NSN 7540-01-075-3786

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

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

Iraqi Citizen in ≈ 1715 c̄ (1) (R) Eye Globe injury.
(2) (L) shoulder fragment wounds
(3) (R) finger. frag.

(2) AEOX3:
♡ = RRR 75 140/73 pulse ox RA 80's ~~78~~ lungs = LTA (B)
(R) Neck shoulder frag wounds. ABD = Soft NT
Lower ext = nl

Ø PNTX
ABL stable.

CXR.
C-Spine
Skull
(R) shoulder

Fulus (P).

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

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

CODES

DIAGNOSIS
(1) (R) eye globe injury
(2) Fragment wounds.

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

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

NAME: _____ L Civ KS [redacted]

TRAUMA FLOW SHEET

DATE: TIME:

INITIAL ASSESSMENT

Airway: Patent

Breathing: NL

Circulation:

Disability: (* E/V/M = Glasgow Coma Scale) CIRCLE Moved

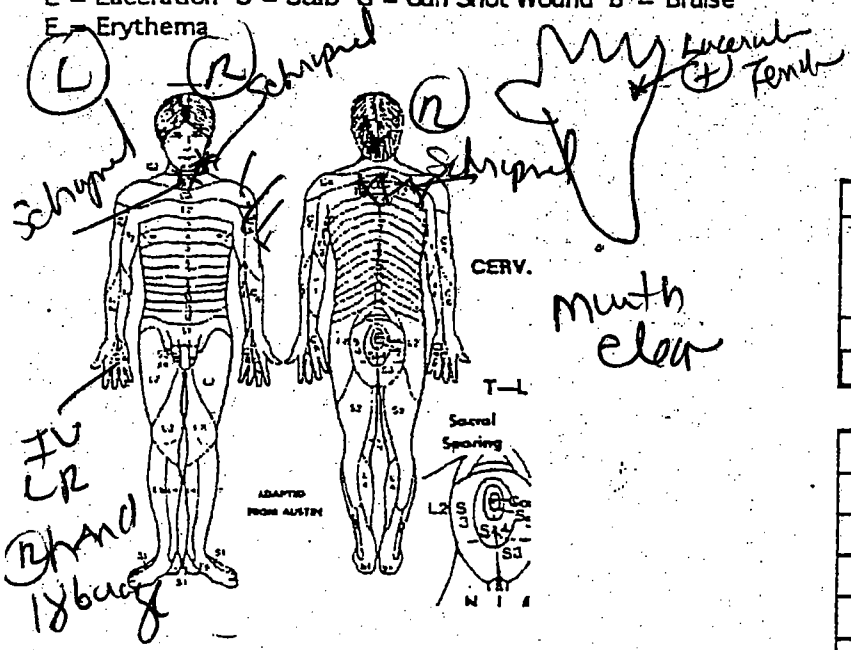
Eyes Open	Verb. Resp.	Motor Resp.
4 - Spontan.	5 - Oriented	6 - Obey Commands.
3 - To Speech	4 - Confused	5 - Localize Pain
2 - To Pain	3 - Inapprop. Words	4 - Flex Withdraw
1 - None	2 - Incomp. Sounds	3 - Flex Abnormal
0 - Closed by Swelling	1 - None (ETT or Trach)	2 - Extension
		1 - No Response

Vitals:

Time	1730				
Pulse	68				
Resp					
BP	143 / 76	/	/	/	/
Temp					
Rhythm					
Pupils	L R	L R	L R	L R	L R

Expose: (Skin Integrity)

X = Abrasion ▯ = Burn F = Fracture OF = Open Fracture
L = Laceration S = Stab G = Gun Shot Wound B = Bruise
E = Erythema



History: ("AMPLE T")

Allergies: No Sure

Meds: ▯ None

Past: ▯ Noncontributory

Hx:

Last Meal:

Event: Date: _____ Time: ___

Tetanus:

Physical Examination

Head	▯ Normal	See Diagram
Neck	▯ Normal	Schrapnel
EENT	▯ Normal	
Chest	▯ Normal	Ant + Post cp
Cardiac	☑ Normal	
Abdom.	☑ Normal	
Pelvis	☑ Normal	
Back	▯ Normal	See Diagram
Genit.	☑ Normal	
Neuro.	▯ Normal	
Extrem.	▯ Normal	See Diagram

Medications

Time				
Meds	Tetanus 0.5cc IM Lot #			
Nurse				
V.O Dr.				

Special Orders

▯ O_2 : ___ lpm ▯ NC ▯ Mask ▯ Pulse Ox		
▯ ETT ___ mm	Time:	
▯ EKG ▯ Monitoring		
▯ Foley ___ fr to gravity		
▯ NG Tube ___ fr	Guaiac ▯ + ▯ -	
▯ Peri.Dial. ▯ + ▯ -	Time:	
▯ Chest Tube ▯ Left ___ cm H_2O ▯ Right ___ cm H_2O		
▯ X-rays	Labs: ▯ CBC ▯ PT / PTT ▯	
	▯ HCG ▯ ESR ▯ ABG ▯ T&C	
	▯ Chem 7 ▯ Chem 20 ▯ T	

(b)(6)-4

[redacted]

ADMISSION

ATE: Time:

Admit to: ICU IGW 1 2 3

Dx: Mesc

Allergies

Condition: Good Fair Poor

Vitals: Routine Q__ h

Activity: BR BRP Ad Lib

Diet: NPO Clear Liq. Regular

IV Fluids: LR @ ___cc/h NS @___cc/h ____@___cc /h

___KVO ___KVO ___KVO

Analgesia: ▯ MS
▯ Tylox
▯ Tyl #3
▯ Tylenol
▯ Motrin 800
▯ ASA

Antibiotics: ▯ Rocephin
▯ PCN ____
▯ Gentamycin
▯ Cefadyl
▯

NG Tube: Suction: ▯ None ▯ LIS

Foley: ▯ None ▯ Gravity

Chest Tube: ▯ None ▯ ____cm H_2O ▯ Water Seal

O_2: ▯ None ▯ NC ____lpm Mask ____lpm

Ventilation: ▯ None ▯TV:_____ ▯FIO_2:_____ ▯PEEP:_____ ▯RR:_____

Meds:

Pre-Op: ▯ Emergent ▯SemiEmerg ▯ Routine

Signature:

LABS:

UA:

Other:

X-Rays: C-Spine Chest, Skull (L) hand (R) shoulder

PLAN:

Procedure/Progress Notes:

NURSE'S NOTES

VITALS						Nurse's Notes
e & Time	T	P	R	Wt.	Stool	Medications & Nurse's Notes

MEDICAL RECORD	PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT For use of this form, see AR 40-66; the proponent agency is The Office of the Surgeon General.
1. AGE: 25 - 30 y.o. HEIGHT: 5'8" ≈ WEIGHT: 70 Kg	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): Chart states "NKDA." — 3. PREVIOUS SURGERY [ ] NO [ ] YES (type): unknown —

4. PROPOSED SURGICAL PROCEDURE:
I+D, back of shoulders, (L) hand repair, EUA other injuries

5. ADDITIONAL INFORMATION:
Bomb blast with shrapnel injuries.

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to unknown, surgery, pain.	o Pt. verbalizes any specific anxiety. o Pt. exhibits relaxed body posture.	✓ Allow pt. to verbalize freely. ✓ Explain OR environment and answer questions regarding surgery. Does not speak English ✓ Offer comfort measures, (e.g., warm blanket, touch) ✓ Explain all nursing procedures before they are done. ✓ Remain with pt. whenever possible. o Maintain family interface. N/A
B. AERATION ✓ Potential for respiratory dysfunction due to anxiety, positioning, pain	o PT. will be able to breathe without difficulty during immediate intra-operative phase.	✓ Offer to elevate head of litter or offer pillow. ✓ Observe pt. while awaiting surgery for signs of distress ✓ Assist anesthesia during intubation and extubation
C. INTEGUMENT ✓ Potential impairment of skin integuity due to prep, positioning	o PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	✓ Utilize pressure preventing devices on OR table and accessories. ✓ Check for proper positioning and support to maintain good body alignment. ✓ Pad pressure points. ✓ Place ESU ground pad on non compromised skin surface area. ✓ Keep prep fluids from pooling.

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

(b)(6)-4

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

(b)(6)-2 Maj/AN 16 Apr 03 DATE

11. POSTOPERATIVE EVALUATION:

Bovie pad site skin clear + intact. Pt moving all extremities by self end of case.

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)

(b)(6)-2 Maj/AN

DATE: 16 Apr 03 TIME: 1925

13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)

(b)(6)-2 Maj/AN

DATE: 16 Apr 03 TIME: 2055

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.01

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

For use of this form, see AR 40-407, the pr[illegible] agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY Anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY (b)(6)-2 Maj

3. DATE 16 APR 03 TIME PATIENT ARRIVED IN SUITE 1920

4. PATIENT IN ROOM TIME 1930 NUMBER ISO #1, Bed #

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: pt x-rayed in pre-op area for left hand. Iraqui civilian, did not speak English.

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC (b)(6)-2	RELIEF SCRUB	Ø
			Ø
ASSIGNED CIRCULATOR	MAJ (b)(6)-2	RELIEF CIRCULATOR	Ø
			Ø

7. POSITION AND POSITIONAL AIDS (Specify) Pt on side, (R) side up for first procedure, axillary roll in place, (L) arm on armboard, pillow between arms, (R) arm over pillow, hel[illegible] ☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☒ RIGHT SIDE UP

COMMENTS: 3" silk tape, down leg bent, pillow between legs. Pt supine for second procedure, arms in anatomical position, warm sheets given, blue fo[illegible] leggrate donut under head for both procedures.

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

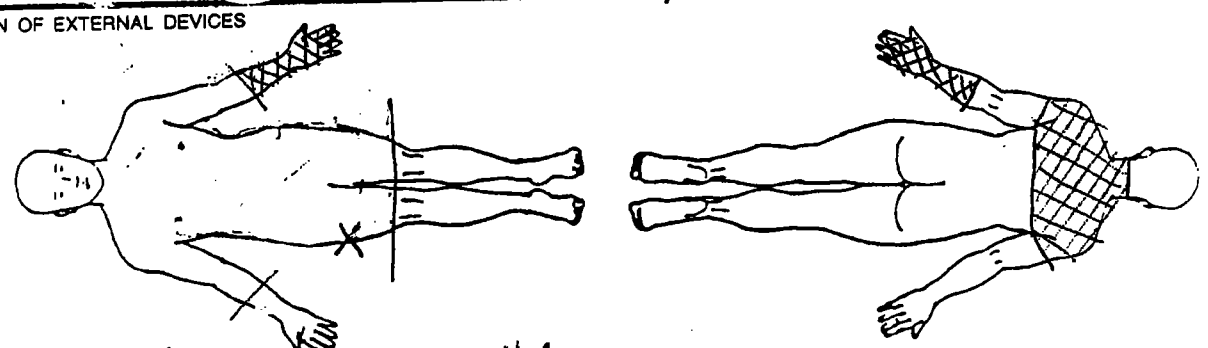
PREP SOLUTION (Specify) Betadine scrub + paint

SITE: upper back BY WHOM: MAJ (b)(6)-2

SITE: left arm BY WHOM: MAJ (b)(6)-2

COMMENTS: No pooling noted. Please se[illegible] #9

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C = Correct I = Incorrect

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

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

(b)(6)-4

(b)(2)-2

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

☒ ESU NO: Valleylab Force 2 00 0 36[illegible]

GROUND PAD: BRAND Valleylab Rem II

LOT NO: 65492 exp 2004-1[illegible]

☐ ESU NO: Ø

GROUND PAD: BRAND Ø

LOT NO: Ø

☐ BIPOLAR NO: Ø

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

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

N.A.

14 MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
0.9% NaCl	qs	intraop	irrigation	manufacturer, Dr.	(b)(6)-2
Ø	Ø	Ø	Ø	Ø	Ø

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NaCl.

OTHER ORDERS	TIME	CARRIED OUT BY
Ø	Ø	Ø

(b)(6)-2

PHYSICIAN'S SIGN

15 X-RAY IN OPERATING ROOM YES ☒ NO ☐ IF YES, SITE — ② arm/hand in pre-op hold ā case

16 LABORATORY SPECIMENS

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

17 TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION (Specify)

shoulders + back = 2x2's, 4x4 combine dressings, ABD's, 3" silk tape.

Left hand = Kerlix, Fluffs, 4 ace wrap.

19 ADDITIONAL INFORMATION

underwear x2 in labelled bag to ICU #1.

20 OPERATION(S) PERFORMED

I+D multiple wounds upper back, I+D left hand ē EDQ repair.

21 PATIENT TRANSFERRED TO ICU # ~~2~~ 1 (b)(6)-2 TIME 2050 METHOD Litter

22 REGISTERED NURSE SIGNATURE (b)(6)-2 Maj/AN

REVERSE OF DA FORM 5179-1, OCT 87

*U.S. GPO 1996-404-613/40449

MEDCOM - 7980

LABORATORY RESULT FORM

(Subject to Privacy Act of 1974)

LAST, FIRST, (b)(6)-4	STATUS	DATE 14Apr03	SSN

Chemistry (i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO_2		35-45 mmHg (art) 41-51 mmHg (ven)
PO_2		80-105 mmHg (art) N/A (ven)
TCO_2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO_3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO_2		95-98%
BEecf		(-2) – (+3) mmol/L
AGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Blood Bank

ABO/Rh		IAT	

Unit	Type	Crossmatch

Misc. Chemistry

CKMB		
Troponin		
DOA		
Alcohol		

Microscopic Urinalysis

Chemistry (Piccolo Analyzer)

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

Urinalysis

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

Hematology

TEST	RESULT	REF. RANGE
WBC	24.9	4.8-10.8 x 10^3
RBC	5.33	4.7-6.1 x 10^9
Hgb	14.9	14-18 g/dl (M) 12-16 g/dl (F)
Hct	48.4	42-52% (M) 37-47% (F)
MCV	90.8	80-94 fl (M) 81-99 fl (F)
Plt	324	130-500 x 10^3 verified
Lymph%	4.8	20.5-51.1%
Retic		0.5-1.5% (adult)
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml
Segs		Mono
Bands		Eos
Lymph		Baso
Atyp		Imm
RBC Morph		
Other		
Spun Crit		42-52% (M) 37-47% (F)
Man WBC		4.8-10.8 x 10^3
Manual Plt		130-500 x 10^3 verified

Microbiology

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

I & NKA

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)												
Midazolam	(mg)	2											
Fentanyl	(mcg)	50/100/100											
Propofol	(mg)	150											
Succinylcholine	(mg)	100											
Vecuronium	(mg)		5										
MgSO4	(mg)				10								
VOLAT AGENT: Iso	% del	.8	.8	1.0	1.0	.7							
	% e.t.												
AIR	L/Min												
N2O	L/Min												
O2	L/Min	10-2	2	2	2	2							

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

FLUIDS

LINE site													
(2) hand	☐ Warmed	500		1000		1500							
	☐ Warmed												
	☐ Warmed												
	☐ Warmed												

LOSSES

EST BLOOD LOSS	—												
URINE -	—												

PHYS STATUS (1 2 3 4 5 / E)

BODY WEIGHT: 70 KG / LB

HEMATOCRIT: —

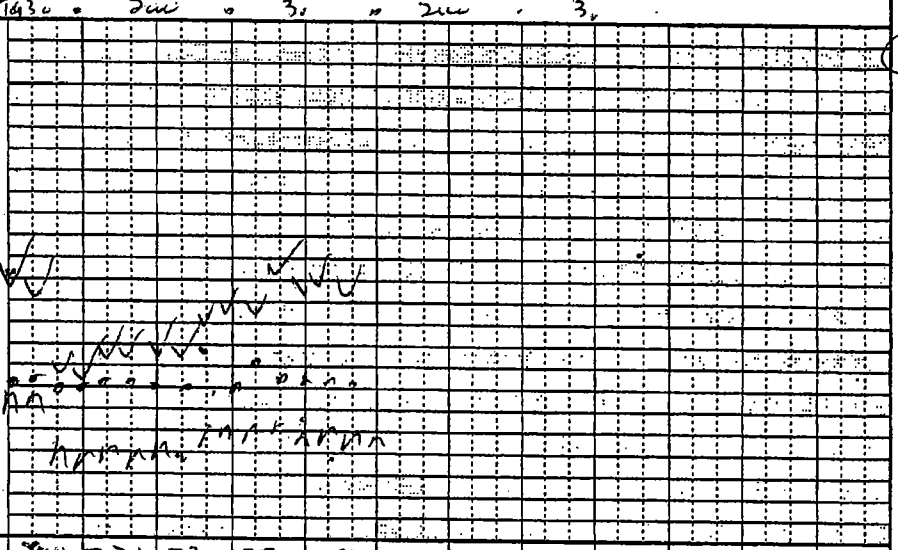
INITIAL DATA: BP- / HR-

EQUIP CHECK: OK?- Y N

PATIENT: OK for PROCEDURE? TIME-

TIME 1630 2000 30 2100 30

SYMBOLS: BP by cuff; Heart rate; Resp rate; BR (transduced); TOURNIQUET; ANES- X-X; PROC-



VENTIL

VT - ml		800	720	730	720	1100
f - breaths/min		8	7	7	7	8
Peak inf pres / PEEP						
MODE - S(pon), A(ssist), C(on)		S-C	C	C	C	S

MONITORS/ACCESSORIES

BP/Auto Cuff	✓	ET CO2 (torr)					
BP/oth	✓	FIO2 (Frac or %)	1.0	1.0	1.0	1.0	1.0
ART line	✓	SpO2 (%)	100	100	100	100	100
Steth- PC/ES	✓	ECG	SR	SR	SR	SR	SR
Gas analyzer	✓	TEMP-site	skin	—			
	✓	N-M Block (T/4)	0/4	0/4	0/4	3/4	4/4 SUCC
Warming blkt							
Conv warmer							

Mark with letters & symbols, explain under REMARKS

EVENTS Position → OT — Anesthesia rollover placed 1st medication.

TOTALS

TOTAL EBL	TOTAL URINE
min	N.M.

FLUIDS - SUMMARY

CRYSTALLOID- 1,500

COLLOID- NONE

BLOOD- None

REMARKS — Code drugs with numbers, events with letters

(1615) Id checked NPO 2 0700.

Preop assessment completed

(1630) Room. Monitors on.

RECOVERY AT: 2355

FACILITY ICU (Specify)

OTHER

CONDITION: Awake, A

RESP- 16 SpO2- 100% 2L

BP- 147/72 HR- 70

ANESTHESIA/PROCEDURE TIMES

	Start	Room	End
ANES	1615	1630	2100
	Ready	Begin	End
PROC	1940	1950	2050

PROCEDURES and CPT Codes: Debridement of Back Shoulders (L) Hand.

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

GETA

OG → SY

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

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

Pt preoxygenated → induced → DVL 1 Miller 2. Airway secured. Cleared. B.U. confirmed ETT to 23cm @ lip. BBS(+) ETCO2. Cricoid pressure

SURGEONS: (b)(6)-2

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

(b)(6)-4

PROCEDURE LOCATION: OR

DATE: 16 Apr 03

PAGE 1 **OF** 1

DA FORM 7389, FEB 1998

COPY 1 - PATIENT'S MEDICAL RECORD

USAPA V1.00

MEDCOM - 7982

I E

143/76, 68

C-Spine

Anaef ; gm Tol

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

PRE-ANESTHETIC EVALUATION

1974 The proponent is Dept of Surgery

OTSG APPROVED (Date) QI Appr 11 Dec 96

DATE OF PROPOSED SURGERY	AGE	WEIGHT	ALLERGIES (List react)	FAMILY HISTORY	Tob HX- EtOH- DRUGS	CONSULTATIONS (Check when completed)
16 Apr 03	05-30	2024	☑ NKDA	☑ NO ANES PROB	None	☐ 1 ☐ 2 ☐ 3
PROPOSED SURGERY	SEX	HEIGHT				
(L) hand (R) Shoulder	M					

PREVIOUS ANESTHESIA/SURGERY ☑ NO PROBLEM

None

MEDICATIONS ☑ NONE * = ORDERED AS PRE-MED

1. CARDIOVASCULAR
- ☑ No Pathology
- ☐ Angina
- ☐ MI
- ☐ Hypertension
- ☐ Low Exercise Tol
- ☐ Arrhythmia
- ☐ CHF
- ☐ Valvular Disease
- ☐ CABG
- ☐ Periph Vasc Dis
- ☐ Other

2. RESPIRATORY
- ☑ No Pathology
- ☐ Asthma
- ☐ COPD
- ☐ URI
- ☐ Other

3. RENAL
- ☑ No Pathology
- ☐ CRF/Renal Insufficiency
- ☐ Other

4. HEPATIC
- ☑ No Pathology
- ☐ Hepatitis
- ☐ Cirrhosis
- ☐ Other

5. GI
- ☑ No Pathology
- ☐ Reflux
- ☐ Hiatal Hernia
- ☐ Other

6. NEURO
- ☑ No Pathology
- ☐ CVA
- ☐ Neuropathy
- ☐ Seizures
- ☐ Other

7. ENDOCRINE
- ☑ No Pathology
- ☐ Insulin-Dep Diabetes
- ☐ Non-Insulin-Dep Diabetes
- ☐ Thyroid
- ☐ Steroids
- ☐ Other

8. HEMATOLOGIC
- ☑ No Pathology
- ☐ Anemia
- ☐ Coagulopathy
- ☐ Sickle Cell Dis
- ☐ Hx Transfusion
- ☐ Other

9. MUSC-SKELETAL
- ☑ No Pathology
- ☑ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ TMJ Disease
- ☐ Other

10. OB/GYN
- ☐ Non-Preg
- ☐ Preg
- ☑ EGA
- G P
- ☐ Pre-eclampsia
- ☑ Other

11. PEDIATRIC
- ☐ Normal Growth Dev
- ☐ < 48 wks PCA
- ☐ Congenital Defects
- ☐ Cerebral Palsy
- ☐ Other

- ☐ DENTURES
- ☐ CONTACTS
- ☐ PROSTHESIS

NOTES
- ☐ See Anesthesia Consult for more details.
- ☐ Other Medical Conditions (List)

(1) - (L) hand Injury
(2) Wounds to ↑ back / shoulder.
(3)

PHYSICAL EXAM: HR 68 BP 143/76 T RR 16

AIRWAY: MP 1 (2) 3 4
Teeth Intact
ROM limited rom of TMJ / mask
TMD (FB) <2 2 (3) >3

HEART: S.S2

LUNGS: ☑ CTAB

NEURO/BACK: Plox3

BLOCK SITE: —

VASC ASSESS: (L) Hand

EXT/OTHER:

Na	Cl	glu	ECG ☑ WNL
K	CO_2	BUN/Cr	
WBC	Hct	plts	
PT	PTT	βHCG	CXR ☑ WNL
ABG			
PFT			
OTHER			

PROBLEM LIST
(1) (L) Hand Wound
(2) (R) Eye injury
(3) wounds to ↑ Back / shoulder.

Discussed injuries / anesthesia plan via interpreter

ASA 1 2 3 4 5 (E) ☐ Counselled to remain NPO

PLAN
- (General) — Discussed ↑ pt via interpreter
- ___ MAC
- ___ Regional: ___
- ___ Block: ___
- ☐ Post Op ICU/Vent ☐ Awake Intubation
- ☐ Art Line ☐ CVP ☐ PA
- ☐ Special Techniques

PREMED: Anaef ; gm to ER

PATIENT'S CONSENT
☐ All plans, risks, options discussed and understood. All questions answered. Final plan subject to change by the assigned anesthesia team.

PATIENT'S SIGNATURE: (b)(6)-4

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC REVIEWED BY:

DATE 16 Apr 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) Suppl SF 517
☐ DIAGNOSTIC STUDIES
☐ TREATMENT

(b)(6)-4

DA FORM 1 MAY 78 4700

PREVIOUS EDITION IS OBSOLETE.
REQUIREMENT OF PRIVACY ACT OF 1974

SG OVPT 34-R (Mar 02)

MEDCOM - 7983

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

BED# 4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 16 Apr 03 — TIME OF ORDER: 1820 HOURS — LIST TIME ORDER NOTED AND SIGN

1) Admit to ICU #1 - Medicine
2) Dx (R) globe injury
(L) hand laceration
Shrapnel to back/chest/face/skull
3) Condition stable
4) All: NKDA [redacted] b(6)-2
5) VS: Q4°

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER — TIME OF [redacted] HOURS

6) Diet: NPO [redacted]
7) IV: LR @ 125/hr x 2l then [redacted]
75 cc/hr. [redacted]
8) Meds: Emycin opthalmic 1 cm to [redacted]
(R) globe QID
MSO4 2mg IV Q3° prn pain [redacted]

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER — TIME OF ORDER

9) Eye patch + (R) eye. [redacted]
10) Ancef 1gm given in ED [redacted]
Tetanus OSSC given c 1823 [redacted]
11) Dressing Δ moist to dry BID [redacted]
12) On call to OR [redacted] (b)(6)-2

(b)(6)-2

MAJ MC Int Med

SGT LEM

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 16 Apr 2003 — TIME OF ORDER: 2120 HOURS

1) S/P I+D Back + (L) hand [redacted]
2) Resume current orders [redacted]
3) LR 125cc/hr Hep Lock when [redacted]
4) Ancef 1 Gram IVPB Q 8 hrs [redacted]
5) Tylenol 650 mg P.O. Q 4 hrs PRN (b)(6)-2
6) Percocet 1-2 P.O. Q 4-6 hrs PRN
7) Regular diet. (b)(6)-2

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

MEDCOM - 7984

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

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

Mo. ____ Yr. ____

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	16	17	18	19	20	21
16APR	(b)(6)-2	Condition - Stable	05		(b)(6)-2				
	.....		1700	(b)(6)-2					
16APR	(b)(6)-2	Vital Signs Q4°	4	✓	(b)(6)-2				
	.....		8	✓					
	.....		12	✓					
	.....		16	✓					
	.....		20	✓					
	.....		24	(b)(6)-2					
16APR	(b)(6)-2	Diet - Regular	05	✓	(b)(6)-2				
	.....		17	(b)(6)-2					
16APR	(b)(6)-2								
	.....	IVF - LR @ 125 cc/hr	05	✓	(b)(6)-2				
	.....	Heplock when tol P.O.	17	(b)(6)-2					
16APR	(b)(6)-2	E-mycin ointment	6	✓					
	.....	1 cm to (R) Globe	12	✓					
	.....	QID - Eye Patch (R) eye	18	✓					
	.....		24	(b)(6)-2					
16APR	(b)(6)-2	Dss Δ moist to	05	✓					
		dry Bid	1700	(b)(6)-2					
16APR	(b)(6)-2								
	.....								
	.....								
	.....								
	.....								
	.....								
	.....								
	.....								

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS:
(R) Globe injury.
(L) hand laceration
Schrapnel to back/chest/head

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:
(b)(6)-4

BED # 4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				Mo._____ Yr._____
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
	.....	Tetanus 1823 pm	Dove		(b)(6)-2	
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
.....	.....	MSO4	17	18												
16 [illegible]	(b)(6)-2	Percocet 0/1 - 00/11	0930 (b)(6)-2													
.....	.....	P.O. Q 4-6 hrs														
.....	.....	prn														
16 [illegible]	(b)(6)-2	Tylenol 650mg														
.....	.....	P.O. Q 4-hrs														
.....	.....	prn														
16 [illegible]	.....	MSO4 2mg	0430 2mg (b)(6)-2	0930 2mg												
.....	.....	Q3 prn														
.....	.....															
.....	.....															
.....	.....															
.....	.....															

USAPA V1.00

Iraq Soldier

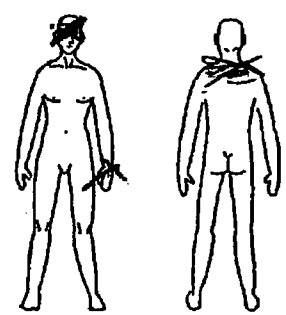
1. LAST NAME, FIRST NAME / NOM ET PRÉNOM	RANK / GRADE	MALE / HOMME / FEMALE / FEMME
SSN / NUMÉRO MATRICULE	SPECIALTY CODE / GPM	RELIGION / RELIGION

2. UNIT / UNITÉ

FORCE / ÉLÉMENT				NATIONALITY / NATIONALITÉ
A/T	AF/A	N/M	MC/M	
	BC / BC		NBI / BNC	DISEASE / MALADIE / PSYCH / PSYCH

3. INJURY / BLESSURE

FRONT / DEVANT — BACK / ARRIÈRE



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

Bulging (R) eye
holes in back
Lac. ti (R) hand

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE

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

5. PULSE / POULS	TIME / HEURE	6. TOURNIQUET / GARROT	TIME / HEURE
		NO / NON — YES / OUI	

7. MORPHINE / MORPHINE	DOSE / DOSE	TIME / HEURE	8. IV / IV	TIME / HEURE
X NO / NON — YES / OUI				

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

gauze to back
Patch to eyes
gauze & Kravat to hand

10 mg morphine
1 ANOF

10. DISPOSITION / DISPOSITION	RETURNED TO DUTY / RETOUR À L'UNITÉ / EVACUATED / EVACUÉ / DECEASED / DÉCÉDÉ	TIME / HEURE

11. PROV (b)(6)-2 — DRS — DATE/DATE (YYMMDD) 0:04:6

DD Form DEC 91 — U.S. FIELD MEDICAL CARD / MÉDICALE DE L'AVANT ÉTATS-UNIS

---

12. REASSESSMENT / RÉASSESSMENT

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

TIME / HEURE	BP / PS	PULSE / POULS	RESP / RESP

DATE / TIME / DATE / HEURE	13. CLINICAL COMMENTS / DIAGNOSIS / INFORMATION MÉDICALE / DIAGNOSTIQUES

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

15. PROVIDER / OFFICIER MÉDICALE — DATE/DATE (YYMMDD)

16. DISPOSITION / DISPOSITION: RETURNED TO DUTY / RETOUR À L'UNITÉ — EVACUATED / EVACUÉ — DECEASED / DÉCÉDÉ — TIME / HEURE

17. RELIGIOUS SERVICES PERFORMED

PROVIDED READING/PRAYER WITH INDIVIDUAL
(CATHOLIC/ JEWISH/ MUSLIM/ OTHER)
1st AB LIMIT / CH (CPT (b)(6)-2
DA FORM 1380, DEC 91 (BACK)

(b)(2)-2

[redacted]

ADMISSION AND CODING INFORMATION

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

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

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
[redacted]	25	X	9	unk

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
	—	99 20	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	U	1707	—

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø	ICU2	unk

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

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYYYMMDD)
26		20030416

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
ABAA		20030414

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

FOR LOCAL USE

① GSW (R) FLANK

② MULTIPLE SHRAPNEL WOUNDS

DX: 8713
8739
2765
8821
87350
8749
88010
E8919

Trauma
1
Injury
449

ADMITTING OFFICER (Signature, as required)

Dr. (b)(6)-2 (b)(6)-2 mass me

PX, BG22, (b)(6)-2

SIGNATURE OF ADMITTING CLERK

(b)(6)-2

18605

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

MEDCOM - 7988

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER (b)(6)-4		2. (b)(6)-4				3. GRADE —	ADMISSION REMARKS
4. SEX M	5. AGE —	6. RACE Z	7. RELIGION MUS	8. LENGTH OF SVC —	9. ETS —	10. PREVIOUS ADMISSION NO	
11. FMP 99	(b)(6)-4		13. ORGANIZATION —			14. WARD IC112	
15. FLYING STATUS	16. RATING/ DSG —	17. DEPT./ BEN 78 ~~199~~	18. BRANCH/CORPS —	19. UIC/ZIP —		20. TYPE CASE WIA	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from ER				22. HOURS OF ADMISSION 1707	23. CLINIC SERVICE ABAA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK			25. TYPE DISPOSITION		26. DATE OF DISPOSITION 030417		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK			27b. TELEPHONE NO. UNK		28. DATE OF THIS ADMISSION 030416		ADMITTING OFFICER
(b)(3)-1					30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED	

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW (L) Flank

Trauma

DX: 8795
E9912

Injury
450

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	1	1

36. Total Days All Facilites

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

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

DA FORM 3647, MAY 79 EDITION OF USAPPC V1.10

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	1 2 3 4 5 6
2. MTF LOCATION (State or Country Code.)	7 8
3. REGISTER NUMBER	9 10 11 12 13 14 15
NAME (Last, First, Middle Initial)	(b)(6)-4
4. PAY GRADE	16 17
5. SEX	18 M
6. DATE OF BIRTH (Y Y Y Y M M D D)	19 20 21 22 23 24 25 26
7. AGE AT ADMISSION	27 28 29
8. RACE	30 Z
9. ETHNIC BACK-GROUND	31 9
RELIGION	Muslim
10. LENGTH OF SERVICE	32 33 34
ETS	—
11. FMP	35 36 99
12. SOCIAL SECURITY NUMBER	37 38 39 40 41 42 43 44 45
ORGANIZATION (Active Duty Only)	—
13. MARITAL STATUS	46 Z
HOUR OF ADMISSION	1707
BRANCH / CORPS	—
14. FLYING STATUS	47 48 49
15. BENEFICIARY CATEGORY	50 51 52 A99
16. ZIP CODE OF RESIDENCE	53 54 55 56 57 58 59 60 61
17. UNIT LOCATION (State or Country Code)	62 63
18. MOS	64 65 66 67 68 69 70
19. TRAUMA	71 9
PREV. ADMISSION	YEAR ☒ NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	72 0
WARD	ICU2
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	UNK
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	UNK
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE	UNK
21. TYPE OF DISPOSITION	73 74
22. MTF TRANSFERRED TO	75 76 77 78 79 80
23. DATE OF DISPOSITION (Y Y M M D D)	81 82 83 84 85 86 03 04 17
24. CLINIC SVC - ADMITTING	87 88 89 90 ABAA
25. MTF TRANSFERRED FROM	91 92 93 94 95 96
26. DATE THIS ADMISSION (Y Y M M D D)	97 98 99 100 101 102 03 04 16
27. LOCATION OF OCCURRENCE (Battle Casualty Only)	103 104
28. MTF OF INITIAL ADMISSION	105 106 107 108 109 110
29. DATE INITIAL ADMISSION (Y Y M M D D)	111 112 113 114 115 116

(b)(3)-1

(b)(6)-4

(b)(6)-4

(b)(6)-4

(b)(3)-1

FOR LOCAL USE

D : GSW (2) Flank

ADMITTING OFFICER (Signature, as required)

(b)(6)-2

SIGNATURE OF ADMITTING CLERK

(b)(6)-2

DA FORM 2985, MAR 89

MEDCOM - 7990

PATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER (b)(6)-4		2. NAME (Last, First, MI) (b)(6)-4				3. GRADE CIV	ADMISSION REMARKS
4. SEX M	5. AGE unk	6. RACE X	7. RELIGION 9	8. LENGTH OF SVC N/A	9. ETS N/A	10. PREVIOUS ADMISSION NO	
11. FMP 99	12. SSN (b)(6)-4		13. ORGANIZATION N/A			14. WARD ICW1	
15. FLYING STATUS NO	16. RATING/DSG	17. DEPT./BEN K78	18. BRANCH/CORPS N/A	19. UIC/ZIP unk		20. TYPE CASE NBI	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from ER				22. HOURS OF ADMISSION 1906	23. CLINIC SERVICE ABAA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE unk			25. TYPE DISPOSITION 26		26. DATE OF DISPOSITION 17 Apr 03		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) unk			27b. TELEPHONE NO. unk		28. DATE OF THIS ADMISSION Apr 16 03	ADMITTING OFFICER DR (b)(6)-2	
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(2)-2					30. DATE OF INTIAL ADMISSION	32. COMPONENT TRANSFUSED	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx ① Melt. b-sw $\bar{o}$ Ex lap (abd, Lt elbow, Lt foot, Rt thigh) 863.30 825.35

② - S/P Negative ex-lap 890.1

③ Fever, resolved. 881.11 E922.9

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL (b)(6)-2 DR (b)(6)-2

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER (b)(6)-2

DA FORM 7 ... EDITION OF 1 AUG 76 IS OBSOLETE

MEDCOM - 7991

509-113

NSN 7540-00-634-4122

MEDICAL RECORD

PROGRESS NOTES

DATE

16 April 03

16 ... EPW wounded today presents on transfer for (b)(2)-2 for further care/evacuation. Patient sustained GSW to ABD requiring exp laparotomy and 1° repair of interotomy x2, GSW to CL foot S/P I&D, GSW to R prox & distal femur S/P I&D, and I&D of CL elbow superficial laceration. Patient presents on transfer c̄ non functional IV and intact medical records. Patient denies sig pain at this time.

115/70, 60, 97°, 14, 99%

NC/AT

RRR

CTA B

ABD 3-4" vertical midline incision CDI

CLLQ 1½" wound closed c̄ staple x 2

R sup/inf iliac spine wounds open and packed

circ / foley in place 150cc light yellow urin in bag

LLE GSW t dorsum of CL foot wound open, mern bleeding

RLE GSW t prox thigh c̄ packing in place

GSW through and through distal thigh, packing in place

ext N/V/I

neuro non focal

140
115
255
85
255
3 | 24
15

2+ DT
1+ DP
cap refill
~4 sec
vs new
intact

(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.

PROGRESS NOTES

Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

PROGRESS NOTES

DATE

XRAY (R) distal femur (+) fragments, but Ø fx
(L) foot (+) fragments (+) fx of 2nd MT
unable to assess midfoot on XRAY

A/P - S/P GSW to ABD c̄ exploratory x2 repair
ext GSW c̄ associated fx of (L) 2nd MT,
ext GSW to (R) prox / distal femur

IV placed .9NS 1liter given
and 1 gm IV (2nd dose) (given @ 1550 R Bourrous, corpsman)
among transport to level 3 care

CPT (b)(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
4-14-03 0905	BRIEF OP NOTE:
	PROCEDURE: (1) Exploratory Laparotomy
	(2) Right thigh wound debridement + irrigation.
	(3) Left foot + Left Elbow wound debridement
	PRE-OP DIAGNOSIS: Intra-abdominal injury
	POST-OP DIAGNOSIS: Same
	SURGEON: (b)(6)-2 ASSISTANT: (b)(6)-2
	EBL: 200 cc
	FLUIDS: 2500 cc
	UOP: 75 cc
	TT: 0
	POST-OP PLAN: Recovery Room, Pain Management.
	Findings: Small enterotomy x 2, Repaired c̄ 3 0 silk
	(b)(6)-2 MD

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.

LOG#: (b)(6)-4
SSAN#:
NAME:

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	PROGRESS NOTES
DATE	
17Apr03 0640	(cont.) A&OX3, PERRLA bilat; good grasp Cardio: S1 S2 Bounding pulses x4 extremities cap Ref ≤ 3 sec. Resp. Equal bilateral expansion - breath sounds normal clear GI/GU - pt voiding QS clear yellow urine NPO - hypo active bowel sounds Integ - abd drsg marked for bleeding progression; drsg to (L) F.A., (L) foot heplock (L) F.A.; other than obvious pain, pt seems to be in good spirits. Will continue to monitor throughout shift (b)(6)-2 SPC LPN
17Apr03 0930	Foley DC'd - prior to DC - Foley emptied 920 cc urine - will continue to monitor for next 6 hours for urine output
17Apr03	Drsg to (L) foot reinforced; will continue to monitor for bleeding (b)(6)-2 SPC LPN
17Apr03 1510	BP: 110/61, HR: 105, Pox: 98, T: 99.7°; incentive spirometry encouraged. (b)(6)-2 LPN SPC
17Apr03	Concur c above. (b)(6)-2 CPT, AN
17Apr03	Total shift urine output 1450 cc (b)(6)-2 SPC, LPN
17Apr03	1830: HR 115, BP 126/57, RR 24 c sats 97% RA, T=100.5. Neuro Intact, able to follow simple commands. Resp: RR WNL, even unlabored respirations, lungs CTA bilat. CV: Pt tachycardic in 1-teens, BP stable, palpable pulses. GI/GU: (+) BS x4, voids using urinal, clear yellow urine. Dsg to abdomen c marked serosang. drainage, dsg to (R) thigh CDI. Dsg to LUE CDI. Dsg to (L) foot c serosang. drainage. PIV to (L) FA c LR @ 100cc/hr. (b)(6)-2 CPT AN
17Apr03	1845: 250cc UOP via urinal. (b)(6)-2 CPT AN
17Apr03	2145: 300cc UOP via urinal (b)(6)-2 SPC, LPN

(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.

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE	
16Apr03	1945 : HR 99, 113/65, RR 20, 97% RA. — (b)(6)-2 CPT RN
16Apr03	2030 : 1100 cc urine from foley. — (b)(6)-2 CPT RN
16Apr03 @ 2100	: CBC drawn & taken to lab — (b)(6)-2
16Apr03	2152: Pt admitted from EMT at 1945. VSS. A+O×3. Ø c/o pain. Follows simple commands. MAE weakly. Resp.: Even + unlabored, CTA bilat, sats >95% on RA, CV: $S_1 S_2$ palp pulses in all extremities. GI: hyperactive BS in all quadrants. GU: foley to gravity draining clear yellow urine. Dsg to (L) FA CDI, dsg to (L) foot c̄ serosanguinous drainage. Abdominal dsg CDI. (R) thigh dsg c̄ serosanguinous drainage. Dr (b)(6)-2 & Dr (b)(6)-2 performed drsg Δ's upon pts arrival. PIV to (L) FA. LR infusing at 100 cc/hr. — (b)(6)-2 CPT RN
16Apr03	2200 : 300 cc UOP — (b)(6)-2 CPT RN

Intake				Output
2000 hrs	100cc	0000	100cc	2000 : 1100 cc
2100	100cc	0100	100cc	2200 : 300 cc
2200	100cc	0200	100cc	0230 : 400 cc
	100cc abx	0300	100cc	
2300	100cc	0400	100cc	0430 : TOTAL 1800

total intake → 1000cc total output

17APR03	0015 : 96, 114/63, RR 24, T-99³. — (b)(6)-2 CPT RN
17APR03	0430 : 91, 116/58, RR 18, T-99² — (b)(6)-2 CPT RN
17APR03	0450 : Dsgs to (R) thigh & (L) foot saturated c̄ serosanguinous drainage. Old dsgs removed & clean 4x4 dsgs applied + wrapped c̄ Kerlix gauze. Pt tolerated c̄ minimal discomfort. — (b)(6)-2 CPT RN
17Apr03	BP: 119/65 HR: 92 T: 98.6 POX: 99% Neuro: neurologically intact

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

(b)(6)-4

MEDICAL RECORD	PROGRESS NOTES
DATE	
18Apr03 0915	BP: 112/62 HR: 96 T: 99.2° Pox: 96% Neuro: A&OX3 complains of pain in ankle & foot given 4mg MSO4 will monitor for effectiveness denies tingling or numbness in affected area. Cardio: S,S2, strong pulses x3, unable to assess injured foot. Cap Ref <2sec Resp: Lungs CTA, equal & bilat expansion, GI/GU - pt voiding QS clear, yellow urine via urinal, hyperactive bowel sounds No BM this Am. pt denied breakfast, will offer food later; Integ: pink, dry, warm to touch all drsgs CDI; pt sleeping peacefully, will continue to monitor throughout shift (b)(6)-2 spc/[illegible]
18Apr03 1400	Discharge Summary Young Iraqi male admitted for multiple GSW (abd, Lt elbow, Lt foot, Rt thigh). S/P negative ex-lap. Post-op fever w/ no obvious source. Now afebrile. Abx course stopped - No source. Being transferred w/ his father. - Pain control - drsg d's. (b)(6)-2 (b)(6)-2
18Apr03 1415	Pt D/C to ASMC. (b)(6)-2 [illegible]/RN

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

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

NSN 7540-00-634-4176 600-108

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
16 APR 03	S. 16 y/o ♂ post op exploratory laparotomy
T 102 (R)	(R) thigh wound GSW (numerous x 2) GSW (L) foot,
P 106	GSW to ABD Pt presents with IV bolus N.S. (non functional
R 18	after TX to FLA. Pt has a patent airway states no
BP 115/70	difficulty breathing or pain at this time. Pt arrived
SPO2 100	with intact medical records.
	O. ⊖ difficulty breathing, febrile 102 rectal
1742 SPO2 99	lungs CTA Bilateral all dressings have been reinforced
P 103	Pt alert and oriented, urinary catheter
R 20	CV - RRR ∅m/G/R
T 102	ABD - 1g dressing covering exp lap x 2
	∅ active bleeding
NKDA med Amoxi x 2 (1gm) tetanus x 1	(L) elbow GSW superficial through + through
	(L) ft - GSW entry wound only (~~[illegible]~~) ? fx per
	previous chart
	(R) distal femur GSW entry medial exit lateral c̄ multiple
	exit wounds
	A: multiple GSW to abd (L) elbow (L) ft (R) femur
	P: (1) tx pnt to CSH for ICU eval.

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

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

CHRONOLOGICAL RECORD OF MEDICAL CARE

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

MEDCOM - 7998

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
17 Apr 03		2247	Nsg: 300 cc out via urinal. (b)(6)-2
18 Apr 03		0430	Nsg: Total intake 1300 cc
			Total output 850cc (b)(6)-2
18 Apr 03		0435	475cc UOP via urinal (b)(6)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

NURSING NOTES

Medical Record

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

(b)(6)-4

MEDCOM - 7999

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Patient)*	LOG NUMBER	TREATMENT FACILITY
		RECORDS MAINTAINED AT	

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

SEX

DUTY/LOCAL PHONE: AREA CODE | NUMBER

AGE

HOME PHONE: AREA CODE | NUMBER

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			

MEDICAL HISTORY OBTAINED FROM

ARRIVAL

DATE *(Day, Month, Year)* | TIME

TRANSPORTATION TO FACILITY

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS

ALLERGIES

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☒ NON-URGENT

TIME 1900 b(6)-2

INITIALS [redacted]

VITAL SIGNS

TIME	1900				
BP	128/76				
PULSE	104				
RESP	28				
TEMP	98.2				
WT					

LAB ORDERS

☐	CBC/DIFF	☐	ABG	☐	PT/PTT	☐	BHCG/URINE/BLOOD/QUANT
☐	URINE C&S	☐	UA MSCC/CATH	☐	CHEM:		
☐	BLOOD C&S X						

X-RAY ORDERS

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

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE

DISPOSITION

☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

DISPOSITION QUARTERS /OFF DUTY

☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE

☐ IMPROVED ☐ UNCHANGED

☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ | TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

(b)(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

STANDARD FORM 558 (REV. 9-86)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

MEDICAL RECORD — **INTRAOPERAT[illegible]JMENT**

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 (b)(2)-2 Staff

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT (b)(6)-2

3. DATE 16 Apr 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 0725 NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Civilian Iraqi

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: on canvas litter

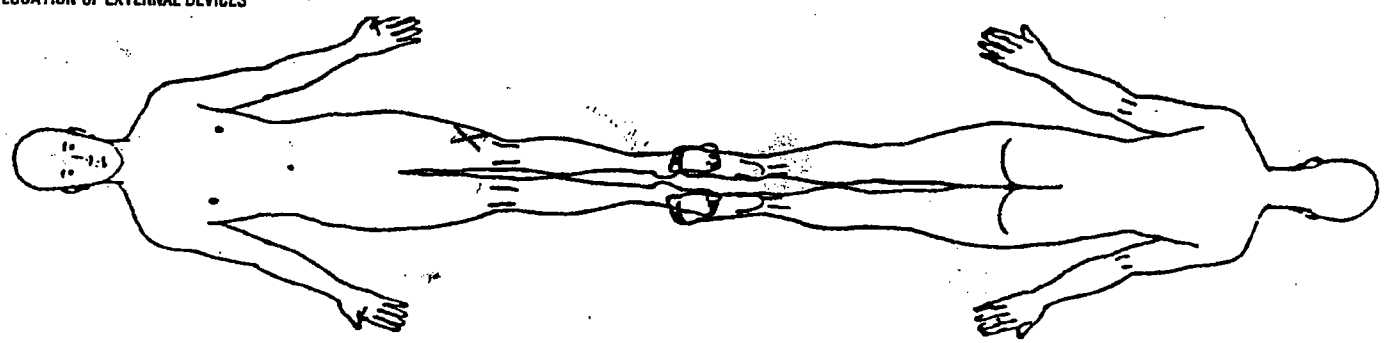
8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine
SITE: Abdomen BY WHOM: Maj (b)(6)-2
SITE: BY WHOM:

COMMENTS: Ø nicks or cuts by CPT (b)(6)-2 COMMENTS:

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		C	C	(b)(6)-2	(b)(6)-2
Needle Sharp	☒ Yes ☐ No		C	C		
Instrument	☐ Yes ☒ No				SPC	CPT
Other	☐ Yes ☒ No					

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

LOG# (b)(6)-4

SSAN#

NAME:

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO 30/30

☐ ESU NO: Form 2
GROUND PAD: BRAND Conmed
LOT NO: 021272

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM [illegible] USAPA V1.01

MEDCOM - 8001

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NaCl

OTHER ORDERS	TIME	CARRIED OUT BY
16 FR Foley draining clear yellow urine via gravity	Intraop	Dr (b)(6)-2

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

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

YES ☐ NO ☒

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1.	2.	3.
	16 Fr Foley	Kerlix pack	
SITE	1.	2.	3.
	To Bladder	Rt. thigh	

18. DRESSING/IMMOBILIZATION *(Specify)*

4x4 Tape ABD } Abdomen

Kerlex, Ace } Lt. foot

4x4 + Kerlex Ace } Lt. Elbow

Kerlex, ABD – Rt. thigh

19. ADDITIONAL INFORMATION

Surgeons: Dr. (b)(6)-2

Dr. (b)(6)-2

APLOB 0750 – GETA by (b)(6)-2 Marcello, RSI ? cricoid, atraumatic, SS throughout the case, EBL – 200, LR 2500, UO – 75 cc urine. IV, drugs. Ketamine, Valium, Succinylcholine, MSO4, rocuronium, cefazolin 1gm, PT extubated, to RR

LOG # (b)(6)-4

SSAN#

NAME:

20. OPERATION(S) PERFORMED

Ex-lap. closed 2 small enterotomies, Rt. thigh wound I+D, Lt. foot wound I+D I+D Lt. elbow

21. PATIENT TRANSFERRED TO (b)(2)-2 Post op TIME 0917 METHOD Litter

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

REVERSE

USAPA V1.01

MEDCOM - 8002

Doctor's Orders—Post-OP (b)(2)-2 OP 4256

Nurse Complete	Dr.'s Select	DATE: 16 April 03 TIME: 0907
☑	☑	1. Admit to: ☐ OR ☑ PACU ☐ ICW ☐ Patient Holding
☑	☑	2. Diagnosis: S/P Exp. Lap.
☑	☑	3. Condition: ☐ Critical ☐ Guarded ☑ Stable ☐ VSI ☐ SI
☐	☐	4. Allergies: See SF 558
☑	☑	5. Vitals: ☑ Unit SOP ☐ Notify Dr. for SBP >80 or <90, DBP 100 or 50, HR 65 or 50, RR 55 or >10, or Temp >10.9
☑	☑	6. Activities: ☑ Bed Rest, ☐ BRP, ☐ OOB ASAP w/ assist, ☐ Sit up and dangle when stable ☐ Other:
		7. NRSG:
☑	☑	a. Propaq monitor w/ Pulse-ox
☑	☑	b. O_2 to maintain SAT's above 94%
☐	☑	c. Maintain Vent settings at MODE=_____ Vt=_____ RR=_____ PEEP= FIO_2=
☑	☑	d. ☑ Reinforce or ☑ Change dressing for bleed-through X1 then notify Dr.
☑	☑	e. I's & O's
☐	☐	c. Suction NT ETT PRN
☐	☐	d. CT to ☐ H_2O seal or ☐ Suction at
☑	☐	8. Diet: ☑ NPO ☐ Clear fluids as tolerated ☐ Other:
☑	☐	9. IV: ☐ NS or ☑ LR TRA 5 cc/hr ☐ DEXTRAN or ☐ Hespan X 500 cc bolus titrated then _____ cc/hr ☐ Albumin 100cc X ____ TRA _____ cc/hr ☐ When tolerating PO fluids, complete current fluid then SL.
☐	☐	10. BLOOD: ☐ T&S or ☐ T&C _____ units ☐ Transfuse _____ units ☐ PRBCs or ☐ Whole Blood
		11. Medications:
☐	☐	a. Tobramycin 300mg IV Q12hrs X | e ☐ Ceftriaxone 750 mg IV
☐	☐	b. Clindamycin 600mg IV | f ☐ PEN G 2 million Units IV
☐	☑	c. Cefazolin 1 gram IV 80 (1st dose @ 0800 local) ← intra-op
☐	☑	d. Phenergan 12-25mg Titrate ☐ IV ☐ IM Q4hrs PRN nausea/vomiting
☐	☐	g. Droperidol 1mg ☑ IV ☐ IM X 1 PRN Nausea/Vomiting
☐	☑	h. MSO_4 1-3mg Titrate ☑ IV ☐ IM Q10min PRN Pain
☐	☐	i. Robinul 0.1mg IV X 1
☐	☐	j. Zantac 50 mg ☐ IV or ☐ IM or ☐ 6.25mg/hr infusion
☑	☑	k. Tetanus Immune Globulin done @ 10^{30} (L)
☑	☑	l. Toradol ☑ IV 30mg or ☐ IM 60 mg
☐	☐	m. Maintain sedation/paralysis w/ Rocuronium and MSO_4 PER SOP
☐	☐	12. LABS: a. iSTAT ☐ Glucose ☐ ABG ☐ BMP ☐ CMP
		13. Additional:
☑		Foley to gravity
		(b)(6)-2
		Signature:

LOG# PT NAME: PT SSAN# 10JAN03

(b)(6)-4

MEDCOM - 8003

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	Crystalloid	2500	OR	EBL	200
PACU	NS Bolus	1000	OR	Urine (Foley)	75
	LRC 125%	300	PACU	Urine	175
TOTAL	+	3800	TOTAL		− 450

~~PACU NURSING NOTES: NURSING CARE PROBLEM NO.'S~~ IDENTIFIED. ~~Refer to FH MDA OP 39~~

~~NURSING CARE PROBLEMS: 1. RESP; 2. CIRC; 3. ACT; 4. LOC; 5. TEMP; 6. PAIN; 7. SAFETY; 8. ANXIETY; 9. EDUC; 10. OTHER~~

10am (L) Pt progressing well post operatively; hemodynamically stable + tolerating extubation (moved post op) well + s̄ s/s of dyspnea or laryngospasm. SpO_2 100% on RA. CM depicts S-tach s̄ ectopy ± Ax ↑ to 98°. Lungs CTA (B). Sel dsgs reinforced due to mod large amounts of saturation c̄ dilute sanguinous drainage (dr beverly aware). Pt neuro-vascular WNL/intact × (B)UE + (B)LE. (L)LE ↑ Pt resting quietly NAD evident, but arousable to voice + 0×2-3; pt mother @ bedside. Plan: pt to recover here + then transported to the nearby ASMC for further care. [redacted] CRT/AN

1100 (L) Pt rec'd 1 LNS bolus (over 20min) for hypotension + ↓ UOP per dr beverly ~~for effective~~ 10^{35} (L). Bolus effective. Pt remains stable + resting comfortably. Awake + 0×3 c̄ his mother @ bedside to translate. Pt awaiting evac to ASMC [redacted] CRT/[redacted]

MEDICATION GIVEN BY:	D[redacted]IVED IN PACU/ICU [redacted]OSE	ROUTE	(LOCAL) TIME	EFFECTIVENESS
CRT [redacted] CRNA	Claforan	1g	IV	0800 intra-op	−
↓	MSO4	14mg	IV		(+)
CRT [redacted]	Toradol	30mg	IV	10^{30}	(+)
↓	Tetanus Toxoid	250cu	IM	10^{30}	−

~~DISPOSITION SUMMARY: Nursing Care Problems No.'s~~ ~~Resolved; No.'s~~ ~~Continue.~~
~~Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in~~ wheelchair.
Dressing status: reinforced + intact PAR Score 8 ~~Safety~~ Litter Straps intact
Report given to Transport Medic. Patient released by Anesthesia CRT [redacted] CRNA
Time out _____. Nurses Signature: [redacted] CRT/AN

LOG#: [redacted] PT NAME: PT SSAN#:

CBC

LABORATORY RESULT FORM
(Subject to Privacy Act of 1974)

LAST FIRST MI	STATUS	DATE	SSN
(b)(6)-4 (b)(6)-4		16 APR 03	

Chemistry (i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO_2		35-45 mmHg (art) 41-51 mmHg (ven)
PO_2		80-105 mmHg (art) N/A (ven)
TCO_2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO_3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO_2		95-98%
BEecf		(-2) – (+3) mmol/L
AGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Blood Bank

ABO/Rh		IAT	

Unit	Type	Crossmatch

Misc. Chemistry

CKMB		
Troponin		
DOA		
Alcohol		

Microscopic Urinalysis

Chemistry (Piccolo Analyzer)

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

Urinalysis

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

Hematology

TEST	RESULT	REF. RANGE
WBC	10.1	4.8-10.8 x 10^3
RBC	3.91	4.7-6.1 x 10^9
Hgb	11.4	14-18 g/dl (M) 12-16 g/dl (F)
Hct	36.9	42-52% (M) 37-47% (F)
MCV	94.3	80-94 fl (M) 81-99 fl (F)
Plt	260	130-500 x 10^3 verified
Lymph%	15.1	20.5-51.1%
Retic		0.5-1.5% (adult)
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml
Segs		Mono
Bands		Eos
Lymph		Baso
Atyp		Imm
RBC Morph		
Other		
Spun Crit		42-52% (M) 37-47% (F)
Man WBC		4.8-10.8 x 10^3
Manual Plt		130-500 x 10^3 verified

Microbiology

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

☺ "SHADOW" PJR

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4	17 Apr 03	0800 HOURS	
(b)(6)-4	(1) Advance diet as tolerated -		noted
	(2) D/C Foley.		17Apr03 0815.1
	(b)(6)-2	(b)(6)-2	(b)(6)-2
NURSING UNIT / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
	17 Apr 03	HOURS	
	(1) Δ Cefotetan 1 gm to 2 gm BID IV (Consulted with BID IV Dr. Tester)		17Apr 17[illegible]
	(b)(6)-2		
	(b)(6)-2		PharmD, MS
	MAJ, MS Chief, Clinical Pharmacy		
NURSING UNIT / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
		HOURS	
	18 Apr 03 1400		
	(1) D/C IV. D/C Abx. D/C Foley.		Noted
	(2) Transfer to ASMC.		18Apr03 0615.1
	(b)(6)-2	(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.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
16 APR 03	1930 HOURS	
1	ADMIT TO ICW	
2	DX: SIP MULT. GSW C̄ EX	LAP
3	COND: STABLE	
4	VS: ~~BOUT~~ Q4°	
5	STRICT I/O's	
6	DIET: NPO	
7	IVF: LR @ 100 cc/hr	

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
	HOURS	
8	ACTIVITY: OOB IN CHAIR IN A.M.	
9	LABS: CBC NOW	
10	MEDS: HEPARIN 5000 UNITS SQ BID	
	CEFOTAN 1 gm IVPB Q12°	
	JMSO4 ~~T~~ 3-5 mg IV Q1-2° PRN PAIN	
11	INCENTIVE SPIROMETRY Q1° WHILE AWAKE	
12	FOLEY TO GRAVITY	

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
	HOURS	
13	RADIOLOGY: LEFT FOOT AP/LAT	
14	CALL M.D. FOR: T > 101.5	
	HR > 110,	
	UOP < 120 cc/hr	

Chart ✓ 0300 4-17-03

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

(b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
17 APR 03	0630 HOURS	
1	OOB IN CHAIR Q SHIFT	
2	TO O.R. TOMORROW A.M.	FOX Noted 18 APR 03 0640
4	FOOT WASHOUT	

(b)(6)-2

(b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD

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
4/16	(b)(6)-2	Admit to ICW, cond stable	05	(b)(6)-2		
			17			
4/16		VS : Q4°	05	(b)(6)-2		
			17			
4/16		Strict I+Os	05	(b)(6)-2		
			17			
4/16		Diet : NPO	07	/		
			11	/		
			16	(b)(6)-2	DC 17Apr03	(b)(6)-2
4/16		Act: OOB in chair in a.m.	05	(b)(6)-2		
			17			
4/16		CBC now		done 2100	(b)(6)-2	
4/16		Incentive Spirometry Q1° while awake	05	(b)(6)-2		
			17			
4/16		Foley to gravity	05	(b)(6)-2		
			17		DC 17Apr03	
4/16		Call MD for T>101.5, HR>110, MOP<120cc/hr	05	(b)(6)-2		
			17			

ALLERGIES ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Mult. GSW c̄ Ex lap

ADDITIONAL PAGES IN USE. ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 8008

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. 4 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 17	18	19
17Apr	(b)(6)-2	Advance diet as	08		denied (b)(6)-2	
		tolerated	12	(b)(6)-2		
			18	(b)(6)-2		
17Apr	(b)(6)-2	OOB to chair & shift	05 17	/	(b)(6)-2	
			17 05	/		

ALLERGIES ☐ YES ☐ NO

PRIMARY DIAGNOSIS: mult. GSW c̄ Ex lap.

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 4 Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
17Apr	(b)(6)-2	D/C foley	17Apr03	0800		
17Apr		To OR tomorrow a.m. for (L) foot washout	18Apr	am		

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

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,~~ MEDS FREQUENCY, TIME	HR	DATE COMPLETED 16	17	18
4/16	(b)(6)-2	LR @ 100cc/hr	05	(b)(6)-2		
			17			
4/16		Heparin 5000u SQ BID	10	(b)(6)-2		
			22			
4/16		Cefotan 1gm IVPB Q12°	10	/ (b)(6)-2		
			22	(b)(6)-2		(b)(6)-2
4/17		Cefotan 2gm IVPB q12°	10	/ (b)(6)-2		
			22	/ (b)(6)-2		

Nd 17 Apr 03

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Mult. GSW c̄ Ex lap.

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION: (b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)					Mo _____ Yr _____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
4/16	(b)(6)-2	radiology: (L) foot AP/Lat		done	2000hrs	(b)(6)-2	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION														
			TIME/DATE COMPLETED														
4/16	(b)(6)-2	MSO4 3-5mg IV	date	4-16	4-17	4-17	4-17	4-18									
		Q1-2° PRN pain	time	2318	0050	1505	2315	0413									
			dose	3mg	4mg	4mg	5mg	5mg									
			init	(b)(6)-2													
			1/E		E	E		E									

☆ U.S. GPO -290/55267

200 Clot C 03 14 MSW
2500 75

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is The Office of The Surgeon General

REPORT TITLE: POST ANESTHESIA CARE UNIT FLOWSHEET

OTSG APPROVED (Date): 17 Jan 80

PROCEDURE: (R) fx finger (L) elbow shrapnel & laceration

PHYSICIAN: Dr [redacted]

ANESTHESIA BY: CRNA [redacted]

Gen / Spinal / MAC / Axillary / Local / Bier / Epidural / Other

ALLERGIES: unknown

AIRWAYS: _____ Time DC'D 0910

ETT / Nasal / Oral / Trach

OXYGEN: intra-op

Mask / Nasal Prongs / Face Tent / Blow-By

Liter/min. 5 SpO2 100 %

ASA History: unknown

Cardiac Rhythm: S-tachycardia

IV#1 Patent Infiltrated Site (L) AC Rate 100 Gauge 18

IV#2 Patent Infiltrated Site (R) FA Rate 125/° Gauge 16g

Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	/												Extr: (L) R Upper (Lower) Pulse DP PT RAD; Blanche Warm; Pulse Moves Y N
PRE-OP	/												Blanche Warm; Pulse Moves Y N
0920	121/56	115	17	100% SL FM	96°	0	2	2	1	1	6	(R) LE cool to touch	Blanche Warm; Pulse Moves Y (N)
0925	126/56	110	16	100% SL FM	/	0	2	2	1	1	6	c palpable pulses & cap refill ≤ 5 sec.	Blanche Warm; Pulse Moves Y (N)
0930	111/36	109	16	100% SL FM	/	0	2	2	1	1	6		Blanche Warm; Pulse Moves Y (N)
0935	127/63	111	20	100% SL FM	/	1	2	2	1	1	7		Blanche Warm; Pulse Moves Y (N)
0945	124/49	115	22	100% SL	/	1	2	2	1	1	7		Blanche Warm; Pulse Moves Y (N)
1000	108/58	110	20	100% RA	98° Ax	1	2	2	1	2	8	1035 (L):	Blanche Warm; Pulse Moves (Y) N
1015	00/141	111	18	100% RA	/	1	2	2	1	2	8	800cc NS	Blanche Warm; Pulse Moves (Y) N
1030	93/141	124	18	100% RA	/	1	2	1	1	2	7	plus IV for	Blanche Warm; Pulse Moves (Y) N
1045	00/144	110	20	100% RA	/	1	2	2	1	2	8	hypotension &	Blanche Warm; Pulse Moves (Y) N
1100	15/134	105	16	99% RA	/	1	2	2	1	2	8	vital. [redacted]	Blanche Warm; Pulse Moves (Y) N
1115	18/141	99	20	100% RA	/	1	2	2	1	2	8		Blanche Warm; Pulse Moves (Y) N
1130	11/71	87	20	100% RA	/	1	2	2	1	2	8		Blanche Warm; Pulse Moves (Y) N

Local

POST ANESTHESIA RECOVERY SCORE "PARS"

Activity - General Anesthesia
2--Maintain head lift and open eyes
1--Unable to maintain head lift and open eyes
0--Unable to lift head and open eyes

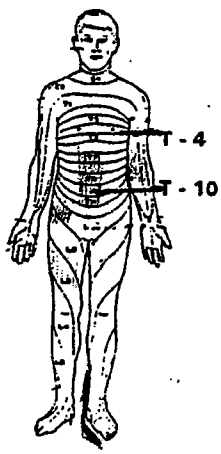
Activity - SAB or Subarachnoid Block
2--Moves all four extremities with control
1--Moves both upper extremities

Respirations
2--Spontaneous respiration; needs no support
1--Limited effort; needs artificial airway or jaw support
0--Needs ventilator; no spontaneous respiration

Circulation
2--BP 20% preanesthetic level
1--BP 20 - 50% preanesthetic level
0--BP 50% or more preanesthetic level

Level of Consciousness
2--Awake and alert; seldom dozes
1--Awakens when gently stimulated
0--Awakens only when vigorously stimulated

Skin
2--Normal skin color & temperature greater than 96°
1--Skin is pale, blotchy, dusky &/or temperature 95 - 96°
0--Cyanotic &/or temperature less than 95°



DRESSING:	Status	Location
Gauze		
Opsite	all sutured areas	
Bandaid	represent small digs	
Steri-strips	& silk tape that	
Collodian	required see tracings	
Peri-pad	2° to saturation &	
Coban	dilute Sat. wounds found	
Cotton Balls	(Dr [redacted] aware) Splint	
Ace Wrap	applied & now dry	
	to (L) LE	[redacted]

TUBES AND DRAINS: Hemovac / Chest / Jackson-Pratt

(Continue on reverse)

PREPARED BY (Signature and Title): [redacted] CPT [redacted]

DEPARTMENT/SERVICE/CLINIC: ICU [redacted]

DATE: 16 Apr 03

PAT[illegible] ...ped or written entries give: Name--last, first, mid... ...ical facility)

LOG# [redacted]

SSAN# [redacted]

NAME:

EPW

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTICS STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

FH MDA OP 132-11a (Revised) 1 Oct 94

MEDCOM - 8013

ADMISSION AND CODING INFORMATION

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

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

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

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
N/A		1906	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
NO	X99	

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION YEAR	
IZ		1		☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
6	JCW1	UNK	UNK

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
(b)(2)-2	UNK

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
26		030418

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
ABAA		030416

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

FOR LOCAL USE

Dx: multiple GSW

Dx 99674 Trauma
99889 Inj 287
7806
86330
8920
8980
89101

(b)(6)-2

ADMITTING OFFICER (Signature, as required)

(b)(6)-2 (b)(6)-2 M.C. MAJ(P)/MC

SIGNATURE OF ADMITTING CLERK

(b)(6)-2

DA FORM

IN[illegible]ENT TREATMENT RECORD COVER SH[illegible]

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

1. REGISTER NUMBER (b)(6)-4	2. NAME (Last, First, MI) (b)(6)-4				3. GRADE EPW	ADMISSION REMARKS
4. SEX n	5. AGE	6. RACE X	7. RELIGION unk	8. LENGTH OF SVC N/A	9. ETS NA	10. PREVIOUS ADMISSION
11. FMP 99	12. SSN (b)(6)-4		13. ORGANIZATION NA			14. WARD ICW
15. FLYING STATUS NO	16. RATING/DSG	17. DEPT./BEN KZ8	18. BRANCH/CORPS N/A	19. UIC/ZIP N/A		20. TYPE CASE AAAA
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from ER			22. HOURS OF ADMISSION 1906	23. CLINIC SERVICE		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE unk		25. TYPE DISPOSITION 21		26. DATE OF DISPOSITION 17 Apr 03		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) unk		27b. TELEPHONE NO. unk		28. DATE OF THIS ADMISSION 16 Apr 03		ADMITTING OFFICER DR (b)(6)-2
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(2)-2				30. DATE OF INTIAL ADMISSION		32. UN[illegible] CO[illegible]

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX GSW (R) thigh
Open fx (L) arm
R/O sepsis; ruled out.

812.50
813.17
890.0
998.89
E922.9

78.12
78.13
79.69
86.28

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDIC[illegible] (b)(6)-2 (b)(6)-2 SIGNATURE OF BAD OR MEDICAL RECORDS OFFICER (b)(6)-2

DA FO[illegible] BY

EDITION OF 1 AUG 76 IS OBSOLETE

MEDCOM - 8015

NAME: (b)(6)-4 (b)(6)-4 (b)(6)-4

TRAUMA FLOW SHEET

DATE: TIME:

INITIAL ASSESSMENT

Airway: OK

Breathing: OK

Circulation: OK

Disability: (* E/V/M = Glasgow Coma Scale) CIRCLE

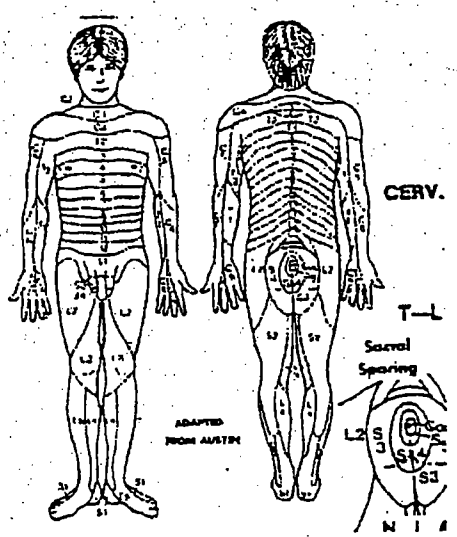
Eyes Open	Verb. Resp.	Motor Resp.
4 - Spontan.	5 - Oriented	6 - Obey Commands.
3 - To Speech	4 - Confused	5 - Localize Pain
2 - To Pain	3 - Inapprop. Words	4 - Flex Withdraw
1 - None	2 - Incomp. Sounds	3 - Flex Abnormal
0 - Closed by Swelling	1 - None (ETT or Trach)	2 - Extension
		1 - No Response

Vitals:

Time	1910				
Pulse	109				
Resp	16				
BP	154/84	/	/	/	/
Temp	101				
Rhythm					
Pupils	L R	L R	L R	L R	L R

Expose: (Skin Integrity)

X = Abrasion ▯ = Burn F = Fracture OF = Open Fracture
L = Laceration S = Stab G = Gun Shot Wound B = Bruise
E = Erythema



History: ("AMPLE T")

Allergies:

Meds: ▯ None

Past: ▯ Noncontributory

Hx:

Last Meal:

Event: Date: Time:

Tetanus:

Physical Examination

Head	☑ Normal	
Neck	☑ Normal	
EENT	☑ Normal	
Chest	☑ Normal	
Cardiac	☑ Normal	
Abdom.	☑ Normal	
Pelvis	☑ Normal	
Back	☑ Normal	
Genit.	☑ Normal	
Neuro.	☑ Normal	
Extrem.	▯ Normal	(L) Sxt Fix humeral Fx ope (R) thigh GSW

Medications

Time				
Meds	Tetanus 0.5cc IM Lot #			
Nurse				
V.O Dr.				

Special Orders

▯ O_2 : ___ lpm ▯ NC ▯ Mask ▯ Pulse Ox.	
▯ ETT ___ mm Time:	
▯ EKG ▯ Monitoring	
☒ Foley ___ fr to gravity	
▯ NG Tube ___ fr Guaiac ▯ + ▯ -	
▯ Peri.Dial. ▯ + ▯ - Time:	
▯ Chest Tube ▯ Left ___ cm H_2O ▯ Right ___ cm H_2O	
▯ X-rays	Labs: ☒ CBC ▯ PT / PTT ▯ L
	▯ HCG ▯ ESR ▯ ABG ▯ T&C
	▯ Chem 7 ▯ Chem 20 ▯ T&

(b)(6)-4

ADMISSION

ATE: Time:

Admit to: ICU : ICW 1 2 3

Dx: (L) Ext Fix humeral Fx
(R) thigh GSW

Allergies

Condition: Good Fair Poor

Vitals: Routine Q 4 h Temp

Activity: BR BRP Ad Lib

Diet: NPO Clear Liq. Regular

IV Fluids: LR @ 100 cc/h NS @ ___ cc/h ___ @ ___ cc /h
___ KVO ___ KVO ___ KVO

Analgesia: ☑ MS 5mg q 4° PRN
☐ Tylox
☐ Tyl #3
☐ Tylenol
☐ Motrin 800
☐ ASA

). Antibiotics: ☐ Rocephin
☐ PCN ___
☐ Gentamycin
☐ Cefadyl
☒ Ancef 1gm q 6° (next 2000)

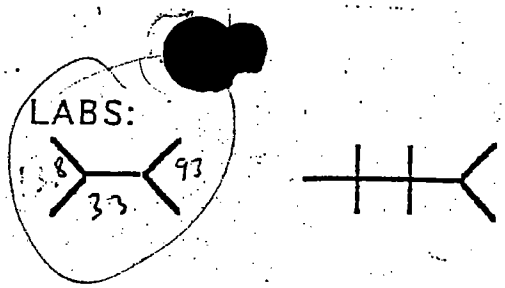
I. NG Tube: Suction: ☐ None ☐ LIS
2. Foley: ☐ None ☒ Gravity
3. Chest Tube: ☐ None ☐ ___ cm H_2O ☐ Water Seal
4. O_2: ☐ None ☐ NC ___ lpm Mask ___ lpm
5. Ventilation: ☐ None ☐ TV: ___ ☐ FIO_2: ___ ☐ PEEP: ___ ☐ RR: ___

6. Meds:

. Pre-Op: ☐ Emergent ☐ SemiEmerg ☐ Routine
.: Signature:

* encourage Deep inhalation/chest PT

LABS:



UA:

Other:

X-Rays: ∅

PLAN:
↑ pulmonary toilet

Sepsis vs post op fever

Procedure/Progress Notes:

NURSE'S NOTES

VITALS						Nurse's Notes
te & Time	T	P	R	Wt.	Stool	Medications & Nurse's Notes

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

16 apr 03

BRIEF OP NOTE:

PROCEDURE: external fixation + debridement of LUE multiple fx washout. RUE wound

PRE-OP DIAGNOSIS: GSW to LUE

POST-OP DIAGNOSIS: same

SURGEON: (b)(6)-2 ASSISTANT: (b)(6)-2

EBL: 300 cc

FLUIDS: 1600 cc crystalloid

UOP: 0

TT:

POST-OP PLAN:

external fixator + immobilization of LUE

distal pins anchored to both bones of forearm.

extensive debridement of ventral + lateral surface of forearm

pain control, ambulate TID, regular diet

ancef x 24°

radial n. - intact but contused (severely contused)

(b)(6)-2

(b)(6)-2 MP

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.

LOG#:

SSAN#: (b)(6)-4

NAME:

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

16 April 03 @1449 (Z+3)

B/P 149/79 P 108 SpO2 95% R 20 T 102°F

pt is a 49 y/o ♂ s/p GSW to LUE & RLE occurred today & Had Surgery This AM for Distal Humerus Fx & proximal Radius Fx s/p I&D and External Fixation. He also has a Through & Through GSW to Right Thigh s/p Through & Through GSW to (R) Thigh s/p washed & packed w/ Iodoform gauze

a) ASA in no distress pt w/ post op fever pain minimal pain pt w/ pain only in (L) Hand/Arm

conversant w/ broken English

HEENOT: CNII – XII intact pernl equal PERRLA ~4mm & sluggish

neck supple

Chest: mild Tachycardia, RRR ∅ MUG

BS = (B) good air movt

Abd soft NT/ND NABS ∅ peritoneal signs

Ext External Fixation in (L) Arm sparing Humerus & Distal ulna/radius good sensation in all digits w/ full ROM.

(R) upper lateral Thigh 3 Holes w/ Packing in distal RLE NVI intact

A/P 1) Distal Humerus & proximal Radius Fx s/p ext Fixation

2) Through & Through GSW to (R) upper lateral Thigh

will need IV ABX (Ancef) @1450 Tiq q6° x 48°, will need occupational therapy & extended care

3) post op fever will draw CBC, Chem 7

monitor vitals q 2°

Advance diet to Regular

16 Apr 03 1450

1 gm Ancef, IV [illegible] CPT [illegible]

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

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
16/Apr/03	49 y/o ♂ injury to (L) arm Ex fix
1715 BP 144/75	applyed to left arm through & through
P 134	gun shot wound to the (R) Leg
SP 02 98	
R	
Temp 102	Started ~~two~~ one ~~1g bore~~ IV's bolus
	5 mg of morphine IV @ 1745
1745 P 110	glucose 110 HCT 33 @ 1750
R 20	
1800 BP 152/79	@ 1800 ~~started~~ gave another bag of LR
P 83	1000 ml
Temp 101.6	chest ap & lat X ray = ∅ abnl noted
	See attached.
	a: 03 MAD, Heart RRR 5 MRGNT (≈ 135)
	lungs (R), CTA abd: atraumatic, (+) BS
	soft supple, ∅ TTP, ~~quiet~~
	rectal: ∅ gross blood
	HEENT: dry lips, pale conjunctiva
	(R) thigh through & through: ant → lat
	∅ sm's infection
	(L) elbow: ext fixation, ∅ sm's infect

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

RECORDS MAINTAINED AT:

PATIENT'S NAME (Last, First, Middle Initial)		SEX
(b)(6)-4		♂
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION EPW
DEPART./SERVICE	SSN/IDENTIFICATION NO. (b)(6)-4	DATE OF BIRTH 1954

CHRONOLOGICAL RECORD OF MEDICAL CARE

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

MEDCOM - 8020

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
GSW	A: ∘ through / through (R) thigh
	∘ open fx (L) elbow / ext fixation
	∘ fever / tachycardia: R10 sepsis
	Post-op fever
	∘ dehydration
	P: per Col (b)(6)-2 : Level III pt:
	transfer to CASH
presented pt to Dr (b)(6)-2	(b)(6)-2
	cpt / [illegible]
(ortho)	who evaluated pt
	and agreed c̄ plan

49
1954
2003
9 13

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
16 Apr 03	H&P
	49 yo ♂ Iraqi; s/p GSW to LUE & RLE today.
	Ext Fix surgery. ① Distal humerus & Prox Radius Fx s/p
	I&D & Ext. Fix. ② through & through thigh (R) GSW, s/p
NKDA	Irrigation & drsg.
Ø purity	— From (b)(2)-2 2° to Level III post op care & Fever
Ø Meds	w/u. 102 today despite Ancef IV (last @ 1450)
	HCT 33 Glucose 110 today, no WBC.
	(8) A&O Ø distress. broken english.
	P = RRR ABD = Soft NTND
	lgs = LTA (B) Ext = (L) Ext Fix, good sensation distal
	(R) thigh/drsg c̄ blood otherwise
	13. 33 93 minimal bleeding.
	distal Foot pulse present.
	(A) 1. Ext Fix (L) UE Fx; stable good distal function.
	requires post op rehab
	2. (R) GSW thigh; stable needs wound care
	3. Post-op Fever No Sepsis; X (P); needs pain control
	& ↑ pul toilet. ICW (b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S			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

(b)(6)-4

PROGRESS NOTES

DATE	
17APR03	0230. TEMP -100.8 PT RESTING COMFORTABLY. INTAKE PO FLUID - 100cc OUTPUT - 300cc USED INCENTIVE SPIROMETER (b)(6)-2 SGT, LPN
	0240: 1150 cc UOP. (b)(6)-2 LPT
17APR03	0411: ANCEF GIVEN 1gm IV. PT RESTING COMFORTABLY. WILL CONTINUE TO MONITOR THROUGHOUT. OUTPUT 400cc INTAKE 100cc. (b)(6)-2 SGT LPN
17APR03	0440: VS P: 95 B/P 130/82 T: 101.4 R: 21 POX: 98% RA. PT COMPLAINS OF WRIST RESTRAINTS OPEN. NO COMPLAINTS OF PAIN. WILL CONTINUE TO MONITOR THROUGHOUT INTAKE 100cc (b)(6)-2 SGT, LPN
	TOTAL INTAKE: 500cc OUTPUT: 300cc
17Apr03	BP: 158/89 HR: 103 POX: 98% T: 100.5 Neuro: A&O x3, speaks english well, responds to verbal commands, bilat PERRLA Cardio: S1 S2 +3 bounding pulses x3 extremities, unable to assess (L) arm due to bandage. Resp: Equal & bilat chestwall expansion; equal & bilat Normal lung sounds-clear GI/GU - voiding QS clear, yellow urine via foley, active bowel sounds integ- pink, moist, warm to touch, heplock in (R) F.A. (b)(6)-2 SG
17Apr03 1595	incentive spirometry encouraged; 3 balls raised x 10 (b)(6)-2 spc, LPN
17Apr03 1645	incentive spirometry encouraged; 3 balls raised X10 (b)(6)-2 spc, LPN
	Concur with above. (b)(6)-2 LPT, PN
17Apr03	1845: HR 121, BP 128/72, RR 24 & sats 97% on RA, Temp 102°.
17Apr03	1930: Dr (b)(6)-2 notified of elevated temp & HR. Pt medicated c̄ MSO4 for pain + given Tylenol for temp. Will continue to monitor closely (b)(6)-2 LPT, PN
17Apr03	2245: 400cc UOP from foley. T = 100.4. Neuro intact. RR WNL, CTAB, sats >95%. CV: tachy, MD aware. (+) pulses. PIV to (R) AC. GI/GU: (+) BS, tol. reg diet, foley to gravity draining clear yellow urine. Dsg to LUE CDI. (b)(6)-2 LPT, PN

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
16APR03	2020 - PT ADMITTED TO ICW VIA LITTER. VS - P98 B/P 125/72 T 100.8 R 20 POX: 96% RA DX: (L) ARM EX, GSW TO (R) THIGH. PT RESTRAINED TO BED BY LEATHER RESTRAINT ON (R) WRIST AND SOFT RESTRAINT ON (L) WRIST. WILL CONTINUE TO MONITOR. INTAKE 100CC (b)(6)-2 SGT, LPN
16Apr03 2026	UA from Foley 700cc clear yellow. (b)(6)-2
16APR03	PT. AFOX3. PUPILS BOTH EQUAL AND REACTIVE TO LIGHT. SKIN WARM TO TOUCH. LUNGS SOUNDS CLEAR TO AUSCULTATION. HEART SOUNDS NORMAL. ACTIVE BOWEL SOUNDS IN ALL 4 QUADRANTS. PT IS NOT COMPLAINING OF PAIN. (L) ARM HAS NOTICEABLE DRAINAGE AROUND OPEN AREAS. (R) THIGH IS ALSO SHOWING DRAINAGE. BOTH ARE PINK IN COLOR, NO SIGNS OF INFECTION. PT SPEAKS LITTLE BITS OF ENGLISH. WILL CONTINUE TO MONITOR PATIENT (b)(6)-2 SGT, LPN
16Apr03	2200: 650cc UOP (b)(6)-2 CPT AN
16Apr03	2200: Concur c̄ above assessment. Pt currently receiving 1L LR, upon completion, IV will be HL. External fixator in place to (L) arm. Leather restraints to wrists bilat d/t EPW status. (b)(6)-2 CPT AN
16APR03	2322. TEMP - 101.8. COMPLAINS OF LITTLE PAIN IN (R) HIP/LEG. BUT MORE PAIN IN (L) ARM. INTAKE PO FLUIDS - 100CC. USED INCENTIVE SPIROMETER (b)(6)-2 SGT.
16APR03	2330 - GAVE 5mg MORPHINE IV FOR PAIN. PT. RESTING COMFORTABLY. WILL CONTINUE TO MONITOR. ~~(Continue on reverse side)~~ (b)(6)-2 SGT, LPN

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

REGISTER NO.

WARD NO.

(b)(6)-4

PROGRESS NOTES
Medical Record

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
18 Apr 03	BP: 116/72 HR: 109 T: 99.6° Pox 97% Neuro: A&OX3 denies any pain; c/o a little tingling & numbness in thumb & 1st digit of affected arm Cardio: S1S2 strong pulses x3, unable to assess affected arm. Cap Ref ≤ 2sec Resp. lungs CTA, equal & bilat expansion GI/GU - pt voiding QS, clear, yellow, urine via Foley; active Bowel sounds; pt ate 100% of breakfast, no BM this AM. Integ. pink, warm, dry to touch, all drsgs CDI. pt resting comfortably will continue to watch throughout shift. (b)(6)-2 SPC/WWMG
1220 18 Apr 03	BP: 131/77 HR: 107 T: 100.0 Pox: 97%
18 Apr 03	Discharge Summary Unknown age Iraqi male admitted w/ Lt arm (humerus) fx w/ external fixation and GSW Rt thigh. Transferred for post-op fever. He has remained w/ low grade temps - most < 101.5. We have not isolated a source. It is not sepsis - his clinical condition has been stable. It may be pulmonary atelectasis. - Keflex 500 po bid (rec by Ortho for wound prophylaxis until screws come out.) - Drug d/s. - Ambulate. (b)(6)-2 (b)(6)-2
18 Apr 03	Pt D/C to ASMC. (b)(6)-2 CPT/USA

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

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

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Patient)*	LOG NUMBER	TREATMENT FACILITY
		RECORDS MAINTAINED AT	

PATIENT'S HOME ADDRESS OR DUTY STATION				ARRIVAL	
STREET ADDRESS				DATE *(Day, Month, Year)* 16 Apr 03	TIME 1905
CITY		STATE	ZIP CODE	TRANSPORTATION TO FACILITY	

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

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

CHIEF COMPLAINT
(L) arm broken, GSW to (R) thigh

CATEGORY OF TREATMENT		VITAL SIGNS					
☐ EMERGENT	TIME	TIME	1910				
		BP	154/84				
☒ URGENT	1905	PULSE	109				
	INITIALS	RESP	16				
☐ NON-URGENT	CH	TEMP	101				
		~~WT~~ ox	94%				

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

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1950	Morphine 5mg IV				

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

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

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

(b)(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

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
18Apr03	0430		UOP 475cc via urinal (b)(6)-2
18Apr03	0430		I+Os for 1700-0500
			total intake: 300cc (100cc IVPB, 200cc H_2O PO)
			total output: 875cc (b)(6)-2 CPT

(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

(b)(4)

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

MEDCOM - 8027

MEDICAL RECORD — **INTRAOPERATIVE ASSESSMENT**

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 (b)(2)-2 Staff

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT (b)(6)-2

3. DATE 16 Apr 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 0810 NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: EPW

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: on mesh litter

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

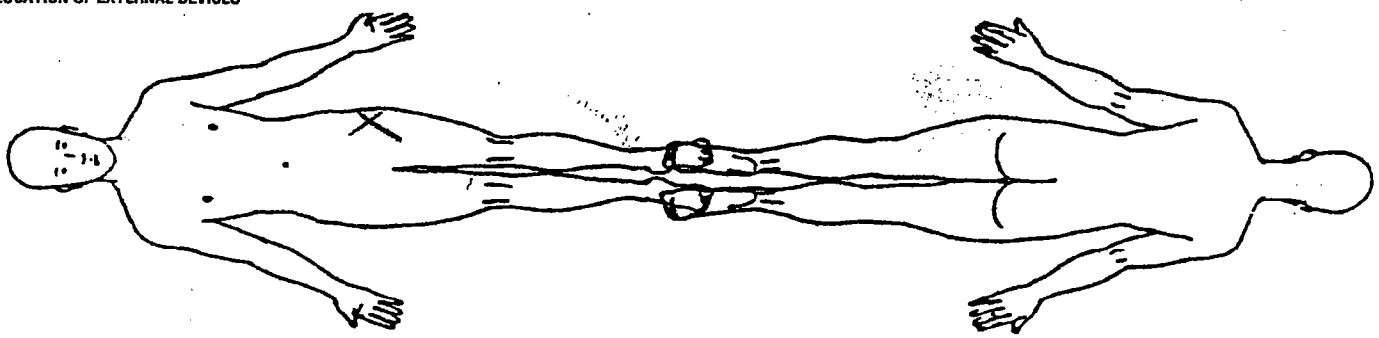
PREP SOLUTION *(Specify)* Betadine / Betadine

SITE: Lt. arm BY WHOM: Maj (b)(6)-2

SITE: (R) Thigh BY WHOM:

COMMENTS:

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 (b)(6)-2	CIRCULATOR (b)(6)-2
Sponge	☐ Yes	☒ No			C		
Needle Sharp	☒ Yes	☐ No			C		
Instrument	☐ Yes	☐ No				SPC	Maj
Other	☐ Yes	☐ No					

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

LOG# (b)(6)-4

SSAN#

NAME:

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO 30/30

☐ ESU NO: Force 2

GROUND PAD: BRAND Conmed

LOT NO: 0211272

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

13. PROSTHESIS, IMPLANTS X YES ☐ NO IF YES NAME: ID NUMBER,

X-Fix (L) Arm (Hoffman II) Ref# (b)(6)-4

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION X YES ☐ NO, TYPE(S): 0.9% NaCl

OTHER ORDERS	TIME	CARRIED OUT BY

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

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

YES ☐ NO X

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 X

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

18. DRESSING/IMMOBILIZATION (Specify)

(R) Thigh 4x4 + ~~Kerlex~~ TS, Tape

(L) Arm 4x4 + Kerlex, Xeroform, Ace

19. ADDITIONAL INFORMATION

Surgeons: Dr. (b)(6)-2

Dr. (b)(6)-2

LOG (b)(6)-4

SSAN# (b)(6)-4

NAME:

20. OPERATION(S) PERFORMED

I + D Lt. elbow, I + D wound Rt. ~~hip~~ TS thigh

(b)(2)-2 RED TO Post-op TIME 1030 METHOD Litter

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

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

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	Crystalloid	1600	OR	EBL	300
1200	LR	1800	OR	Urine (Foley placed)	800
	NSC 110/• (all to yam I&O credit)				
TOTAL	+ 1400		TOTAL	− 1100	

PACU NURSING NOTES: NURSING CARE PROBLEM NO.'S IDENTIFIED. Refer to FH MDA OP 39

NURSING CARE PROBLEMS: 1. RESP; 2. CIRC; 3. ACT; 4. LOC; 5. TEMP; 6. PAIN; 7. SAFETY; 8. ANXIETY; 9. EDUC; 10. OTHER

16APR03 1035 Received Pt from OR. Dressing intact X-Fix to (L) arm intact. Dress to RLE intact drainage noted. See page 1 for V.S. Will continue to monitor VS and pain levels (b)(6)-2 SSG/E-6 9/CWM
1100 / ↓O2 to 2 liters nasal lucite mask. O2 Sat's remain @ 100% will continue to monitor (b)(6)-2 SSG (b)(6)-2 9/CWM
1130 / Pt temp 100° axis. O2 removed O2 Sat 98-100% room air (b)(6)-2 SSG/E-6 9/CWM

MEDICATION RECEIVED IN PACU/ICU

MEDICATION GIVEN BY:	DRUG	DOSE	ROUTE	TIME	EFFECTIVENESS
CPT (b)(6)-2 CRNA	Ancef	1g	IV	0815	—
	MSO4	10mg		intra-op	+
	Valium	5mg			+
SSG (b)(6)-2	MSO4	1mg	IVP	1315(L)	+

DISPOSITION SUMMARY: Nursing Care Problems No.'s _____ Resolved; No.'s _____ Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status: C, D & I PAR Score 9 Safety Straps Intact
Report given to transport medics Patient released by Anesthesia CPT G
Time out 1330 Nurses Signature: (b)(6)-2 SSG/E-6 9/CWM
LOG#: (b)(6)-4 PT NAME: PT SSAN#:

9026

ID: b(6)-4 16-04-03
WB 19:51

				Patient Limits	
WBC	13.8	H	x10^3/uL	4.5	10.5
RBC	3.85	L	x10^6/uL	4.00	6.00
Hgb	10.5	L	g/dL	11.0	18.0
Hct	33.9	L	%	35.0	60.0
MCV	88.1		fL	80.0	99.9
MCH	27.4		pg	27.0	31.0
MCHC	31.1	L	g/dL	33.0	37.0
Plt	93.	L	x10^3/uL	150.	450.
LY%	24.9	*	%	20.5	51.1
LY#	3.4	*H	x10^3/uL	1.2	3.4

Doctor's Orders—Post-OP

(b)(2)-2 OP 4256

Nurse Complete	Dr.'s Select	DATE: TIME:
☐	☑	1. Admit to: ☐ OR ☑ PACU ☐ ICW ☐ Patient Holding
☐	☑	2. Diagnosis: S/P OVE fractures
☐	☑	3. Condition: ☐ Critical ☑ Guarded ☐ Stable ☐ VSI ☐ SI
☐	☐	4. Allergies: See SF 558
☐	☑	5. Vitals: ☑ Unit SOP ☑ Notify Dr. for SBP < 80 or > 200, DBP < 40 or > 110, HR < 50 or > 120, RR < 8 or > 30, or Temp > 101.5
☐	☑	6. Activities: ☐ Bed Rest, ☑ BRP, ☐ OOB ASAP w/ assist, ☐ Sit up and dangle when stable ☐ Other:
		7. NRSG:
☐	☑	a. Propaq monitor w/ Pulse-ox
☐	☑	b. O_2 to maintain SAT's above 94%
☐	☐	c. Maintain Vent settings at MODE=____ Vt=____ RR=____ PEEP= FIO_2=
☐	☑	d. ☐ Reinforce or ☑ Change dressing for bleed-through X1 then notify Dr.
☐	☐	e. I's & O's
☐	☐	c. Suction NT ETT PRN
☐	☐	d. CT to ☐ H_2O seal or ☐ Suction at ____
☐	☑	8. Diet: ☐ NPO ☐ Clear fluids as tolerated ☑ Other: regular
☐	☑	9. IV: ☑ NS or ☐ LR TRA 110 cc/hr ☐ DEXTRAN or ☐ Hespan X 500 cc bolus titrated then ____ cc/hr ☐ Albumin 100cc X ____ TRA ____ cc/hr ☑ When tolerating PO fluids, complete current fluid then SL.
☐	☐	10. BLOOD: ☐ T&S or ☐ T&C ____ units ☐ Transfuse ____ units ☐ PRBCs or ☐ Whole Blood
		11. Medications:
☐	☐	a. Tobramycin 300mg IV Q12hrs X ____ | e ☐ Ceftriaxone 750 mg IV
☐	☐	b. Clindamycin 600mg IV ____ | f ☐ PEN G 2 million Units IV
☐	☑	c. Cefazolin 1 gram IV q 8°
☐	☑	d. Phenergan 12-25mg Titrate ☑ IV ☐ IM Q4hrs PRN nausea/vomiting
☐	☐	g. Droperidol 1mg ☐ IV ☐ IM X 1 PRN Nausea/Vomiting
☐	☑	h. MSO_4 1-3mg Titrate ☑ IV ☐ IM Q10min PRN Pain
☐	☐	i. Robinul 0.1mg IV X 1
☐	☐	j. Zantac 50 mg ☐ IV or ☐ IM or ☐ 6.25mg/hr infusion
☐	☐	k. Tetanus Immune Globulin
☐	☐	l. Toradol ☐ IV 30mg or ☐ IM 60 mg
☐	☐	m. Maintain sedation/paralysis w/ Rocuronium and MSO_4 PER SOP
☐	☐	12. LABS: a. iSTAT ☐ Glucose ☐ ABG ☐ BMP ☐ CMP
		13. Additional:
		x-ray film of LVE
		Signature: (b)(6)-2

LOG# PT NAME: PT SSAN# 10JAN03

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

EPW

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 16 April 03 TIME OF ORDER 1930 HOURS

LIST TIME ORDER NOTED AND SIGN

Admit ICW

D.X (L) Ext Fx humeral GSW Fx / (R) thigh Fx / Sepsis R/O post-op Fever

Cond = stable

Vs q 2° → 4° temp. q shift other VS

Allergies NKDA

Act. BR / Foley to gravity

Nursing = ↑ pulmonary toilet

PATIENT IDENTIFICATION

(b)(6)-4

(b)(6)-2

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
Chart V	0300	4-17-03

DATE OF ORDER TIME OF ORDER HOURS

Labs - CBC (ER obtained)

Diet = Reg

IVF = finish IV LR then heffock

Special = Dsg Δ to (R) thigh

Meds = - Ancef ↑ gm q 6° next @ 2000 4/10 1622

- Morphine 5mg IV q 4° PRN

(b)(6)-2

(b)(6)-2

MAJ MC

FAMILY PRACTICE

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

ORDER TIME OF ORDER

17 Apr 03 1930 HOURS

1. Tylenol 975 mg PO Q4° PRN.

v.o. Dr (b)(6)-2 / (b)(6)-2

18 Apr 03 1400

(1) D/C - transfer to ASMC

18 Apr 03 RHS

(b)(6)-2

(b)(6)-2

(b)(6)-2

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TI HOURS

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994-363-710

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
4/16	(b)(6)-2	Q2°-4° temp	05	✓ (b)(6)-2		
		other VS Q shift	17	(b)(6)-2		
4/16		Act : BR	05	✓ (b)(6)-2		
			17	(b)(6)-2		
4/16		Foley to gravity	05	✓ (b)(6)-2		
			17	(b)(6)-2		
4/16		Nsg : ↑ pulmonary toilet	05	✓ (b)(6)-2		
			17	(b)(6)-2		
4/16		Diet : Reg	05	✓ (b)(6)-2		
			17	(b)(6)-2		
4/16		Dsg Δ to (R) thigh	05	✓ (b)(6)-2		
			17	(b)(6)-2		

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: (L) ext. fix humeral GSW fx / (R) thigh fx
sepsis r/o post-op fever

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION: (b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo _____ Yr _____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
4/16	(b)(6)-2	Admit to ICW, cond. Stable				(b)(6)-2
4/16		CBC (ER obtained)				
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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. ____ Yr. ____

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 16	17	18
4/16	(b)(6)-2	IVF: finish IV LR	05	/	(b)(6)-2	
	.....	then heplock	17	(b)(6)-2		
	.....					
4/16	(b)(6)-2	Ancef 1gm Q6° next	04	/	(b)(6)-2	
	.....	C2200	10	/		
	.....		16	/	(b)(6)-2	
	.....		22	(b)(6)-2		
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ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: (L) ext. fix. humeral GSW fx/(R) thigh fx sepsis r/o post-op fever

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Verify by Initialing

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)
(MEDICATIONS)

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

Mo. ___ Mo. ___ Yr. Yr. ___

VERIFY BY INITIALING

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES / RECURRING ACTIONS, FREQUENCY, TIME	HR	INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION: Date to be Given / DATE COMPLETED	Time to be Given	Time Given	Initials
ORDER DATE	CLERK/ NURSE						

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION: TIME/DATE DISPENSED			
4/16	(b)(6)-2	Morphine 5mg IV q4° PRN	date	16Apr	17Apr	17Apr
			time	2330	0900	1921
			dose	5mg	[illegible]	5mg
			init	(b)(6)-2		
4/17	(b)(6)-2	Tylenol 975mg PO Q4° PRN	1930			
			975mg			
			(b)(6)-2			

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

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

DA FORM 4677, 1 OCT 78

EDITION OF 1 DEC 77 MAY BE USED.

USAPA V1.00

MEDCOM - 8037

1900 5 Vial 1800 (b) IVPU Slow Gen (b) Butt 1600 350 EBL

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is The Office of The Surgeon General

REPORT TITLE: POST ANESTHESIA CARE UNIT FLOWSHEET

OTSG APPROVED (Date): 17 Jan 80

PROCEDURE: extend Fixation LUE / Washout RLE
PHYSICIAN: (b)(6)-2 (b)(6)-2
ANESTHESIA BY: (b)(6)-2
Gen Spinal MAC Axillary
Local Bier Epidural Other

ALLERGIES: NKDA
AIRWAYS: _____ Time DC'D ____
ETT Nasal Oral Trach
OXYGEN:
Mask Nasal Prongs Face Tent Blow-By
Liter/min. 5 liters 100 % %

ASA ___ History _____
Cardiac Rhythm _____
IV#1 _____ Patent Infiltrated
Site _____ Rate ____ Gauge 18
IV#2 _____ Patent Infiltrated
Site _____ Rate ____ Gauge ____

VITAL SIGNS						PAR SCORE						OTHER	
Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	190 92	110	22	94	39C								Extr: L R Upper Lower; Pulse DP PT RAD
PRE-OP	146 86	105	16	100	38C								Blanche Warm Pulse Moves Y N
1035	146 84	104	24	100	98	0	2	1	0	2	5		Blanche Warm Pulse Moves Y N
1040	161 94	102	24	100	98	0	2	1	0	2	5		Blanche Warm Pulse Moves Y N
1045	161 90	119	22	100	98	1	2	2	1	2	8		Blanche Warm Pulse Moves Y N
1050	151 92	115	22	100	98	1	2	2	1	2	8		Blanche Warm Pulse Moves Y N
1057	141 91	115	18	100	98	1	2	2	1	2	8		Blanche Warm Pulse Moves Y N
1100	150 40	115	18	99	98	1	2	2	1	2	8		Blanche Warm Pulse Moves Y N
1115	151 94	101	18	99	99	1	2	2	1	2	8		Blanche Warm Pulse Moves Y N
1130	138 84	105	18	100	100	2	2	2	1	2	9		Blanche Warm Pulse Moves Y N
1200	136 87	110	18	98	100	2	2	2	1	2	9		Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N

POST ANESTHESIA RECOVERY SCORE "PARS"

Activity - General Anesthesia
2--Maintain head lift and open eyes
1--Unable to maintain head lift and open eyes
0--Unable to lift head and open eyes

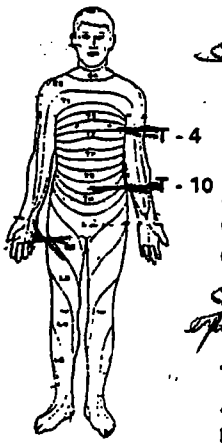
Activity - SAB or Subarachnoid Block
2--Moves all four extremities with control
1--Moves both upper extremities

Respirations
2--Spontaneous respiration; needs no support
1--Limited effort; needs artificial airway or jaw support
0--Needs ventilator; no spontaneous respiration

Circulation
2--BP 20% preanesthetic level
1--BP 20 - 50% preanesthetic level
0--BP 50% or more preanesthetic level

Level of Consciousness
2--Awake and alert; seldom dozes
1--Awakens when gently stimulated
0--Awakens only when vigorously stimulated

Skin
2--Normal skin color & temperature greater than 96°
1--Skin is pale, blotchy, dusky &/or temperature 95 - 96°
0--Cyanotic &/or temperature less than 95°



DRESSING:	Status	Location
Gauze		
Opsite		
Bandaid		
Steri-strips		
Collodian		
Peri-pad		
Coban		
Cotton Balls		
Ace Wrap	intact	Groin
Splint Frog	Intact	Groin

TUBES AND DRAINS: Hemovac Foley NGT Chest Jackson-Pratt

(Continue on reverse)

(b)(6)-2

DEPARTMENT/SERVICE/CLINIC (b)(2)-2

DATE 16 Apr 03

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

LOG # (b)(6)-4
SSAN#:
NAME:

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

DA FORM 1 MAY 78 4700

FH MDA OP 132-11a (Revised) 1 Oct 94

MEDCOM - 8038

1. DATE AND TIME OF CAPTURE	2. SERIAL NO. (b)(6)-4 **A**	
3. NAME (b)(6)-4	4. DATE OF BIRTH [redacted]	
5. RANK Offic[redacted]	6. SERVICE NO.	
7. UNIT OF EPW	8. CAPTURING UNIT (b)(2)-2	
9. LOCATION OF CAPTURE *(Grid coordinates)*		
10. CIRCUMSTANCES OF CAPTURE	11. PHYSICAL CONDITION OF EPW	12. WEAPONS, EQUIPMENT, DOCUMENTS

DD FORM 2745, MAY 96 REPLACES DA FORM 5976, JAN 91, USABLE UNTIL EXHAUSTED.

1. DATE AND TIME OF CAPTURE	2. SERIAL NO. (b)(6)-4 **B**	
3. NAME	4. DATE OF BIRTH	
5. RANK	6. SERVICE NO.	
7. UNIT OF EPW	8. CAPTURING UNIT	
9. LOCATION OF CAPTURE *(Grid coordinates)*		
10. CIRCUMSTANCES OF CAPTURE	11. PHYSICAL CONDITION OF EPW	12. WEAPONS, EQUIPMENT, DOCUMENTS

DD FORM 2745, MAY 96 REPLACES DA FORM 5976, JAN 91, USABLE UNTIL EXHAUSTED.

1. DATE AND TIME OF CAPTURE	2. SERIAL NO. (b)(6)-4 **C**
3. NAME	4. DATE OF BIRTH
5. RANK	6. SERVICE NO.
7. UNIT OF EPW	8. CAPTURING UNIT
9. LOCATION OF CAPTURE *(Grid coordinates)*	
10. DESCRIPTION OF WEAPONS, SPECIAL EQUIPMENT, DOCUMENTS	

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: (b)(2)-2	7 8: I Z	9 10 11 12 13 14 15: (b)(6)-4	(b)(6)-4 (b)(6)-4	16 17: EPW	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	27 28 29	30: X	31: 9	muslim

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34	N/A	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
N/A	46: U	1906	N/A

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49: N 0	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: I Z	64 65 66 67 68 69 70	71	YEAR; [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: 6	ICW	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(2)-2

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
73 74: 2 1	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: A A A A	91 92 93 94 95 96	97 98 99 100 101 102: 0 3 0 4 1 6

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

Dx: GSW (R) THIGH
Open fx (L) Arm
R/O Sepsis

Dx 99889 Trauma
7806 INJ 284
81250
81315
8900

(b)(6)-2

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

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

DA FORM ... EDITION OF MAY 79 IS OBSOLETE

MEDCOM BATES PAGES 8041-10841
WERE PREVIOUSLY RELEASED
AS FOLLOWS:

8041-8240 15 AUG 2005
8241-8440 30 AUG 2005
8441-8840 30 JUL 2005
8841-9440 15 AUG 2005
9441-9640 30 JUL 2005
9641-10840 15 AUG 2005