
	DISPOSITION: DISCHARGE to MP's custody
	RECOMMENDATIONS: ① Remove STAPLES AND Sutures for abdomen and left elbow in 3 days ② Recommend Abdominal ultrasound by local IRAQI hospital to assess abdominal aortic aneurysm.
	MEDICATIONS: PERCOCET Give 1-2 tabs by mouth every 4 hours as needed
	MOTRIN 600mg: Give 1 tab by mouth every 6 hours with food
	COLACE 100mg - Take 1 capsule twice daily.
	(b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

EMERGENCY CARE AND TREATMENT
(Medical Record)

ARRIVAL

DATE			TIME
DAY	MONTH	YR.	
23	SEP	03	1405

TRANSPORTATION TO HOSPITAL (Check one, circle where)
- PRIVATE VEHICLE
- ✓ AMBULANCE
- OTHER (Specify)

CURRENT MEDICATION (Include name, dosage, frequency, route, last injection and other)
Rx for Diabetes Pills

HISTORY OBTAINED FROM: PATIENT / OTHER (Specify)

ALLERGIES: N&DA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)
TOI 1300. Last meal 0730.

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT (S) (Include complaint(s), duration)
GSW ~~chest~~ ABD

SEX: ♂ AGE: 64

POSSIBLE THIRD PARTY PAYER: YES / NO

VITAL SIGNS

TIME	1405	1415	
BP	136/91		
PULSE	93		
RESP.	30		
TEMP.	98.2 (R)		
WT. (Child)	92		

PO2

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)

S: Pt is a 64 yo Iraqi ♂ who ran a checkpoint & had a weapon in his vehicle. Sustained GSW to Abd. Arrived by ground. Location of injury near T. Knit. ? which checkpoint.

TIME SEEN BY PROVIDER: 1405

PMH
CAD
MI 10 yr.
DM.
PSHx ⊖.
Tob ⊖.

ORDERS	INITS.	TIME
CBC, Chem 12, T&Cs		
PCXR		
Xray ABD, (L) elbow CR		
Morphine 5 mg IV q 4 hr		
Tet .5 cc IM.		
Unasyn 3 gm IV,		

O: ~~WD Awake mod dist 2° to Abd GSW.~~ ⊕ omentum exposed ⊖ obvious bleeding. ⊖ Resp distr. A&O x3 GCS 15
HEENT: NC/AT PERRLEOMT.
Chest: NT (B) eq CTA cor RRR ⊖⊖
Abd: ⊕ ⊖ BS. (B) ant lat entry, (L) Ant Lat exit ⊖ 2" round omentum exposed.
Hematoma medial to exit tract. ⊕ mild distention.
⊕ gen tTP. FAST ⊖.
Pelvis stable ⊖ Crep NT.
Rectal: enlarged prostate Brn Stool guaiac ⊖.
Ext: (L) elbow c 3" medial lac deep to joint capsule ⊖ fx palpated. N/vascular.

Xrays: CXR: ⊖ f
(L) elbow: ⊖ fx ⊖
Abd: Grainy overall
⊖ A/F levels ⊖ fra

EKG: NSR @ 83
Q waves II, III, AVF
⊖ Acute Δ's

147 / 3.7 | 113 / 21 | 21 / 1.4 / 200
Amy 113
17 / 48 / 15 / 281
VBG: 7.35/38/87/21/-4/9
UA: LT yel/Clr, 1.025 5
Alb ⊖ ⊖ Bld ⊖ Glu.
ABG: 7.31/44/196/22/-4/100
T&S.

ASSESSMENT/DIAGNOSIS
GSW thru Ant Abdomen.
Fragment to (L) elbow.

DISPOSITION (Check all that apply)
- HOME
- FULL DUTY

QUARTERS: 24 Hrs. / 48 Hrs. / 72 Hrs.

MODIFIED DUTY UNTIL:

DAY	MONTH	YEAR

REFERRED TO (Indicate clinic)
Gen Surg.

- EMERGENCY
- TODAY
- 72 HOURS
- ROUTINE

ADMIT TO HOSP. UNIT/SERVICE
OR.

CONDITION UPON RELEASE
- X IMPROVED
- UNCHANGED
- DETERIORATED

TIME OF RELEASE: 1500.

Foley.
IV NS @ 100 cc/hr

(b)(6)-2

(b)(6)-4

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

SIGNATURE OF PATIENT (REQUIRED)

INSTRUCTIONS: Medications ordered, any limitations and follow-up

To OR

EMERGENCY CARE AND TREATMENT
Medical Record Copy

STANDARD FORM 558 (Rev. 5-
Prescribed by GSA and ICMR

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: 64
HEIGHT: 68"
WEIGHT: 74 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: Ex Lap, D+I Lt elbow EMERGENT

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition Lt elbow / 2 abrd. wounds
Tobacco (-) ppd X___yrs. Body Piercing Ø 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 no teeth 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 X Potential for anxiety related to: X 1) Surgical Procedure & Operating Room Environment ___ 2) Separation Anxiety (Child) ___ 3) Surgical Outcomes	o Pt. verbalizes any specific anxiety [redacted] o Pt. Exhibits relaxed body posture. per interpreter / anesthesia record (b)(6)-2 H/O MI, CAD	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.~~ N/A (b)(6)-2
B. AERATION X Potential for respiratory dysfunction due to: ___ 1) Positioning X 2) Effects of Anesthesia X 3) Medical/Smoking History	o Pt. will be able to breathe without difficulty during immediate intraoperative phase . (b)(6)-2	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. (b)(6)-2
C. INTEGUMENT X Potential impairment of skin integrity due to: X 1) Intraoperative Immobility X 2) ESU Pad Placement ___ 3) Positional Aids ___ 4) Prosthesis X 5) Pooling of Prep Solutions	o Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas (b)(6)-2	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. (b)(6)-2

9. PATIENT'S IDENTIFICATION: (For typed or written entries give: Name- last, first, middle; grade; date; hospital or medical facility)
(b)(6)-4

VERIFICATION [redacted] HOLDING AR (b)(6)-2
! ID/Allergy Ba[redacted] Dentures Remove
! H & P ? (b)(6)-2 ! Contacts Remove
! NPO Since___ ! Jewelry Remove
! ~~UHCG/LMP~~ N/A Body Pierce Remo
! ~~Consent/Blood Transfusion~~ Signed/Witnessed/Dated N/A
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon [redacted] (b)(6)-2
! Contact Precautions (Y) (N)
! ~~Family/Friend:~~ N/A

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION X Potential for inadequate tissue perfusion due to: X 1) Intraoperative Mobility ___ 2) Positioning X 3) Existing Disease X 4) Safety Devices ___ 5) Hypothermia	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse. (b)(6)-2	o ~~Check for support stockings or ace wraps. If none, check with doctor.~~ N/A 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.~~ N/A o Check that rings and piercing has been remove (b)(6)-2
E. NEUROMUSCULAR CONTROL E.1. X Potential impairment of mobility due to: ___ 1) Pain X 2) Intraoperative Hazards ___ 3) Prosthesis X 4) Positioning X 5) Transfer pt. to/from OR table E.2. X Potential discomfort due to: X 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. (b)(6)-2	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. (b)(6)-2
F. SPECIAL SENSES F.1. ___ Diminished visual perception due to being: ___ 1) Pre-Medicated ___ 2) W/O Glasses F.2. X Potential for decreased communication due to: ___ 1) Diminished Hearing X 2) Language Barrier Arabic F.3. ___ Potential injury due to dentures: Edentulous ___ 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. (b)(6)-2	o Introduce self. Keep pt. informed as where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from _____ side. o Validate pt.'s understanding of verbal communication. o Verify removal of dentures. N/A (b)(6)-2
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.

(b)(6)-2 MAJ, AN 23 SEP 03 DATE

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

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) (b)(6)-2 MAJ, AN
DATE: 23 SEP 03 TIME: 1445

13. POSTOPERATIVE EV BY (Signature and Title) (b)(6)-2 MAJ
DATE: 23 SEP 03 TIME: 1915

MEDICAL RECORD — INTRAOPERAT[redacted]OCUMENT

For use of this form, see AR 40-66, the prop[redacted]gency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROO[redacted] VIA: [redacted] BY CPT (b)(6)-2 CRNA

2. PATIENT [redacted] RECORD REVIEWED AND PROCEDURE VERIFIED B[redacted] (b)(6)-2 MAJ AN

3. DATE: 23 SEP 03 TIME PATIENT ARRIVED IN SUITE: 1450

4. PATIENT IN ROOM TIME: 1450 NUMBER: 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Arabic speaking. Alert.

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC (b)(6)-2 9ID	RELIEF SCRUB	SPC (b)(6)-2 9ID (clsf)
ASSIGNED CIRCULATOR	MAJ (b)(6)-2 AN,66E	RELIEF CIRCULATOR	CPT (b)(6)-2 AN,66E (1630-END) MAJ (b)(6)-2 AN,66E (1755-1830)

7. POSITION AND POSITIONAL AIDS (Specify) (B) arms abducted less than 90° on padded

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

COMMENTS:

8. SKIN PREPARATION

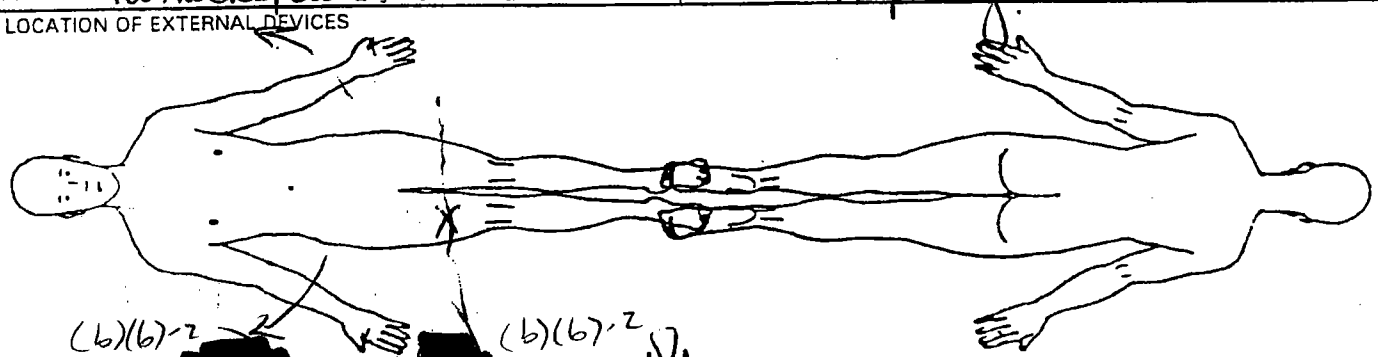
HAIR REMOVAL: ☒ YES ☐ NO
DONE BY: ☒ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP

COMMENTS: No nicks/cuts noted.

PREP SOLUTION (Specify): Beta/Betadine
SITE: abd BY WHOM: (b)(6)-2
SITE: [redacted] BY WHOM:

COMMENTS: No pooling noted. Chux used.

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safe[redacted] = = = Tourniquet

C = Correct I = Incorrect

Shift by (b)(6)-2 (b)(6)-2

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

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

(b)(6)-4

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

Settings 40/40

☒ ESU NO: 000442 VL FORCE II
GROUND PAD: BRAND VL Polyhesive
LOT NO: 69263 EXP 2005-02

☐ 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): NSS

OTHER ORDERS	TIME	CARRIED OUT BY
Ø		

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

15. X-RAY IN IF YES, SITE
YES ☐

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

TYPE/SIZE	1. 16 Fr Foly	2. (L) elbow	3.
SITE	1. Bladder	2. Guaze	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Reofom
4x8
Abd pad
Gum Ad

19. ADDITIONAL INFORMATION
Dr (b)(6)-2, Dr. (b)(6)-2
CPT (b)(6)-2 CRNA
CPT (b)(6)-2 CRNA
MAJ (b)(6)-2 CRNA

Foley from EMT.

20. OPERATION(S) PERFORMED
Ex Lap c̄ bowel resection and Repair, (L) elbow incision debridement

21. PATIENT TRANSFERRED TO ICU TIME 19:15 METHOD Litter

22. REGISTERED NURSE SIGNATURE (b)(6)-2 MAJ, AN (b)(6)-2

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

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 OR Staff

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY (b)(6)-2 CPT

3. DATE 25 Sept 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 0925 NUMBER 1-1 2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NPO status ∅ [illegible]

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC (b)(6)-2 GID	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT (b)(6)-2 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

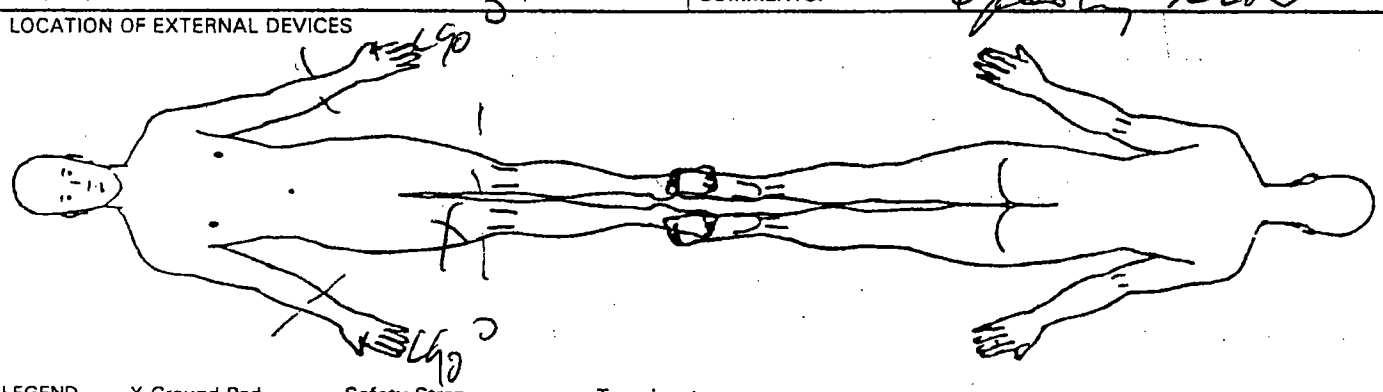
8. SKIN PREPARATION

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

COMMENTS:

PREP SOLUTION *(Specify)* Betadine/Betadine
SITE: L arm BY WHOM: CMOO
SITE: Nipple to groin BY WHOM: CMOO
COMMENTS: ∅ [illegible] not

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		C	C	[redacted] (b)(6)-2	[redacted] (b)(6)-2
Instrument	☐ Yes	☑ No					
Other	☐ Yes	☑ No					

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

(b)(6)-4

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

☑ ESU NO: 1-1 30/30
GROUND PAD: BRAND Valleylab
LOT NO: 69263

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

ESU pad site Chest Post ∅

13. PROSTHESIS, IMPLANTS ☐ YI NO IF YES NAME: ID NUMBE CTURER

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 c 2gm Ancef

OTHER ORDERS	TIME	CARRIED OUT BY

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

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

16. ECIMENS

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

17. TUBES, DRAINS/PACKING YES ☑ NO ☑

TYPE/SIZE	1. Fluffs x 3	2. Foley 16 Fr	3.
SITE	1. lateral Abd	2. Bladder	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
fluffs Kulix
4x8 ACE
Abd pad Xeroform

19. ADDITIONAL INFORMATION
Dr (b)(6)-2 (b)(6)-2
Anesthesia Gata CRNA (b)(6)-2

20. OPERATION(S) PERFORMED
Abd / (L) elbow GSW washout closure

21. PATIENT TRANSFERRED TO ICU TIME 1620 METHOD Gurney

22. REGISTERED NURSE SIGNATUR (b)(6)-2

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

For use of this form, see AR 40-66, the propo[illegible] [illegible]y is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING RO[illegible]M
VIA litter BY OR Staff

2. PATIENT [illegible]DENTIFIED [illegible]ORD REVIEWED AND PROCEDURE
VERIFIED BY (b)(6)-2 , MAJ, AN

3. DATE 28 SEP 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM
TIME 1205 NUMBER L-1 #3

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NPO per nursing staff x 5cc H_2O c Atibolol at 1000
Arabic speaking

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	SP7 (b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

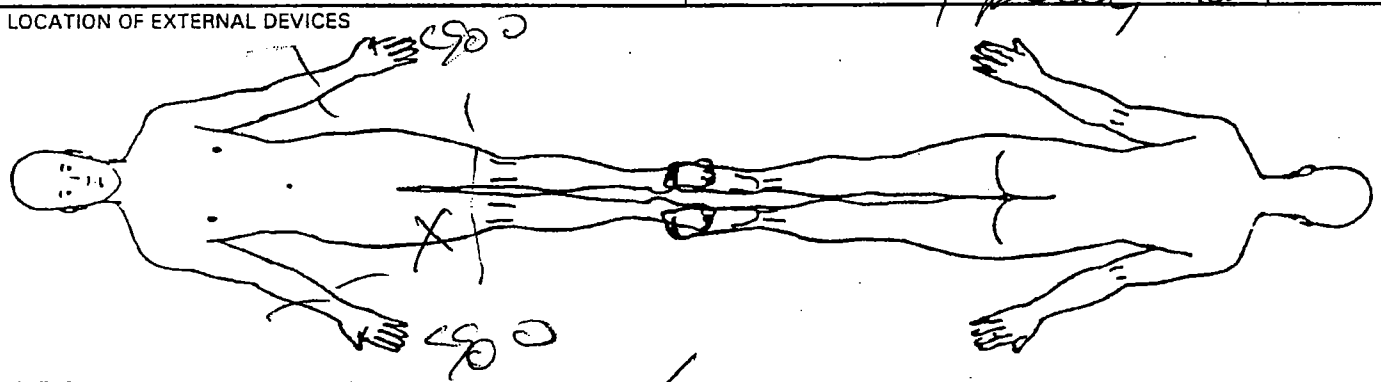
HAIR REMOVAL ☐ YES ☑ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Beta/Beta
SITE: apple → groin BY WHOM: CLASS
SITE: BY WHOM:

COMMENTS: + prodiy alcohol

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

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

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

(b)(6)-4

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

☒ ESU NO: Valley Lab 30/30
GROUND PAD: BRAND
LOT NO: 69263

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

Pad site clean prior to

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

MEDCOM - 7564

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

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):
NSC

OTHER ORDERS	TIME	CARRIED OUT BY

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

15. X-RAY IN OPE SITE
YES ☐

16. MENS

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)*
4x8
Coban All

19. ADDITIONAL INFORMATION
Post Induc - 2 fluffs out (c) flank
1 fluff out (r) flank

20. OPERATION(S) PERFORMED
I&D wound closure to ab & flanks

21. PATIENT TRANSFERRED TO ICU TIME 1330 METHOD Litter

22. REGISTERED NURSE SIGNATURE (b)(6)-2 RN

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY		10				11			12														
POST-OPERATIVE DAY																							
MONTH-YEAR	DAY	Oct 2		3		3			4														
19	HOUR	2	2	01	1	12			00	1													
PULSE (O)	TEMP. F (°)	80	80	60	40	52			80	94													TEMP. C
	105°			00		20			35	80													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		O	O			^																	
70		^		O	O	O			O	O ^													
60									^														
50																							
40																							
RESPIRATION RECORD				45					34														
BLOOD PRESSURE		138/66	137/81	120/64 / 115/68	92/67	124/76			125/67 / 107/57	120/63													
HEIGHT:	WEIGHT →	97%	98%	96% / 97	100%	98%			100% / 96	95													

Record special data only when so ordered

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

(b)(6)-4

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

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

(Centigrade Equivalents, for Reference only)

Ward/Section: EMT

Requesting Physican:

LABORATORY RESULT FORM

(Subject to the Privacy Act of 1974)

Name: (b)(6)-4

Date:

Time:

Patient #

Chemistry 7

Test	Result	Ref. Range
GLU	200	73 - 118 mg/dL
BUN	21	7 - 22 mg/dL
Creat	1.4	0.6 - 1.2 mg/dL
Na	143	128 - 125 mmol/L
K	3.7	3.3 - 4.7 mmol/L
Cl	113	98 - 108 mmol/L
tCO2	21	18 - 33 mmol/L

Chemistry 12/LFT

ALB	4.0	3.5 - 5.5 g/dL
ALP	48	26 - 84 µg/dL
ALT	15	10 - 47 µg/dL
AMY	113 *	14 - 97 µg/dL
AST	28	11 - 38 µg/dL
Tbili	0.7	0.2 - 1.6 mg/dL
TP	7.1	6.4 - 8.1 g/dL
Ca	8.7	8.0 - 10.3 mg/dL
Chol	239	100 - 200 mg/dL
Creat	1.4	0.6 - 1.2 mg/dL
BUN	18	7 - 22 mg/dL
GLU	195	73 - 118 mg/dL

Other Chem

Troponin		Negative
GLU Only		73 - 118 mg/dL
CK		39 - 380 µg/L - Male
		30 - 190 µg/L - Female

Urinalysis

Test	Result	Ref.Range
Color	Lt Yellow	N/A
App	Clear	N/A
Glu	NEG	Negative
Bili	NEG	Negative
Ket	NEG	Negative
SGav.	1.025	N/A
Bld	NEG	Negative
pH	5.0	N/A
Prot	NEG	Negative
Urob	0.2	0.2 - 1.0
Nit	NEG	Negative
Leuk	NEG	Negative
Micro UA		

Venous Blood Gas

ph	7.355	7.31 - 7.45
PCO2	38.5	35 - 45: Art
PO2	87	80 - 105
HCO3	21	22 - 26
TCO2	23	23 - 27
BE	-4	(-2) - 3
sO2	96	95 - 100%

Hematology(CBC)

Test	Result	Ref. Range
WBC	16.9	4.8 - 10.8 x 1E3
RBC	5.45	4.7 - 6.1 x 1E6
Hgb	15.4	14 - 18 g/dL (M); 12-16 (F)
Hct	47.5	45 - 52% (M); 37 - 47% (F)
MCV	87.2	80 - 99 fL
Plt	281	130 - 500 1E3
Lymph%	27.6	20.5 - 51.1 %

Hematology Manual Diff

Segs	Lymph
Bands	Atyp
Mono	Imm
Eos	RBC Morph
Baso	Plt. Est

Coagulation

PT		9.8 - 13.6 sec
aPTT		21 - 34 sec
INR		N/A

MISC

Malaria		Negative
Gram Stain		N/A
UA Tox:		Negative
HCG		Negative

Additional Instructions:

Reported By: (b)(6)-2

Date: 23 SEP 05

Lab ID #

Ward/Section: OR

Report ... physician:

Name: (b)(6)-4

Date:

Time:

LABORATORY RESULT FORM

(Subject to the Privacy Act of 1974)

Patient #:

Chemistry 7

---

i-STAT E07+

Pt: (b)(6)-4

Pt Name:_____

Na_____141 mmol/L

K_____3.8 mmol/L

TCO2_____24 mmol/L

iCa_____1.19 mmol/L

Hct_____39 %PCV

Hb*_____13 g/dL

*via Hct

At 37C

pH_____7.311

PCO2_____44.4 mmHg

PO2_____196 mmHg

HCO3_____22 mmol/L

BEecf_____-4 mmol/L

sO2*_____100 %

*calculated

At Patient Temp

pH_____7.310

PCO2_____44.5 mmHg

PO2_____196 mmHg

Patient Temp: 98.7F

FIO2_____: 70

Sample Type_: ART

23SEP03 14:37

Oper: [redacted] 66-2

Physician:_____

Ser# 40500

Ver: JAM5046A
CLEW A93

---

iCa = 1.13

Urinalysis

Test	Result	Ref.Range
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SGav.		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2 - 1.0
Nit		Negative
Leuk		Negative

Micro UA

Blood Gas

ph	7.32	7.31 - 7.45
PCO2	34	35 - 45: Art
PO2	325	80 - 105
HCO3	19	22 - 26
TCO2	19	23 - 27
BE	-9	(-2) - 3
sO2	100	95 - 100%

Hematology(CBC)

Test	Result	Ref. Range
WBC	14.5	4.8 - 10.8 x 1E3
RBC	5.21	4.7 - 6.1 x 1E6
Hgb	14.7	14 - 18 g/dL (M); 12-16 (I
Hct	44.8	45 - 52% (M); 37 - 47% (I
MCV	86.0	80 - 99 fL
Plt	257	130 - 500 1E3
Lymph%	16.6	20.5 - 51.1 %

Hematology Manual Diff

Segs	Lymph
Bands	Atyp
Mono	Imm
Eos	RBC Morph
Baso	Plt. Est

Coagulation

PT		9.8 - 13.6 sec
aPTT		21 - 34 sec
INR		N/A

MISC

Malaria		Negative
Gram Stain		N/A
UA Tox:		Negative
HCG		Negative

Reported By

Date

Ward/Section: OR

Requ[illegible] hysician:

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

Name: #154

Date: 23 SEP 03

Time: 1550

Patient #: 154

Chemistry 7

Test	Result	Ref. Range
GLU		73 - 118 mg/dL
BUN		7 - 22 mg/dL
Creat		0.6 - 1.2 mg/dL
Na	138	128 - 125 mmol/L
K	5.4	3.3 - 4.7 mmol/L
Cl	113	98 - 108 mmol/L
tCO2	20	18 - 33 mmol/L

(*)

Chemistry 12/LFT

ALB		3.5 - 5.5 g/dL
ALP		26 - 84 µg/dL
ALT		10 - 47 µg/dL
AMY		14 - 97 µg/dL
AST		11 - 38 µg/dL
Tbili		0.2 - 1.6 mg/dL
TP		6.4 - 8.1 g/dL
Ca		8.0 - 10.3 mg/dL
Chol		100 - 200 mg/dL
Creat		0.6 - 1.2 mg/dL
BUN		7 - 22 mg/dL
GLU		73 - 118 mg/dL

Other Chem

Troponin		Negative
GLU Only		73 - 118 mg/dL
PK		39 - 380 µg/L - Male
		30 - 190 µg/L - Female

Urinalysis

Test	Result	Ref.Range
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SGav.		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2 - 1.0
Nit		Negative
Leuk		Negative

Micro UA

Blood Gas

ph	7.355	7.31 - 7.45
PCO2	34.4	35 - 45: Art
PO2	167	80 - 105
HCO3	19	22 - 26
TCO2	20	23 - 27
BE	-6	(-2) - 3
sO2	99	95 - 100%

Hematology (CBC)

Test	Result	Ref. Range
WBC	17.8	4.8 - 10.8 x 1E3
RBC	4.54	4.7 - 6.1 x 1E6
Hgb	12.9	14 - 18 g/dL (M); 12-16 (I
Hct	39.4	45 - 52% (M), 37 - 47% (I
MCV	86.8	80 - 99 fL
Plt	274	130 - 500 1E3
Lymph%	16.9	20.5 - 51.1 %

Hematology Manual Diff

Segs	Lymph
Bands	Atyp
Mono	Imm
Eos	RBC Morph
Baso	Plt. Est

Coagulation

PT	14.6	9.8 - 13.6 sec
aPTT	25.0	21 - 34 sec
INR		N/A

MISC

Malaria		Negative
Gram Stain		N/A
UA Tox:		Negative
HCG		Negative

(*) NO Hemolysis noted

iCa: 1.20

Additional Instructions:
ABG ± Ca++, CBC, PT/PTT / Lytes

Reported By: (b)(6)-2

Date: 22 Sep 03

MEDCOM - 7569

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

LAST FIRST MI	DATE	TIME	SSN/PSEUDO SSN
(b)(6)-4	23Sep03		(b)(6)-4

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC	13.5	4.8-10.8 x 10
RBC	5.25	4.7-6.1 x 10
Hgb	14.8	14-18g/dl (M) 12-16 g/dl (F)
Hct	45.1	45-52% (M) 37-47% (F)
MCV	89.859	80-94 fl (M) 81-99 fl (F)
Plt	256	130-500 x 10 Verified
Lymph %	15.8	20.5-51.1%

(Hematology) Manual Diff

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

Coagulation Studies

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

Urinalysis

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

MET[redacted] 7

TEST	RESULT	REF. RANGE
GLU	257	73-118 mg/dl
BUN	17	7-22 mg/dl
CRE	1.2	0.6-1.2 mg/dl
[redacted]		
NA*	131	128-145 mmol/l
K*	6.3	3.3-4.7 mmol/l
CL*	107	98-108 mmol/l
CO2	18	18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

Chemistry 12

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

Malaria Smear

Results:

Microscopic UA

Results:

Remarks:

Reported by:	DATE:	LAB ID NO:

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

LAST, FIRST, MI (b)(6)-4 (b)(6)-4	DATE: 24Sept03	TIME: 0500	SSN (b)(6)-4

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC	14.7	4.8-10.8 x 10
RBC	5.71	4.7-6.1 x 10
Hgb	15.9	14-18g/dl (M) 12-16 g/dl (F)
Hct	49.1	45-52% (M) 37-47% (F)
MCV	86.0	80-94 fl (M) 81-99 fl (F)
Plt	207	130-500 x 10 Verified
Lymph %	13.9	20.5-51.1%

(Hematology) Manual Diff

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

Coagulation Studies

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

Urinalysis

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

METE[redacted] 7

TEST	RESULT	REF. RANGE
GLU	139	73-118 mg/dl
BUN	18	7-22 mg/dl
CRE	1.7	0.6-1.2 mg/dl
[redacted]		
NA*	130	128-145 mmol/l
K*	4.5	3.3-4.7 mmol/l
CL*	107	98-108 mmol/l
CO2	19	18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

Chemistry 12

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

Malaria Smear

Results:

Microscopic UA

Results:

Remarks:

(b)(6)-2	DATE: 24Sept	LAB ID NO: [redacted] (b)(6)-4

IV 5(25

W/O 1045

EBL 400

+ 3685

4C/WP

Ward/Section: ICU	Requesting Dr (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
Name:	Date: 25 Sept 03 / Time: 0833	Patient # (b)(6)-4

Chemistry 7

Test	Result	Ref. Range
GLU	78	73 - 118 mg/dL
BUN		7 - 22 mg/dL
Creat		0.6 - 1.2 mg/dL
Na		128 - 125 mmol/L
K		3.3 - 4.7 mmol/L
Cl		98 - 108 mmol/L
tCO2		18 - 33 mmol/L

Chemistry 12/LFT

ALB		3.5 - 5.5 g/dL
ALP		26 - 84 µg/dL
ALT		10 - 47 µg/dL
AMY		14 - 97 µg/dL
AST		11 - 38 µg/dL
Tbili		0.2 - 1.6 mg/dL
TP		6.4 - 8.1 g/dL
Ca		8.0 - 10.3 mg/dL
Chol		100 - 200 mg/dL
Creat		0.6 - 1.2 mg/dL
BUN		7 - 22 mg/dL
GLU		73 - 118 mg/dL

Other Chem

Troponin		Negative
GLU Only		73 - 118 mg/dL
CK		39 - 380 µg/L - Male
		30 - 190 µg/L - Female

Urinalysis

Test	Result	Ref.Range
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SGav.		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2 - 1.0
Nit		Negative
Leuk		Negative
Micro UA		

Blood Gas

ph		7.31 - 7.45
PCO2		35 - 45: Art
PO2		80 - 105
HCO3		22 - 26
TCO2		23 - 27
BE		(-2) - 3
sO2		95 - 100%

Hematology(CBC)

Test	Result	Ref. Range
WBC		4.8 - 10.8 x 1E3
RBC		4.7 - 6.1 x 1E6
Hgb		14 - 18 g/dL (M); 12-16 (F)
Hct		45 - 52% (M); 37 - 47% (F)
MCV		80 - 99 fL
Plt		130 - 500 1E3
Lymph%		20.5 - 51.1 %

Hematology Manual Diff

Segs	Lymph
Bands	Atyp
Mono	Imm
Eos	RBC Morph
Baso	Plt. Est

Coagulation

PT		9.8 - 13.6 sec
aPTT		21 - 34 sec
INR		N/A

MISC

Malaria		Negative
Gram Stain		N/A
UA Tox:		Negative
HCG		Negative

Additional Instructions:

Reported By (b)(6)-2	Date 25 Sep 03	Lab ID #