274/0
12kg

INI[redacted]NT TREATMENT RECORD COVER SH[redacted]

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

(b)(6)(4)

1. REGISTER NUMBER [redacted]	2. NAME (Last, First, MI) EPW - [redacted] (b)(6)-4		3. GRADE EPW	ADMISSION REMARKS
4. [redacted] M	5. RACE UNK X	7. RELIGION UNK	8. — 9. ETS —	10. PREVIOUS ADMISSION NO
11. FMP 99	12. SSN [redacted]	13. ORGANIZATION (b)(6)-4		14. WARD ICU1
15. FLYING STATUS N	16. RATING/DSG	17. DEPT./BEN K78	18. BRANCH/CORPS — 19. UIC/ZIP —	20. TYPE CASE UIA
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION DIRECT FROM ER			22. HOURS OF ADMISSION 2022	23. CLINIC SERVICE ABAA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK			25. TYPE DISPOSITION XFER TO EPW CAMP	26. DATE OF DISPOSITION 30 APR 2003
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK			27b. TELEPHONE NO. UNK	28. DATE OF THIS ADMISSION 16 APR 2003
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] (Forward)				30. DATE OF INTIAL ADMISSION
31. SELECTED ADMINISTRATIVE DATA (b)(2)-2				32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

ADMITTING OFFICER (b)(6)-2 DR [redacted]

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

Shot by US soldier

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW (R) buttocks

877.1
879.7
894.1
823.90
892.2
892.1
825.1
E991.2

86.04
86.28
93.57
93.54

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	14	14

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[redacted]

DR. [redacted]

SIGNATURE OF PAD OR [redacted]

DA FORM 364[redacted] MAY 79 (b)(6)-2 EDITION OF 1 [redacted] (b)(6)-2

~~SCHEDULE~~ Recurring ACTION

Date	Action	Time	Initials
17APR03	VS: Q8°	0030	[redacted] (b)(6)-1
17APR03	Act: BRIT bedside urinal	0030	[redacted]
17APR03	Woundcare to Buttocks + BLE Q8°	0030	[redacted]
17APR03	~~Act: NB~~ DC'd.	0030	[redacted]
17Apr03	Bedrest c̄ restraints	0700	[redacted]
17Apr03	Bilat LE splints	0700	[redacted]
17Apr03	Regular diet		

PRN MEDS

	Time	Int	Out
2mg MSO4	1100	(b)(6)-2 [redacted]	relief of pain thumbs
2mg MSO4 IVP	1320	(b)(6)-2 [redacted]	c/o "much pain"
2mg MSO4 IVP	~~1355~~ 1400	(b)(6)-2 [redacted]	resting quietly
2 percocet tabs PO	1400	(b)(6)-2 [redacted]	resting quietly

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

16 Apr 03 Syrian EPW S/P GSW (72° ago)

① (R) Bu Hocks & back

② (R) heel c̄ Calcaneous Fx

③ (L) Lower Ext. c̄ Distal tib Fx } splinted

I&D under General done today c̄ 2gm Ancef.

EVAC'd extubated for higher level care.

(8) A&O x3 92% on RA

V = Tachy RR Lungs = (B) CTA ABD = ND NT ∅ wounds

HEENT = nl NABS

Ext = (L) Calcaneous .2 open wounds ∅ Gross blood, nl Rectal.

(R) Lower Ext. 2 open wounds

distal pulses intact in feet

Buttocks (R) deep 3"-4" wound / Lower back wound to facia

X-Ray = pelvis = ∅ Fx ; multiple fragments

① (R) Calcaneous Fragment (Fx?) & (1st mid shaft Phanglex Fx)

② (L) Comminuted Distal tib Fx

(A) S/P GSW c̄ Buttock/Back (B) L ext wounds S/P I&D. c̄ (L) Distal Tib Fx

(P) & ? (R) Calcaneal Fx → Admit ICW await ortho c/s

[redacted] (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.

EPW / Syrian

[redacted]

(b)(6)-4

PROGRESS NOTES
Medical Record

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

(b)(6)-4
[redacted]

MEDICAL RECORD	PROGRESS NOTES
DATE 17 Apr 03 0600	ICU staff Admit Unknown age male s/p GSW to multiple areas. - buttocks, back, legs, achilles - Rt calcaneal Fx, Lt tibial Fx these areas debrided by FST. - Ancef T 5mg8° - pain control (b)(6)-2 - dressings. [redacted]
18 APR 2003 0940	ORTHO OP NOTE. PRE-OP DX - (1) MULTIPLE GSW, SUPERIORLY, INCLUDING BUTTOCKS, BOTH LEGS (2) GRADE II OPEN (L) DISTAL TIBIA FX STABLE (3) SEGMENTAL LOSS (R) ACHILLES TENDON 2° GSW. (4) DEEP SOFT TISSUE WOUND (R) FOOT. (5) RIGHT CALCANEAL FX, GRADE II OPEN. PROCEDURE - I+D, BILL WOUNDS, SPLINTING EBL - MIN. FLUIDS - 500 LR UOP - 250 ~~FST~~ I+D CLEAN NOTE IN OR FINDINGS - BILL WOUNDS CLEAN AND WITHOUT NECROTIC TISSUE. BILL WOUNDS SCATTERING INJECTED, GRANULATING TISSUE FOLLOWING

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE

PLAN: IV ANTIBIOTICS → ORAL ANTIBIOTICS
IS FIT TO THEREFOR. WILL NEED
NOT TO DO DRESSING CHANGES DAILY.
CONTINUE SPLINTING, THEN CASTING WHEN
WOUND CLOSE FOR (L) TIBIA FX (Compound Contam)
AND (R) CLAVICLE FX.

[redacted] CDR [redacted]

(b)(6)-2

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

NSG PROGRESS NOTES

DATE	
20 Apr 03 0400 VS 104/48, 78, 16, 99.7	Pt currently resting in NAD. ↓ Lo of pain noted. Pt rated Ordered for Sleep x1 - Pharmacy has none. Will voice in AM Rounds. Pt rated Benadryl PRN for sleep again. Pt. had large hard BM - Relieved. - late entry. Pt. Hawthat informed on Pt request for Insomnia Benadryl/Motrin? (b)(6)-2 [redacted] Sgt USA
4-20-03 0700	Received report from Sgt [redacted] (b)(6)-2 Pt resting quietly, @ change of shift.
BP 103/47 HR 80	N a/o x2 Pt is 3 mm brisk, cooperative, appropriate c staff
SpO2 99% 99.5°F (o)	ev S1 S2 NSR
	Resp even & unlabored bilateral BS clear
	ant & post. on RA. denies SOB.
	GI BS hypo x4 quads. tolerating regular diet
	GU using urinal @ bedside
	Skin dressings intact scant serosanguinous drainage noted on buttock. wounds well granulated. ~~drainage~~ drainage.
	Pt verbalizes discomfort c repositioning only.
	Per ward rounds pt is to be evacuated to 86CSH as soon as transport & weather allows.
1500 VS 88 BP 111/63 SpO2 100% @ RA 99.1°F (o)	Pt approached w/ pt c/o ↑ bilat leg pain, pt rated total 4 mg MS & IVP & 2 tabs percocet over 2 hour period. Pt resting quietly at this time. ~~[illegible]~~ Also loosened dressings & ace bandages on L & R. Will count to monitor.
1520 intake 580 cc 40-95	Pt continues to refuse to eat, denies n/v, pt encouraged to eat, explained rationale pt to ↑ food intake, pt verbalized understanding, but verbalized wanted oil for system.

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
	0730 pt consumed 100% of breakfast and drank
19APR03	1/2 litre of water [redacted] Talked to pt about performing
	personal hygiene and will conduct pt teaching about sleep
	cycles [redacted] SPC
	0930 pt performed personal hygiene on himself and voided (b)(6)-2
	700ml @ 0830 Clean linens were placed on bed pt tolerated
	procedure pt is currently resting comfortably. will continue to
	monitor [redacted] gluembspc
	~~Nursing~~ [redacted] (b)(6)-2
19APR03	Nursing I&O
1625.	pt has a total output of 1400cc via urinal.
	Total Input was 860cc of water po.
	I&O balance = 1400-860 = -660 [redacted]
19APR03	Nursing addendum:
1630	pt has 2 gms of ancef added in 50cc bags = 100cc. (b)(6)-2
1700	New I&O balance = 1400-960 = -560
19Apr03	Pt currently in NAD. Assessments charted unchanged. see day
1800	shift. Resp even/unlabored. AOX3, cooperative/coherent.
	Neurovasc status unchanged to BLE. cap ref brisk - mobility
	+ sensation intact. new PIV to LFA patent/benign. Max
	Emotional Support Provided. Guard @ the bedside.
U0-800cc	Tol po well. Voiding C.S. [redacted] RN/SGT
2200 V/S	Intake 500 cc/H2O (b)(6)-2
Sat 97%, 99862	

(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. ICU/#1

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

PROGRESS NOTES
Medical Record

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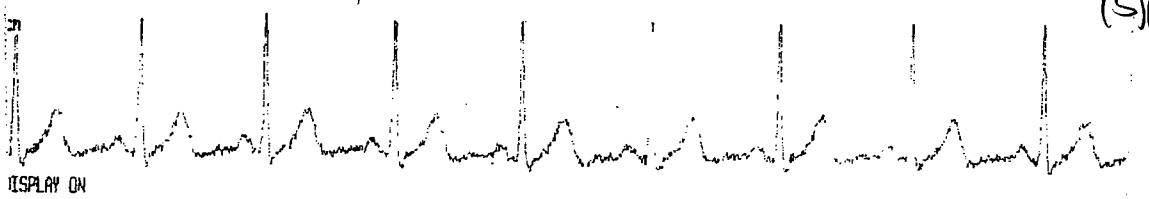
MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

21APR03 1718: HR 82, BP 101/53, RR 18 c̄ sats 95% on RA, T-97.1(o). Received report + assumed care of pt at 1700. Pt drowsing after returning from surgery but easily [redacted] (b)(6)-2 rousable to verbal + physical stimuli. Neuro intact, follows commands and interacts appropriately. PERRLA, 2mm bilat c̄ brisk rxn to light, Hand grasps = bilat, pt able to wiggle toes bilat. weakly. Resp: even, unlabor CTA (B), symetrical chest rise/fall. CV: palp pulses to upper extremities, unable to palpate pedal or post tib pulses d/t bilat. bulky dsgs. Brisk cap refill to fingers + toes, PIV to (L) FA. GI/GU: (+) BS in all quadrants, abd. soft, non-distended, non-tender to touch. Pt has not yet voided since arrival from OR. Splints + dsgs to bilat. lower legs (from foot to just below the knee) CDI. Dsg to (L) thigh CDI, Dsg to (R) Buttock CDI, and dsg to lower back CDI. Pt c/o pain to legs, given 2mg MSO4 IVP c̄ good relief noted. Will continue to monitor closely. [redacted]

21Apr03 1745: Pt restrained bilat. c̄ leather wrist restraints [redacted]

03 17:48:25 HR=83 P1=OFF P2=OFF RR=11 SpO2=OFF NIBP=OFF T1=OFF T2=OFF ΔT=OFF 21Apr03 1748 hrs [redacted] (b)(6)-2



PR .14sec HR 83

QRS .08sec NSR c̄ ectopy

RELA RESP ER

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

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

[redacted]

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 [redacted]

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
21Apr03	1812: LR that was infusing from OR now complete. IV heplocked. Total intake 1000cc. [redacted] CPT AN
21APR03	2200: 50cc Ancef [redacted] (b)(6)-2 CPT AN
21APR03	2300: Pt voided 600cc via urinal. Dsg to (R) buttock c̄ serosanguinous drainage. Old dsg removed + new wet to dry dsg placed [redacted] CPT AN
	2315: 18G placed to (R) Brachial site as PIV infiltrated [redacted] (b)(6)-2 (L) FA. Pt given 4mg MSO4 for pain to GSW [redacted] CPT AN
22Apr03	0200: Pt resting at this time. Does not appear to be in any distress. Will continue to monitor closely [redacted] CPT AN
22Apr03	0430: I+O for shift 1700-0500 as follows [redacted] (b)(6)-2
	intake: 1000cc LR; 50cc Ancef; 100cc PO intake = 1150 total intake. output: 600cc urine. 600cc total output
	[redacted] (b)(6)-2 CPT AN
22APR BP-118/53 P-74 RR-16 Sats 98%	0515 Received pt in bed c̄ bilateral restraints. Pt [redacted]. Pt has patent airway c̄ no difficulty breathing. Lung sounds clear to auscultation in all lobes. S1/S2 sounds present c̄ no extra sounds. Pulses equally strong in UE. Strength equal in UE. Unable to assess LE. Skin is warm and dry to touch. IV 20g in (R) bicep site is patent c̄ no s/s of infiltration. Pt gets 1.6mg Ancef in SCMLs q6h. Nothing infusing at this time. Pt has multiple dressings to buttocks and back, draining serosanguinous fluid. Both LE splinted and dressed. Pt voids c̄ difficulty via urinal. Pt is on regular diet. Pt has recently become uncooperative and demanding. Will continue to monitor [redacted] RN SPC
	(b)(6)-2

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

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

(b)(6)-4 [redacted]

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
4-22-05.	Transfer Note Briefly, Pt is a Syrian EPW s/p GSW to (L) buttocks, (L) Distal Tib/Fib Fx - open, (R) calcaneal fx, (R) achilles lac - s/p initial stabilization to debridement by FST and f/u wash-out / stabilization by ortho here. Pt continues on IV Abx - Ancef 1gr. IV q8h and Percocet for pain control. Continues to receive dressing Δ's to all open wound sites - wet → dry, t/d. Pt remains afebrile and stable. (b)(6)-2 [redacted] PTs Transfer Note (Evac VS 119/68 pulse 114 resp 20 Pt. discharged from ICU. Pt transported via litter to PAD for Evac. Pt is alert and oriented X3. Pt [redacted] Pt verbalized understanding. [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			
SGT TYCRA	LAST	FIRST	MI	(SSN or Other) (b)(6)-2

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

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

PROGRESS NOTES
Medical Record

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

[redacted] (b)(6)-4

MEDCOM - 8050

MEDICAL RECORD	PROGRESS NOTES
DATE	
27 APR 03	PT lying in bed denies pain or complaints. Alert
1750	and oriented. [redacted], [redacted] CTC [redacted], bowels active
P59 BP 112/91	x 4 quads. Abd soft & nontender. Heart (S1, S2) (b)(6)-2
R 18 T 99.2	reg rate/rythm. Pulses equal x (L) (R) radial. Cap refill
	< 3 sec x both feet [redacted] (b)(6)-2 [redacted]
2230	PT resting eyes closed [redacted]
P 74 BP 106/48	0700: VS 98.2 HR 72, PO 98% RA. BP 110/49
R 8 T 99.5	Pt. A&O. Pt. c/o Ø pain. [redacted] (b)(6)-2
	0830: Pt. HR Reg. BS CTA throughout, BS active x 4 [redacted]
	PT A&O X3. Drsngs to lower extremities intact. Old
	drainage noted on outer ace wraps. Pt. refuses supplies
	for personal hygiene at this time. [redacted] (b)(6)-2
28 Apr 03	PT Note
Hx:	Have dressing Δ
Tx/m:	Dressing Δ & assist Nursing
	Wounds packed & Iodoform strips / wet Kerlix "fluff"
	& Kerlix roll;
Prog:	Dressing Od
Inter:	edu / As above
	Hold off amb 20 pt need heal (L) arch wound
	Cont as prev
Ex:	Ø Δ [redacted] (b)(2)-2
	[redacted] CPT, SP
	(b)(6)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

#[redacted]

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE	
28/1850 APRO3	Lying in bed awake oriented x 3 Perrla
P74 BP 103/88	Lungs clr Bilat: Heart (S1,S2) reg rate/rythem
T99.1 R14	bowels active x 4 quad (soft non tender). pulses (b)(6)-2
	strong, even x 4 extremities — no complaint [redacted]
2200	up to bedside comode hard brown stool Ambulate
P 91 BP 99/74	c help of nurse. — (b)(6)-2 [redacted]
R 12 T99.1	0717: BP 104/57. HR 66, 98% RA, RR 14, 98.4 ⊕ AS
	HR Reg, Lungs CTA, BS ⊕ X4. Drsngs to feet
	have sm. amt. bloody drainage. Pedal pulses 2+
	Pt. denies pain at this time. — [redacted]
	(b)(6)-2

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

PROGRESS NOTES

DATE	
29 1750 APR 03	Living awake in bed. Ø complaints, Feeds,
BP 109/46 P73	Lungs CTA Bilat. Heart S1, S2, reg rate/rythm. bowel
R 12 T 98.7	Hypo active, Abd soft nontender pulses strong equal
O_2 - 98	x 4 extremities — [redacted] /AN
	(b)(6)-2
29 2200 APR 03	
BP 91/47 P 85	
R 12 T 98.7	
O_2 - 99	
Ø 30 APR 03	Pt transferred to ASMC. — [redacted] /AN
	(b)(6)-2

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

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

P=91 4/19/03 Nursing: Assessment.
T=100.7 0600 A: Pt A&Ox3 calm cooperative follows commands Pt has patent
BP 89/41 airway breath sounds auscultated in all lobes S1 S2 sounds present in sinus tach
R-20 c̄ no extra sounds pulse equally strong x2 UE unable to assess
LE pulses. Pt has sensation in extremities x4. Skin is warm
and dry to touch. Hyperactive bowel sounds present
abdomen is soft non distended. Pt voids c̄ difficulty. Pt is on
regular diet. Pt has patent IV site to ⓡ forearm c̄ no s/s
of infiltration no fluids infusing at this time. Bulky dressing
on both lower extremities and buttocks. Dressings on lower
ext. clean dry and intact, mild drainage present on buttocks
dressing. Pt is resting comfortably will continue to assess
(b)(6)-2 [redacted] E-4
4/19/03 Nursing: Dressing Δ.
1316hrs Right buttocks has about 4"x4" deep wide wound that is clean
c̄ fresh deep reddish bleeding during dressing Δ: the upper
right quad of the wound is very deep requiring long time saturation
of old dressing c̄ saline before it could be removed. The bleeding is
minimal and pt tolerated Δ. There are multiple areas:
(4 areas) of left lower clavicle, left flank, inferior aspect
of the ⓡ iliac and ⓡ gluteal and lateral aspect of the thigh.
The largest of the ⓛ side wound is about 50 cents coin size

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

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

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

IC 4 1

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

on the medial thigh and about 1" deep. All wounds look clean S/S of infection or foul odor. The D&I wound has foul odor but did not have prolonged drainage. The wound appear to be healing by granulation.
(b)(6)-2
Pt. fever may [redacted] IV pain to dsg change. Pt. verbalized positive effect from pain medication. Bilateral lower extremity dsg has ace wrap over bulky dsg & soft cast on R leg. LE dressing Δ were not done [redacted] Dr [redacted]. Will continue to monitor pt's status [redacted]
(b)(6)-2
(b)(6)-2

558-104

7540-01-075-3781

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

ARRIVAL

DATE *(Day, Month, Year)*: 16 Apr. 03 | TIME: 2255

TRANSPORTATION TO FACILITY

SEX: M

AGE

DUTY/LOCAL PHONE — AREA CODE | NUMBER

HOME PHONE — AREA CODE | NUMBER

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			✓
FLYING STATUS			✓

MEDICAL HISTORY OBTAINED FROM

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS

ALLERGIES

INJURY OR OCCUPATIONAL ILLNESS

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

HOW

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☒ NO

TETANUS

DATE LAST SHOT | COMPLETED INITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: GSW bil. legs + (R) buttock to (R) lower leg

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☒ NON-URGENT

TIME: 2255

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

VITAL SIGNS

TIME	2255	2305	2315	2330
BP	119/74	122/63	110/61	122/71
PULSE	105	104	94	96
RESP	16	20	12	16
TEMP	95.5	—	—	—
~~WT~~ OK	99%	99%	95	95

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	X (B) Lower Ext
X Pelvis	

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
2300	morphine 5mg	[redacted]	Lt [redacted] (b)(6)-2	2310	pt went to sleep

DISPOSITION: ☐ HOME ☐ FULL DUTY

DISPOSITION QUARTERS /OFF DUTY: ☐ 24 HRS. ☐ 48 HRS. ☐ 72 HRS

MODIFIED DUTY UNTIL

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)*

EPW, Syrian

[redacted]

(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)

(b)(6)-4 [redacted]

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

ARRIVAL

DATE *(Day, Month, Year)* 25 APR 03 | TIME 1700

TRANSPORTATION TO FACILITY FLA

SEX M

AGE [redacted]

DUTY/LOCAL PHONE	
AREA CODE	NUMBER
HOME PHONE	
AREA CODE	NUMBER

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

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

CURRENT MEDICATIONS (b)(6)-4

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 Shrapnal to lower extremities & Left flank (1 week old)

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☐ NON-URGENT

TIME

INITIALS

VITAL SIGNS

TIME	1700					
BP	100/50					
PULSE	73					
RESP	11					
TEMP	99.5					
WT	5'6 100					

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

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

MODIFIED DUTY UNTIL

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)*

[redacted] (b)(6)-4

EPW #

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

NSN 7540-01-075-3786

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

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

DIC note
Daily DRSG D's. Wounds healing well. Rare pain meds
Ambulatory c crutches
Shield

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

DIAGNOSIS

CODES

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

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		0030	Pt recieved from ER sedated but alert to
BP - 101/58			stimuli, later verbalizing thirst - Denies N/V/D
R - 22			C/S c/o Pain - Pt NPO @ this time, RLC KOD
T - 97.8			VIA ETT PT V. GSW's X4 assessed - to be Δ'd
P - 98			@ 0600 - Pt uncooperative c̄ staff - restrained
SPO2 - 97%			c̄ Bilat, US leather restraints per protocol
			N: A&O - Ø c/o pain R - clear Bil. to auscl - RA -
			CV: NSR, BP stable, A&O - GI - (+) BS X4 - GU
			voids (b)(6)-2 [redacted] CPT AN
	0300		DSG's Δ'd w → D & dressed c̄ Kerlix - tolerated
			well - resting in NAD (b)(6)-2 [redacted] CPT AN
	0400		BP 121/64 / P - 93 / SPO2 97% / RR 15 -
			Temp - 98.2° - USS, A&O x3, NAD [redacted] CPT AN
	0405		Ativan 1/2 cm given IV (b)(6)-2 [redacted] CPT AN
BP 110/61	0700		Rcvd report from Cpt (b)(6)-2 [redacted]. Pt resting quietly
RR - 18			at change of Shift. USS. Denies Nausea
T 98.2			N Alert oriented, Perrla 3mm bright, follows commands
SPO2 98% on RA			appropriate c̄ staff
			CV S1 S2 110s
			R ~~even~~ Respirations even & unlabored SPO2 99-100 on
			RA
			GI BS hypo x4
			GU amber urine uses urinal @ bedside.
			SM multiple wounds (continued on reverse side) abdomen, back / lower back

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

(b)(6)-4

[redacted]

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

MEDCOM - 8059

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
			(L) heel, (R) leg. Dressings reinforced. No drainage noted
			Lines LAC & LRE TKO infusing.
~~HB 4-17~~		1430	Dressing changes done at approx 1100. small
VS 1430			amount serosanguinous drainage from ~~(R) buttock~~
BP 114/58			(L) buttock. scant - ∅ drainage from other
RR 16			wounds. on lower back & (L) side of abdomen.
HR 101			All wounds free of purulent drainage. All
SpO2 98% on RA			wounds healthy red. Pt tolerated dressing changes
			well, rcvd 2 mg MSO4 IVP prior to dressing Δ.
			Pt tolerating regular diet well.
		1600	1gm Ancef given via IV. (b)(6)-2 [redacted]
17APR03 1730			Assessments checked unchanged - see day shift note.
			Pt repositioned for comfort - supine now - dsgs. moist
			& intact to buttocks BIE - splints on. HL to (D) wrist
			patent/benign. ∅ complaints voiced. Pt currently
			hungry - will feed. VSS/Afebrile. Restraints on
			(b)(6)-2 [redacted] LPN Sgt.
17APR 2200			Pt resting comfortably in NAD. V/S 117/54, 20, 99, 99%
			Repositioned for comfort. Tol. MRE well. New PIV started
U/O 900cc			to RFA - old inadvertently pulled out. [redacted] Sgt
INTAKE 2400cc			V/S 101/58, 80, 16, 100.1 - Pt slept through entire shift (b)(6)-2
0400			in NAD. dsgs moist/intact w/ scant sang drainage.
			∅ side effects from abx. tx. Hand/Restraints on
			[redacted] LPN/Sgt.
			(b)(6)-2

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
18 Apr 03		1345	PT resting comfortably, left leg casted by ortho tech. Pt prepared for OR. BP 110/56 HR 80 RR 14 SpO2 100
		1530	BP 111/55 HR 82 RR 12 SpO2 100 Pt resting still since recovery (Post-op) has had no PO all day, & no urine out put. Received 2000mL LR
		1635	~~and~~ Pt awake, C/o thirst & hunger. gave 16oz H2O. Pt will wait for HOT meal. C/o being cold, gave another blanket BP 108/58 HR 91 T 100.1 RR 16 SpO2 100% (b)(6)-2 [redacted]
18 Apr 03 1730			Rec'd pt AtOx3/coherent/cooperative. VSS/Afebrile. PIV to RFA patent/benign. LLE cast/splint C,D,+I-. Cap ref. brisk-unable to wiggle toes this time. RLE-cap ref. brisk sensation/mobility intact. Bulk dsg moist/intact. Care plan reinforced: meds, pain control, act. level, D/C planning, diet/act. level, Rehab, voice understanding. Max Emotional Support provided (b)(6)-2 [redacted] Sgt. LPN
1800 INTAKE 360 ensure UO - 500cc			
(b)(6)-2 [redacted]			
18 ~~Apr~~ Apr	1900		Pt tol dinner well. Protein drinks / PO intake highly encouraged. Pt teaching done; nutritional needs, wnd. healing, coping; voice understanding. Currently on side / comfort measures [redacted] Sgt.
2000 ~~22~~ V/S 99.8	100/56, 100% 8, 12		
0400 V/S 100/52, 84, 16 0200 UO - 600cc		100%	0400 - Pt currently in NAD. Med. x 1 for pain (b)(6)-2 effect. Repositioned for comfort & [redacted] LPN Sgt.

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

STANDARD FORM 510 (REV. 7-92) BACK

(b)(6)-2

MEDCOM - 8061

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
13APR03	0530		Recieved nurses brief, Pt resting in NAD at this time. Last feeding at 0400, tolerated well. Fluids = & RTL, Breath Sounds CTA, Heart S1S2, Bowel Sounds presen VS BP 102/52 HR 79 R 12 T 100.5 Dressings secure. (b)(6)-2 [redacted]
	0730		Pt repositioned per pt request, 2mg of
	~~0730~~		MSO4 for pain. (b)(6)-2 [redacted]
	0830		Pt to OR for I&D (b)(6)-2 [redacted]
	1020		Pt back from OR. I&D wounds buttocks agn anest. 2mg versed, 150 mcg Fent. vecuronium, 500 LR, 250 urine output, no blood loss. VS 102/49, 73, spO2 100, R 19, T 97.4. RR even unlabored, Arousable only to tactile stimulation, will continue to monitor (b)(6)-2 [redacted]
18APR03	1030		Anced. 1gm given IVPB (b)(6)-2 [redacted] BP 111/57 HR 75, RR 10. SpO2 100% on R/A. more arousable when touch (b)(6)-2 [redacted]
	1035		BP 104/56 HR 68, SpO2 100, RR 19. Arousable to commands [redacted]
	1040		BP 114/55, HR 75, RR 13. SpO2 [redacted]
	1045		BP 103/59, HR 76, RR 10, SpO2 100 [redacted]

(Continue on reverse side)

(b)(6)-2

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

REGISTER NO.

WARD NO. ICU#1

[redacted] (b)(6)-4

NURSING NOTES
Medical Record

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

(b)(2)-2

PERIOPER[redacted] NURSING NOTE [redacted] AUTHORIZED FOR LOCAL REPRODUCTION

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

HOW PATIENT TRANSPORTED litter

WHO TRANSPORTED: OR staff

TIME TO OR PRE-OP: 1305 TIME IN OR SUITE: 1305

SURGICAL PROCEDURE I&D legs b-Hocks

PATIENT STATUS: (Allergies, Primary medical history, primary surgical history, crying, sedated, verify consent.)

NKDA 27yo Iraqi SPW Fwild this AM

CIRCULATOR NAME: [redacted] (b)(6)-2

SCRUB TECH NAME: [redacted]

SHAVE Ø

PREP: Betadine/Betadine

BOVIE PAD PLACEMENT (E) thigh 66226 2004-11

BOVIE PAD #: BOVIE MACHINE #: 1-1

SAFETY STRAP PLACEMENT thigh

POSITIONING DEVICES beach boy

POSITION OF OR BED Supine

COUNTS:		CIRCULATOR (b)(6)-2	SCRUB	IC	FC
	SHARPS:	[redacted] C	[redacted]		
	SPONGES:	C	C		
	INSTRUMENTS:	Ø	Ø		

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.

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

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

MEDICATIONS GIVEN: (name, manufacturer, amount, time, method)

Ø

IRRIGATION NACL

IMPLANTS Ø

SPECIMENS Ø

TUBES & DRAINS ~~Ø~~ Penrose (R) cheek battle drain

DRESSING Kling Kerlix Ace Tape

SURGEON: [redacted]

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

Ø TQ

DISPOSITION OF PATIENT: stable Drsgs intact & blood soaked. ambulatory with clear battle
Nous extubated

TIME PATIENT LEFT OR 1555

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

OPERATION PERFORMED I & D leg, battle

POST-OP NOTE: (Bovie pad site, moves extr. resp. status, dressing status)

See Disposition of pt.

NURSING SIGNATURE: [redacted] (b)(6)-2 CNA

- Jeweled 5 mgm — OR
- EBL min — 1300 cc LR
- Cl

MEDICAL RECORD | Nursing PROGRESS NOTES

DATE	
30 Apr 03 (1300)	assumments (vital sign changes) (see clin. shift note) pt. currently asleep in NAD. VS & afebrile. pt currently
VS 102/50, 78, 16, 99.0	waiting for transp → OR. LFA HL patent/benign, (5)(6)-2 [redacted] pt LPN
30 Apr 03 2300	pt currently resting in NAD. pt aware of PRN
VS 104/43, 76, 16, 99.2	pain meds, offered, refused @ this time. Repositioned for comfort. pt still waiting for OR. ~~pt~~ voiding
	q.s. / tol. PO well - u/o 500cc [redacted] LPN (5)(6)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

EPW # [redacted] (5)(6)-4

[redacted]

Bed #

ICU #

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	Nursing
21 APR 03	0530 - Received pt AOx3, calm cooperative obeys commands. Pt
B/P 90/45	has patent airway & no difficulty breathing. lungs clear to auscultation
Sat 95%	x4 lobes. S1/S2 sounds & no extra sounds. pulses equally strong
P-84	in both UE, strength equal UE. Unable to asses LE pulses
RR-16	sensation (+) x4 Extremities. Cap refill <2 sec. Skin is warm/dry
	to touch. IV 20g (L) forearm site is patent & no s/s of infiltration.
119/71	Pt on Ancef 1 gm in 50ml NS q6h. Pt has multiple dressings
P-61	to buttocks and back. both legs in splint. Pt needs ~~[illegible]~~ & diff. lay
Sats 100%	normal. Pt is on regular diet. pt currently resting comfortably will
T-97°	continue to assess. [redacted] 91 wnl SPC
	(b)(6)-2
	0615 IV site flushed. site is patent & Ancef started for 0600 [redacted]
118/57	0705 Ancef 1 gm 50ml NS finished pt tolerated, sleeping comfortably [redacted]
P-80	0830 pt performed oral hygiene and drank 1/2 liter water also (b)(6)-2
RR-17	consumed food. Urine output 4 [illegible] but that dressing (b)(6)-2
Sats 100%	Δ's are non-ID pt understood [redacted] SPC
T 97.1	1000 pt received 2 percocets for dressing Δ's. Docs notified
104/63	during dressing Δ and looked at pt's wounds. Docs discussed poss
P-62	debridement in OR. Pt notified of possible procedure placed small
RR-18	covering over wounds on feet per Doc. Pt currently resting
Sats 100%	comfortably [redacted] SPC 1145 pt NPO per
	(b)(6)-2 [redacted] for wound care in OR [redacted] SPC

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST (b)(6)-2 | FIRST (b)(6)-2 | MI | SPONSOR'S ID NUMBER (SSN or Other)

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

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

EPW # [redacted] (b)(6)-4 ICU #1

[redacted]

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 [redacted]

MEDCOM - 8066

LAST NAME	F. NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	1330 Ancef 1 Gm 50 ml NS started IV site flushed and patent SPC
	pt resting comfortably [redacted]
	(b)(6)-2
21 Apr 03	Brief Op Note
	Dx: multiple leg / buttock shrapnel wounds.
	Surg Dx: [redacted] (b)(6)-2
	Procedure: I & D wounds c̄ DPC of buttock and leg wounds.
	EBL min
	Fluids 300 cc
	Anesthesia GETA
	Complications Ø. (b)(6)-2 [redacted]
21 Apr 1600	Received from OR ~1600 [redacted]
	Pt under General Anesth. tol. procedure
	Well. BP 119/71 Temp 97. toes pink, mobile
	RR 18-20/min. O2 Sat 98% HR 86/min.
applied pulse ox pt.	Pt ō c/o discomfort. 1300 Total fluids in OR as Per CRNA. ↓ output.
	Sucpt [redacted]
I+O	
500 ml pre hydration	(b)(6)-2
~~35~~ 2400 ml IV	
3400 total	
450 out	
950 diff	

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

MEDCOM - 8067

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | Nursing | PROGRESS NOTES

DATE	NOTES
22APR03	1030 Pt had 1 tab percocet [redacted] (b)(6)-2 for pain and dressing changes were preformed, Pt tolerated procedure. Pt had urine output of 400cc via bed side commoder. Pt had 500ml PO of ensure and consumed food. Pt is currently resting comfortably in bed side chair. Will continue to monitor. [redacted] LPN SPC (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

(b)(6)-4

[redacted]

MEDCOM - 8068

10

510-112 NSN 7540-00-634-4123

MEDICAL RECORD — NURSING NOTES

(Sign all notes)

DATE	HOUR [redacted] P.M.	OBSERVATIONS (b)(6)-2 Include medication and treatment when indicated
20 Apr 03	1510	127/86 BP
23-4-03 T - 100		99.9 Temp
BP - 10/46		86
R - 12		12
P - 83	1540	18g angiocath started (L) forearm NS @ KVO
	1550	1gm Ancef given piggyback [redacted]
	1620	c/o leg pain ii tylenol #3 given PO [redacted]
	2130	1gm Ancef IV given piggy back, site ī s/s (b)(6)-2 infection infiltration, sleeping [redacted]
	(2324	T = 97.8 P = 75 R = 15 BP = 105/80) [redacted] (b)(6)-2
	2330	T = 96.8 P = 56 R = 13 BP = 105/100 Sgt. [redacted]
	0830	1gm Ancef IV piggy back, site ī s/s infection / infiltration (b)(6)-2 [redacted] CPT
	0930	IV d/c'd breakfast tolerated [redacted] CPT
	12N	asking to have dog changed [redacted] CPT (b)(6)-2
	1430	dog s/d ī asst of Cpl [redacted] c/o pain ī procedure tylenol #3 ii given [redacted] CPT
	1800	Keflex 250 ii po given [redacted] CPT (b)(6)-2
	2030	resting quietly no complaints [redacted] CPT
0600	2115	URINE EMPTIED (b)(6)-2
BP 110/46 24-4-03	1000	Keflex 250 ii po given [redacted] CPT
P 72	0100	1 Tabolet Tylenol ī extreme for pain. Sgt [redacted]
R 12		(b)(6)-2
Temp 100.4		

(Continue on reverse side)

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

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

REGISTER NO. | WARD NO.

NURSING NOTES
Medical Record

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

MEDCOM - 8069

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
25Apr03	0440	~~0~~	T97.5°F P 69 R 15 BP 94/58 [redacted]
	1130		Kflex 280 ÷ po no complaints [redacted]
		1400	resting quietly [redacted] CPO (5)(6)-2

STANDARD FORM 510 (REV. 7-91) BACK

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

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY Anesthesia OR RN's

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY LT [redacted] (b)(6)-2

3. DATE 20030418 TIME PATIENT ARRIVED IN SUITE N/A

4. PATIENT IN ROOM TIME 0540 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] (b)(6)-2	RELIEF SCRUB	—
ASSIGNED CIRCULATOR	LT [redacted] CPT [redacted]	RELIEF CIRCULATOR	—

7. POSITION AND POSITIONAL AIDS (Specify)

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

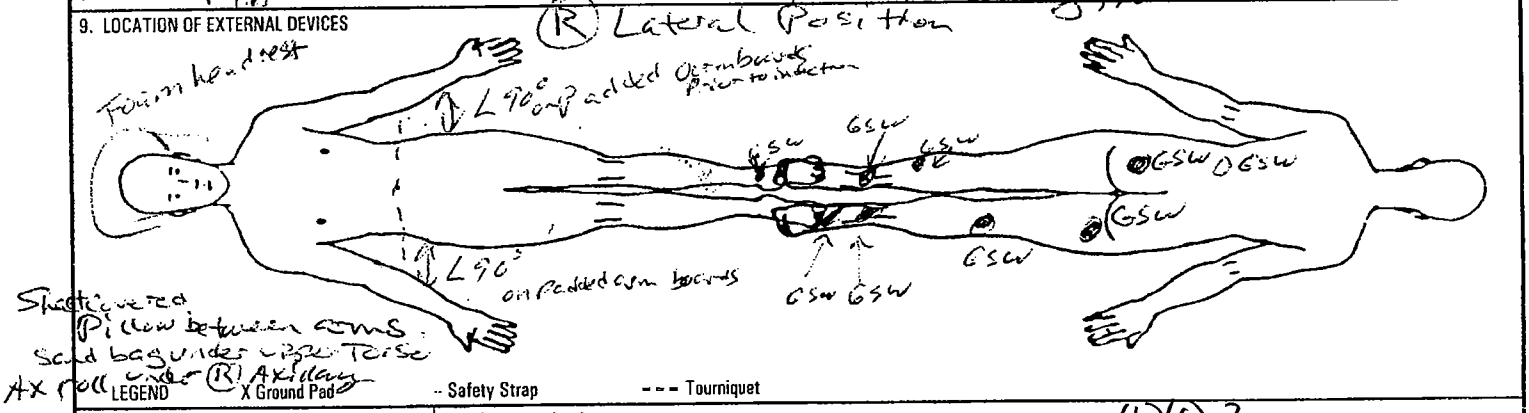
COMMENTS: See Back

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Betadine
SITE: B/lateral legs from
SITE: Patella to ankles circumferentially
B/lat. Buttocks cheeks
BY WHOM: LT (b)(6)-2
BY WHOM: LT [redacted]
COMMENTS: No problems, No RN's noted

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

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

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

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

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

[x] ESU NO: #1
GROUND PAD: BRAND Valley Lab
LOT NO: 63492 EXP 20040

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

[ ] BIPOLAR NO:

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

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%, NS

OTHER ORDERS	TIME	CARRIED OUT BY
PHYSICIAN'S SIGNATURE		

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION (Specify)
Fluffs (wet) Combine dsg 3" Silk tape — Buttock dsgs
4x8 Kerlix Mask splint Face wound — Bilateral lower Legs

19. ADDITIONAL INFORMATION 27 y.o. Israeli → WKDA. Delayed in room due to patient attempting to urinate and case change of order. NPO before midnight.

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

(b)(6)-2 [redacted] Dr. (mes) [redacted]
CRNA GG F Dr [redacted]
OR RN GGE
OR RN GGE
9ID

Reb Rubber Foley Inf/out catheterization (16 Fr)
Performed post-op diff difficulties made of 350 amber/clear urine present — [redacted]
~~Procedure End~~
Surgical Procedure completed @ 1003 — [redacted]

20. OPERATION(S) PERFORMED Debridement of Bilateral Buttocks Cleeks
I Migration & drainage of multiple wounds on posterior lower legs (Bilaterally) [redacted] (b)(6)-2

21. PATIENT TRANSFERRED TO ICU (b)(6)-2 TIME 1010 METHOD Litter

22. REGISTERED NURSE SIGNATURE ICT [redacted] RN

REVERSE OF DA FORM 5179-1, OCT 87 MEDCOM - 8072 USAPA V1.01

MEDICAL RECORD - ANESTHESIA

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

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

DRUG (Units)																		
Midazolam (mg)		2																
Fentanyl (mg)		150																
STP (mg)		375																
Succ (mg)		100																
Vec (mg)			3	2														
Neostigmine/glycopyrrolate (mg)							5/.8											
VOLAT AGENT	150 % del		.9	.6	.6	.6	X											
	% e.t.																	
AIR	L/Min																	
N2O	L/Min																	
O2	L/Min	6	2	2	2	2	2	8	8	RA								

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

FLUIDS

LINE site																
LF(cc) 18g RA	☐ Warmed					300		500								
	☐ Warmed															
	☐ Warmed															
	☐ Warmed															

LOSSES: EST BLOOD LOSS; URINE - Foley 250cc @ 1010

PHYS STATUS: 1 2 3 4 5 (E)

BODY WEIGHT: N 72 (KG) LB

HEMATOCRIT:

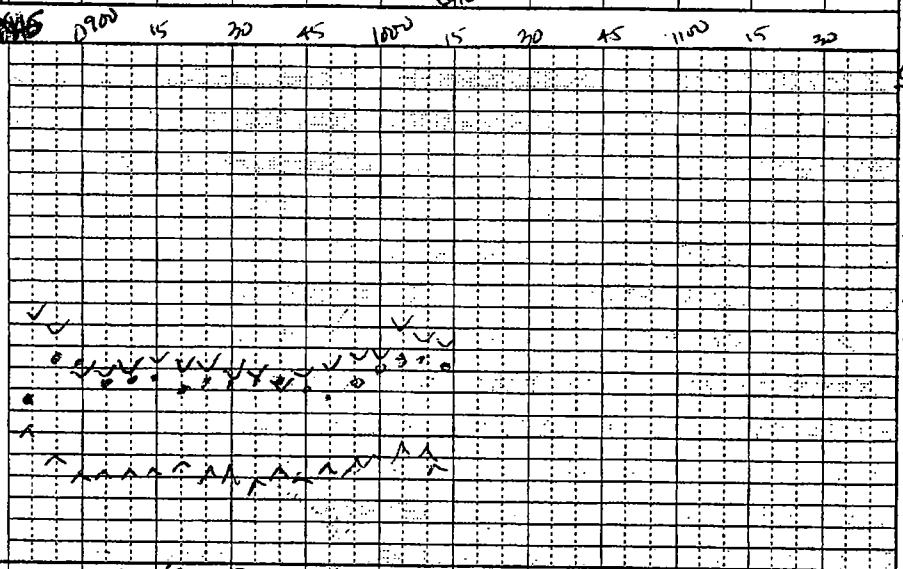
INITIAL DATA: BP- 116/61; HR- 75

EQUIP CHECK: OK?- (Y) N

PATIENT: OK for PROCEDURE? yes; TIME- 0830

TIME → 0800 0900 15 30 45 1000 15 30 45 1100 15 30

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



VENTIL.

VT - ml		750	780	820	790	>400	>
f - breaths/min		10	10	8	8	13	14
Peak inf pres / PEEP		20	18	19	19	—	—
MODE - S(pon), A(ssist), C(on)		S CV	CV	CV	C	S	S

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	(B) 35	31	33	34	36	—
BP/oth	✓ FIO2 (Frac or %)	.90	.91	.91	.87	.91	RA
ART line	✓ SpO2 (%)	100	100	100	100	100	100
Steth- PC/ES	✓ ECG	SR	SR	SR	VSR	SR	SR
✓ Gas analyzer	TEMP-site /Vail						
	✓ N-M Block (T/4)	4/4	4/4	4/4	4/4	3/4	4/4 EST
Warming blkt			✓				
Conv warmer							

Mark with letters & symbols, explain under REMARKS — EVENTS Position → Supine + RLD - bean bag → → @ 0800 roll. All pressure points padded/vel.

TOTALS	TOTAL EBL
2	Nan.
150	
375	TOTAL URINE
100	280cc X

FLUIDS - SUMMARY

CRYSTALLOID- LR = 500cc

COLLOID-

BLOOD- X

REMARKS

Code drugs with numbers, events with letters

0800 - Greeted pt @ ID. NPO verified. Prep complete. Agrees to GETA w/ translator. Denies questions.

0810 DOR 1-1 via litter. Monitors on. IV induction. Eyes taped shut. See airway note below.

1005 Resp event (Reg) moved to litter by 4. Oral sxn. TV 700. Extubated. Airway reflexes intact.

1010 → To ICU #1 Dec 9. Via litter. Report to Rn. VSS. As stable.

X

RECOVERY AT: 1011

PACU ICU #1 - bed 9 (Specify)

OTHER

CONDITION: Stable (b)(6)-2

RESP-20 SpO2-100% BP- 102/49 HR-92

ANESTHESIA/PROCEDURE TIMES

	Start	Room	End
ANES	0800	0840	1005
	Ready	Begin	End
PROC	0853	0900	1015

PROCEDURES and CPT Codes: I&D + dressing change of buttocks + BLE wounds

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA (O2/1so)

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Easy mask vent. DL x1 c̄ View 3 grade. View VC. 8.0 ETT placed + taped @ 24cm @ teeth. @ Stylet @ Sevoflurane ETCO2 @ BBS. @ Sciatic block

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

Syrian [redacted] (b)(6)-4 (b)(6)-2

SURGEONS: [redacted]

ANES: [redacted] CPT/CA

PROCEDURE LOCATION: OR1-1

DATE: 18 APR 13

PAGE 1 OF

MED[illegible] RECORD-SUPPLEMENTAL MEDICAL DA[illegible]

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

REPORT TITLE

PRE-ANESTHETIC EVALUATION

The proponent is Dept of Surgery

(b)(6)-4

OTSG APPROVED (Date) QI Appr 11 Dec 96

DATE OF PROPOSED SURGERY	AGE	WEIGHT	ALLERGIES (List react)	FAMILY HISTORY	Tob HX-	CONSULTATIONS (Check when completed)
17 APR 03	[redacted]	72kg	☒ NKDA	☒ NO ANES PROB	EtOH-	☐ 1
PROPOSED SURGERY	SEX	HEIGHT			DRUGS	☐ 2
IOD Bilateral Leg + buttock wounds	M					☐ 3

PREVIOUS ANESTHESIA/SURGERY ☒ NO PROBLEM

Ø

MEDICATIONS ☐ NONE • = ORDERED AS PRE-MED

MSO4

Ancef 1g (0400)

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 buttocks + ② left thigh + BLE injuries (GSW)

PHYSICAL EXAM: HR 79 BP 102/53 T 100.5 RR 12

AIRWAY: MP (1) 2 3 4

Teeth

ROM Full

TMD (FB) <2 2 3 (>3)

HEART: SR, (NL)

LUNGS: ☒ CTAB

NEURO/BACK:

BLOCK SITE:

VASC ASSESS:

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

NPO since 1600

ASA (1) 2 3 4 5 (E)

☒ Counselled to remain NPO

PLAN

✓ General ___ MAC

___ Regional: ___

___ Block: ___

☐ Post Op ICU/Vent ☐ Awake Intubation

☐ Art Line ☐ CVP ☐ PA

☐ Special Techniques

PREMED:

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: Via Interpreter

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC REVIEWED BY:

DATE 17 APR 03

PAT[redacted] or written entries give: Name—last, first, middle, grade, date; hospital or medical facility)

Syrrar

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

[redacted]

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☒ OTHER (Specify) Suppl SF 517

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

PREVIOUS EDITION IS OBSOLETE.

REQUIREMENT OF PRIVACY ACT OF 1974 IS COVERED BY DD FORM [illegible]

SG OVPT 34-R (Mar 02)

MEDCOM - 8074

1440 MSO4 5mg Versed 2mg PNL-opp

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)	1415 30	X	1500													
Fentanyl	(cc)	3															
STD / Bnex	(mg)	4 mg	25	75													
	( )																
	( )																
	( )																
Ephedrine	(mg)	5															
VOLAT AGENT Forane	% del	1%	.6	1.5	X												
	% e.t.																
AIR	L/Min	-1	—	1	1	X											
N2O	L/Min																
O2	L/Min	8	2	1	1	X											

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS → Narcan 40mg

FLUIDS

LINE site LR																
☐ Warmed	400-600	LR														
☐ Warmed																
☐ Warmed																
☐ Warmed																

LOSSES

EST BLOOD LOSS																
URINE - Ø																

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: 72 KG LB

HEMATOCRIT:

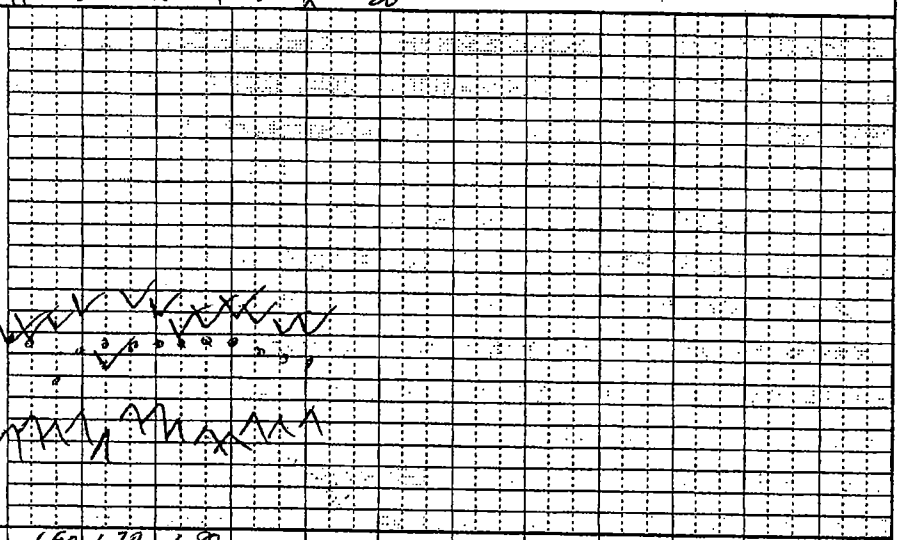
INITIAL DATA: BP- 90/45 HR- 84

EQUIP CHECK OK?- Y N

PATIENT OK for PROCEDURE? TIME- 1400

TIME → 1415 30 X 1500 X 30

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



VENTIL

VT - ml	650	670	680		
f - breaths/min	10	10	10		
Peak inf pres / PEEP	18	18	18		
MODE - S(pon), A(ssist), C(on)	S C	C	C	A/	

MONITORS/ACCESSORIES

BP/Auto Cuff — ET CO2 (torr)	46	38	34	47	
BP/oth — FIO2 (Frac or %)	1.0	.6	.5	1.0	
ART line — SpO2 (%)	100	100	100	100	
Steth-PC/ES — ECG	SR	SR	SR	SR	
Gas analyzer — TEMP-site					
N-M Block (T/4)					
Warming blkt					
Conv warmer					

Mark with letters & symbols, explain under REMARKS — EVENTS Position → a a APPP + eye + ear V'd

TOTALS — TOTAL EBL: mini — TOTAL URINE: Ø

FLUIDS - SUMMARY — CRYSTALLOID- 1000 — COLLOID- Ø — BLOOD- Ø

REMARKS — Code drugs with numbers, events with letters

RECOVERY AT PACU ICU _____ (Specify) OTHER _____

CONDITION: RESP- 16 SpO2- 98 BP- 113/60 HR- 74

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1355	1400	1600
	Ready	Begin	End
PROC	1420	1440	1530

PROCEDURES and CPT Codes: Back + Back wound Id & Bilat Feet wounds

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

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

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments Tube / Eyes taped

SIVI, DVOIX1, RSI, Cricoid, Cuff +, BS-BS

SURGEONS: Dr [redacted]

ANESTHE [redacted] MAJ, CRNA

PROCEDURE LOCATION: # OR 1

DATE: 21 Apr 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 — MEDCOM - 8075 (b)(6)-2 — COPY 1 - PATIENT'S MEDICAL RECORD — USAPA V1.00

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE: **PRE-ANESTHETIC EVALUATION**
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-	CONSULTATIONS (Check when completed)
(b)(6)-4	[redacted]	72K	☐ NKDA	☒ NO ANES PROB	EtOH-	☐ 1
PROPOSED SURGERY	SEX	HEIGHT			DRUGS	☐ 2
	M					☐ 3

PREVIOUS ANESTHESIA/SURGERY ☐ NO PROBLEM
I&D of multiple Fragment Wounds (Back + Legs Bilat)

MEDICATIONS ☐ NONE * = ORDERED AS PRE-MED
Ancef

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)

PHYSICAL EXAM: HR 84 BP 90/45 T 99' RR 16

AIRWAY: MP 1 2 3 4
Teeth
ROM
TMD (FB) <2 2 3 >3

HEART:

LUNGS: ☐ CTAB

NEURO/BACK:

BLOCK SITE:

VASC ASSESS:

EXT/OTHER:

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

PFT

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

PROBLEM LIST

ate 0900 this am

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

PLAN
RSA
___ General ___ MAC
___ Regional: ___
___ Block: ___
☐ Post Op ICU/Vent ☐ Awake Intubation
☐ Art Line ☐ CVP ☐ PA
☐ Special Techniques
PREMED: (b)(6)-4 EPW # [redacted]

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: ___

(Continue on reverse)

PRE [redacted] (Signature & Title) MAJ CRNA

DEPARTMENT/SERVICE/CLINIC REVIEWED BY:

DATE 21 Apr 03

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☒ OTHER (Specify) Suppl SF 517
☐ DIAGNOSTIC STUDIES
☐ TREATMENT

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

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

EDW [redacted]

Bed # [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 17 APR 03 TIME OF ORDER 0630 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit ICU buttock
2. GSW - Lt [redacted], back, legs, achilles, Rt calcaneous Fx Lt tibial Fx
3. Stable
4. VS per protocol
5. Bedrest w/ restraints
6. Bilat LE splints (b)(6)-2

[redacted]

PATIENT IDENTIFICATION

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

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

7. ~~Regular diet~~
8. ~~Ancef 1 gm IV q8°~~
9. ~~MSO4 2-4 mg IV q 4-6° prn.~~
10. Salinelock IV.

(b)(6)-2

[redacted]

PATIENT IDENTIFICATION

EDW # [redacted]

[redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 18 APR 03 TIME OF ORDER 0900 HOURS

(b)(6)-2

1. S/P 2 ND OF WOUNDS
2. RESUME ABOVE ORDERS
3. MAY BE TRANSFERRED TO EDW / CWIWW HOSPITAL

[redacted]

PATIENT IDENTIFICATION

EDW # [redacted]

[redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 20 APR 03 TIME OF [redacted] HOURS

(b)(6)-2

1. Restoril 15mg PO X1 NOW — [redacted]

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

Noted 21 APR 03

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
EPW # [redacted] (b)(6)-4 [redacted] Bed #9 FCU #1			20 Apr 03 1420 HOURS	
			(1) per V/O Dr. [redacted] (b)(6)-2 1-2 PO percocet 6-8 hrs prn	1420
			(2) per V/O Dr. [redacted] (b)(6)-2 2-4mg IM/IV q 4-6 hrs prn (b)(6)-2 breakthrough pain prn	[redacted]
NURSING UNIT	ROOM NO.	BED NO.		
FCU #1		[redacted]		

PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER	
EPW # [redacted] (b)(6)-4 [redacted] (b)(6)-4			21 APR 03 0710 HOURS (b)(6)-2	
			(1) CHANGE ALL DRESSINGS (WET-DRY) TID	
			Noted [redacted] Noted [redacted] (b)(6)-2 [redacted]	[redacted]
NURSING UNIT	ROOM NO.	BED NO.		
FCU #1		[redacted]		

PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER	
EPW # [redacted] (b)(6)-4 [redacted]			21 Apr 03 1500 HOURS	
			Resume previous orders [redacted] (b)(6)-2	
NURSING UNIT	ROOM NO.	BED NO.		
FCU #1		[redacted]		

PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER	
(b)(6)-4			4-22-03 1045 HOURS	
			(1) Tx pt to C Med for Care (b)(6)-2 [redacted]	[redacted]
NURSING UNIT	ROOM NO.	BED NO.		

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
EPW # [redacted] (b)(6)-4			↓	30 Jun 03	1030 HOURS	
				C/ O/C & EPW camp		
					(b)(6)-2	
NURSING UNIT	ROOM NO.	BED NO.		[redacted]		
ICW1						
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

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

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-APR Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 25	26	27	28	29	30
25	[redacted]	Regular Diet	6	/	[redacted]				
	.....		12	/	[redacted]				
	.....		18	[redacted]					
25	[redacted]	PT for daily DSG Δ's	1000	[redacted]					
25	[redacted]	VS q shift	6	/	[redacted]				
	.....		14	/	[redacted]				
	.....		22	[redacted]					
25	[redacted]	BSC	17	/	[redacted]				
	.....		05	/	[redacted]				
			05	[redacted]					
			17	[redacted]					
25	[redacted]	Ambulate ⊂ transfer +	17	/	[redacted]				
	.....	assist ⊂ PT.	05	/	[redacted]				
			05	[redacted]					
			17	[redacted]					
29APR03	[redacted]	Out of bed ambulate TID	6	/	/	/	/	/	[redacted]
	.....		14	/	/	/	/	/	
	.....		22	/	/	/	/	[redacted]	
	.....								
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(b)(6)-2

(b)(6)-2

ALLERGIES: ☐ YES ☑ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

EPW # [redacted]

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo APR Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
25 APR	[redacted]	Admit FCW – [redacted] Dx: GSW				[redacted]
		Cond: Good (b)(6)-2				(b)(6)-2
25	[redacted]	No IV				[redacted]
		(b)(6)-2				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
25	[redacted]	Call MD T>101														
		(b)(6)-2														

USAPA V1.00

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 17	18	19	20	21	22	23	24	25
17APR	0030 [redacted]	Ancef + Gmg 6° IV	04	[redacted]								
	(b)(6)-2		10									
			16									
			22									
17APR	0030 [redacted]	IV LR @ KVO	05	[redacted]								
			17									
18APR	[redacted]	Resume above	08	[redacted]								
		orders may be	16									
		taken second 48	24									
		GPW civilian										
		Hospital										
18APR	[redacted]	Wat to day dsg	10	[redacted]								
		A's daily										
19Apr	[redacted]	Ancef + Gmg	06	[redacted]								
		8°	14									
			22									
17Apr	[redacted]	Saline Lock	05	[redacted]								
		flush q shift	17									
17Apr	[redacted]	VS per protocol	05	[redacted]								
			17									
17Apr	[redacted]	Bed Rest & Restraints	05	[redacted]								
			17									
17Apr	[redacted]	Bilat LE splnts	05	[redacted]								
			17									
17Apr	[redacted]	Regular Diet	05	[redacted]								
			17									

(b)(6)-2

See Below 19 APR 07

(b)(6)-2

Order D'ed 21 Apr

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW (L) Butt, Back, Leg, Arm (R) Calcaneus Ft (L) Tibial Ft.

ADDITIONAL PAGES IN USE: ☑ YES ☐ NO

PAGE NO. 7

PATIENT IDENTIFICATION: EPW [redacted]

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo.____ Yr.____
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
17 Apr	[redacted]	Cont Stable	[redacted]			
2	[redacted]	S/P I+D of Wound Rsume 19 Apr				
	(b)(6)-2	Above Orders, Mugre			(b)(6)-2	
	[redacted]	Transferred to Civilian hosp			Pin	[redacted]
20 Apr 03		Restoril 15mg PO x 1 now	20 Apr 03	2145	pharmacy	
21 Apr	[redacted]	Resume Previous Orders	[redacted]			
	(b)(6)-2					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
17 APR 0030	[redacted]	MSO4 2mg IV Q4H PRN	2mg IV	0930 17 APR	1330	1630	1930	21 APR 2330							
17 APR 0030	[redacted]				(b)(6)-2										
.....	.....	(b)(6)-2													
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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. Apr Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 21	22	23	24	25
~~[illegible]~~	[redacted]							
21APR	[redacted]	Dressing Δ's TID wet to dry	06	[redacted]				
	(5)(6)-2		14					
			22	(5)(6)-2				

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW (L) Buttock

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. 2

PATIENT IDENTIFICATION: CPW # [redacted] (5)(6)-4

[redacted]

Bed # [redacted]

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

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
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	.....					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
4-20	[redacted]	1-2 percocet per q	4-20 7:55 2 1400	[redacted] 21:00 0850	4-22 [redacted] 21:00											
.....	(5)(6)-2	6-8 hrs prn			[redacted]	(5)(6)-2										
4-20	[redacted]	2-4 mg MEDIVP	4-20 1400 2mg	9/21 1710 [redacted] 2mg												
.....	.....	q 4-6 hrs prn par-														
.....	.....	breakthrough pain														
.....	.....															
.....	.....															
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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. APR Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED													
				3 26 27													
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ALLERGIES: ☐ YES ☑ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

EPN # [redacted]

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. APR Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
	.....					
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	.....					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED													
25	[redacted]	T#3 1-2 q 4/0														
.....	(b)(6)-2															
25.	[redacted]	Percocet 1-2 q 4/6°														
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USAPA V1.00

010
~~038~~

ADMISSION AND CODING INFORMATION

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

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

3. REGISTER NUMBER						
9	10	11	12	13	14	15

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

4. PAY GRADE		5. SEX
16	17	18
EPW		M

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

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS (b)(6)-4
—	46: U	2022	—

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

17. UNIT LOCATION (State or Country Code)		18. MOS							19. TRAUMA	PREV. ADMISSION YEAR	
62	63	64	65	66	67	68	69	70	71		☒ NO
—		—							7		

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: 0	ICW	UNK

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted]

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION (b)(2)-2		22. MTF TRANSFERRED TO						23. DATE OF DISPOSITION (YYYYMMDD)							
73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88
0	1							2	0	0	3	0	4	3	0

24. CLINIC SVC - ADMITTING				25. MTF TRANSFERRED FROM						26. DATE THIS ADMISSION (YYYYMMDD)							
89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106
A	B	A	A							2	0	0	3	0	4	1	6

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

FOR LOCAL USE

T: 1
Inj: 450
Dx: 8771
8760
8351
8340
8604
Dx: GSW (R) buttocks

ADMITTING OFFICER (Signature, as required): ~~DEC?~~ (b)(6)-2 [redacted]

SIGNATURE OF ADMITTING CLERK: [redacted]

DA FORM 2985, MAR 2000 — EDITION OF MAR 89 IS OBSOLETE — MEDCOM - 8088 — USAPA V1.00

(b)(6)-2

(b)(6)-4

PATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER [redacted]	2. NAME (Last, First, MI) [redacted] (b)(6)-4			3. GRADE EPW	ADMISSION REMARKS
4. SEX M	5. AGE UNK	6. RACE X	7. RELIGION UNK	8. LENGTH OF SVC —	9. ETS —
10. PREVIOUS ADMISSION NO					
11. FMP 99	12. SSN [redacted]	13. ORGANIZATION —		14. WARD ICW1	
15. FLYING STATUS N	16. RATING/DSG	17. DEPT./BEN K78	18. BRANCH/CORPS (b)(6)-4	19. UIC/ZIP —	20. TYPE CASE WIA
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION DIRECT FROM ER			22. HOURS OF ADMISSION 1715	23. CLINIC SERVICE ABAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK			25. TYPE DISPOSITION NFER TO EPW CAMP	26. DATE OF DISPOSITION 19 Apr 2003	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK			27b. TELEPHONE NO. UNK	28. DATE OF THIS ADMISSION 18 Apr 2003	ADMITTING OFFICER (b)(6)-2 DR. [redacted]
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted]				30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA (b)(2)-2

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

Grenade blast injury.

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

1. Penetrating head trauma

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING [redacted] for [redacted]

SIGNATURE OF RAD OR [redacted]

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

DA FORM 3647, JUL 79 EDITION [redacted] (b)(6)-2

MEDCOM - 8089

558-104

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: (b)(6)-4 | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 4-18-03 | TIME: 1715

TRANSPORTATION TO FACILITY

SEX: [redacted]

DUTY/LOCAL PHONE: AREA CODE | NUMBER

HOME PHONE: AREA CODE | NUMBER

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			

MEDICAL HISTORY OBTAINED FROM

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS

ALLERGIES

INJURY OR OCCUPATIONAL ILLNESS

ITEM	YES	NO
IS THIS AN INJURY?		
INJURY/SAFETY FORMS		

WHEN *(Date)*

WHERE

HOW

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: old shrapnel wound to (R) scalp + ~~(R) ankle~~

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☒ NON-URGENT

TIME: 1715

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

VITAL SIGNS

TIME	1715	1730			
BP	136/56	113/71			
PULSE	82	77			
RESP	16	16			
TEMP	98 –	–			
WT	ok – 98	98			

LAB ORDERS

X	CBC/DIFF		ABG		PT/PTT		BHCG/URINE/BLOOD/QUANT
	URINE C&S		UA MSCC/CATH	X	CHEM: 7		
	BLOOD C&S X						

X-RAY ORDERS

	CXR PA & LAT/PORTABLE		C-SPINE
	ACUTE ABDOMEN		LS SPINE
	SINUS		HEAD CT
	ANKLE R/L	X	A P, lat. skull

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. ☐ 72 HRS

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS: Continue AE toward Neurosurgical Evaluation

CONDITION UPON RELEASE: ☒ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE: ICU

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)*

Iraqi EPW (b)(6)-4

[redacted]

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)

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 O2	PH	PO2	RESULTS	
H/H			PCO2	SAT	OTHER		
PLT							
T			U/A	DIP		EKG INTERPRETATION	
PTT	BHCG	ETOH	GLU	MICRO			

PROVIDER HISTORY/PHYSICAL

S: Pt is a [redacted] yo Iraqi who presents c̄ wife, baggage & Birth Certificate from [redacted]. He reports he took fragments to his (R) Parietal Skull/Brain on 10 April 03 when he was operating an Iraqi tank & was bombed. Pt had ? brain surgery done with reported retained metallic fragment in (R) brain & (L) sided weakness. As near as I can tell, pt presents for care in order to have brain surgery to remove metal fragments or wants to go to U.S. with his wife for care. Unsure of status as 1) Iraqi soldier in a tank & therefore an EPW, 2) Innocent bystander Iraqi Civilian, or 3) US Citizen who happened to be "recruited into Iraqi Army. Pt & wife speak broken English. ⊖ fevers. ⊖ focal Chief C/O. Clarification: wife later reports that he was injured at his front door of his home & had paid someone to not have to be in the Iraq Army. He has lived in Iraq since he was 2 years old.

O: WD WN NAD A&O Non Toxic ⊖ Resp distress Communication ⊖ Slur.
HEENT: Healing Scalp Surgical wound PERRL Symmetric face.
Neuro: (L) weakness but poor participation. Ace wrap on (L) ankle for support.
Lungs: (B) CTA.
Cor: [redacted] MD.
Abd: [redacted]
Ext: [redacted]
(b)(6)-2

7.3 / 36 / 11 / 434
5.1 / 134 / 92 / 10.9 / 99 CK 356

Skull X Rays: mult frags located deep in brain above Petrous ridge. Doubtful these would be safely removable.

1/2 of Sutures Removed ⊖ D/C. ⊖ pus. ⊖ b-down.

CONSULT WITH	TIME	ACTION	RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP
			PROVIDER SIGNATURE AND STAMP
			[redacted]

DIAGNOSIS
S/p Brain Surgery c̄ retained Fragments

CODES (b)(6)-2

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

[redacted] (b)(6)-4

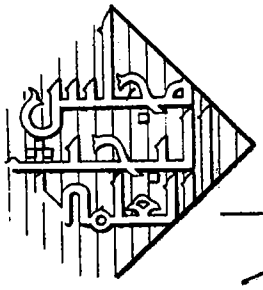
EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

(b)(6)-4 [redacted]

(b)(6)-4

[redacted]



المؤتمر العلمي الثالث

THE THIRD SCIENTIFIC CONFERENCE
OF THE
SCIENTIFIC RESEARCH COUNCIL
Oct. 29th- Nov. 2nd, 1983

The accedient on Thursday 10th April 7,a:m hour
Surgery at 7p.m. at Adnan Kharaleh hospital
Treatments

1- C.S. 4/day from the first to the fifth day
2- Claverno 1x4 4 day after the fourth to the sixth day
3- Garamisine 1x3 to the sixth day
4- Nominal 1x2
5- ~~Ranitidine~~ Umitidine from the fifth day
6- Decadron from the fifth day

Very important note

Suchen should be removed from his head on Saturday 17th april

BAGHDAD - IRAQ

(b)(6)-4

[redacted]

Iraqi EPW

[redacted] (b)(6)-4

MISC	
URGENCY	PATIENT STATUS
☐ ROUTINE	☒ BED ☐ AMB
TODAY ☐	OUTPATIENT ☐
☒ PRE-OP	☐ NP ☐ DOM
STAT ☐	SPECIMEN SOURCE (Specify)

SPECIMEN/LAB RPT. NO

PATIENT'S MED. RECORD

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

REQUESTING PHYSICIAN'S SIGNATURE	REPORTED BY	MD	DATE	LAB ID NO.
Maj [redacted]	(b)(6)-2	TECH	18 Apr	

REMARKS

CBC + Chem 7

557-107

MISCELLANEOUS

TEST(S)	SPECIMEN TAKEN DATE	TIME A.M.	REQUESTED	RESULTS
	18 Apr	1735	CBC + Chem 7	

PICCOLO

18/04/03 17:48

REFERENCE RANGE: MALE

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

MULTYTE 8

DISC LOT #: 3083AA4 (b)(6)-2

OMER #: 007 DR #: [redacted] (b)(6)-4

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

GLU	99	73-118	MG/DL
BUN	10	7-22	MG/DL
CRE	0.9	0.6-1.2	MG/DL
CK	356	30-300	U/L
NA+	134	128-145	MMOL/L
K+	5.1*	3.3-4.7	MMOL/L
CL-	92*	98-108	MMOL/L
tCO2	28	18-33	MMOL/L

INST QC: OK CHEM QC: OK

HEM 0 , LIP 1+, ICT 0

ID: [redacted] 18-04-03

WB 17:52

			Patient Limits	
WBC	7.3	x10^3/uL	4.5	10.5
RBC	3.99 L	x10^6/uL	4.00	6.00
Hgb	11.0	g/dL	11.0	16.0
Hct	35.8	%	35.0	60.0
MCV	89.8	fL	80.0	99.9
MCH	27.7	pg	27.0	31.0
MCHC	30.8 L	g/dL	33.0	37.0
Plt	434.	x10^3/uL	150.	450.
LY%	17.1 L	%	20.5	51.1
LY#	1.2	x10^3/uL	1.2	3.4

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
		[redacted]

DATE OF ORDER: 18 Apr 03 TIME OF ORDER: ~~22~~ 1830 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit to ICW
2. Dx: Brain fragments s/p Neurosurg, en route to further eval.
3. Cond Stable.
4. VS q shift.
5. NPDA.
6. Keflex 250 mg po qid
   Tagamet ~~200~~ 400 mg po q HS OK.

PATIENT IDENTIFICATION

(b)(6)-2 [redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 4/18/03 TIME OF ORDER: HOURS

Motrin 800 mg po tid prn.
Percocet T-II po q 4-6° prn pain.

(b)(6)-2 [redacted]

MAJ, MC, USA
DEPT OF EMERGENCY MEDICINE

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 18APR03 TIME OF ORDER: 2240 HOURS

1. Haldol 5mg IVP x 1 now.
   V.O. Dr [redacted] PT/AW

(b)(6)-2

[redacted] 18APR03 2350

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 18Apr03 TIME OF ORDER: 0016 HOURS

1. Haldol 10mg IVP x 1 now.
   V.O. Dr [redacted] PT/AW

(b)(6)-2

[redacted] (b)(6)-4

[redacted] 19APR03 2351

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 - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] (b)(6)-4 EPW # [redacted]				19 Apr 03	2359 HOURS	
			L	Ativan 2 mg IV push now (Two)		[redacted]
					(b)(6)-2	
				[redacted]		
					Read back	
NURSING UNIT	ROOM NO.	BED NO.				DO
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

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

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													
				18	19												
4/18	[redacted]	VS : q shift	06	/	[redacted]	(5)(6)-2											
	(5)(6)-2		14	/													
	.....		22	TJK													
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ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: Brain Fragments s/p neuro surg en route to further eval

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

PATIENT IDENTIFICATION:
[redacted]
(5)(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

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
4/18	[redacted]	Admit to ICW; Cond. Stable	—		—	[redacted]
	(b)(6)-2					(b)(6)-2

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

USAPA V1.00

CLINICAL RECORD

...ERAPEUTIC 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 18	19	20
4/18	[redacted]	Keflex 250mg PO	04	✓		
	(b)(6)-2	QID	10	✓	[redacted]	(b)(6)-2
			16	✓		
			22	TSL		
4/18	[redacted]	Tagamet ~~200~~ 400mg PO qHS	22	TSL	[redacted]	(b)(6)-2
	(b)(6)-2					

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: Brain Fragments s/p neurosurg en route to further eval

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 4 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
4/18	[redacted]	Haldol 5mg x 1 now IVP stat effective	18 Apr	now	2300	[redacted]
4/19	[redacted]	Haldol 10mg IVP x1 now effective	19 Apr	now	0020	[redacted]
	(b)(6)-2					(b)(6)-2
	.....					
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	.....					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
4/18	[redacted]	Motrin 800mg PO	date time													
.....	(b)(6)-2	TID prn	doc init													
4/18	[redacted]	Percocet 1-11 PO	date time													
.....	.....	q 4-6° prn pain	doc init													
.....	.....															
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USAPA V1.00

(b)(6)-4 → [redacted]

ADMISSION AND CODING INFORMATION

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

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

3. REGISTER NUMBER							NAME (Last, First, Middle Initial)	4. PAY GRADE		5. SEX
9	10	11	12	13	14	15	EPW # [redacted]	16	17	18
[redacted]							[redacted] (b)(6)-4	EPW		m

6. DATE OF BIRTH (YYYYMMDD) (b)(6)-4								7. AGE AT ADMISSION			8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19	20	21	22	23	24	25	26	27	28	29	30	31	
											X	9	UNK

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46: U	1715	(b)(6)-4

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

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

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

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

24. CLINIC SVC - ADMITTING				25. MTF TRANSFERRED FROM						26. DATE THIS ADMISSION (YYYYMMDD)							
89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106
A	B	A	A							2	Ø	Ø	3	Ø	4	1	8

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

FOR LOCAL USE

Dx: Brain fragments (shrapnal wnd) S/P neuro surg en route to further Eval.

(b)(6)-2

[redacted] for [redacted]

ADMITTING OFFICER (Signature)	SIGNATURE OF ADMITTING CLERK
maj [redacted] MC	

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

MEDCOM - 8100

9	10	11	12	13	14	16	17	18

6. DATE OF BIRTH (Y Y Y Y M M D D)								7. AGE AT ADMISSION			8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19	20	21	22	23	24	25	26	27	28	29	30	31	

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

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

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

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

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

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

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

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

FOR LOCAL USE

Dx: V5843
85411

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

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

IN...IENT TREATMENT RECORD COVER SHE

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

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

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

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99	[redacted]	(b)(6)-4	FCW 1

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

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
DIRECT FROM ER	1952	AAAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
UNK	TRF TO ASMC	21 Apr 2003

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
UNK	UNK	18 Apr 2003	(b)(6)-2 DR [redacted]

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

31. [redacted]ELECTED ADMINISTRATIVE DATA

(b)(2)-2

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

Shooting incident (UNK)

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	3	3

36. Total Days All Facilites

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

SIGNATURE OF A[redacted]

DR. [redacted]

SIGNATURE OF PAD OR M[redacted]

DA FORM 3647 MAY [redacted]

(b)(6)-2

MEDCOM - 8102

(b)(6)-2

426 FSB
19 APR 03
0750

(S) IRAQI FREEDOM FIGHTER SENT TO FSB S/P HX OF BEING IN VEHICLE AND HITTING A MINE 24hrs AGO. DEN AMB CREW PT S/P PAIN, UNABLE TO SEE ON HERN (2) RYN/RMA. PT NOT ABLE TO STEAD UNDERSTAND ENGLISH NO FURTHER HX DONE NO INTERPITER

T
P 60
R 12 [redacted]
B/P 120/70

(O) GEN NAD, ALERT, GAIT NORMAL ONLY (2) RYN COVER
H-NC AT, E (2) PERRL (R) (+) RUPTE DEBRIS, HYPHEMA, CLOUDY. EM (R) TM DEBRIS RYBERM (2) WNL, N CLEAR
T-CLEAR N-S/NT.,
CHEST-CTA (R) NO WANNS SEEN CVS RRR - BRAC CLEAR
ABD-S/NT DELUS S'DRATE LR S INTRY
CN II/III/IV/VI NOT TESTED 2° INTRY V-XII GROSSLY INTACT
MS RAT 5/5 2+ DTRS 5/5 5/5 5/5 5/5
GAIT NORMAL

XRAY NO OBVIOUS FB

(A) PENETRATING OCULAR TRAUMA
(1) COVER BOTH EYES NO PRESSURE ON DRESSINGS
(2) IV NS TKO
(3) ANCEF 1 GM IV WILL ADMIN SMALL AMOUNT 20cc WAIT 30min ADMIN REST (WATCH TO GET ALLERGIES/HX)
(4) XRAY WITNESS/ORBIT
(5) FLIGHT BACK FOR OPTR

(b)(6)-2
[redacted]

CAT, SP
RRDA-C

*PT ID CARD IN TRACKER WITH UNIT LOCATION.

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	(b)(6)-4 NOTES
18 Apr 03	[redacted] yo ♂ Iraqi EPW s/p GSW 17 days ago, (L) Face. Wound cleaned @ the time. Then 7 days ago he lost vision in his (L) eye. Denies pain.
NKDA	(B)- AF VSS A&O x3
purulent/pstly	HSSNT= (R) EOMI ; (L) minimal Eye movement
unknown	(L) Globe ⅋ laceration c̄ ecchymosis.
	(+) ptosis ; Sub-conjunctival hematoma. (L)
Med	fundus exam= post Blood seen. No clear disc seen.
Ø	No Antecid pulsation seen. pulpil ≈ 7mm ; No Reaction
	to light. No detection of Light per patient.
13.3 / 41.1 363	Face= (L) supra auricular 1cm lacerations surrounding edema/
	ecchymosis/erythema. pus expressed c̄ palpation.
139/102/0.6/115	
1.6/29/14	Lungs= CTA (B) [illegible] A&O= [illegible]
Ch 273	
	(A) = 1. minor Laceration c̄ Abscess ; irrigated & packed
Skull Film=	(P) Unasyn 3.0gm IV sivep.
Nondisplaced Fx	2. (L) eye ptosis/blindness/Ant.chamber hematoma. ? 2° abscess vs
(+) sinus	hematoma retroorbital; evac for ophtho eval. Keep
fragments	head up. 3. Skull [redacted] displaced Fracture.

RELATIONSHIP TO SPONSOR	LAST (b)(6)-2 [redacted] MI	SPONSOR'S ID NUMBER (SSN or Other)
DEPART./SERVICE [redacted]	AL FACILITY	RECORDS MAINTAINED AT
PATIENT'S IDENTIFICATION: (For [redacted] first, middle; ID No or SSN; Sex; Date [redacted]	REGISTER NO.	WARD NO.

EPW

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

(b)(6)-4 [redacted]

LAST NAME	F ME	MIDD.	D NUMBER

DATE	NOTES
19 April 03	maxillofacial 24
21033	[redacted] (b)(6)-4 yo/m 18 days S/P Hx of GSW to (L) face
	Pt c̄ 8 day Hx of loss of vision
	Pt is A/O x3 VSS
	Pt c̄ left eye edema + subconjunctival hematoma present. limited EOM.
	Pt ccs is left lid. left pupil dilated to 7mm c̄ no rx to light.
	Pt c̄ c/o pain on palpation.
	1.5cm wound surface 1.5cm zygomatical temporal wound surface
	c̄ purulent exudate present.
MEDS	no crepitus felt. no palpable steps
unasyn	per radiology = skull film c̄ non displaced fx of left maxillary sinus.
	(R) EOMI Pupil reactive to light.
	A/P [redacted] (b)(6)-4 yo/m c̄ (L) eye blindness c̄ left temporal wound c̄ purulent exudate
	(1) will irrigate wound & pack c̄ NS gauze
	(2) keep HOB ↑ 30°
	(3) Ophtho consult
	(4) ung tx for facial fx's needed
	(5) continue ABX. (b)(6)-2 [redacted]
	(6) Δ NS gauze daily [redacted] ORAL & MAXILLOFACIAL SURGERY

STANDARD FORM 509 (REV. 5/1999) BACK

(b)(6)-4 USAPA V1.00

[redacted]

PROGRESS NOTES

DATE	
18APR03 2218	VSS. T slightly elevated @ 55° and provided Tylenol for pain relief. IV Heparinized per doctor's order. Placed in restraints ad libitum for patient safety and hospital protocol. PSG placed to (L) side of temple to absorb serosanguinous drainage. Continue to monitor on shift protocol. [redacted] SV
0130	Pt remained awake and complained of burning on both VE restraints. Interpreter interpreter to reiterate policy for restraints. Reluctantly complied. Appeal terminated for slap and refused. 550cc output of urine and received 50cc of Urosp. DSG on (R) temple dry and intact. [redacted]
19APR03 0630	VS 99.9 95 123/78 20@98% [redacted] (b)(6)-2 Pt alert and oriented. (R) Pupil 2mm Brisk (L) Pupil 4mm Fixed Pt states "bad eye" by gesturing c̄ hand. (L) Eye c̄ edema and ecchymosis closed cannot open spontaneously. S1, S2 Present MAE Pulses 2+ all extremities. Lungs B/L CTA x(5). GI BS(+) Bm the AM @ 0620. GU Voides spontaneously to urinal. Pt with restraints per hospital protocol. q 2hr circ checks done throughout night. Good Circ; c̄ 3 secs cap refill fingers slightly cold. Will continue to monitor [redacted] (b)(6)-2 URINE OUTPUT 150cc Amber Urine. [redacted]
0830	URINE OUTPUT 200cc Light amber urine [redacted]
0900	Pt had small soft brown BM. Pt had no complaints per interpreter. Pt used BSC [redacted] (b)(6)-2
0910	Dressing Change: Pt c̄ 2x2 to left side of face beside eye. Drsg removed serosanguinous and purulent drainage on dressing. Wound approximately 2" c̄ minor areas of pink tissue and small [redacted] (b)(6)-4

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
	amount of purulent drainage @ site. Dress change q shift.
	Will monitor for drainage and Δ PRN. [redacted] (b)(6)-2
0930	Urine Output 75cc [redacted] (b)(6)-2 [redacted]
0930	Circulation Check done for restraints. Pulses 2+ to BUE,
	Cap Refill ≤ 3 secs. [redacted] (b)(6)-2
1130	Circ Check restraints loosened, taken off and reapplied [redacted] (b)(6)-2
1145	Dr. [redacted] (b)(6)-2 came to irrigate wound to (L) face. Packed c̄ NU
	GAUZE and covered c̄ 4x4. Will monitor for drainage and reinforce.
	PRN. [redacted] (b)(6)-2
1200	Pt ~~BM~~ loose stool dark brown. This is Pt 3rd BM today.
	Will continue to monitor. Pt tolerated lunch Effort affecting
	ate approx 75% of lunch. [redacted] (b)(6)-2
1400	V/S B/P 113/67, P 92, R 18, Pt continues to sleep - [redacted] (b)(6)-2
1415	Circ Check. Restraint removed and replaced. 2+ Pulses Cap Refill
	≤ 3 secs. [redacted] (b)(6)-2
1600	Circ check Restraints removed and replaced. 2+ Pulses Cap Refill
	≤ 3 secs. [redacted] (b)(6)-2
1615	Pt resting quietly medicated ~~4~~ Tylenol 650 mg for H/A. Drains to
	@ Face Reinforced, NSD. Continue to monitor [redacted] output
1655	Total UO 150cc — Input (b)(6)-2
	200cc — 100cc NaCl
	75cc — 100cc NaCl (b)(6)-2
	425cc — 240cc H2O [redacted]
	850cc TOTAL (continue on reverse side) — 440cc TOTAL

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

REGISTER NO.

WA [redacted]

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

19 Apr 03 ED Note

S: Iraqi freedom fighter injured 24 hrs ago in blast injury. Only injured (R) eye. State via interpreter that can only see some light. mild pain

O: (R) eye: (+) swollen bilateral lids ↑ > ↓ c̄ singe; EOMI but pupil dilated & unreactive

(-) photophobia (-) obvious globe penetration. X-ray reported (-) for fb

(-) obvious fb seen in cornea. (-) hyphema (-) d/c seen

Orbital floor & roof - nontender; (-) step off palpated

A: Traumatic blast injury to (R) eye

Unreactive pupil ? 2° to blast (traumatic mydriasis)

Globe appears intact

Probable corneal abrasion / burn

P: Light patch to eye

Bent Ophth ointment q 4°

Eye irrigated

Needs ophth consultation

(b)(6)-2

[redacted]

MAJ MC

FP/Spontaneous

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.

Civilian Iraqi

(b)(6)-4

[redacted]

PROGRESS NOTES
Medical Record

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

[redacted]

LAST NAME	FIRST NAME	MIDDLE	ID NUMBER

DATE	NOTES
19 APR 03 1820	USS. T-98.5, BP-113/63, P-51, R-18. AO. Obeys & follows commands. (L) eye DSG dry & intact. Provided tylenol for pain relief of headache. LS clear bilaterally. S_1, S_2. (-) murmur or ectopy. OSOX4. Voiding adequately. 500cc urine output - clear yellow. (+)2 pulses in all extremities. Continue to monitor and provide DSG Δ as scheduled. [redacted] (b)(6)-2
2205	DSG Δ. (R) pupil is fixed & nonreactive to light. Very red and cloudy over cornea. Tetracaine ointment placed. 4 mm open. [redacted] (b)(6)-2
20 Apr 03 0530	Pt received resting in bed c̄ DSG to (R) eye clean, dry, & intact. V/S B/P 90/42, P 63, R 18, Temp 97.9. C/O slight pain in (R) eye. S_1 S_2 ō ectopy. Lungs CTA bilaterally. Abd round, soft, & non-tender. No BM noted since admission. (R) pupil 2-3mm & brisk. Will continue to monitor (b)(6)-2 [redacted]
1400	Pt continues to rest in bed. V/S B/P 98/46, P 59, R 16, Temp 98.3. Will continue to monitor (b)(6)-2 [redacted]
1420	Pt voided 680cc of amber colored urine [redacted]
1630	(R) eye dsg A'd & gent. ointment applied. Pupil 4mm & fixed. Denies discomfort @ present time (b)(6)-2 [redacted]
20 Apr 03 1745	Pt received resting in bed. A&O x3, OD Bx c̄ gauze bandage and eye shield, pt os reactive to light and accomodates. OD experiences pain during cardinal testing when pen moves towards nose. Lungs CTA B/L. S_1 S_2 present rate rythum regular. Upper & Lower extremity pulses +2 equal. Skin warm & Dry to t[redacted] c/o pain to OD. Will continue to monitor [redacted] PFC LPN

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

[redacted]

PROGRESS NOTES

DATE	
	OMFS Procedure note
20Apr 03 @0848	Pt c̄ purulent ② face wound. removed dressing, irrigated & repacked c̄ nu gauze. ↓ purulent exudate noted. still awaiting evac for opthto consult. ① continue dressing Δ's. (b)(6)-2
	[redacted] MAJ/DC
1835 20Apr 03	HR 90 SpO2 98% RA NBP 118/74 (90) T= 98.0 oral - LT [redacted]
2000 20Apr03	N-alert, oriented, appropriate behavior for situation, (b)(6)-2 nonaggressive or violent. CV - S1 S2 no murmurs or extra heart sounds noted, pulses 2+ throughout. Resp: CTA bilat, SpO2 795% RA GI/GU: spont void, cyu, voids q 2-3 hrs ō BM x2 since 1700. BS x4 quads, SNTND. ~~Intg: RLE wrapped, able to move toes, skin warm + dry throughout. 2-3+ edema to RLE noted.~~ [redacted] (b)(6)-2
	Integ: Intact, OS/cheek bandaged, CDI ō packing. - LT [redacted]
2000 20Apr 03	U/O 400 cc CYU ——— LT [redacted] (b)(6)-2
2242 20Apr03	HR: 76 NBP 145/67 (94) RR: 12 SpO2 98% RA T: 98° oral - LT [redacted]
0400 21APR03	U/O 400 cc CYU ——— LT [redacted] AN
0430 21APR03	Total U/O 800 cc ——— LT [redacted] (b)(6)-2 AN
0550 21 April 03	Pt alert c̄ arousal. Appropriate and cooperative. Pt is non aggressive and cooperative. ⓡ eye moves appropriately & PERRLA. ⓛ eye is unresponsive to light. Eyelid to ⓛ eye does not open spontaneously. Breath sounds clear to all fields. HR regular. Breathing is even and HR=88 BP= 126/76 (91) RR=16 T=97.8 oral. Sa=98% RA ——— unlabored. Bowel sound (+) x4 quads. Pt voiding ~~[illegible]~~ assistance. Voiding 100-200 cc at a time. Equal strength and pulses to all extremities. Wound to ⓛ cheek urinally covered. Nickel-sized serous drainage to bandage. ——— (b)(6)-2 [redacted] LT, AN
0745 21 April 03	BM large, 300 cc uop. ——— [redacted] LT AN

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
19APR03 1625	CONT'D PT resting quietly. Significant swelling of left eye PT able to open left eye still unable to see. Pupil Nonreactive Related c 4mm [redacted] (b)(6)-2
19Apr 03	1745 Pt lying in bed A&O x3 (R) Pupil [redacted] reactive to light. 2mm in size. (L) Pupil dilated at 4mm non reactive to light. 4x4 gauze to Left side of face CDI. Lungs CTA B/L $S_1 S_2$ present. Denies pain at this time. Will continue to monitor. — [redacted] (b)(6)-2 9WMB PFC
19Apr03	2200 VS 112/65, 91 HR, 14 RCSP @ 98% SPO_2 on RA Temp 98.8°F (O) [redacted] PFL
20Apr03	UOP 950 cc's Total Intake 200 IV (b)(6)-2 600 PO 800 cc's Total [redacted] PFL LPN (b)(6)-2
20APR03 0630	VS HR95 B/P 119/77, R-19, 98% RA, T-98.3 oral. PT AAO, RT pupil round reacts to light 4 cm LF eye ~~bandaged~~ dilated @ 4cm does not react to light. (b)(6)-2 [redacted]
OUTPUT -450 -200	$S_1 S_2$ present ∅ extra sounds, PPP x4 extremities Bilat equal/strong, BBS CTA ∅ equal chest wall expansion. Bowel sounds present x 4 quad. Voiding clear yellow urine via urinal. I.V. HL RT AC ∅ s/s of inf/inf skin warm/dry/intact. ∅ complaints of pain at present will continue to monitor. — SGT [redacted] LPN
1408	VS HR90 BP 127/69 R-20 98% RA T-98.6 oral — SGT [redacted] - LPN (b)(6)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

MEDICAL RECORD	PROGRESS NOTES

DATE

21 1025 April 03 Dressing Δ to (L) maxilla completed. Old dressing had large amount of purulent drainage to exterior bandages. Nasal gauze from wound also had yellow, purulent drainage. Nasal gauze & 2x2 gauze replaced using sterile technique. Tylenol 650mg PO given post-procedure for pain. [redacted] —ICD AN

(b)(6)-2

Transfer Note

21 Jun 03 20 yo Iraqi s/p GSW & (L) face ~ 1 qual. 2 wks later last night in (L) eye, presented to CSH 18 Jun c̄ purulent wound (L) face, ptosis, scleral + blindness of (L) eye. He has had wound I+D, packed, + has been on Unasyn 3 gm IV q6°. Blindness is felt to be 2° to possible/probable effect behind eye, but he hasn't been seen by an ophthalmologist.

[redacted]

(b)(6)-2

(Continue on reverse side)

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

[redacted]

(b)(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
21 1010 April 03	Concur c̄ the assessment by SGT [redacted] as noted @ 0630. Pt will continue to be monitored until ophthalmology can be arranged or pt. is discharged. [redacted] (b)(6)-2
21APR03@1400	VS HR 47 BP 113/53 R-13 98% RA T 98.7° oral – SGT [redacted] (b)(6)-2
21APR03@1700	PT complained of pain @ eye was given Tylenol will continue monitor – SGT [redacted]
21 April 03 1700	Assumed care of pt. (+) facial grimacing, Bilat hands grasping (@) eye. Tylenol PO administered per off coming shift Nurse per PRN protocol.
BP 108/54 1800	Pain assessment pending. [redacted] (b)(6)-2
HR 47 1800	Pt sleeping quietly responds spontaneously to environmental
T 97.9°F	stimuli. No nonverbal indicators of pain evident. Eye patch
RR: 12	in place, intact. LS clear throughout. S_1S_2 present, ↓BS.
SpO2: 98% RA	Ø UOP Ø BM this shift will monitor throughout. CR ≤3 sec
Ø PIV;	Bilat U/L extremity pulses strong, +2 x 4; Bilat U/L extremities
equal	strength intact, strong. Pt consuming every meal w/out problems
Pt.	Monitoring to cont. throughout shift – [redacted] (b)(6)-2
2000:	Pt sleeping quietly. No evidence of pain or discomfort
	UOP – 500 clear amber urine Ø BM. Monitoring to [redacted]
2200:	Pt sleeping w/out evidence of discomfort – Sent opth. (b)(6)-2
	ointment placed to (R) eye. Pupil non reactive to light.
	(+) redness & tearing. Eye repatched. Tylenol 500 mg PO (b)(6)-2
	administered, pt encouraged to sleep. – [redacted]
0200	Pt continues to sleep w/out evidence of pain – [redacted]
0445	Pt sleeping w/out evidence of needs – [redacted]
22APR03 0545	VSS- BP- 103/44 HR: 56 POx: 96% RA TEMP: 97.5 R: 17 (b)(6)-2
	PC. A&O x3. (+) PUPIL REACTIVE TO LIGHT. (P) EYE COVERED BY

(Continue on reverse side)

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

[redacted]

(b)(6)-4

Civ #[redacted]

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	
	PATCH WHICH IS CLEAN AND INTACT. LUNG SOUNDS CLEAR TO AUSCULTATION, S_1-S_2 STRONG AND REGULAR. HYPO ACTIVE BOWEL SOUNDS x 4 QUADRANTS. + PULSES DIALPAPLE IN ALL EXTREMITIES. SKIN WARM TO TOUCH. (b)(6)-2 PT RESTING COMFORTABLY. WILL CONTINUE TO MONITOR — [redacted] SGT, USA
22APR03	0725 - GAVE PT 500mg TYLENOL FOR PAIN. — (b)(6)-2 [redacted] SGT, USA
22APR03	0900 - PT TOOK EYE DRSG OFF. REDNESS NOTED IN EYE AND TEARING. ADMINISTERED GENTAMYCIN AND NEW DRSG. — (b)(6)-2 [redacted] SGT, USA
22Apr03	S) 3yo Iraqi civilian 9 day SP ocular injury gross - gr 2 upper sup eyelid edema gr 3+ diffuse bulbar ~~inj~~ injection iris - fixed & dilated K - chr stain blood visible in A/C, complete traumatic cataract. pain ↑ since yesterday c/o feeling pressure in eye
	A) traumatic eye injury ⊃ resulting traumatic cataract ⊃ reduced light perception vision (permanent)
	P) Dr Ed - keep inpatient x 3-4 days gent ung q 4-6 hrs for comfort, watch for ↑ in conj injection / pain level if so treat for pos. endophthalmitis not likely, b/c not evidence of penetrating foreign body. → fortified topical tobramycin or ~~subjong~~ subconj. AB injection.
	(b)(6)-2 [redacted]

STANDARD FORM 509 (REV. 7-91) BACK
[redacted] PC 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
20 Apr ~~1755~~ PT			Pt received 500 mg Tylenol for [redacted] (b)(6)-2
1755			to OD. Will monitor for effectiveness. [redacted] LPN
20 Apr 03	2210		VS BP-102/49, HR 50, 12 Resp @ 98%
zt			SpO_2, Temp 96.2°F (O) [redacted] PPL LPN (b)(6)-2
21 APR 03	0630		VS HR-50 BP-98/42, R-14 98% RA, T 97 oral, PT AAOx3
			PERLA 3cm, S_1 S_2 present PPPx4 extremities Right equal/strong
			BBS-CTA ē equal chestwall expansion. Bowel sounds present
			x4quad ø distention noted. skin warm/dry/intact. 18ga IV
			Right AC HL ø s/s of inf. ø complaints @ present, will continue
			to monitor ——— SGT [redacted] 91WM6-L1
			(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)

[redacted] (b)(6)-4

REGISTER NO.

WARD NO.

NURSING NOTES

Medical Record

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

MEDCOM - 8115

MEDICAL RECORD	PROGRESS NOTES
DATE	(b)(6)-2
221030 Apr 03	Concur c̄ SGT [redacted] assessment. Will continue to monitor for endophthalmitis as discussed c̄ optometrist. (b)(6)-2 [redacted]
22 APR 03 1245.	Pt TOLERATED REF ALER. RESTORE COMFORTABLE CN BILO AWAITING [redacted]

(b)(6)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

Civ # [redacted] (b)(6)-1

PROGRESS NOTES
Medical Record

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

558-104

7540-01-075-378

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: M

AGE

DUTY/LOCAL PHONE — AREA CODE | NUMBER

HOME PHONE — AREA CODE | NUMBER

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			✓
FLYING STATUS			✓

MEDICAL HISTORY OBTAINED FROM

ARRIVAL

DATE *(Day, Month, Year)*: 18 Apr 03 | TIME: 2000

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: GSW

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT

c/o 17 day old wound to left side of face in front of ear

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☒ NON-URGENT

TIME: 2000

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

VITAL SIGNS

TIME	2000				
BP	137-88				
PULSE	118				
RESP	16				
TEMP	97.0				
WT	100#				

LAB ORDERS

✓ CSC/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	X	skull AP + Lat

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
2030	3.0 gm vancyn IV	[redacted]			
2030	Irrigate wound 250 cc NS		SSG [redacted]	2035	wound cleaned
		(b)(6)-2	(b)(6)-2		

DISPOSITION: ☐ HOME ☐ FULL DUTY

DISPOSITION QUARTERS /OFF DUTY: ☐ 24 HRS. ☐ 48 HRS. ☐ 72 HRS

MODIFIED DUTY UNTIL

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)*

Iraq! EPW

[redacted]

[redacted] (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)

(b)(6)-4 [redacted]

MEDCOM - 8117

NSN 7540-01-075-3786

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

PATIENT'S HOME ADDRESS OR DUTY STATION				ARRIVAL	
STREET ADDRESS				DATE *(Day, Month, Year)* 19 APR 03	TIME 1000Z
CITY	STATE	ZIP CODE		TRANSPORTATION TO FACILITY	

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

CHIEF COMPLAINT

~~SHRAPNAL SHRAPNAL~~ SHRAPNAL WOUND TO RIGHT EYE

CATEGORY OF TREATMENT		VITAL SIGNS					
☐ EMERGENT	TIME (b)(6)-2	TIME					
☐ URGENT		BP 120/37					
	INITIALS	PULSE [redacted] 62					
☐ NON-URGENT		RESP 24					
		TEMP 98.9					
		~~WT~~ SPO2 99					

LAB ORDERS													
		CBC/DIFF		ABG		PT/PTT		BHCG/URINE/BLOOD/QUANT		X-RAY ORDERS		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

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 0956	I have received and understand these instructions.		
		PATIENT'S SIGNATURE		

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

EPW [redacted]
(b)(6)-1

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Doctor)*	TIME SEEN BY PROVIDER 0940

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

S: Strong Freedom fighter s/p minor blast ∅ & Right eye/FB ∅
(R) Eye pain FB rule

O: VS: Ok as above

HEENT ∅: (R) eye ∅ dilated irregular pupil ∅ EOM ∅ conjunction
Globe grossly intact ∅ lesion
(O) eye EOMI, PERRL ∅ injury identified
Oral mucosa intact ∅ bleeding signs

Resp: CTA (B) Chest: ∅ abnormal Back: ∅ injury

Ext: ∅ pain ∅ palpation

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

[redacted]

DIAGNOSIS

P/P (1) (R) eye foreign body - penetrating
- Evaluation tools for ophtho consult

CODES (5)(6)-2

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

- Eye shield applied removed
TC at next level. Being escorted
5 5 ↑ pending

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

558-104

7540-01-075-378

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: M

AGE: 18

DUTY/LOCAL PHONE: AREA CODE | NUMBER

HOME PHONE: AREA CODE | NUMBER

ARRIVAL

DATE *(Day, Month, Year)*: 19APR03 | TIME: 1355

TRANSPORTATION TO FACILITY

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			

MEDICAL HISTORY OBTAINED FROM

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS

ALLERGIES

CHIEF COMPLAINT

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 INITIAL SERIES ☐ YES ☐ NO

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☒ NON-URGENT

TIME

INITIALS

VITAL SIGNS

TIME	1350				
BP	119/57				
PULSE	59				
RESP	12				
TEMP	98.5				
WT	99 lb				

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. ☐ 72 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 [redacted] SSN or other); hospital or*

[redacted]

(b)(6)-4

[redacted]

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)

[redacted]

MEDCOM - 8120

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

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

18yo ♀ ☿ injury + (R) eye ~~A~~ 0×3, ∅SOB, RA c/o ∅ sight in (R) eye; Tetracain administered c̄ relief. Pt wait further MD orders. [redacted] 2LOA

(b)(6)-2

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

DIAGNOSIS

CODES

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)

[redacted] (b)(6)-4

[redacted]

NAME: [redacted]

[redacted]

TRAUMA FLOW SHEET

DATE: TIME:

INITIAL ASSESSMENT

Airway: open

Breathing: EQUAL clear

Circulation: (+) 2 in ad extremities

Disability: (* E/V/M = Glasgow Coma Scale) CIRCLE (14)

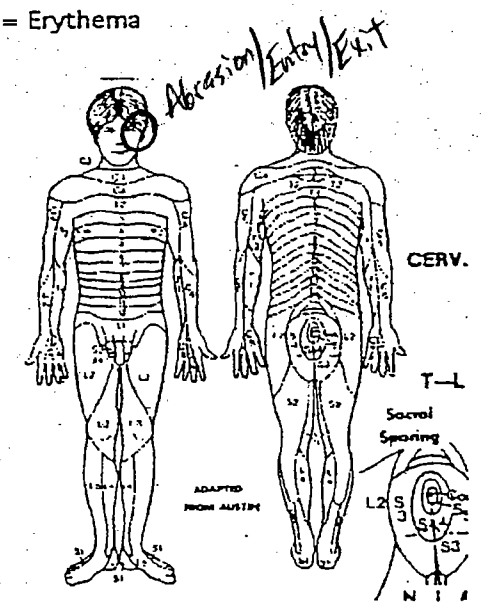
Eyes Open	Verb. Resp.	Motor Resp.
(4) - Spontan.	5 - Oriented	(6) - Obey Commands.
3 - To Speech	(4) - Confused	5 - Localize Pain
2 - To Pain	3 - Inapprop. Words	4 - Flex Withdraw
1 - None	2 - Incomp. Sounds	3 - Flex Abnormal
0 - Closed by Swelling	1 - None (ETT or Trach)	2 - Extension
		1 - No Response

Vitals:

Time	2115				
Pulse	94				
Resp	18				
BP	124/81	/	/	/	/
Temp	99°				
Rhythm	NSR				
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: NKDA

Meds: ▯ None

Tylenol PO

Unasyn IV

Past: ▯ Noncontributory

Hx:

Last Meal: Unknown

Event: Date: 1 APR 03 Time:

Pt stated GSW to Head

Ex affecting (2) eye

Tetanus:

Physical Examination

Head	▯ Normal	
Neck	☑ Normal	
EENT	▯ Normal	(1) Pupil fixed @ 4mm (2) pupil is reactive
Chest	☑ Normal	
Cardiac	☑ Normal	
Abdom.	☑ Normal	
Pelvis	☑ Normal	
Back	☑ Normal	
Genit.	☑ Normal	
Neuro.	▯ Normal	AOX2 - appears confused via interpreter
Extrem.	☑ Normal	

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

[redacted] [redacted]

(b)(6)-2

TEST(S)

SPECIMEN TAKEN

DATE 18 APR 03 TIME 2000 A.M. P.M.

REQUESTED

[redacted]

RESULTS

WBC 13.3
RBC 4.71
Hgb 12.6
Hct 41.5
MCV 88.1
Plt 393
Lymph 26.9

Glu 115
Bun 14
Creat 0.6
Ck 273
Na 139
K 4.6
Cl 102
CO_2 24

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

557-107

REMARKS [redacted]

CBC

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

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

REPORTED BY

MD DATE

TECH 18 APR 03

[redacted]

(b)(6)-4

MISC

URGENCY ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT

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

SPECIMEN SOURCE (Specify)

LAB ID NO.

SPECIMEN/LAB RPT. NO.

PATIENT'S MED. RECORD

NSN 7540-01-165-7294 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN *(Sponsor)*	WARD/CLINIC	REGISTER NO.
Skull xray anterior view Orbit	M		[redacted]	EMT	
	FILM NO. (5)(6)-4				PREGNANT ☐ YES ☐ NO
	REQUESTED BY *(Print)* [redacted] (5)(6)-2				TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR [redacted]				DATE REQUESTED 18 Apr 96

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

Ⓓ side wound to head 17 day old?

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*
18 Apr 96		

RADIOLOGIC REPORT

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

RADIOLOGIC CONSULTATION REPORT
MEDCOM - 8124
PATIENT MEDICAL RECORD

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW 1		

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
18 Apr 03	HOURS	
1 Admit (ICW)		
2 Dx = GSW Laceration / (R) eye Blindness / (R) skull FX		
3 Cond = stable		
4 VS = q shift		
5 Allergies = NKDA		
6 Nursing: Keep pt's head up in bed		
7 BRP, Ablib pain restraints SOP		

PATIENT IDENTIFICATION

[redacted] (b)(6)-4 [redacted] (b)(6)-2 2148 18 Apr 03

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
7. Diet = Reg	HOURS	
8. IV = heplock		
9. Drsg Δ to (L) face q shift		
10. Meds = Tylenol 325mg ii po q4° PRN		
Unasyn 3.0gm IV q6° 6-12-18-24		
(b)(6)-2 [redacted]		
[redacted] MAJ, MC FAMILY PRACTICE		

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.
ICW 1		

DATE OF ORDER	TIME OF ORDER	
18 APR 03	2300 HOURS	[redacted] 1158 03
(1) Benadryl 50mg po XT prn insomnia.		[redacted]
~~19 April 03 Earl OKP~~		(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
19 April 03	1158 HOURS	
(1) irrigate (L) face wound		
CNS and Δ nucomse		(b)(6)-2
dressing qd [redacted]		
[redacted] ORAL & MAXILLOFACIAL SURGERY		
(b)(6)-2		

Ø38

NURSING UNIT	ROOM NO.	BED NO.

24hr done 21 Apr 03 0650 [redacted] /JAN

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

19 Apr 03 (b)(6)-2

☆ U.S. GOVERNMENT PRINTING OFFICE [redacted]-710

MEDCOM - 8125

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

Iraqi civilian

[redacted]

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 19 April TIME OF ORDER: 1800 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit - ICW 1 ✓
2. Dx: (R) eye injury ✓
3. Cond: stable ✓
4. Wtch: q shift ✓
5. All: NKA ✓
6. Actv: ad lib ✓

PATIENT IDENTIFICATION

DATE OF ORDER: TIME OF ORDER: HOURS

7. Nursing: eye dressing change qd. ~~+ surgical wound care~~ ✓
8. Diet: regular ✓
9. IV: heplock p̄ 1 liter done ✓
10. Med: Erythromycin ophth ointment: small ribbon to (R) eye q6 hrs. — 4, 10, 16, 22

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2 [redacted] 19 APR 03

PATIENT IDENTIFICATION

DATE OF ORDER: TIME OF ORDER: HOURS

11. Labs - none noted
12. Tylenol 500mg po q 8° prn pain

(b)(6)-2 [redacted]

MAJ, MC
FP/Spouted

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 20 APR 03 TIME OF ORDER: 1633 HOURS

1. D/C IVF
2. D/C IV [redacted]
3. D/C when transportation available

(b)(6)-2

[redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

24 V done 21 Apr 03 0655 [redacted] CPT/AN

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	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] (b)(6)-4 [redacted]	Iraqi EPW ICW 1			21 Aug 93	1200 HOURS	
				① Transfer to ASMC/civ hospital per AAD		
					(b)(6)-2 [redacted]	[redacted]
PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	
[redacted] (b)(6)-4					HOURS	
PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	
[redacted] (b)(6)-4					HOURS	
PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	
[redacted] (b)(6)-4					HOURS	

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

MEDCOM - 8127

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

Civ # [redacted]

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW /	[redacted]	

DATE OF ORDER 4/22/03 TIME OF ORDER 0730 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Tetracaine eye gtts - 4 gtts to Right eye q 30 min prn.
2. Percocet 1-2 po q 4-6° prn pain (b)(6)-2 [redacted]

PATIENT IDENTIFICATION [redacted]

(b)(6)-2

1LT, AP 22 April 03 1239

DATE OF ORDER 22 Apr 03 1230

1. Patient stable for transfer to Optometry section @ 54th ASMC
2. Patient may be DCd from ASMC if approved by optometrist [redacted]

(b)(6)-2 [redacted]

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

NURSING UNIT	ROOM NO.	BED NO.

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. 4 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 18	19	20	21
4/18	[redacted]	VS : Qshift	06	/ [redacted]			
			14	/			
			22				
4/18	[redacted]	Nsg : Keep pts head up in bed	05	/ [redacted]			
			17				
4/18	[redacted]	BRP ; ad lib per restraints SOP	05	/ [redacted]			
			17				
4/18	[redacted]	Diet : Regular	08	/ [redacted]			
			12	/			
			18	/ [redacted]			
4/18	[redacted]	Dsg Δ to (L) face q shift	10	/ [redacted]			
			22				
4/19	[redacted]	Irrigate (L) Face Wound c NS & Δ nugauze dsg qd	10	/ [redacted]			
				/	/	/	
				/	/	/	

(b)(6)-2

Δ'd 19 Apr 03 1200

(b)(6)-2

ALLERGIES: ☐ YES ☒ NO	PRIMARY DIAGNOSIS:	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
NKDA	GSW laceration / (L) eye blindness / (L) skull fx	PAGE NO: 1

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo Apr Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
4/18	[redacted]	Admit ICW; cond: stable	—			[redacted]
	(b)(6)-2					(b)(6)-2
	.....					
	.....					
	.....					
	.....					
	.....					
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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. 4 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 18	19	20	21
4/18	[redacted]	IV: Heplock	05	/	[redacted]		
			17	[redacted]			
4/18	[redacted]	Unasyn 3.0gm IV	06	/	[redacted]		
		96°	12	/			
			18	/			
			24	[redacted]			

(b)(6)-2

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: GSW laceration / (L) eye blindness (L) skull fx

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

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. APR Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
18APR	[redacted]	~~Benadryl 50mg po x 1 prn insomnia~~	~~18APR~~	~~2300~~	~~2320~~	[redacted] PT refused
	(b)(6)-2					(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
4/18	[redacted]	Tylenol 325mg ii	date	18APR	19APR	20APR	20 Apr	21 April							
	(b)(6)-2	PO 94° PRN	time	2215	1250	1215	2230	[redacted]							
			dose	2T	ii	ii	ii	ii PO							
			init	[redacted]											
					(b)(6)-2										

USAPA V1.00

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. 83

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 19	20	21	22	23
4/19	[redacted]	Vitals q shift	06	✓	[redacted]			
			14	✓	[redacted]			
			22	[redacted]				
4/19	[redacted]	Act: ad lib	05	✓	[redacted]			
			17	[redacted]				
4/19	[redacted]	eye dressing change QD	10	✓	[redacted]			
4/19	[redacted]	Diet: Regular	06	✓	[redacted]			
			12	✓	[redacted]			
			18	[redacted]				

(5)(c)-2

(5)(c)-2

ALLERGIES: ☐ YES ☒ NO

NKA's

PRIMARY DIAGNOSIS: (R) eye injury

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

Iraqi civilian [redacted]

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

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
4/19	[redacted]	Admit ICW ; Cond. stable				[redacted]
4/22	[redacted]	Patient stable for transfer to optometry section @				(5)(6)-2
	.....	[redacted] (5)(2)-2				
4/22	[redacted]	Patient may be DC'd from ASMC if approved				
	.....	by optometrist.				
	.....					
	.....					
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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. 4 Yr. 83

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

VERIFY BY INITIALING: ORDER DATE	CLERK/NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 19	20	21	22
4/19	[redacted] (b)(6)-2	IV: heplock ~ 1 liter done	05	/	[redacted]	D/C	
			17		[redacted] (b)(6)-2		
4/19	[redacted] (b)(6)-2	Gent. opth. ointment small ribbon to (R) eye Q6°	04	/	[redacted]		
			10	/	[redacted] (b)(6)-2		
			16	/	[redacted]		
			22		[redacted]		

ADDITIONAL PAGES IN USE: YES NO

PAGE NO.

ALLERGIES: YES NO

NKA

PRIMARY DIAGNOSIS: (R) eye injury

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

PATIENT IDENTIFICATION:

Iraqi Civilian [redacted] (b)(6)-4

USAPA V

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

DA FORM 4678, 1 FEB 79

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. 4 Yr. 03

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
4/19	[redacted]	Tylenol 500mg PO Q8° prn pain	date	15 APR	20 Apr	21 APR	21 APR	21 APR	21 APR							
			time	1545	1755	0510	1700	500mg 2230	CLAR 0125							
			dose	500	500	✓	✓	1 TAB	1 TAB							
			Init.	[redacted]												
4/22	[redacted]	Tetracaine eye gtts 4 gtts to (R) eye q30min prn.														
4/22	[redacted]	Percocet 1-II PO q4-6° prn pain														

(b)(6)-2

USAPA V1.00

ADMISSION AND CODING INFORMATION

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

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

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
	27Y	X	9	UNK

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	V	1952	Army (b)(6)-4

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K76	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
8 (b)(2)-2	ICW	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
[redacted]	

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYYYMMDD)
21		20030421

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
AAAA		20030418

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

FOR LOCAL USE

Dx C820
36960
36000
9213
V5419

Pr: 9659

GSW laceration / (L) eye blindness / (L) skull fracture

802.59
682.0
369.00
374.30
372.72
921.2
E991.2

86.28

(b)(6)-2

ADMITTING OFFICER [redacted]

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

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

MEDCOM - 8137

(b)(6)-4

PATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTRATION NO. [redacted]	2. NAME (Last, First, MI) [redacted] (Civ [redacted]			3. GRADE —	ADMISSION REMARKS
4. SEX M	5. AGE 25	6. RACE	7. [redacted] OF SVC	9. [redacted]	10. PREVIOUS ADMISSION NO
11. FMP 99 20	12. SSN (b)(6)-4	13. ORGANIZATION			14. WARD ICU 1
15. FLYING STATUS —	16. [redacted] RATING/ DSG —	17. DEPT/ BRN 1478 K76	18. BRANCH/CORPS —	19. UIC/ZIP —	20. TYPE CASE SI

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from ER

22. HOURS OF ADMISSION: 1730

23. CLINIC SERVICE: ABCA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: —

25. TYPE DISPOSITION: D/C HOME

26. DATE OF DISPOSITION: 15 MAY 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): —

27b. TELEPHONE NO.: —

28. DATE OF THIS ADMISSION: 25 Apr 03

ADMITTING OFFICER

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

30. DATE OF INTIAL ADMISSION

32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GUNSHOT WOUNDS X4

OPEN BILATERAL HUMERUS FRACTURES

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	20	20

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 OFFICER: [redacted]

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER: [redacted]

DA FORM [illegible] 79

(b)(6)-2

MEDCOM - 8138

(b)(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	(b)(2)-2 SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

251311 APR03 [redacted] AO Eagle 3 IRAQ

P: 120
B/P defered
Pox: 98%
T: defered
R: 12
Aller ?
meds: ?
LMP: Ø
PMH: Ø

5 Gunshot wounds from US Forces. Enemy POW ambushed US forces & shot in process.
1 wound back T4, 1 right Arm T1, Gunsht (R) Upper Arm,
Gunshot wound Lateral (R) side T4
Suggested Fracture (L)+(R) Arm, Gunshot wound (L) Forearm

Foley given 1328 Z → UOP 150cc
Ige Ancef
U/A - 30mg/dL prot, SG 1.030 pH 5.6
All else negative
50mg demerol
O2 given
Wounds dressed and reinforced, sam splints applied
Chest clear equal bilat.
(A) multiple GSW, (B) airway
(P) evac to [redacted] (b)(2)-2 for further care

(b)(6)-2
[redacted]
CPT, MC

(b)(2)-2
[redacted]

11 APR 03

2513

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

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

[redacted]

25 years old (b)(6)-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

25 APR 03 2200

BRIEF OP NOTE

PRE-OP DX: 1.) (B) HUMERUS FX'S (OPEN)

2.) GSW TO POST. THORAX → RLO INTRA-ABDOMINAL INJURY

POST-OP DX: (B) OPEN HUMERUS FX'S

PROCEDURE: 1.) EX LAP, DEBRIDEMENT (L) CHEST WALL WOUND

2.) I+D (R) HUMERUS FX c̄ EX FIX

3.) I+D (L) HUMERUS FX c̄ SPLINT

SURGEONS: [redacted]

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

INF: 2800cc LR EBL: 100cc UOP: 700cc

FINDINGS: 1.) NEG. EX LAP.

2.) TANGENTIAL (L) CHEST WALL WOUND

3.) OPEN (R) HUMERUS FX c̄ SATISFACTORY REDUCTION/FIXATION [redacted] (b)(6)-2

4.) (L) HUMERUS FX SPLINTED ~~in a long arm splint~~

DRAINS: Ø

COMP: Ø (b)(6)-2

DISP: TO ICU #1 [redacted] 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.

[redacted]

(b)(6)-4

OP NOTE
25 Apr 03

PROGRESS NOTES
Medical Record

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

(b)(6)-4
[redacted]

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
05Apr03 @2330	Pt. admitted to ICU ~~HO~~ from OR, S/P Ex Lab. V.S.S. upon arrival. Pt. arrived from OR or surgery c̄ & NRB at 15L O2 sat 100%. chest tube to 20cm of suction c̄ sanguenous fluid drainage. Dsg chest tube located on (R) side of chest; Dsg to chest tube ~~is~~ c̄ drainage. NGT to (R) nare to LIS. Dsg to mid abd is DRI. Fixator to (R) ~~side of~~ arm intact c̄ ~~drain~~ drainage noted to dsg. Splint to (L) side of arm intact. Pt. arrived c̄ LR infusing into IV in (L) foot; will continue to monitor. ——— (Pt [redacted] (b)(6)-2
26Apr 03 0600	Pt drowsy but able to voice concerns. Asking for something to drink and eat. Respirations unlabored c̄ BBS CTA. CT to (R) CW 15cm suction. Palpable pulses (B) abd soft c̄ drsg to midline ø drainage Ø Bowel sounds. Drsg to (R) CW bloody. foley cath to BSO. External fixator to (R) arm (humerus) and ace bandage in a sling to (L) arm. NGT LIS. IVF LR c 125/hr. No distress noted will continue to monitor ——— [redacted] (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

EPW

[redacted] (b)(6)-4

[redacted]

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

(b)(6)-4 [redacted]

LAST NAME	FIRST N.	MIDDLE INI.	ID NUMBER

DATE	NOTES
26 APR03	GENERAL SURGERY : POD #1
0715	(S) PT C/O (R) LWE PAIN
	(O) VS : Tc: 99° HR: 103 BP: 114/60 SaO2: 94% - RA
	NGT: 20 FOLEY: 600cc / 8 hrs CT: 95cc, small AIR LEAK
	EXAM: CHEST: CTA (B) - POOR INSPIRATORY EFFORT
	CARD: TACHYCARDIA, REG RHYTHM
	ABD: ∅ BS; SOFT, ND; DRESSING INTACT; EXPECT INCISIONAL PAIN c̄ PALP. EX: (B) DRESSINGS INTACT
	A/P S/P MULT. GSW c̄ (R) PTX, (B) HUMERUS OPEN FX
	- AGGRESSIVE PULM. TOILET
	- OOB IN CHAIR
	- CONT CHEST TUBE TO SUCTION
	- SIPS H_2O ; KEEP NGT
	(b)(6)-2 [redacted]
26 Apr03 1300	Pt lying in bed. O2 sats 92-93%. Per the interpreter pt. stating he has difficulty breathing RR 40-44. O2 applied. Respiration rapid but unlabored. BBS CTA c̄ equal expansion. Pt refusing to get OOB and not utilizing the incentive spirometer as instructed refusing to take deep breaths and cough. Medicated sporadically c̄ MSO4 for pain upon request. NGT remains to LIS. CT to 15cm suction no air leak noted. Dr [redacted] (b)(6)-2 notified. No orders c̄ present Angelu
1640	CT placed to water seal RR 20-30's. SaO2 92-93% RA. up to chair encouraging IS use c̄ little cooperation. Refuse to take deep breaths. coughed blood tinged sputum. Drsg to CT S'ed. No distress noted - [redacted]

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

(b)(6)-2 [redacted]

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

26 Apr 03 1730 Nursing Note: Pt. c̄ chest tube to (R) side of chest to H_2O Seal, Dsg to site is DRI. Dsg to abd area is DRI. Fixator, external, to (R) arm intact, no drainage noted. Splint to (L) arm is in place. NGT to ~~(L)~~ LIS. Foley to Gravity. Pt to R.A. O2 SATS >93%. V.S.S. will continue to monitor. ——— CPT [redacted]

(b)(6)-2

29 Apr 03 GENERAL SURGERY: POD #2

(S) PT c/o PAIN AT (R) ARM; Ø FLATUS/BM

(O) T: 98 HR: 94 BP: 159/73 SaO2: 93% - RA

CHEST TUBE: Ø AIR LEAK; 90 cc/24°

EXAM: CHEST: POOR INSP. EFFORT, Ø RHONCHI

CARD: RRR

ABD: HYPOACTIVE BS, SOFT, ND; EXPECTED INCISIONAL PAIN c̄ PALP; Ø EVIDENCE OF WOUND INFECTION

EX: (B) LE DRESSINGS INTACT

(A/P) DOING WELL S/P (B) PTX, EX LAP, (B) HUMERUS FX'S (OPEN)

- D/C NGT, FOLEY, CHEST TUBE - CLEAR LIQUID A[illegible]

- TO O.R. TOMORROW FOR [redacted] (b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME		SPONSOR'S ID NUMBER
	LAST	FIRST	[redacted]
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	R[redacted]	

(b)(6)-2

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

[redacted]

(b)(6)-4

PROGRESS NOTES
Medical Record

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

(b)(6)-4
[redacted]

LAST NAME	FIRST	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
27Apr03 0600	Pt resting comfortably in bed. Respiration even and unlabored breath sounds CTA (R). CT to ~~15cm suction~~ water seal. Abd drsg intact. ø drainage, NO, c̄ no bowel sounds. NGT to LIS c̄ grainy substances in tube (tan in color) Coughing blood tinged sputum. Palpable pulses. Ace wrap to (R) UE c̄ external fixator. (L) UE c̄ splint. foley cath to BSP ø sediments. Encouraging use of incentive spirometer c̄ minimal effort exhibited by the pt. Will continue to monitor (b)(6)-2 [redacted]
27Apr03 0820	Pt viewed by Dr [redacted] (b)(6)-2. SaO2 remain 90-92% RA. Interpreter explained the procedures (plan of care). CT removed and vaseline gauze c̄ 4x4 applied. NGT clamped and removed. foley cath removed. Upon auscultation diminished breath sounds to (R) lobes. Pt encouraged to deep breath and use IS. Not very cooperative c̄ IS use. Medicated sporadically c̄ MSO4. Will cont. to monitor (b)(6)-2 [redacted]
1600	Asleep c̄ intervals. Staples to midline abdomen. Drinking H2O on occasion. IVF cont. to infuse void 200cc yellow urine. No distress noted. O2 via NRB Mask. SaO2 99-100% (b)(6)-2 [redacted]
1830	Nursing Process Note; Pt. had chest X-Ray at ~~9~~ ≅ 1730 for S/P chest tube removal. Dsg to site is D+I. External fixator to (L) arm is in place and dsg is D+I. Splint to (L) arm intact. staples to abd intact. Pt. is on a NRB at 8L, O2 SAT 100%. Pt. will be NPO ~~p~~ midnight for surgery to (L) arm. — CPT [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00 (b)(6)-2

038

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
	HR 67 BP 149/61 98% R12
28 Apr 03 0600	Awake c intervals Respirations even and unlabored. Breath sounds on (R) diminished. CTA to (L) Dressing to (L) CW CDI. O2 via NRB mask c 10L. Sa O2 98-100%. Coughing bloody sputum. Palpable pulses. NSR Abd c̄ staples to midline. NPO for OR procedure. Drsg to (B) extremities (R) arm c̄ external fixator c̄ bloody drainage to elbow area. Splint to (L) arm. PIV 18G to (L) foot. LR 125/hr. (b)(6)-2 CXR done Will cont. to monitor — [redacted]
0800	pt Taken to OR via litter. IVF infusing. No distress noted
	[redacted]
28APR03	Brief Op Note (b)(6)-2
	Preop Dx: (B) open humerus fx's
	Postop Dx: same
	Procedure: ORIF (L) humerus fx, ORIF (R) humerus fx
	Surgeon: [redacted] (b)(6)-2
	Anesthesia: [redacted]
	EBL: 100 cc
	Fluids: 1400 cc
	Findings: highly comminuted fx (L) humerus
	Cx: Ø
	Postop Plan: Splint (L) UE 4-6 wks, nonop (R) Elbow
	Post op ADX Plan care

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 ID No or SSN; Sex; Date of Birth; FINDINGS 28 APR04

EGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

(004)
159/73
3b - 123 038 Tes

MEDCOM - 8145

LAST NAME	FIRST	MIDDLE INITIAL	ID NUMBER

DATE	NOTES

DATE TIME	BP	HR	RR	T	Onset	INTAKE	OUTPUT
05							
06							
07							
08							
09							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
01							
02							
03							
04							

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

MEDCOM - 8146

038

PROGRESS NOTES

DATE	
29Apr03 0830	Pt up to chair. AM care performed. Attempted BM loose watery brown colored stool. IVF cont. to infuse. Dsg changed incentive spirometer in use. ROM conducted to (R) UE and (L) hand. O2 changed to venti mask 40%. voiding freely NO (b)(6)-2 further changes [redacted]
29Apr 03 0900	Pt tolerated lunch w/ difficulty, up in chair 3°. Rash noted to (L) upper back area. Skin tear to (L) mid-back area (tape tear) bacitracin applied to site. No c/o pain. Temp 101° Dr [redacted] informed. Ordered to ↑ use of incentive spirometer. Will cont. to monitor [redacted] (b)(6)-2
29Apr03 2100:	Pt. had chest x-rays ordered. Radiologist and Dr. (b)(6)-2 [redacted] viewed the film. Pt. also coughed up blood, Dr. (b)(6)-2 [redacted] is aware. Pt. had temp of 101.7, and 975mg of tylenol po was ordered. Lung sounds diminished (R) side, staples to back is pt I and open to air. Dsg to (L) side of back will be Δ'd. (L) arm is immobilized, (R) arm remains c̄ external fixator and Dsg is Pt I. will continue to monitor. CPT [redacted] (b)(6)-2
30 Apr03 0700	GEN SURG: POD #5/2
	FEVER TO 102°; TOLERATING REG DIET
	T: 102 HR 88 SaO2: 100% - FMO2
	XM: CARD: RRR
	CHEST: ↓ BS - (R) CHEST; GRANULATING (L) CHEST WALL WOUND
	ABD: NONDISTENDED, NABS, EXPECTED INCISIONAL PAIN c̄ PALP; WOUND s̄ EVIDENCE OF INFECTION
	EX: (R) UE DRESSINGS INTACT
	XR: RLL INFILTRATE
	H/P S/P GSW c̄ (R) HUMERAL FX, (-) EX LAP, NON c̄ FEV s̄ [illegible] PNEUMONIA [illegible]

Post-OP pneumonia RLL 2/52

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
28Apr03 1320	Pt returned from OR. Awake ~~AOX3~~ alert, reporting pain Respirations unlabored. O2 10L face mask. VSS T98 R36 BP 159/73 SaO2 100% P123. Splint c̄ ace bandage ⊕ (L) arm. (R) arm c̄ external fixator. IVF NS infusing. No further changes — [redacted] CPT
1330	Rec'd Demerol 12.5mg for shivers and % pain voided (b)(6)-2 220cc urine. VSS ~~AH~~ — [redacted] CPT
28Apr03 1600	Pt resting c̄ intervals VSS. No changes in status Rec'd MSO4 for % pain Will cont. to monitor status for changes — [redacted] CPT (b)(6)-2
28Apr 2215	NPN: Pt. has V.S.S. Drg to CSW to (L) side of back ~~is~~ was changed. Ø signs of infection noted. Drg to forme chart tube side of (R) side is D&I. Pt. on 8L of O2 via NRB, O2 SAT 100%. Fixator to (R) arm c̄ drg is D&I. Splint to (L) arm intact. Pt. ate dinner and tolerated well. Will continue to monitor. — CPT [redacted] (b)(6)-2
29Apr03 0700	Pt asleep at intervals. O2 via NRB mask c̄ 10L. Respiration even and unlabored. Diminished breath sounds to (R) lobes. Palpable pulses. Hypoactive bowel sounds Tender to palpation Midline abd c̄ staples. Drg to (L) lateral CW and (R) CW. (R) arm c̄ ace bandage and external fixator (L) arm c̄ splint and ace bandage. Foley cath to BSD. Tolerated Breakfast well Will cont. to monitor [redacted] 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)

REGISTER NO.

NO. (b)(6)-2

#[redacted] (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	
30 Apr 03 0600	Resting comfortably in bed. Respirations even and unlabored SaO2 95-98% RA. BBS CTA. Abd soft c̄ active bowel sounds. Tolerated meals fairly. Dsg to (R) arm CDI c̄ external fixator. (L) arm c̄ splint. Strong palpable pulses. Denies any pain. No distress noted will cont. to monitor (b)(6)-2 [redacted]
30 Apr 03 1300	Ambulated on unit. Chest PT performed. ROM conducted to (R) UE and (L) hand. Voiding freely. Coughing blood tinged sputum. Incentive spirometer in use. Tolerated activity well. IVF cont. to infuse. Will continue to monitor (b)(6)-2 [redacted]
30 April 03 1530	Pt given 4 puffs Albuterol MDI. Pt tolerated well but must improve effort to inhale puffs fully. Performed CPT to (b)(6)-2 (R) lower lobes and incent. spirometry. [redacted] RT
30 Apr 1800	NPN. Pt. c̄ staples to stomach DI&I and open to air. Breath sounds deminished at (R). Dsg to former chest tube site is DI&I. Dsg to (L) side of back is DI&I. Splint to (L) arm is intact. LR infusing at 125 cc/hr. will continue to monitor. [redacted] CPT
1 May 03 0600	Pt resting in bed. No discomforts voiced. Respirations even and unlabored BBS CTA. SaO2 100%. Coughing thick blood tinged to tarry colored sputum. Palpable pulses. Abd soft c̄ active bowel sounds. IVF LR infusing 125/hr No distress [redacted] CPT (b)(6)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE	
1 MAY 02	GENERAL SURGERY: POD #6; EDSYN D#3
	(S) GOB AMBULATING, TOLERATING REG. DIET
	(O) T: 100° HR: 61
	EXAM: CARD: RRR
	CHEST: L (R) BREATH SOUNDS
	ABD: NABS, SOFT, ND; INCISION INTACT c̄ EVIDENCE OF INFECTION; EXPECTED INCISIONAL PAIN.
	EX: DRY DRESSINGS TO (B) LE WOUND
	LAB: (4/30): WBC = 16,100
	(A/P) 6 DAYS S/P EX LAP, (R) LE EX. FIX, (L) LE PLATE
	- REPEAT CXR
	- CONT PULM TOILET (NT SUCTION CHEST PT)
	- HEPLOCK IV
	- D/C STAPLES
	(b)(6)-2 [redacted] MD
1 May 02 1000	Up to chair Chest PT done. O2 via venti c 4L. IV heplocked cont. c̄ antibiotic therapy. Staples to abdominal incision removed and steri-strips applied. Drsg changed. AM care done. Incentive spirometer in use. and albuterol MDI. Continues to cough blood tinged sputum. Will cont. to monitor [redacted] (b)(6)-2
1 May 02 1420	Performed CPT pt complained of pain Albuterol 4 puffs admin. and also coughing exercises and incent spirom. Pt tolerated well — [redacted] RT (b)(6)-2
1 May 02 1630	Pt up to chair 7° ambulated in corridor x2. Continues IV antibiotics. IV Heplock (R) hand ROM performed UE's. No complaints Will cont. to monitor [redacted] (b)(6)-2

91) BACK
USAPPC V1.00

MEDICAL RECORD	PROGRESS NOTES
DATE	
1-MAY03 1700	PT awake in bed, Ø c/o pain or requests. VSS. PT on 6LPM O_2 via venturi mask ē 100% SpO_2. PT' lungs are CTA on (L), (R) side has ~~lung~~ clear lung sounds in upper lobes but diminished in lower lobes. PT has Ø dyspnea at this time. Heart sounds S_1 S_2, RRR, I.V. heparin ∴ (R) hand, ABD soft, BS active x4, nontender, midline incision intact. PT urinated 300 cc clear yellow urine. (R) arm external fixator intact, (L) arm dressing ~~and~~ clots and is elevated. PT has +1 pitting edema in (B) hands and (L) foot. Pulses present x4 in extremities and cap refill is <3 seconds. (b)(6)-2 [redacted] SSG
1MAY 03 1800	RT does chest PT and administers Albuterol Tx. PT tolerates procedure and coughs up brown tinged sputum. PT ate salad and drank a soda. (b)(6)-2 [redacted]
1MAY 03 1930	PT uses IS, can get 2 balls elevated. PT assists ē RD with (R) arm and (L) wrist. (b)(6)-2 [redacted]
2230	C/o pain to left arm per interpreter. medicated with 2mg MSO4 IVP. Tol well. (b)(6)-2 [redacted] 1LT Hav.
0300	Assisted out of bed to commode, Client noted grunting and straining in attempt to move bowels. small formed BM noted. MD notified orders received for enlace. Client back to bed ē two assist. medicated ē enlace for stool softening. (b)(6)-2 [redacted] 1LT Hav.
0400	PT Asleep. VS 124/56 - 69 - 20 - 99% - SpO_2 99% 4LPM O_2 via venturi mask. PT still has ↓ lung sounds on the (R) lung. NO Δ's noted. [redacted] SSG (b)(6)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

ICh #2

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE	
0610	VS 74 122/46 2L 99%.
2 ~~APR~~ MAY 03	Pt awake in bed. NAD. Will continue to monitor [redacted] (b)(6)-2 [redacted] (b)(6)-2
2 MAY 03 0700	GENERAL SURGERY : POD [redacted]
	IMPROVED OXYGENATION
	T: 99° HR 74 BP: 122/46 SaO2: 99% - RA
	EXAM: SLIGHT ↓ BS (R) BASE
	RRR
	(+) BS; NONDISTENDED; (-) EVIDENCE OF WOUND INFECTION
	A/P S/P GSW → (R) HUMERAL FX, PNEUMONIA
	- DIC D2
	- ✓ CBC
	- IF WBC NORMAL → ORAL ABX (b)(6)-2
	[redacted]
2 May 03 0800	Pt up to chair Tolerating meals. Alert Respirations even and unlabored BBS CTA Palpable pulses Abd soft Bowel sounds x 4 quads. external fixator to (R) arm splint to (L) arm Edema noted to hands. elevated on blankets. voiding freely IV Heplock intact. No distress noted — [redacted] CONT
2 May 03 ~~1250~~ 1320	Transferred to ICW 2. No changes in status — [redacted]
3 May 03 0030	Pt voided 350 cc Dark yellow urine SPC [redacted] volume (b)(6)-2

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
2 MAY 03	Pt transferred to ICW#2 from ICU #2. NSS. A+Ox3. O_2, S_2
12:00	(+) cap refill <3 sec palpable pulses x 4 extremities. + 2 edema (L) lower extremity. (+) 1 edema going up leg to knee. painful to touch. (R) UE dressing with external fixator, (-) UE Bandage CDI in splint (B) LS CTA, (+) BS x 4. Requires minimal assistance with mvmt. Will continue to monitor. [redacted]
1500	MD notified of edema (L) LE. (b)(6)-2 [redacted]
1600	8mg MSO4 given IV PRN (B) UE pain [redacted]
1900	IV infiltrated D/C'd cath intact. New IV started 18G (R) FA. Patient (b)(6)-2 [redacted]
02 May 03 2300	Received report, assumed care @ 2200°. Pt supine in bed
2230 VS: BP 120	awake, alert, (-) evidence pain. VS WNP. CV: S1S2 regular, cap refill
HR 84	toes ≤3 secs, pulses palpable bilat LE. (-) palpation radially (+) pain
RR 18 (nurses)	(+) cast (R) arm. Resp: lungs are clear throughout, slightly diminished bases,
SpO2: 94%	(-) evidence resp difficulties, Is @ BS; ↓BS x 4q, abdomen soft, non-
T: 97.8	distended, (-) evidence discomfort on palpation. Pt voiding
	per urinal clear yellow out; (+) firm muscles bilat LE, (+) full ROM
2230: MSO4 4mg IVP	(-) Homan's! (+) External fixator to (R) UA intact, (-) evidence drainage
2400: Tylenol	of discomfort while @ rest. (+) movement in all fingers (+) ↓ muscle
	strength, (+) Splint to (L) Arm, (-) evidence drainage, (+) sensation
	& movement all digits cap refill bilat UE. ≤3 sec. Dressing
	Δ's to gsw wrist to back x 1 and (L) lateral thorax Δ'd - wet to dry.
	healing well, (-) evidence infection. MSO4 4mg SIVP Admin.
	Pre dressing Δ. 1 cm open lesion noted to (R) back shoulder, 3 cm:

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

[redacted]

ZPW

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
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1800

[redacted] (b)(6)-4

PROGRESS NOTES

DATE	
2230	diameter lesion, open to air, healy w/o evidence of infection. Noted to (R) thoracic area. (+) 1+ Edema noted to bilat hands & feet w/↑ edema to (L) sided extremities. Abd incision approximated w/ steri strips C/D/I. (-) evidence exudate - drainage. Pt resting @ this time (b)(6)-2 [redacted]
	2400 - Zosyn 3.375 g IVPB ↑ to 18g PIV to (R) AC. (+) flush (+) BR.
2	0230: Pt resting w/out evidence of discomfort (b)(6)-2 [redacted]
	0300: UOP - clear yellow 275 cc out. - [redacted]
	0330: Pt c/o (R) arm pain, throbbing dx described by translator. MSO4 3mg IVSP administered. Pt returned to sleep [redacted] (b)(6)-2
	0345: UOP = 325 clear yellow [redacted]
0546	Vital signs taken BP 126/78 P 68 T 98.7 R 14 (b)(6)-2 SPC [redacted] 91W
3 MAY 03 0600	Pt awake in bed. Denies c/o discomfort. VSS. Dsg to (R) arm, (R) chest & back DI. AL patent. lungs CTA, diminished in (R) base. BS active x4. Staples to mid abd, ∅ signs of infection noted [redacted] 91W
3 MAY 03 0700	GEN SURG: [redacted] (b)(6)-2 (b)(6)-2
	(S) NO COMPLAINT
	(O) T: 97.8 HR 84 SaO2: 95% - RA
	EXAM: CHEST: LBS (B) LOWER LUNG FIELDS; (L) CHEST WALL/BACK WOUNDS GRANULATING
	CARD: RRR
	ABD: NO INCISION & EVIDENCE OF INFECTION
	EXT: ↓ (L) LE SWELLING, (-) HOMAN'S SIGN. (B) LE DRESSINGS INTACT
	(A/P) S/P BILAT GSW; RLL PNEUMONIA, RULE OUT CXR, CBC, LLE DUPLEX TODAY (b)(6)-2 [redacted]

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
03 MAY 03 1645	Assumed care of Pt @ 1300. VSS. A&O x3 (B) BS CTA d'd @ bases (+) S_1, S_2 RRR, (+) cap refill <2 sec. (+) palpable pulses x 4 extremity (L) LE +1 Edema. d'd from yesterday, warm, painful to palpation, red streak up medial side of lower leg. MD notified, examined, no new orders given. (B) UE dsg - CDI, (L) back GSW w/D dsg CDI, chest dsg CDI. (+) SKIN PASTE on BACK. Pt c/o pain, relieved/controlled by MSO4. Pt OOB to chair x 2 hrs, ambulated around ward. Will cont to monitor [redacted]
1700	Pt able to feed himself [redacted] (b)(6)-2
2200	Pt voided 2000cc yellow fluid [redacted]
2315	Pt voided 2000cc foul smelling yellow fluid [redacted]
2330	Pt care assumed @ 2100. Pt alert with complaints of pain in both arms. VSS. Lung sounds clear to auscultation with equal bilateral lung sounds. + palpable pulses x4 extremeties. Bowel sounds present x4 quadrants. Dressing on LUE CDI, dressing on RUE CDI. (+) sensation and capillary refill <3 seconds on LUE and RUE. Chest dressing CDI, (L) back dressing CDI. 650mg Tylenol given for pain. Will continue to monitor. SPC [redacted] (b)(6)-2 WMC
4 MAY 03 0800	Assumed pt. care @ 0500. VSS. A&O x3. Lungs CTA, diminished @ bases. Dsg D&I. ∅ signs of infection. Minimum movement in upper extremities. Denies any discomfort @ this time [redacted]

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; rank; rate; hospital or medical facility) | REGISTER NO. | WARD NO. (b)(6)-2

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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PROGRESS NOTES

DATE	
4 MAY 03	Assumed care of Pt @ 1300. VSS. A+O x 3, (B) LS CTA ↓'d @ bases, (b)(6)-2
1330	(+) S1, S2, cap refill <3 sec, palpable pulses x 4 extremities. (+) sensation, full range of (B) ROM. Dressing to (B) UE CDI, Reinforced dsg to (L) P. flank, CDI. (+) skin rash on back. (L) LE slight swelling, red streak (+) warmer than (R) LE. no Δ from yesterday. Δ'D tubing to (R) FA 18G PIV, flushes well. Will cont to monitor [redacted] (b)(1)-
1615	Pt ambulated around ward w/out assistance. Now sitting in chair by bedside, Exercising Fingers will cont to monitor [redacted]
2120	PT VOIDED 120 CC CLOUDY DARK YELLOW IN COLOR (b)(6)-2
2230	Pt. care assumed @ 2100. Pt. alert & follows commands. Lungs CTA, ↓'d @ bases. HR Reg. Cap refill < 3 sec. Palpable pulses x 4 ext. (+) sensation. Edema noted to (L) hand. Dsng Δ wet to dry done on post. CW. (L) LE has slight swelling, red streak noted, (L) LE warmer than (R) LE. will continue to monitor. (b)(6)-2 [redacted] LT AN.
2330	cont'd. midline ASP incision Ø s/s infection GSA X4. (b)(6)-2 (b)(6)-2 [redacted]
5 May 03	0530 Assume ~~pt~~ care of patient. Pt Alert c/o pain. Lung sounds CTA, diminished in bases. Radial/pedal pulses palpable strong/regular. S1 & S2 regular. Cap refill < 3 sec. (L) hand edema noted. Dsg CDI, will continue to monitor, [redacted]
5 MAY 03	GEN SURG [redacted] (b)(6)-2 (b)(6)-2
	(S) ↓ LUE SWELLING TOL REG DIET
	(O) VSS, AF
	MINIMAL LLE EDEMA
	(A&P) S/P MULT GSW - (B) OPEN HUMERUS FX, PNEUMONIA
	- CONT AUGMENTIN
	- PT

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

(b)(6)-2

MEDICAL RECORD	PROGRESS NOTES
DATE 5 May 03	1240 pt c/o pain (R) side. tylenol 650mg adm. will cont. to monitor. pt was up in chair for approx 90 min today. (b)(6)-2 [redacted]
5 May 03	1400 Pt CAOX3 & obeys orders. c/o 150 P96 R16 (B) 97 T 99.6 voids freely (b)(6)-2 [redacted] SPC 9W
5 May 03	1400 - Assumed care of Pt @ 1300. VSS. Pt c/o (R) flank pain with breathing. (B) LS CTA w/ ↓ @ bases, abd firm. (+) pain in abd with palpation. (+) CVA tenderness (R) flank. Pt given ibuprofen 800 mg will cont to monitor flank pain. (+) S_1, S_2. (B) UE dressing intact, (+) cap refill <3 sec, [illegible], sensation in (B) hands. (+) palpable pulses x 4 extremities. Back, chest and [illegible] dressing intact. Will monitor [redacted]
1800	~~1400~~ Pt ambulatory around WARD x 15 min. OOB to chair (b)(6)-2 for 2 hrs. (+) use of IS [redacted]
2300	Pt care assumed @ 2100. VSS, AOX3. Pt c/o pain, tylox given. Lungs CTA w/ equal rise and fall of chest. Pulses palpable in lower extremeties. Dressings on RUE and LUE CDI. Dressing on back CDI. Pt has shown increased independence. Will continue to monitor. SPC [redacted] (b)(6)-2 9WM6
2330	Dressing Δ done on dressing on back. Wound appears pink and moist with slight blood draining. SPC [redacted] 9WM6
6 May 03 0640	PT vitals T 99.0 P 72 R 20 Spc [redacted] 9W (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)

[redacted]

[redacted] (b)(6)-4

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WARD NO.

PROGRESS NOTES
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PROGRESS NOTES

DATE	
6 May 03	SURGERY DAY 2 ALIGNMENT IN
	(S) ↑ EFFORT C̄ PT
	(O) T 99; HR: 80
	EXAM: CARD: RRR
	CHEST: SHALLOW BREATHS C̄ ↓ BIBASILAR BS
	GRANULATING (L) CHEST WOUND
	ABD: WOUND C̄ EVIDENCE OF INFECTION
	EX: (B) LE DRESSINGS INTACT
	(A/P) S/P MULT GSW, PNEUMONIA, (B) OPEN HUMERUS FX'S
	- CONT ALIGNMENT
	- PT, ↑ PATIENT INDEPENDENCE
	(b)(6)-2
	[redacted]
8 May 03	@ 810 Changed dressings on Pt. Pt CAOX3. Odiferous. Did not see any S/S of infection, edema, slight redness. Sight looked good. Used Sponge gauze. Used Wet & dry dressing sealed on 3 sides. Left R side open for air. No discharge. No smell coming from wounds. [redacted] (b)(6)-2 SPC 9/W
6 May 03	@ 9800 D.C. I.V C̄ 3 Way Stop Clock. No S/S of infection. No edema, No ecchymosis, No erythema. Put 2x2 & tape after sight. Nothing follows. (b)(6)-2 [redacted] SPC 9W
2330	Pt care assumed @ 2100. Pt VSS, AOX3. Pt c/o pain in arms. Tylox given for pain. Pt had bloody nose in (L) nare. Pt ambulated to latrine, w/o assistance. Lung sounds CTA, bowel sounds present x4 quadrants. Dressings on (b)(6)-2 upper extremeties and back CDI. Will continue to monitor. SPC [redacted] 9/WMX

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MEDICAL RECORD	PROGRESS NOTES
DATE	
	(b)(6)-2
7May03 0647	Vital Signs taken BP [redacted] P 70 T98.5 R 14 SPC [redacted]
	(b)(6)-2
7MAY03 0710	GENERAL SURGERY D#3 AUGMENTIN T 99.8, Ø CHANGES - CONT WOUND CARE - CONT AUGMENTIN FOR 7 DAY COURSE.
	(b)(6)-2
	[redacted]
7MAY03 0730	Pt. OOB, up in chair, lungs CTA, ↑ sy to back CRT. Ø distress noted @ this time — [redacted]
7MAY03 1400	Pt vitals taken. BP 120/P, P. 92, R. [redacted] (b)(6)-2 Temp 98.8. SPC [redacted] (b)(6)-2
7MAY03 1500	Pt ambulated for [redacted] 0 min, and sat in chair for 30 min ≈ complaint. SPC [redacted] (b)(6)-2
7May03	Assumed care of Pt @ 1300. VSS. Removed dressing/pen (L) UE. Staples CDI open to air 2x2 applied to GSW on (L) FA. (R) UE Fixator dressing CDI (B) LS CTA. Denies pain. More self-sufficient with tasks. (R) chest tube site ≈ stitches CDI no s/sx of infection. Will cont. to monitor [redacted]
	(b)(6)-2

(Continue on reverse side)

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PROGRESS NOTES
Medical Record

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PROGRESS NOTES

DATE	
7 May 03	PT Note
Hx:	Pt c̄ Ex Fix (a) numerous; Request E/W/H none;
T&M:	supine c̄ ex fix in place c̄ dressing
	Showed pt Elbow Flex/Ext/Supp/Pron
	Wrist - Flex/Ext
	Fingers/Digit mobility -
	Pt min ↓ ability reach full ext (a)
	" " make fist (a)
Diag:	shown E/W/H none
Interv:	1) Pedu/Review c̄ NSG tomm/tonight
	2) Cont PT
G:	Pt (I) c̄ E/W/H none - 1 day - 2 days
	NSG (I) c̄ E/W/H none - 1 day
	(b)(6)-2
	[redacted]
	CPT, SP
8 May 03 1400	Pt vitals taken BP 120/P, P. 80, R. 16, TEMP. 99.0
	SPC [redacted]
	(b)(6)-2

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PROGRESS NOTES

DATE	
5/7/03	2130: Assumed care of PT @ 2100. Pt. A&O. Ø c/o pain. Wet to dry dsng done on (L) Post. chest wall. Lrg amts granulation tissue noted. ~~Ø s/s~~ Some bloody drainage upon removal of old dsng. Dsng to (L) FA CDI, Dsng/ext-fixator to (R) UE CDI. Pt. HR Reg. Dim. LS (L) lung. LS otherwise CTA. BS (+) X4. Peripheral Pulses 2+ X4 & Cap refill < 3sec X4 ext. Pt able to wiggle fingers both hands. T ↓ grip strength. (b)(6)-2 [redacted]
08:0200 May 03	Pt is awake, alert, Ox3. Airway is patent. Breath is even and unlabored. Breath sounds are clear to (L) side. Sounds to (R) side are diminished at bases. Abd is soft, nontender & over distensible, and nondistended. BS(+) x4. Incision is midline & staples are well approximated & s/s of infection. Old chest tube site to (R) flank is also intact & s/s of infection. (R) UE has good capillary refill and strong radial pulses. Dsgs to (R) upper arm ex-fix are CDI. Dsg to ~~(R) UE~~ (L) elbow is CDI. Staples to (L) wrist are well approximated & open to air. Good cap refill and pulses to (L) UE. (R) UE more limited ROM. PT consulted for improvement. Pt is using (R) arm more frequently than before. Pt has good strength, pulses, cap refill to (R) LE. Dsg to posterior thorax, (L) flank is CDI. [redacted] (b)(6)-2
8 May 03	GENERAL SURGERY: AUGMENTIN D#4 (S) NO SIGNIFICANT C/O'S; PT. IS MORE COOPERATIVE AND INTERACTIVE (O) T ~ 99.9 HR: 72 (A/P) S/P MVA W GSW & (R) HUMERUS FX'S, PNEUMONIA - CONT AUGMENTIN - CONT AMBULATION, UE PHYS. THERAPY.

[redacted]

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(b)(6)-2

MEDICAL RECORD	PROGRESS NOTES

DATE

8 May 03 1430 assumed pt care @ 1300. pt resting c̄ eyes closed. VSS. lung sounds CTA bilat c̄ equal rise et fall of chest. Abd soft nondistended BS(+) x4 quads. incision midline c̄ steri stripes. LUE c̄ staples CDI open to air. GSW on (L) FA c̄ 2x2 secured c̄ tape. (R) UE fixator dressing CDI. wound to back dressing CDI. will cont to monitor (b)(6)-2 [redacted] 91WM6

8 May 03 1625 pt c/o itching, back dry c̄ white pustule bumps. MD notified and new orders rec'd, MD said to wash back et apply lotion. pt states "very good, good, very good." will cont to monitor [redacted] 91WM6

8 May 03 1905 pt resting c̄ eyes closed. will cont to monitor (b)(6)-2 [redacted] 91WM

8 May 03 PT Note

Hx: none

Tx/m: 3x20 sec Elbow extension

gentle Gr I mobs 3x5 sec into ext

Dx: working on extension (R) elbow

Interv: edu / As above

Cont home c̄ HSG

(b)(6)-2

[redacted] CPT, SP (b)(2)-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)

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MEDICAL RECORD	PROGRESS NOTES
DATE	
9 May 03 0785	(b)(6)-2 Vital signs taken P 82 R 14 T 98.6 — SPC [redacted]
9MAY03 1400	Pt vitals taken BP 110/P, P 88, R 20, Temp 98.1 SPC [redacted] (b)(6)-2
9 may 03 2000	Condition unchanged — independence & ADLS continues to be encouraged, pt. feeding self and ambulating alone & getting out of bed on own — VSS — dressings intact (b)(6)-2 [redacted]
10 May 0215	Assumed care of PT @ 2100. VSS. HR Reg, Lungs CTA ↓ in (R) UL. Pt. denies SOB. Ø S/S resp. distress. BS (B) X4. Midline incision OTA, Ø S/S infection. Ext. fixator (R) UE intact. Cap refill < 3sec & pulse 2+ X4 extremities. Drsng to (L) Post LW changed wet/dry. Will continue to monitor. [redacted]

(b)(6)-2

(Continue on reverse side)

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PROGRESS NOTES
Medical Record

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PROGRESS NOTES

DATE	
8 May 03	2155 Pt awake, alert oriented. Communicated w/ Drs/RN and hand gestures. No indication of pain c/o this time. Retained fixators to (L) UA intact, ⊘ evidence drainage from pin site dressing. ⊕ movement to all digits, ⊕ sensation, cap refill ≤ 3 sec. ⊕ movement (limited) & muscle strength, ⊕ radial 2+ pulse. (L) UE ↓ movement, & muscle strength, ⊕ tingling to (L) hand. ⊕ sensation, ↓ ROM. Dressing to FA CDI. CVS S1S2 regular, ⊖ swelling peripherally, cap refill bilat toes ≤ 3 sec. Lungs clear w/m lobes diminished bases ⊖ cough ⊖ c/o sob, dyspnea. 1S @ BS, Abdomen tender BS x 4q. ⊖ abd distention. 10cm approximated transverse incision, sternum intact ⊖ evidence infection. ⊕ Lateral dressing CDI, Dressing ⊖ penlly, urine @ BS, pt ambulates w/o assist, utilizes walk commode. Will cont. to monitor (b)(6)-2 [redacted]
	0345 Pt sleeping quietly ⊘ s/s pain, discomfort
09 0530 May 03	Pt's assessment is unchanged from previous assessment. Dressing to (R) UE is CDI, (R) UE staples are well approximated and CDI; wound drsg to (L) thigh is CDI. Pt is neurovascularly intact to (R) UE and (R) LE. FROM to (R) LE, limited ROM to (R) UE. Pt tolerated PO well. BS (+) x 4. Voiding spontaneously. Denies pain at this time. [redacted] (b)(6)-2
9 MAY 03	GENERAL SURGERY : ALIGNMENT [redacted] (b)(6)-2 NO CHANGES T max: 99.9 ⊘ CHANGES S/P GSW : (R) HUMERUS FX'S, PNEUMONIA - CONT ALIGNMENT (b)(6)-2 - CONT P.T. [redacted]

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
120545 May 03	Pt asleep but arousable. Lung sounds diminished to (R) and (L) bases. BS(+)x4. Tolerating PO well. Voiding spontaneously. Drsg to back and chest are CDI. (R) Rash to back [illegible] and upper back. Denies pain at this time. (b)(6)-2 [redacted]
12 May 03 0550	PT vitals T 97.5 P 68 R 18 BP 120/74 (b)(6)-2
12MAY03 1320	PT vitals taken T 98.5 P 79 R 20 B/P 150/88 [redacted] 91W
12 May 03 1340	Assumed care of Pt @ 1300. VSS. A+O x 3. (B)LS CTA, (R)UE Ex Fix drsg/pins CDI, (L)UE staples CDI. CTA, W/D drsg on Back CDI. Lotion applied to skin Rash on Back. Pt able to ambulate on own to BR. C/O assessment WNL. Will Monitor (b)(6)-2 [redacted]
13 May 0120	Pt care assumed @ 2100. VSS, A+O x3, pt has complaints of a small amount of pain. External fixation on (R) ue CDI, staples CDI on (L) UE. Dressing on back CDI. Pt complains of dry skin on (R) ue and back, lotion applied. Lung sounds CTA with equal rise and fall of chest, pulses palpable x4, bowel sounds present x4 quadrants. Will continue to monitor. SPC [redacted] (b)(6)-2 91WM6
13 MAY 0630	Assumed pt care @ 0500: pt. A+O x3. VSS. T 98.3 P 67 R 16 B/P 110/70. Lungs CTA. (+) BS x4. Drsg to (R) back and pin to (R) arm CDI. C/O pain + Tylenol Given PRN for pain. Will Continue to monitor (b)(6)-2 [redacted] 91WM6
13MAY03	1040 pt staples removed from (L) arm, stitches removed from (R) arm. Both sites intact. No S/S of infection. No drainage noted. Steri-strips placed. [redacted] (b)(6)-2

(Continue on reverse side)

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

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WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
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PROGRESS NOTES

DATE	
10May03	@ 1330 Pt CAOX3. 0 c/o @ c/o PO @ this Pt ambulates coastane. pt CAOX3. 0 dizziness, distress. VS 110/60 P 73 R 16 T 98.7° [redacted] (b)(6)-2 SPC PAN
10May03 2030	pt. feeding self and getting out of bed to use bathroom and ambulate on own - dsg (b)(6)-2 intact on back, (L) elbow and pins [redacted]
5/11/03. 0005	assumed care of Pt @ 2100. Pt. A&O. Pt. denies pain at this time. Prsng to (L) Post cw CDI. Ext. Fixator to (R) UE in place. Bilat. ↑ Ext. pulses 2+, cap refill <3 sec. (+) sensation. ↓ ROM (L) hand. Will continue to monitor. [redacted]
11May03 0610	PT's Vitals T 98.4 P 81 R 20 BP 122/64 (b)(6)-2 [redacted]
11 May03	Assume Pt care @ 0500. VSS. Lungs CTA. (+) BS x 4 quad. Dsg to back CDI. Denies any discomfort @ this time. will continue to monitor [redacted] (b)(6)-2
11 May 03 1400	Pt vitals taken. BP 110/p [illegible], P 64, R [illegible]8, TEMP 99.1 SPC [redacted] (b)(6)-2
1420	Assumed care of Pt @ 1800. VSS. A&O x 3. (+) Pain control on Back. (R) UE external fixator Dsg CDI, W-I-D Dsg on Back CDI, Staples to (R) UE CDI OTA, Dsg over (L) FAGSW CDI. (+) ROM exercises with (R) Hand. (B) LS CTA w/ @ bases. O/W assessment WNL. Will monitor [redacted] (b)(6)-2
2000	Pt. A&O. Pt. c/o ∅ pain. HR Reg, Lungs CTA, BS (+) X4. Rash noted to back. Pt c/o itching. Ext. Fixator to (R) UE intact. Bilat. ↑ ext pulses 2+. Cap refill <3 sec. (+) but ↓ ROM fingers both hands. ↓ grip strength. Will continue to monitor. [redacted] (b)(6)-2

(1) BACK V1.00

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

13Mar03 @ 13B VS 90/68, P 78 Reg T 97.9° R 16. Pt CAOX3. C/O drains distress a 0 c/o @ this time. Pt is ambulatory & assistance. Pt is in fowler position looking @ a magazine. C/O Pt @ the time Pt [redacted] 9W SR

13 Mar 03 PT Note (b)(6)-2

Hx: Have ↓ in elbow extension (a); hand extg active

Exam: Anom (a) elbow lacking ~10° ext

- 3x20 sec stretches into extension, prone, supp → able reach full ext (prone) & pm → same & prone / supp;

~ 2/5 active wrist ext (L)

2x10 sec (L) wrist ext

Diag: lacking elbow ext (R) elbow

↓ strength (L) wrist ext

Interv: edu / As above

cont PT - also ⊇ NSG

G: FROM (R) elbow in 6 days

2/5 (L) wrist ext ~ 12 days

[redacted] CPT, SP -

[redacted] (b)(2)-2

(b)(6)-2

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

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

REGISTER NO.

WARD NO. 9W 2

[redacted]

PROGRESS NOTES
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
14 May 03 0800	Pt care assumed @ 2000. VSS, A+Ox3, no complaints of pain. Pt has dressing and ABS on RUE, CDI. Abdominal staple removal site clean w/o signs and symptoms of infection. LUE clean without S/S infection. Pt appears to be more cooperative and in better mood. Dressing on back CDI. Pulses palpable x4, bowel sounds present x4. No other complaints, will continue to monitor. SPC (b)(6)-2 [redacted] qlwmc
14 May 03 0580	PT vitals T 97.3 P [illegible] R 20 BP 120/64 (b)(6)-2 [redacted]
14 May 03	0715: Assumed Pt care @ 0500. A+Ox3. Lungs [redacted] @ BS x4. Drsg on (R) upper back CDI. Denies any discomfort @ this time (b)(6)-2 [redacted]
14 May 03	1315 Took Pt's BP 109/60 R 16 P 68 T 98.1 [redacted] @ this time. Pt states UPN. Pt has been practicing Norm exercises (b)(6)-2 [redacted] qw
14 May 03 1425	Assumed care of Pt @ 1300. VSS, A+Ox3 BS QA, EXT FIX drsg CDI, steri strips to abd (B)UE CDI. BS/LX + infection W→D Back drsg CDI. O/W assessment WNL. [redacted] (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
14 May 03	Nursing Note: —
	2055: Received report on pt. Pt awake alert oriented x 3 watching activity (b)(6)-2 [redacted]
	on wand. (+) Calm, (-) cooperative. (-) PIV. O2 per RA (-) evidence distress -
VS:	2215: Pt supine Extremel fracture to (R) UFA intact, pins in place
BP 106/64	(-) drainage, (-) s/s of infection. (-) movement, (-) sensation to all digits.
60 HR	(-) cap refill < 3 sec. (-) pulse 2+, color normal for race, ↓ ROM to
RR 16	elbow, wrist, (+) ↓ motor strength. Pt denies pain; (+) Healing laceration x:
SpO2 98% RA	to wrist steristrip x 2, (-) drainage, (-) s/s infection. (+) ↓ (L) FA movement,
T 98.2	↓ ROM, ↓ muscle strength. (+) sensation, (+) cap refill < 3 sec, (+)
	Radial pulse 2+. (-) swelling to UR/L extremities. Lung sounds
	clear, S1S2 present regular abd s/t nontender (-) BS x 4. Pt
	up to ward commode voiding w/o difficulty. Monitoring to cont (b)(6)-2 [redacted]
	2230: (+) Healing 10 cm midline incision c̄ 7 steristrips in place, (-) s/s of
	infection, well approximated. (+) dressing to (-) lateral side, c/d/i,
	(+) dry skin, * back, large 15 cm diameter (-) evidence infection.
	(+) 15 cm incision/laceration to (L) UA. Approximated c̄ tape. (-)
	evidence infection. (b)(6)-2 [redacted]
15 May 03	0015: PIV - 18g started to (L) FA, (+) Flush, (+) BR, LR [redacted]
	@ 100 cc/hr. (-) evidence infiltration (b)(6)-2
	0200: UOP = 240 cc clear yellow urine in urinal. [redacted]
	0215: Dotrin applied to Back result of c/o itching and per request
	0435: Pt sleeping quietly. (-) evidence pain [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORD [redacted] PREPARED AT (b)(6)-2
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* | REGISTER NO. | WARD NO. 1611 2

[redacted] (b)(6)-4

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
150530 May 03	Pt is asleep but arousable. Airway is patent. Breathing is even and unlabored, lung sounds diminished in (B) bases. Abd is soft, nontender, ~ distention. Midline incision is well approximated c̄ staples. BS(B) x 4. Pt currently NPO. FROM to (B) LE and neurovascularly intact. PROM to (B) UE. Neurovascularly intact. Staples to triceps area are CDI. Ex fix to (B) UE has drsgs c̄ minimal serosang drng. PROM c̄ Ex fix to (B) UE. Neurovascularly intact otherwise. IV to (B) wrist is large bore and LRO 100 c̄/hr. [redacted]
15May030830	PT vitals T 97.5 P64 R20 BP 136/88 ← (b)(6)-2 [redacted]
5/15/03	Sl. Summary Dx:- (B) open humerus fractures. (L) ~~c̄~~ ORIF (R) p Ex Fix c̄ ↓ to LAC Plan: F/u 3 weeks for repeat XR. - Δ back dressing (dry only) daily or QOD as outpt. (b)(6)-2 [redacted]
151240 May 03	Pt arrived via litter c̄ recovery in ICU #2. Pt ambulated from litter to bed. Assessment is unchanged from this AM x that (R) arm is now in hard cast. Ø drainage or ex-fix pins visable. Pt is neurovascularly intact to fingers of RLE. [redacted]
15May03 1600	Pt d/c'd to MP escort c̄ DIC summary copy, meds, X-Rays (b)(6)-2 and applicators for drsg Δ's

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

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

ARRIVAL

DATE *(Day, Month, Year)*: 25 Apr 03 | TIME: 1730

TRANSPORTATION TO FACILITY

SEX: M

DUTY/LOCAL PHONE: AREA CODE | NUMBER

AGE: 25

HOME PHONE: AREA CODE | NUMBER

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			✓
FLYING STATUS			✓

MEDICAL HISTORY OBTAINED FROM: pt, ∅ significant

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS: ∅

ALLERGIES: PCN

INJURY OR OCCUPATIONAL ILLNESS

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

HOW: attempted ambush

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: GSW to bil. arms + (R) chest

CATEGORY OF TREATMENT

☒ EMERGENT
☐ URGENT
☐ NON-URGENT

TIME
INITIALS

VITAL SIGNS

TIME	1720	1742	1800	1855
BP	147/59	116/51	109/47	134/53
PULSE	113	105	104	86
RESP	16	16	16	20
TEMP	99	—	~~97.1~~	—
~~WT~~ ox	96%	98	99%	100%

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1730	7mg Morphine IV	DK	LT [redacted]	1750	sedated
	5mg Versed IV	DK	LT	1750	
1800	Tetanus 0.5cc IM	DK	LT	1800	∅ Δ

DISPOSITION: ☐ HOME ☐ FULL DUTY

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

MODIFIED DUTY UNTIL [redacted]

RETURN TO DUTY (b)(6)-2

PATIENT DISCHARGE INSTRUCTIONS (b)(6)-2

CONDITION UPON DISCHARGE: ☐ IMPR[redacted]ANGED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

EPW

[redacted] (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

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Doctor)*	TIME SEEN BY PROVIDER 1700.

TEST RESULTS

CBC		SMAC					
WBC 23.3		136	107	8	Pre Tube ABG/PULSE OX		RADIOLOGY — Check if read by radiologist ☐
H/H 11/32.		4.7	24	1.1	SUP O2 NRB	PH 7.307	PO2 72 — RESULTS
PLT 302				159	PCO2 23	SAT 92%	OTHER CK 199
PT					U/A DIP		EKG INTERPRETATION
APTT	BHCG	ETOH	GLU		MICRO		

PROVIDER HISTORY/PHYSICAL

S: Pt is ~25yo Iraqi ♂ EPW who ambushed US Soldiers and was shot 5x as a result. GSW's to (B) humerus c̄ open fx's. GSW's to (R) Axilla, (R) Back x2. C/o mild abd pn to exam. ⊖ LE or head trauma. Last meal early this AM.

PMHx ⊖
PSHx ⊖.
All: PCN.
Meds: ⊖
got Ancef 1gm & Demerol by medics

O: WDW in min dist 2° to GSW's. min Respir dist.
HEENT: Atraumatic (A) intact. ⊖ JVD. ⊖ Trach Dev'n
Lungs: ↓ BS on (R) ⊖ Sq emphy. ⊖ crep.
Cor RRR ⊖⊖.
Abd: ⊕ BS. S. min tend to palp. ⊖ lavol guarding. ⊖ distention.
Ext: (B) GSW to Humerus c̄ open fx + pulses, warm extremities. Pulse ox correlating well.

FAST u/s ⊖ free fluid in Abd. ⊖ pericardial effusion.

A: Chest Tube: Beta prep. MS & Versed sedation 8 mL Marcaine, Lido local. O-Nylon Suture. Tolerated well.
SOD plans to Ex lap due to EPW c/o Abd pn.
To OR for Humerus ex fix + washout.

XRays: Chest (R) 50% PTx
(B) Humerus fx
Abd: ⊖ Free Air ⊖ foreign
P procedure (R) CT in place
min residual PTx.

CONSULT WITH	TIME	ACTION
Dr [redacted]	1715.	
(b)(6)-2		

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP: (b)(6)-2

PROVIDER [redacted] MAJ, MC, USA [redacted] DEPT OF EMERGENCY MEDICINE

DIAGNOSIS Mult GSW
(R) PTx.
(B) open Humerus fx.

CODE

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

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

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

MEDICAL RECORD	**PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT** For use of this form, see AR 40-66; the proponent agency is The Office of the Surgeon General.
1. AGE: 25 HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): UnK 3. PREVIOUS SURGERY [✓] NO [ ] YES (type): UnK

4. PROPOSED SURGICAL PROCEDURE: (L) (R) UE Fx / Ex Lap (GSW)

5. ADDITIONAL INFORMATION: Last PO: Medical Hx: Implants: Medications: Tetanus 7 May 04
Jewelry removed: yes/no Family waiting: yes/no UnK UnK 1gm Ancef 50mg demerol 5 versed
Pt sedated in EMT; unable to interview NPO since AM

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

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

[redacted]

(b)(6)-4

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

[redacted] CPMN 25 Apr 03 DATE

11. POSTOPERATIVE EVALUATION:

(b)(6)-2

Bone site intact, ∅ redness
Transferred via litter

12. [redacted]PERTIVE EVALUATION PREPARED BY

[redacted] CPMN

DATE 25 Apr 03 TIME: 1830

13. PREOPERTIVE EVALUATI[redacted] (b)(6)-2

BY (Signature and Title) [redacted] NA

DATE: 25 Apr 03 TIME: 2322

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.01

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: 25
HEIGHT: 70"
WEIGHT:

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

3. PREVIOUS SURGERY [ ] NO [ ] YES (type):
ORIF RLT Humerus, Rt pneumothorax Exp cap

4. PROPOSED SURGICAL PROCEDURE: Amoxicillin vto @ MN

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition Multiple wounds
Tobacco ___ ppd X ___ yrs. Body Piercing ___ Diabetes (Y) (N) ROM ___ ASA/Motrin w/72 hrs (Y) (N)
ETOH ___ Implants Yes Lt humerus Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures NA Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

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

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

[redacted] (b)(6)-4

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

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

[redacted] PTAN 15 May 03 DATE

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

(5)(6)-2

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] MAJ AN
[redacted] 15 May 03 TIME: 0920

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Ti[redacted] CPT AN
DATE: 15 MAY 03 TIME: 1120

(5)(6)-2

REVERSE OF FORM 5179, JUN 91 USAPA V1.0

MEDCOM - 8176

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Litter BY MAJ [redacted] MAJ [redacted]

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

3. DATE 15 May 03 TIME PATIENT [redacted] IN SUITE 0930

4. PATIENT IN ROOM TIME 0930 NUMBER 21 (2)

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: (b)(6)-2

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] 91D (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

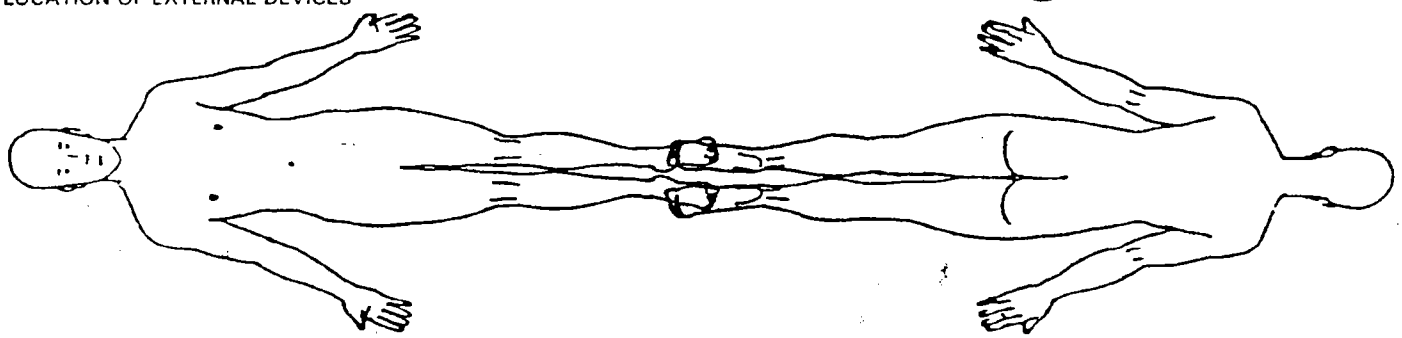
PREP SOLUTION *(Specify)* Beta/Beta (b)(6)-2

SITE: R arm BY WHOM: CPT [redacted]

SITE: BY WHOM:

COMMENTS: no pooling of prep noted.

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

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

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

[redacted] (b)(6)-4

CIV # [redacted]

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

CUT 30 COAG 30

☒ ESU NO: Valleylab # 3

GROUND PAD: BRAND 3M

LOT NO: 2005-10 OT

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS. SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
0.9% NACL

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☒ NO ☐ IF YES, SITE (R) arm

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

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

19. ADDITIONAL INFORMATION

20. OPERATION(S) PERFORMED
adjustment Ex-fix

21. PATIENT TRANSFERRED TO ICU2 TIME 1120 METHOD [redacted] (b)(6)-2

22. REGISTERED [redacted] CPT AN

REVERSE OF [redacted] OCT 8 (b)(6)-2 MEDCOM - 8178 USAPA V1.01

MEDICAL RECORD — **INTRAOP[redacted] DOCUMENT**

For use of this form, see AR 40-66, the [redacted]ent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA litter BY [redacted]/CPT [redacted]

2. PATIENT IDENT[redacted] PROCEDURE
VERIFIED BY [redacted]

3. DATE 25 Apr 03 TIME PAT[redacted]VED IN SUITE (b)(6)-2

4. PATIENT IN R[redacted]
TIME 1855 [redacted] NUMBER #[redacted] (b)(6)-2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: nKA ; pt sedated in ER

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted], 91D (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted], 66E LT [redacted], 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL A[redacted] *(Specify)*

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

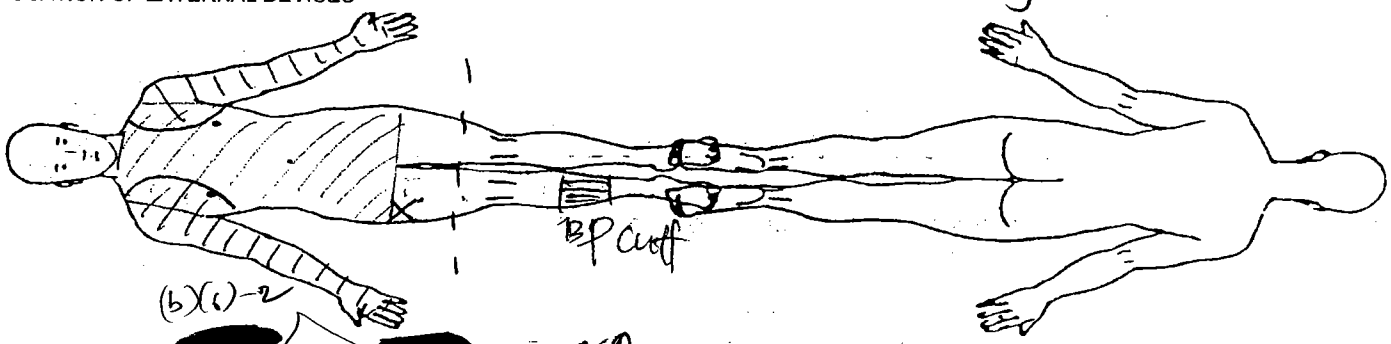
COMMENTS: BP cuff on Rt leg pillow under knees. two arm board used for hand table.

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine/Betadine (b)(6)-2
SITE: ① ABD - pubis to neck BY WHOM [redacted] ①
SITE: ② RUE ③ LUE > hand to shoulder BY WHOM [redacted] ②③
COMMENTS: Ø pooling or irritation

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad [redacted] -- Safety Strap [redacted] === Tourniquet N/A /// = prep

10. COUNTS

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

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

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

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

☒ ESU NO: #1 cut/coag = 30/30
GROUND PAD: BRAND Valley lab
LOT NO: H9402 4

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

Synthes Trauma Fix
4344774
exp 12/2010 X/R [redacted] (b)(6)-2

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

(b)(6)-2

PHYSICIAN'S SIGNATURE [redacted]

15. X-RAY IN OPERATING ROOM
YES ☒ NO ☐ Rt. arm [redacted]

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 16 fr Foley	2. Chest tube	3.
SITE	1. Bladder → pt arrived c̄ in place	2. (R) Thorax	3.

18. DRESSING/IMMOBILIZATION (Specify)
4x8 ABD / fluffs
Kerlix
Webrill
splint (L) [redacted] (b)(6)-2
& arm sling

19. ADDITIONAL INFORMATION
WC
Surgeons: Dr [redacted]
Dr
Dr
Anesthesia: (b)(6)-2
Anesthesia Type: LTC [redacted] Gen anesth
(b)(6)-2

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

20. OPERATION(S) PERFORMED
1) Ex-lap
2) Ex-Fix RUE fx
3) I+D, Splinting LUE fx

21. PATIENT TRANSFERRED TO ICU #1 TIME 2322 METHOD litter

22. R[redacted] WT/AW [redacted] CPT/AW
(b)(6)-2 (b)(6)-2

REVERS[redacted]

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

For use of this form, see AR 40-66, the [illegible]ent 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 [redacted] (b)(6)-2

3. DATE 28 APR 03 TIME PATIENT ARRIVED IN SUITE 0810

4. PATIENT IN [redacted] TIME 0830 NUMBER 1-1 #1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: Unknown, Sleepy, Right arm on External Fix.

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

Pt placed in bed. Blanket sag used. Right arm on arm board <90° / prepped

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

COMMENTS: Axillary roll under Right axilla. Right leg bent, pillow between legs. Wedge under Right knee. Strapped across thigh. Pillow between arms. Left arm across chest. Head secured in a neutral position by anesthesia.

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

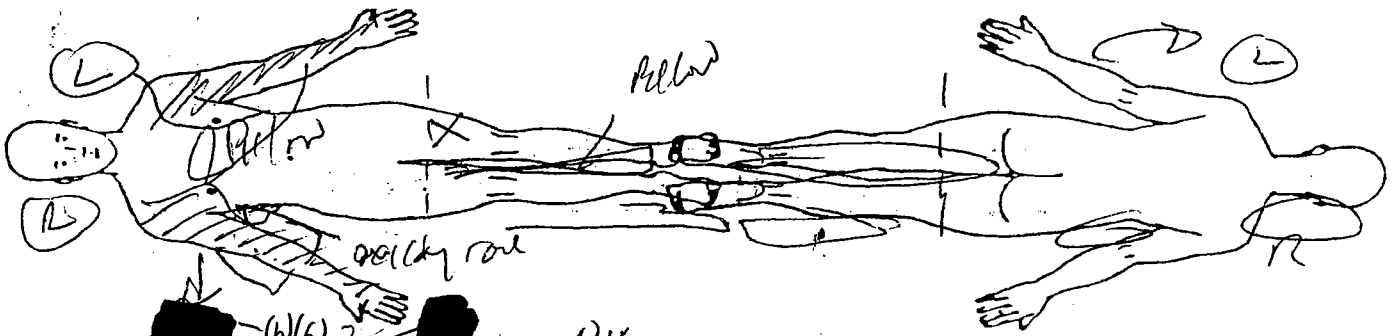
PREP SOLUTION *(Specify)* BETA / BETA (b)(6)-2

SITE: LEFT ARM BY WHOM: [redacted]

SITE: Right arm BY WHOM: [redacted]

COMMENTS: Ø pooling of solution noted

9. LOCATION OF EXTERNAL DEVICES



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

LEGEND X Ground Pad – Safety Strap N/A === 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	C	[redacted]	[redacted]
Needle Sharp	☒ Yes	☐ No					
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

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

EPW # [redacted]

(b)(6)-4

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

☑ ESU NO: #1

GROUND PAD: BRAND Valleylab

LOT NO: LOT # 66226 (11-2004)

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

[redacted] (b)(6)-2

13. PROSTHESIS, IMPLANTS ☑ YES IF YES NAME: ID NUMBER; MANUFACTURER

Synthes small frag
10 Holes 3.5 DCP plate x 1
3.5mm cortex screws
204.14 x 2 204.26 x 2
204.12 x 2 204.22 x 1

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

(b)(6)-2

PHYSICIAN'S SIGNATURE [redacted]

15. X-RAY IN OPERATING ROOM
YES ☒ NO ☐ IF YES, SITE Left arm portable (AP) lateral

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION (Specify)
fluff Kerlix webril splint (plaster) L arm
coban
fluff
Kerlix } Right arm.
coban

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

Bovie Pad site intact pre-op intact; post-op dry Bovie Settings: Coag/Cut 30/30
Tourniquet Site intact pre-op Ø : post-op Ø
Tourniquet Time: Up Ø Down Ø

20. OPERATION(S) PERFORMED
ORIF LEFT Humerus
Washout & debridement Right arm.

21. PATIENT TRANSFERRED TO ICU TIME 1310 METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted]

REVERSE OF DA FORM 5179-1, OCT 8 (b)(6)-2 MEDCOM - 8182 USAPA V1.01

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY							
POST- DAY	2138					2300	
MONTH-YEAR / DAY	9 May	10 May 03	11 May	12 May	13 May	14 May	15 May
19 / HOUR		3 / 22	610 / 1130 / 1530	551 / 1220	3 / 2200	655 / 3	830

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD RR 12 ... 21 20 / 20 20 ... 18 20 ... 12 ... 16 ... 14 ... 21 16 / 16 ... 16 ... 20

BLOOD PRESSURE 116/P 110/80 110/60 122/64 122P 128/74 158/88 120P 110/70 112/76 120/64 112/60 106/62 136/88 120/80

SpO2 98 98% 98 98 98 98 98

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICW

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

(b)(6)-4

MEDCOM - 8183

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY 002

MONTH-YEAR MAY 03 DAY 3 4 5 6 7 8 9

18 2003 HOUR

PULSE (O) — TEMP. F (°) — TEMP. C (Centigrade Equivalents, for Reference only)

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

RESPIRATION RECORD — RR

BLOOD PRESSURE — PAP

SpO2

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICW 2

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

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 8184

25-26 Apr 03

TIME	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05
B/P																			161/74	161/79	168/80	161/77	153/72	139/59	141/59
HR																			84	84	89	98	107	108	104
RR																			16	16	15	20	24	24	21
TEMP																			97	97					
O_2 SAT																			100	100	99	RA 94	RA 95	RA 95	95
INPUT																									
-R																					125	125	125	125	125
OUTPUT																									
NG																				0		0	0	0	0
Chest tube																				1	1	0	5	10	
urine																					2	2	7	17	
foley																				125	125	100	100	100	100
																				125	250	350	450	550	650

PROGRESS NOTES

MEDICAL RECORD

DATE

WARD NO.

REGISTER NO.

(Continue on reverse side)

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

PROGRESS NOTES

Medical Record

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

MEDCOM - 8185

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM _____ HOURS
TO _____ HOURS

TOTAL HOURS COVERED

DATE 26 Apr 03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

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

IRRIGATIONS (N/G, Bladder, etc.)

TIME	HR	BP	SpO2	RR	Temp	AMOUNT	ACCUMULATIVE TOTAL
0600	113	155/74	94%	28		99	
0700	109	144/73	94	21			
0800	111	139/50	94	24			
0900	109	143/52	94	19			
1000	106	140/55	93	22		100	
1100	98	137/62	93	24			
1200	104	150/60	94%	34			
1300	98	168/83	MASL 98%	32		99.8	
1700	105	183/94	92	36			
2100	101	167/70	94	30		100	
01	100	166/78	95	28			
05	105	162/73	94	32		98	

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
GRAND TOTAL INTAKE			

USAPPC V1.00

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0600	100	100	1800	100	650
0700	50	150	2000	100	750
0800	50	200	2200	100	850
0900	50	250	0000	100	950
1000	50	300	02	100	1050
1100	50	350	04	100	1150
1200	40	390	05	100	1250
1300	40	430			
1400	40	470			
1500	30	500			
1600	50	550			
1700	200	750			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0600	16	16	1200	2cc	53
0700	13	29	1400	Ø	
0800	5cc	34	1500	5	58
0900	3	37	1600	13	71
1000	3	40	1700	Ø	71
1100	11	51	1800	Ø	71

~~EMESIS~~ Chest tube

TIME	AMOUNT	TYPE	ACCUM TOTAL
2000	2		73
2200	2		75
0000	Ø		75
02	2		77
04	Ø		77
05	Ø		77

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

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

[redacted] (b)(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 792, JAN 74

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

'JSAPPC V1.00

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM _____ HOURS
TO _____ HOURS

TOTAL HOURS COVERED

DATE 27 Apr 03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

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

IRRIGATIONS (N/G, Bladder, etc.)

TIME	HR	BP ~~TYPE~~	SaO2	RR ~~AMOUNT~~	T ACCUMULATIVE TOTAL
0500	105	162/73	94%	32	98
0600	95	157/70	93%	15	
1000	90	154/72	91%	36	99.5
1400	85	171/72	94%	23	
1800	75	156/65	100%	36	
2200	78	164/65	100	30	99
0000	67	156/63	100	24	
04	69	154/58	100	32	
05	72	156/58	100	30	98.6

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

0820 removed CT

[redacted] (b)(6)-4

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0500	100	100			
0600	dribble 2cc				
1000	dribble 2cc				
1600	200	304			
1000	425	529			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL
0930	600		600

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0500	Ø	Ø			

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

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

[redacted] (b)(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 792, JAN 74 EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 72 WHICH MAY BE USED. USAPPC V1.00

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM _____ HOURS
TO _____ HOURS

TOTAL HOURS COVERED

DATE 28 Apr - 29 Apr

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1800	H2O	400	400
01	H2O	100	500
07	H2O	60	560
1100	H2O	100	660

INTRAVENOUS

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

IRRIGATIONS (N/G, Bladder, etc.)

TIME	HR	BP ~~TYPE~~	Sa02	RR ~~AMOUNT~~	Temp ~~ACCUMULATIVE TOTAL~~
1800	74	164/80	100%	21	
2200	80	172/82	100%	21	
02	85	164/74	100%	26	100
05	74	160/68	100	21	
0700	90	155/74	100	34	99.9
1100	96	123/87	100	26	
1500	101	120/42	97	26	101.9
1800	87	158/62		16	101.9
2200	73	149/62	100	28	98.8
02	74	145/55	100	22	99.4
05	79	117/43	100	28	

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
1900	400	400			
0230	500	900			
0400	350	1250			
0600	300	1550			
0900	?				
1100	150	1700			
1400	200	1900			
2200	300	2200			
01	300	2500			
03	200	2700			
05	200	2900			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL
1900	TAN	soft	—	—
0900	↑ loose (liquid)			

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

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

[redacted] (5)(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 792, JAN 74

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

USAPPC V1.00

30 Apr 8

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0600	300	300			
0900	450	750			
2100	300	1050			
2230	250	1300			
0345	300	1600			
0820	325	1925			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

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

[redacted] (b)(6)-4

CIV #

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 792, JAN 74

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

USAPPC V1.00

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM _____ HOURS
TO _____ HOURS

TOTAL HOURS COVERED

DATE 30Apr03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

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

IRRIGATIONS (N/G, Bladder, etc.)

TIME	HR	BP	TYPE R	SaO2	~~AMOUNT~~ T	ACCUMULATIVE TOTAL
0900	88	132/54	30	99%	100+	
1300	99	137/59	26	100	100+	
1900	87	131/54	26	100	100.1	
2300	88	140/52	26	100		
03	82	144/62	22	97		
0500					99%	

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM _____ HOURS TO _____ HOURS | TOTAL HOURS COVERED | DATE 1 May

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1800	Soda	240	240
2300	H2O	100	340
0200	H2O	100	440
2 APR 0500	H2O	100	540

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
1800	50	Amcf 1gm			
2400	100				
2 APR 0600	50	Rosyl			

IRRIGATIONS (N/G, Bladder, etc.)

~~TIME~~	Vital ~~TYPE~~ Signs			AMOUNT	ACCUMULATIVE TOTAL
0800	HR 83	R 20	BP 146/53	100cc	T
1200	82	20	161/76	996	1006
1600	76	22	144/79	992	
2000	79	20	140/76	990	990
2400	78	20	136/76	990	991
0400	69	20	124/56	990	996
2 APR 0600	74	24	122/46	994	

BLOOD/BLOOD DERIVATIVES

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

~~OTHER INTAKE~~ Output

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
1800	URINE	350	350
2002	Urine	200	550
0200	Urine	400	950
2 APR 0600	Urine	275	1225

~~GRAND~~ TOTAL INTAKE

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

#[redacted]

(b)(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

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

DD FORM 1 JAN 74 792

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

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

TWENTY-FOUR HOUR PATIENT INTAK D OUTPUT WORKSHEET	FROM ____ TO ____ HOURS	TOTAL HOURS COVERED	DATE

INT

~~ORAL~~ Urine			
TIME	~~TYPE~~	AMOUNT	ACCUM TOTAL
0600		400	400
		300	700
		250	950

INTRAVENOUS

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

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

INTAKE EQUIVALENTS (Serving levels cc)

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

DD FORM 1 JAN 74 792

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

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

VENTY-FOUR HOUR PATIEN...NTAKE AND OUTPUT WORKSHEET

FI ____ HOURS TO ____ HOURS	TOTAL HOURS COVERED	DATE 3 May 03

INT

ORAL

TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

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

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
	Vital Signs		
~~0600~~	HR BP R T	SaO2	
0600	74 122/46 24	99%	
1000	80 120/56 22 99°	98	

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

[redacted]

(b)(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

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

[redacted]

PCO2_____ mmol/L

pH

PH_____7.307

PCO2_____45.9 mMHg

PO2_____ mHg

HCO3_____ mmol/L

BE_____-3 mmol/L

sO2*_____ %

calculated

18:11

Physi

Ver: 420

Ver: JAN 19
CLI 31

PICCOLO

25/04/03 17:48

REFERENCE RANGE: MALE

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

METLYTE 8

DISC LOT #: (b)(6)-2 [redacted]

OPER #: [redacted] DR #: 001

SERIAL #: 0000100494

GLU	159*	73-118	MG/DL
BUN	8	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	1991*	39-380	U/L
NA+	136	128-145	MMOL/L
K+	4.7	3.3-4.7	MMOL/L
CL-	107	98-108	MMOL/L
tCO2	24	18-33	MMOL/L

INST QC: OK CHEM QC: OK

HEM 1+, LIP 0, ICT 0

SPECIMEN TAKEN

DATE: 25 Apr 03 TIME: 1735 A.M. P.M.

RESULTS	REQUESTED	(X)
4.08	RBC COUNT	X
11.6	HEMOGLOBIN	X
37.3	HEMATOCRIT	X
91.4	MCV	
28.4	MCH	
31.0	MCHC	
23.3	WBC COUNT	X
	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
	NEUTRO-BANDS	
	NEUTROSEGS	
7.5	LYMPHS	
	EOSINOPHILS	
	BASOPHILS	
	MONOCYTES	
	PLATELETS	
	RBC	
	SED. RATE	
302	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PTT CONTROL	
	PTT PATIENT	
	PT CONTROL	
	PT PATIENT	
	% ACTIVITY	
	RATIO	
	SICKLING TEST	
	LE PREP	

REMARKS: LTG CBC, Metabolyte, ABC, T+S

Blood type

REPORTED BY: [redacted] (b)(6)-4 MD DATE

LAB. ID. NO.

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

REQUESTING PHYSICIAN'S SIGNATURE: [redacted] (b)(6)-4

URGENCY: ROUTINE, TODAY, PRE-OP, STAT

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

SPECIMEN SOURCE: VEIN, CAP, OTHER (Specify)

HEMATOLOGY

549-107

HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
Prescribed by GSA/ICMR
FIRMR (41-CFR) 201-45.505

LABORATORY FILE

[redacted] (b)(6)-4

ICU 2

SPECIMEN/LAB RPT. NO.

HEMATOLOGY

URGENCY: ROUTINE, TODAY, PRE-OP, STAT

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

SPECIMEN SOURCE: VEIN, CAP, OTHER (Specify)

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

REQUESTING PHYSICIAN'S SIGNATURE: [redacted] (b)(6)-2

REPORTED BY: (b)(6)-2 [redacted] MD DATE: 30 APR 03

LAB. ID. NO.

REMARKS: CBC Lymph % 7.3

TEST(S)	RESULTS	REQUESTED	(X)
	2.56	RBC COUNT	
	7.3	HEMOGLOBIN	
	23.4	HEMATOCRIT	
	91.4	MCV	
	28.5	MCH	
	31.2	MCHC	
	16.1	WBC COUNT	
		WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
		NEUTRO-BANDS	
		NEUTROSEGS	
		LYMPHS	
		EOSINOPHILS	
		BASOPHILS	
		MONOCYTES	
		PLATELETS	
		RBC	
		SED. RATE	
	372	PLATELET COUNT	
		RETICULOCYTE COUNT	
		CLOTTING TIME	
		BLEEDING TIME	
		PTT CONTROL	
		PTT PATIENT	
		PT CONTROL	
		PT PATIENT	
		% ACTIVITY	
		RATIO	
		SICKLING TEST	
		LE PREP	

SPECIMEN TAKEN: DATE 30 APR 03 TIME 0825 A.M. P.M.

549-107

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

LABORATORY FILE

(5)(6)-2

Ward/Section: ICW 2	R[illegible]ING PHYSICIAN: [redacted]	[illegible]RATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI	DATE	TIME	SSN/PSEUDO SSN
[redacted] (5)(6)-4	3 Mar 03	0745	[redacted] (5)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	12.4	4.8-10.8 x 10³
RBC	2.54	4.7-6.1 x10⁹ (M)
Hgb	7.1	14-18 g/dL (M) 12-16 g/dL (F)
Hct	22.7	42-52% (M) 37-47% (F)
MCV	89.0	80-94 fl (M) 81-99 fl (F)
Plt	336	130-500 x10³ verified
Lymph %	17.5	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Blood Bank (Crossmatch)

MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED

UNIT	TYPE	CROSSMATCH

Misc Serology

TEST	RESULT	REF. RANGE
RPR		Negative

Microbiology

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

Occ Bld		Negative
H. pylori		Negative

Microscopic Urinalysis

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

MEDICAL RECORD — ANESTHESIA

DRUGS	Units	Dosage
Versed	(mg)	5
Fent	(mcg)	250
STP	(mcg)	200
Sux	(mg)	100
MSOx	(mg)	4 2 2
	( )	
VOLATILE AGENT: Sevo	% del	X-1.5-1.0-0.8-0.6-0.4-X
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	X-8-2-2-2-2-2-8

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

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

LINE site CR — Warmed: 2 (700) 2 (1000) 2

Warmed

Warmed

Warmed

EST BLOOD LOSS

URINE – (b)(6)-2

TOTALS	
TOTAL IN	Ø
TOTAL URINE	4

FLUIDS – SUMMARY	
CRYSTALLOID–	1100
COLLOID–	Ø
BLOOD–	Ø

REMARKS– Code drugs with numbers, events with letters

0915 pt ID'd, transported to OR via stretcher
0930 In OR w/ monitors ON
0935-0940 Induction & Intubation

STATUS 2 3 4 5 E

WEIGHT: 70 KG LB

HAIR/SKIN

INITIAL DATA: BP 106/64 P 70 T 97.5 R 20

IV ORDERS: ? Y N

PRE-OP ASSESSMENT

NEW PROCEDURE? Y

TIME 0930

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

15 MAY

EXT FIX RUE

VT – ml		1000						
f – breaths/min		8	16	15	13	13	25	
Peak inf pres / PEEP		24						
MODE– S(pon), A(ssist), C(on)		S/A	C	A/S	S	S	S	S
BP/Auto Cuff	ET CO2 (torr)	(+)	28	38	43	42	41	43
BP / oth	FIO2 (Frac or %)	1.0	1.0	1.0	1.0	1.0	1.0	1.0
ART line	SpO2 (%)	100	100	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP- site							
	N-M Block (T/4)							
Warming blkt								
Conv warmer								

Mark with letters & symbols, explain under REMARKS

EVENTS — Position → ol

RECOVERY AT	1015
PACU	ICU #2 (Specify)
OTHER	
CONDITION:	Stable
RESP– 18	SpO2– 100
BP– 117/80	HR– 84

	Start	Room	End
ANES	0915	0930	1020
	Ready	Begin	End
PROC	0940	0950	1010

PROCEDURES and CPT Codes: Adj Ext-Fix (R) upper Arm

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: DLX1 & 2 MAC, V3 & 4 cord, Intubated 8.0 ETT to 22cm @ lip, B/L BS, ETCO2 x 5 waves, Eyes taped

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

[redacted] # [redacted]

(b)(6)-4

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

ANESTHETISTS: [redacted] MAJ [redacted] AN, CRNA

[redacted] Nurse Anesthetist

PROCEDURE LOCATION: ISO2-1

DATE: 15 MAY 03

PAGE 1 OF 1

WAMC-OP 376 REVISED 1 Jan 99

PATIENT RECORD

MEDCOM - 8199

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

MEDICAL RECORD - ANESTHE

Use of this form, see AR 40-66; the proponent agency is OTSG

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

DRUG	(Units)													TOTALS	TOTAL EBL
STP	(mg)	(350)												350/150	
Fentanyl	(mcg)	150		100	100			50		100			100	(600) +	
Sux	(mg)	100													TOTAL URINE
Rocuronium	(mg)			30											
	( )														
	( )														
VOLAT AGENT	Forane % del		2.0	2.0	2.0	2.0	1.5	1.5	1.5	1.25	1.25	1.25	1.25		
	% eff	[redacted]			(b)(6)-2										
AIR	L/Min														
N2O		[redacted]													
O2	L/Min	10	1	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5		

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

FLUIDS

LINE site													
L foot	☐ Warmed			200	500								700
L hand	☐ Warmed			500	1500						2000		
	☐ Warmed												
	☐ Warmed												

LOSSES

EST BLOOD LOSS													
URINE -				350			400						600

FLUIDS - SUMMARY

CRYSTALLOID-

COLLOID-

BLOOD-

REMARKS

Code drugs with numbers, events with letters

(A) Pt in EMT. ID v'd, NPO v'd, chart rev'd. IV: (L) hand/(L) foot
(B) Pt to OR, monitors placed
(C) I & I, RSI & cricoid pressure
2110 Anest sign IV over 20 min.

PHYS STATUS 1 2 3 4 5 (E)

BODY WEIGHT: ~70 KG LB

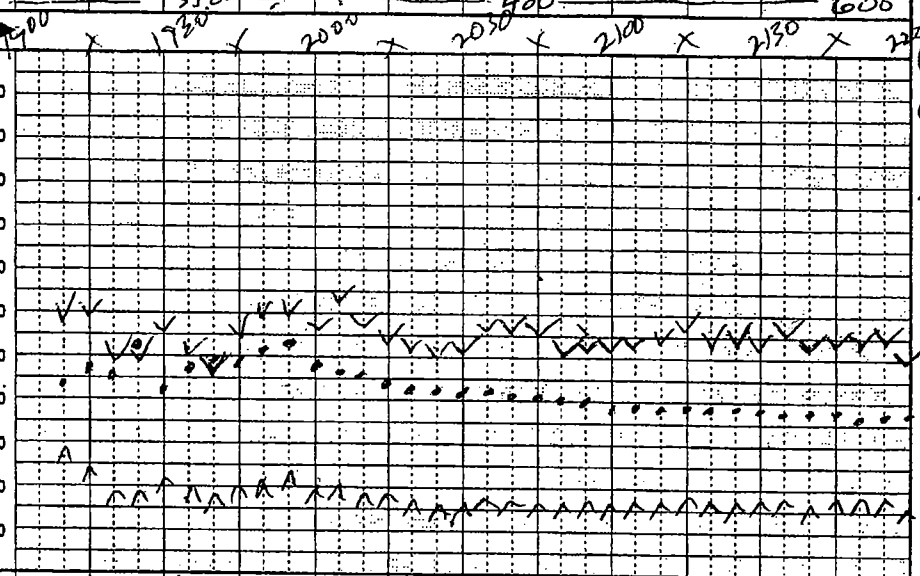
HEMATOCRIT:

INITIAL DATA: BP- 116/57 HR- 89

EQUIP CHECK OK?- (Y) N

PATIENT OK for PROCEDURE? (Y) TIME- 1900

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



VENTIL

VT - ml		570	610	580	560	570	580	570	590	570	570	570
f - breaths/min		10	10	10	8	8	8	8	8	8	7	7
Peak inf pres / PEEP		19	19	20	20	20	21	22	23	24	24	25
MODE - S(pon), A(ssist), C(on)		C	C	C	C	C	C	C	C	C	C	C

MONITORS/ACCESSORIES

X BP/Auto Cuff	ET CO2 (torr)	34	34	32	37	35	32	32	33	31	33	33
BP/oth	FIO2 (Frac or %)	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
ART line	SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	ST	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site	Avail										
	N-M Block (T/4)	0/4	4/4	4/4	0/4	4/4						
Warming blkt												
Conv warmer												

Mark with letters & symbols, explain under REMARKS. EVENTS: Position (A) (B) (C)

RECOVERY AT: 2320

PACU (ICU) 2 (Specify)

OTHER

CONDITION: Anesthe

RESP- 16 SpO2 98%

BP- 164/55 HR- 98

ANESTHESIA/PROCEDURE TIMES

	Start	Room	End
ANES	1830	1909	2330
	Ready	Begin	End
PROC	1920	1928	2310

PROCEDURES and CPT Codes: Ex Lap / Ex Fix (R) humerus / Clean & splint (L) humerus

PATIENT IDENTIFICATION: Typed Medica

EPW # [redacted]

(b)(6)-4

25 APR 03

EXPL LAP

EXT. FIX (R) HUMERUS

I+D (L) HUMERUS

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

8.0 ETT; Miller #2; Grade 1 airway

Propofol / Demerol / DLX1 / VCx1 / tube passed through clear cords 5 d/t

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

(A) = BBS; (B) ETCO2 >30x3; eye taped; tube taped @ teeth @ 23cm; pressure points v'd & padded

SURGEONS: [redacted]

ANESTHETISTS: [redacted] M.D. (b)(6)-2

PROCEDURE LOCATION: OR #1

DATE: 25 Apr 03

PAGE 1 OF 2

DA FORM 7389, FEB 19

COPY 1 - PATIENT'S MEDICAL RECORD

USAPA V1.00

MEDCOM - 8200

LIC MC (b)(6)-2

MEDICAL RECORD-SUPPLEME[redacted]

For use of this form, see AR 40-66; the proponent ag[redacted]on General.

REPORT TITLE: **PRE-ANESTHETIC EVALUATION**
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-	CONSULTATIONS (Check when completed)
	26	~70kg	☐ NKDA PCN	☐ NO ANES PROB	EtOH-	☐ 1
PROPOSED SURGERY	SEX	HEIGHT			DRUGS	☐ 2
						☐ 3

PREVIOUS ANESTHESIA/SURGERY ☐ NO PROBLEM: Ø

MEDICATIONS ☐ NONE * = ORDERED AS PRE-MED
midaz 5mg
MSO4 7mg

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)

(Shot while attempting to attack "medics" along w several buddies)
EPW part of ambush US forces (medics) — suffered 5 GSW's total.
fx (R) humerus, etc

PHYSICAL EXAM: HR BP T RR

AIRWAY: MP 1 2 3 4
Teeth
ROM Unable to assess
TMD (FB) <2 (2) 3 >3

HEART:

LUNGS: ☐ CTAB

NEURO/BACK:

BLOCK SITE:

VASC ASSESS: (L) hand (L) foot

EXT/OTHER:
CXR: min pneumo (R) apex

Na	Cl	glu
136	107	159
K 4.7	CO_2 24	BUN/Cr 8/.61
WBC 23.3	Hct 32	plts 302
PT	PTT	βHCG

ECG ☐ WNL

CXR ☐ WNL

ABG 7.307/72/23/92%

PFT

OTHER

(b)(6)-2

PROBLEM LIST
(R) side c̄ ~T7 (axilla) → CT base (L)
Epigastric pain complaint
(R) humerus fx

ASA 1 2 3 4 5 (E)

☐ Counselled to remain NPO

PLAN
____General ____MAC
____Regional: ____
____Block: ____
☐ Post Op ICU/Vent ☐ Awake Intubation
☐ Art Line ☐ CVP ☐ PA
☐ Special Techniques
PREMED:

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: ____

(Continue on reverse)

PREPARED BY (Signature [redacted] M.D.
[redacted] LIC, MC

DEPARTMENT/SERVICE/CLINIC REVIEWED BY:

DATE 25 Apr 03

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☒ OTHER (Specify) Suppl SF 517
☐ DIAGNOSTIC STUDIES
☐ TREATMENT

DA FORM 1 MAY 78 4700 PREVIOUS EDITION IS OBSOLETE REQUIREMENT OF PRIVACY ACT OF 1974 NSG OVPT 34-R (Mar 02)

MEDCOM - 8201

MEDICAL RECORD - ANESTHE

...se of this form, see AR 40-66; the proponent agen... ...e OTSG

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

DRUG (Units)													
Fentanyl (mcg)				50/50/50									
( )													
( )													
( )													
( )													
( )													
VOLAT AGENT Forane % del	1.0	1.0	1.5	1.5	1.0								
% e.t.													
AIR L/Min													
N2O L/Min													
O2 L/Min	1.5	1.5	1.5	3	1.0								

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

FLUIDS

LINE site												
L foot ☐ Warmed	600	—	—									
L hand ☐ Warmed	2000	X D/C'd										
☐ Warmed												
☐ Warmed												

LOSSES

EST BLOOD LOSS												
URINE -	600-700	—	—									

PHYS STATUS 12345 E

BODY WEIGHT: 0 KG LB

HEMATOCRIT: 32 pre 28 post

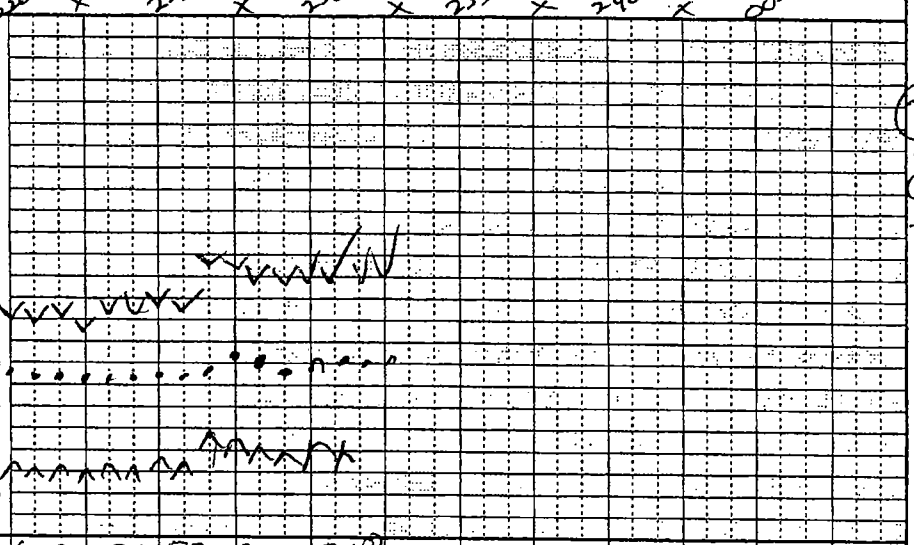
INITIAL DATA: BP- / HR- 4

EQUIP CHECK OK?- Y N

PATIENT OK for PROCEDURE? TIME-

TIME → 2200 X 2230 X 2300 X 2330 X 2400 X 0030

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



VENTIL

VT - ml	610	570	570	340	300
f - breaths/min	7	7	7	12	14
Peak inf pres / PEEP	26	21	21		
MODE - S(pon), A(ssist), C(on)	C	C	C	S	S

MONITORS/ACCESSORIES

X BP/Auto Cuff	ET CO2 (torr)	33	35	35	47	46
BP/oth	FIO2 (Frac or %)	1.0	1.0	1.0	1.0	1.0
ART line	SpO2 (%)	100	100	100	100	100
X Steth- PC/ES	ECG	SR	SR	SR	SR	
Gas analyzer	TEMP-site	Avail				
	N-M Block (T/4)	4/4				
Warming blkt						
Conv warmer						

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

TOTALS 710/0

TOTAL EBL 50

TOTAL URINE 700

FLUIDS - SUMMARY
CRYSTALLOID- 2600
COLLOID- Ø
BLOOD- Ø

REMARKS
Code drugs with numbers, events with letters

(2255) Assumed care [redacted] (b)(6)-2

(2313) Pt sx decatubated E (+) pressure. To ICU TO2. N+m

RECOVERY AT
PACU ICU _____ (Specify)
OTHER _____
CONDITION:
RESP- SpO2
BP- HR

ANESTHESIA/PROCEDURE TIMES

	Start	Room	End
ANES	4 pm		
PROC	Ready	Begin	End

PROCEDURES and CPT Codes: See previous page

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

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

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments See previous page

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

ANESTH[redacted]

PROCEDURE LOCATION: OR #1

DATE: 25 Apr 03

PAGE 2 OF

DA FORM 7389, FEB 1998 — LTC, MC [redacted] — COPY 1 - PATIENT'S MEDICAL RECORD — USAPA V1.00

MEDCOM - 8202

MEDICAL RECORD - ANESTHES

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

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

DRUG (Units)															TOTALS
Versed (mg)	2	1													3 mg
FENT (mcg)		50				50	50	50							250 mcg
Prop (mg)		150													
Vec/Sux (mg)		1/6					1			2	2				
Morphine (mg)									2	2	2	2	2		20 mg
( )															
VOLAT AGENT — Forane % del		1.0	.8	.8	.8	1.0	1.3	1.5	1.3	1.4	1.4				
% e.t.															
AIR L/Min															
N2O L/Min															
O2 L/Min		6	6	2	1		1	1	1	1	1	1	1		

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

TOTAL EBL: < 200 mL

TOTAL URINE: 20 mL No foley

FLUIDS - SUMMARY

CRYSTALLOID- LR 300 NS 100

COLLOID- Ø

BLOOD- Ø

FLUIDS

LINE site														
(L) foot LR	☐ Warmed	800				300								
	☐ Warmed													
(R) wrist NS	☐ Warmed													
	☐ Warmed			400			650	850			1000			

LOSSES: EST BLOOD LOSS / URINE - No foley

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 70 (KG) LB

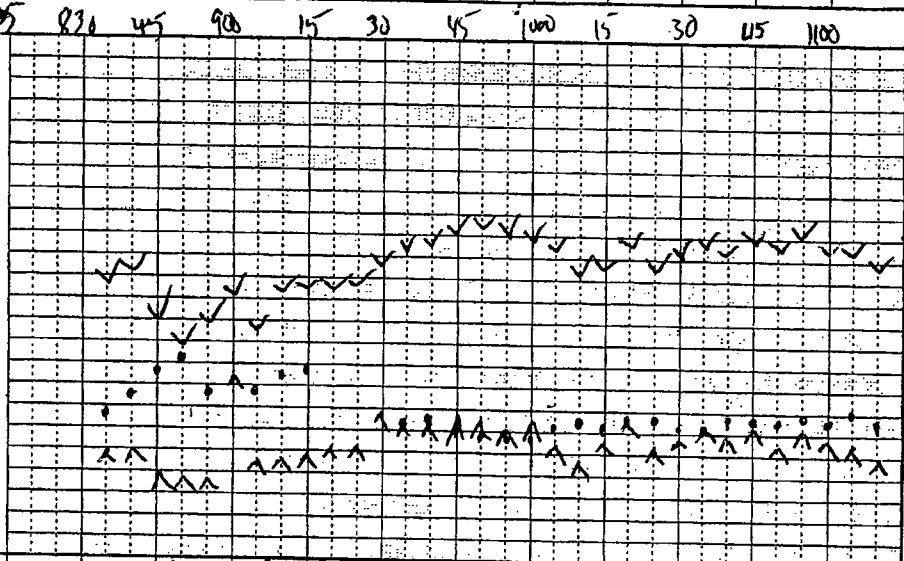
HEMATOCRIT: N/A

INITIAL DATA: BP- 154/64 HR- 72

EQUIP CHECK: OK?- Y N

PATIENT: OK for PROCEDURE? Yes VSS JJW TIME- 0820

SYMBOLS: BP by cuff ∨ ∧; Heart rate ●; Resp rate 10; BR (transduced) ╪; TOURNIQUET T—T; ANES- X-X; PROC- ⊙-Ø



VENTIL.

VT - ml			810	790	810	800	810	770	790	830	800	820
f - breaths/min		20	8	8	8	6	6	6	6	6	6	6
Peak inf pres / PEEP			25	27	28	27		28	27	27	28	27
MODE - S(pon), A(ssist), C(on)		S	C	C	C	C	C	C	C	C	C	C

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)		32	28	30	32	32	32	33	33	34	34
BP/oth	✓ FIO2 (Frac or %)	.8	.72	.72	.71	.70	.70	.7	.71	.7	.71	.71
ART line	✓ SpO2 (%)	100	96	100	100	100	100	100	100	100	100	100
Steth- PC/ES	✓ ECG	SR	SR	SR	SR	SR	SB	SR	SR	SR	SR	SR
✓ Gas analyzer	✓ TEMP-site	SKIN		36				37				
ETCO2 Only	✓ N-M Block (T/4)	4/4	4/4	4/4		0/4	0/4	2/4		2/4	1/4	
Warming blkt												
Conv warmer												

Mark with letters & symbols. explain under REMARKS — EVENTS Position → O— OFF (R) LD ~ letters X-Break ~ X

REMARKS — Code drugs with numbers, events with letters

0825 To OR
Van to table
0830 induction 150 ☡
monitors applied
O_2/Fm
8:40 induction
8:43 intubation
9:45 Position
prep + drape
pr (R) LD axroll
placed good radial pulse
18g IV in (R) wrist
0935 Break cast
0940 T/- Ancef IMPB
100 Surgeon request
1050 - 1100
Replace 10 mg Slow INF
1115 Go to pg 2

RECOVERY AT: PACU IOU ____ (Specify) OTHER

CONDITION: RESP- SpO2- BP- HR-

ANESTHESIA/PROCEDURE TIMES

	Start	Room	End
ANES	0820	0830	1370
PROC	Ready 845	Begin 925	End 1256

PROCEDURES and CPT Codes: ORIF (L) humerus fx / wash out (R) humerus wound

ANESTHETIC TECHNIQUES: Describe block technique under Remarks ETA Forane/Fent/MSO4 Eyes taped

PATIENT IDENTIFICATION: Type Med EPW # [redacted] 28 APR 03 (b)(6)-4 ORIF (L) Humerus I&D

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments 8.0 ET DV 3 MAC Exp x1 Ø Trauma Verified by BBS + ETCO2 Secured @ 20cm cuff to self seek pressure

SURGEON: [redacted]

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

PROCEDURE LOCATION: IOU 1

DATE: 28 APR 03

PAGE 1 OF 2

DA FORM 7389, FEB

COPY 1 - PATIENT'S MEDICAL RECORD USAPA V1.00

MEDCOM - 8203

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**
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-	CONSULTATIONS (Check when completed)
28 Apr 03	25	70kg	☐ NKDA (PCN)	☒ NO ANES PROB	EtOH-	☐ 1
PROPOSED SURGERY	SEX	HEIGHT			DRUGS	☐ 2 N/A
ORIF (L) humerus & possible (R) CT placement	M					☐ 3

PREVIOUS ANESTHESIA/SURGERY ☐ NO PROBLEM: see notes

MEDICATIONS ☐ NONE * = ORDERED AS PRE-MED: 3 mg $MgSO_4$ @ 0750

1. CARDIOVASCULAR	5. GI	9. MUSC-SKELETAL
☐ No Pathology	☐ No Pathology	☐ No Pathology
☐ Angina	☐ Reflux	☐ Osteoarthritis
☐ MI	☐ Hiatal Hernia	☐ Rheumatoid Arthritis
☒ Hypertension (Borderline)	☒ Other NML	☐ TMJ Disease
☐ Low Exercise Tol	6. NEURO	☐ Other
☐ Arrhythmia	☐ No Pathology	10. OB/GYN
☐ CHF	☐ CVA	☐ Non-Preg
☐ Valvular Disease	☐ Neuropathy	☐ Preg
☐ CABG	☐ Seizures	☒ EGA N/A
☐ Periph Vasc Dis	☐ Other NML	G P
☐ Other	7. ENDOCRINE	☐ Pre-eclampsia
2. RESPIRATORY	☐ No Pathology	☐ Other N/A
☐ No Pathology	☐ Insulin-Dep Diabetes	11. PEDIATRIC
☐ Asthma	☐ Non-Insulin-Dep Diabetes	☐ Normal Growth Dev
☐ COPD	☐ Thyroid	☐ < 46 wks PCA
☐ URI	☐ Steroids	☐ Congenital Defects
☐ Other	☐ Other NML	☐ Cerebral Palsy
3. RENAL	8. HEMATOLOGIC	☐ Other N/A
☐ No Pathology	☐ No Pathology	☐ DENTURES
☐ CRF/Renal Insufficiency	☐ Anemia	☐ CONTACTS
☒ Other NML	☐ Coagulopathy	☐ PROSTHESIS
4. HEPATIC	☐ Sickle Cell Dis	
☐ No Pathology	☐ Hx Transfusion	
☐ Hepatitis	☒ Other no transfusion during this admission	
☐ Cirrhosis		
☒ Other		

- Chest tube D/C'd 27 Apr 03

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

25 Apr 03
1) S/P Ex lap, debridement (L) Chest wound - Neg. ex lap
2) S/P I+D (R) humerus fx c̄ Ex fix
3) S/P I+D (L) humerus fx c̄ splint
4) (R) pneumothorax

PHYSICAL EXAM: HR 78 BP 164/65 T 99 RR 30 SaO2 99-100

AIRWAY: MP 1 2 3 4
Teeth
ROM
TMD (FB) <2 2 3 >3

HEART: RRR (-) (-)

LUNGS: ☐ CTAB
↓ R lung sounds

NEURO/BACK:

BLOCK SITE:

VASC ASSESS: (L) Foot 18G PIV 25 Apr 03

EXT/OTHER:

Na	Cl	glu	ECG ☐ WNL
136	107	159	
K	CO_2	BUN/Cr	
4.7	24	8/1.1	
WBC	Hct	plts	
23.3	37.3		
PT	PTT	βHCG	CXR ☐ WNL
ABG			

Apr 25th

PFT

OTHER

(b)(6)-2

PROBLEM LIST
1) B humerus fx's (open
2) GSW to posterior thorax
3) (R) pneumothorax Resolving

ASA 1 (2) 3 4 5 E

☒ Counselled to remain NPO ordered

PLAN
✓ General ___ MAC
___ Regional: ___
___ Block: ___
☐ Post Op ICU/Vent ☐ Awake Intubation
☐ Art Line ☐ CVP ☐ PA
☒ Special Techniques Please place new PIV once asle
PREMED:

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: ___

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC REVIEWED BY:

DATE: 28 Apr 03

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

FPW # [redacted]

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☒ OTHER (Specify) Suppl SF 517
☐ DIAGNOSTIC STUDIES
☐ TREATMENT

MEDICAL RECORD - ANESTHES

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

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

DRUG (Units)																
Lido (mg)									50							
Propofol (mg)					20											
Vec (mg)	2															
Morphine (mg)	2	2	(4)	2												
VOLAT AGENT: FORANI % del	1.4	1.4		1.4	.8	.8	.8	.5	X							
% e.t.																
AIR L/Min																
N2O L/Min																
O2 L/Min	1	1		1	2	2	2	4	4							

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

FLUIDS

LINE site																
	☐ Warmed															
	☐ Warmed															
	☐ Warmed															
(R) Ringer NS	☐ Warmed	1100			1200				1300		1500	1400				

LOSSES: EST BLOOD LOSS; URINE - NO foley

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 70 (KG) LB

HEMATOCRIT: N/A

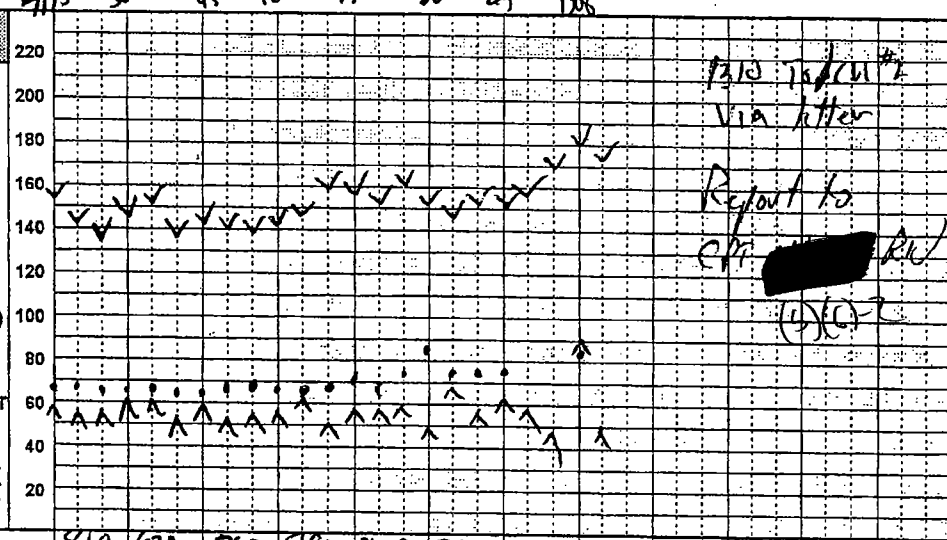
INITIAL DATA: BP; HR-

EQUIP CHECK: ~~OK?~~ Y N

PATIENT: OK for PROCEDURE? TIME-

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

TIME → 1115 30 45 1200 15 30 45 1300



VENTIL.

VT - ml	810	830	780	790	840	780		
f - breaths/min	6	7	7	7	7	7	14	10
Peak inf pres / PEEP	28	27	28	28	27	25		
MODE - S(pon), A(ssist), C(on)	C	C	C	C	C	C	S	

MONITORS/ACCESSORIES

BP/Auto Cuff / ET CO2 (torr)	34	32	31	31	31	33	47	43
BP/oth / FIO2 (Frac or %)	.71	.71	.71	.71	.71	.72	.71	.71
ART line / SpO2 (%)	100	100	100	100	100	100	100	96
Steth- PC/ES / ECG	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer / TEMP-site SKIN	37		37	37	37	37	37	37
N-M Block (T/4)	4/4	0/4		3/4	3/4	4/4	4/4	4/4
Warming blkt								
Conv warmer								

Mark with letters & symbols, explain under REMARKS — EVENTS Position → RLO Xe w/letters

TOTALS: TOTAL EBL; TOTAL URINE

FLUIDS - SUMMARY: CRYSTALLOID-; COLLOID-; BLOOD-

REMARKS — Code drugs with numbers, events with letters

0825 - 1115 See pg 1
1120 Break: Walters
1150
1245 CTT suction w/o
1225 ORIF (L) hand complete
1230 prep & position/drape for (L) arm washing
1235 ⊕ BBS after positio
1250 manual vent
1255 OP Suction
1300 SV 15/min
ETCO2 44
4/4
1306 OP Suct
pt responding
Cx fubent

RECOVERY AT: 1315
PACU ICU (Specify)
OTHER T 98.2
CONDITION: Awake
RESP-40 SpO2 100% On Fio2
BP-159/73 HR-123

ANESTHESIA/PROCEDURE TIMES

ANES	Start	Room	End
PROC	Ready	Begin	End

PROCEDURES and CPT Codes: ORIF (L) humerus fx / (R) Wash out humerus wound

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA FORANI / FENT / Morphine

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

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: See pg 1

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

ANESTHETISTS: [redacted]

PROCEDURE LOCATION: OR #1

DATE: 28 APR 03

PAGE 2 OF 2

DA FORM 7389, FEB 1998 — COPY 1 - PATIENT'S MEDICAL RECORD — USAPA

MEDCOM - 8205

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 25 **DAYS MOS YRS** **Sex** (X) **MALE** ( ) **FEMALE**

ASA Physical State 1 (2) 3 4 5 E
WT: 70 KG/LB **HT:** ____ IN.
ALLERGIES: PCN

PROPOSED PROCEDURE: Adj. Ex Fix (R) humerus
SURGICAL SERVICE: Ortho
NPO SINCE: PMN

HABITS:
TOBACCO: ____
ETOH: ____
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) Augmentin
( ) ____
( ) ____
( ) ____
( ) ____
( ) ____

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

LABORATORY STUDIES:

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

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	
Angina	N	Y	
MI	N	Y	
CVA	N	Y	
Other	N	Y	
Pulmonary System:			
Asthma	N	Y	SP (R) LL pre.
Bronchitis/URI	N	Y	
COPD	N	Y	
Other	N	Y	
Renal System:			
Acute/Chronic RF	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	
Hiatal Hernia	N	Y	
PUD/GERD	N	Y	
Endocrine System:			
Diabetes	N	Y	
Steriods	N	Y	
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	
Other	N	Y	
Gynecological :			
Pregnancy	N	Y	
Other Significant Hx:			
	N	Y	
	N	Y	
Familial HX	N	Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Ex lap
(R) pneumothorax
Ext. Ex (R) humerus
D&D (R) humerus

PHYSICAL EXAMINATION
BP 106/64 HR 70 R 20 T 97.5
Pain Scale 0-10 ____
HEENT - Teeth ____
Trachea ____
TMJ/Neck ____
Oropharnyx ____
Nares ____
CHEST: ____
CARDIAC: ____
EXTREMITIES:
IV Access: (L) Arm
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since PMN

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

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

The patient/legal guardian seems to understand and agrees. Questions answered.
Signed: ____ **Date:** ____ **Time:** ____ Hrs

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

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

(b)(6)-2 [redacted]

Patient Identification: (Ward) ____

[redacted] # [redacted]

(b)(6)-4

SEDATION KEY:

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

ICW-4.

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 25 DAYS MOS YRS Sex (✓) MALE ( ) FEMALE

PROPOSED PROCEDURE: Adj ext Fixation
SURGICAL SERVICE: ortho
NPO SINCE: 24hr

ASA Physical State 1 2 3 4 5 E
WT: 70 KG/LB HT: ____ IN.
ALLERGIES: PCN

HABITS:
TOBACCO: ____
ETOH: ____
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) Augmentin 250mg
( ) Amoxicillin 250mg
( ) Albuterol
( ) ____
( ) ____
( ) ____

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

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

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT
PAST SURGICAL/ANESTHETIC
S/p replap clubfoot U clubfoot
ORIF Lt humerus
Exploratory PE
R Pneumothorax

PHYSICAL EXAMINATION
BP 104/44 HR ____ R 16 T 98
Pain Scale 0-10 ____
HEENT - Teeth WNL
Trachea M/L
TMJ/Neck 3 FB
Oropharnyx ____
Nares ____
CHEST: ____
CARDIAC: ____
EXTREMITIES: ____
IV Access: ____
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since ____

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

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

The patient/legal guardian seems to understand and agrees. Questions answered.
Signed: ____ Date: ____ Time: ____ Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

#[redacted] (5)(6)-4

SEDATION KEY:

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

1800

NSN 7540-01-165-7294

519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN *(Sponsor)*	WARD/CLINIC	REGISTER NO.
Portable CXR		M		Icu 2	
	FILM NO.				PREGNANT ☐ YES ☐ NO
	REQU[redacted]				TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR [redacted] (b)(6)-2				DATE REQUESTED 26 Apr 03

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

change in CT

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*
26 Apr 03 DRU		

RADIOLOGIC REPORT

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

RADIOLOGIC CONSULTATION REPORT

MEDCOM - 8208

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

NSN 7540-01-165-7294

519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
CXR		M	0073	ICU	
	FILM NO.				PREGNANT ☐ YES ☐ NO
	REQUESTED BY (Print)		[redacted] (b)(6)-2		TELEPHONE/PAGE NO.
	SIGNATURE		[redacted], CPT, MC		DATE REQUESTED 29 APR 03

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

S/P chest tube removal

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

RADIOLOGIC REPORT

- obscured RT hemidiaphragm with blunting of RT CPA = p/ effusion with RLL atelectasis is considered. Pneumonia cannot be exclud. Blood is also possible. ⊘ PTX.
- subcutaneous emphysema of the Rt lateral chest wall.
- surgical staples on the mid abd.

[redacted] MD

(b)(6)-2

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

[redacted]

(b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT

MEDCOM - 8209

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

NSN 7540-01-165-7294

519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN *(Sponsor)*	WARD/CLINIC	REGISTER NO.
Chest Xray			[redacted]	ICW2	
	FILM NO.		(b)(6)-4		PREGNANT ☐ YES ☐ NO
	REQUESTED BY *(Print)*		[redacted] MD		TELEPHONE/PAGE NO.
	SIGNATURE OF REQ[redacted] (b)(6)-2				DATE REQUESTED

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

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

RADIOLOGIC REPORT

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

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

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT

MEDCOM - 8210 ORD

STANDARD [illegible] Prescribed by [illegible] FPMR (41 CF[illegible]

NSN 7540-01-165-7294 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
LEFT LOWER EXTREMITY DUPLEX		M		ICW 2	
	FILM NO.				PREGNANT ☐ YES ☐ NO
	REQUESTED BY (Print) [redacted] MD (b)(6)-2				TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR [redacted]				DATE REQUESTED 3 MAY03

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

(L) LE SWELLING (BELOW KNEE)

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

RADIOLOGIC REPORT

normal study from common fem to pop vein of the left lower extremity.

[redacted], MD
(b)(6)-2
3 MAY03
1105 HR

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

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

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT

MEDCOM - 8211 ORD

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
25 APR 03	2200 HOURS	
1) ADMIT TO ICW #2		
2) Dx: S/P EX LAP, TUBE THORACOTOMY		
(R) LE I+D & EX FIX		
(L) LE I+D & SPLINT		
3) COND: STABLE		
4) STATUS: EPW		
5) VITALS: Q4°		

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
↓	↓ HOURS	
6) STRICT I/O'S		
7) DIET NPO		
8) ACTIVITY: BEDREST - HOB ≥ 30°		
9) INCENTIVE SPIRUMETRY Q1° WHILE AWAKE		
10) NGT TO LIS		
11) FOLEY TO GRAVITY		

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
↓	↓ HOURS	
12) (R) CHEST TUBE TO -15 cm SUCTION		
13) MEPS ½ ANCEF 1 gm IVPB Q8°		
MSO4 2-8 mg IVP Q1° PRN PAIN		
NAPSINE 0.25cc IV Q6° PRN NIV		
HEPARIN 5000 UNITS SQ BID		
14) CXR QAM		
15) REINFORCE ARM DRESSINGS PRN		

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
↓	↓ HOURS	
16) 2LNC O2 → WEAN TO RA		
17) CALL M.D. FOR: T > 101.5		
HR > 120		
SaO2 < 92%		
CHEST TUBE OUTPUT > 200cc/hr		

[redacted] (b)(6)-4

NOTE (b)(6)-2 [redacted] CPT 25 APR 2300

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

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

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

EPW (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 25 APR 03 TIME OF ORDER: 2300 HOURS

(1) IVF: LR @ 125cc /hr

[redacted] MD

(b)(6)-2

LIST TIME ORDER NOTED AND SIGN

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 26 APR 03 TIME OF ORDER: 0700 HOURS

26 Apr 03 0730

(1) SIPS H2O PRN

(2) OOB IN CHAIR QID

(3) ENCOURAGE SPIROMETRY

[redacted] (b)(6)-2

[redacted] (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 26 APR 03 TIME OF ORDER: 1600 HOURS

(1) (R) CHEST TUBE TO WATER SEAL

(2) CXR AT 1800 (PORTABLE)

[redacted] (b)(6)-2

26 Apr 03 [redacted] (b)(6)-2 1700

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 27 APR 03 TIME OF ORDER: 0830 HOURS

(1) DIC NGT, ~~&~~ FOLEY

(2) CHEST TUBE DIC'ED

(3) CXR NOW PLEASE

(4) CLEAR LIQUID DIET

(5) WET-DRY DRESSING - (L) CHEST WOUND BID

(6) DIC ANCEF

(7) NPO ~~P~~ MN

27 Apr 03 [redacted] (b)(6)-2 0900

[redacted] (b)(6)-2

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

MEDCOM - 8213

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

ATIENT IDENTIFICATION

[redacted]

(b)(6)-4

DATE OF ORDER: 27 APR 03 TIME OF ORDER: 0950 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) O2 : 10L - FACE MASK

(2) REPEAT CXR 1400

[redacted] (b)(6)-2

[redacted] (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 27 APR 03 TIME OF ORDER: 1605 HOURS

(1) IN/OUT BLADDER CATHERIZATION X1 NOW

27 Apr 03 1605

[redacted] (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 27 APR 03 TIME OF ORDER: 1620 HOURS

NPO 4 MN

[redacted] (b)(6)-2

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

27 Apr 03 1620

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

- Resume Pre Op orders i these
  D5
- Regular Diet
- Ancef 1gm IVPB q8°
- PT for room exercises (R) elbow
- Dressing Δ qpm with care daily (R) arm & chest

NURSING UNIT | ROOM NO. | BED NO.

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

[redacted] (b)(6)-2

MEDCOM - 8214

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

EPW # [redacted]

[redacted]

(b)(6)-4

NURSING UNIT: ICU #2 | ROOM NO. | BED NO.: 7

DATE OF ORDER: 28 APR 03 | TIME OF ORDER: 1820 HOURS | LIST TIME ORDER NOTED AND SIGN

Anesthesia Post Op Pain Order

1 Demerol 125mg IV q 5 min for pain MAX dose [redacted] (b)(6)-2

[redacted] ATG/CRNA 6001

1330 1410

[redacted] 1325 28 Apr 03

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 28 APR 03 | TIME OF ORDER: 1600 HOURS

1 REGULAR DIET AS TOLERATED (b)(6)-2

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 29 APR 03 | TIME OF ORDER: 0800 HOURS

1 DIC QAM CXR

2 NC O2 -2L

3 ODB IN CHAIR 4 hrs/SHIFT (b)(6)-2

4 CXR now

5 Tylenol 975mg PO now [redacted]

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

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 29 Apr 03 | TIME OF ORDER: 1800 HOURS

1 CXR now

2 Tylenol 975mg PO now + 94° RW (b)(6)-2

[redacted] (b)(6)-2 29 Apr 03 1800

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

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

EPW [redacted]

EPW [redacted]

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

DATE OF ORDER: 29 Apr 03 | TIME OF ORDER: 2130 HOURS | LIST TIME ORDER NOTED AND SIGN

(1) Zosyn 3.375 g IV q 6° 1st dose now

(b)(6)-2

[redacted]

Noted (b)(6)-2 [redacted] LPN 2ND ABRUS 5 0244D

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 30 APR 03 | TIME OF ORDER: 0700 HOURS

(1) CHEST PT - FOCUS TO (R) LOWER CHEST, Q 4°

(2) ALBUTEROL NEB 0.5 mg Q4°

(3) NT SUCTION Q2° (b)(6)-2

(4) CBC NOW

30 Apr 03 1415 [redacted] (b)(6)-2

[redacted] MD

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 1 MAY 03 | TIME OF ORDER: 0700 HOURS

(1) D/C IVF, HEPLOCK IV

(2) CXR NOW PLEASE

(3) REMOVE ABD. WOUND STAPLES, PLACE STERI-STRIPS

1 May 03 [redacted] 1230 (b)(6)-2

[redacted] MD

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 1 May 03 | TIME OF ORDER: 2300 HOURS

Colace I po BID - 1st dose now

Noted 1 May 03 [redacted] LT MC 2300

[redacted] (b)(6)-4

[redacted] (b)(6)-2

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

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

EPW# [redacted]

(b)(6)-4

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

NURSING UNIT: ICW2 | ROOM NO. | BED NO.

DATE OF ORDER: 2 MAY 03 TIME OF ORDER: 0710 HOURS

LIST TIME ORDER NOTED AND SIGN

1. D/C D2
2. CBC NOW PLEASE — (b)(6)-2

[redacted]

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT: ICW2 | ROOM NO. | BED NO.

DATE OF ORDER: 2 MAY 03 TIME OF ORDER: 0830 HOURS

1. TRANSFER TO ICW (b)(6)-2
2. PT CONSULT [redacted]

PATIENT IDENTIFICATION

(b)(6)-4

[redacted]

NURSING UNIT: ICW2 | ROOM NO. | BED NO.

DATE OF ORDER: 2 May 03 TIME OF ORDER: 1211 HOURS

Transfer orders

1. Dx s/p GSW to chest/arm/abd
2. Condition stable (s/p ex lap)
3. Diet - Regular
4. IV - heplock
5. meds:

X MSO4 2-8 mg IVP q 2hr PRN pain

PATIENT IDENTIFICATION

(b)(6)-4

[redacted]

NURSING UNIT: ICW2 | ROOM NO. | BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

Dulcolax 10 mg PO q 4° PRN pain

Albuterol Nebs MDI q 4°

Zosyn 3.375 mg IVPB q 6°

Heparin 5000 units SQ BID

Colace 100 mg PO BID

Tylenol 650 mg PO q 4° PRN

Morphine 0.25 cc q 6° PRN Nausea

Incentive Chest PT q 4° & Nebs

Start to dangle Δ BID

Flushed a tolulets

[redacted] (b)(6)-2

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

MEDCOM - 8217 ?(PCN)

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

DATE OF ORDER: 2 MAY 03 TIME OF ORDER: 2100 HOURS

LIST TIME ORDER NOTED AND SIGN

1. D/C HEPARIN
2. LOVENOX 70mg SUBCUT Q12°

(b)(6)-2 [redacted]

NURSING UNIT: Chart ✓ ROOM NO.: [redacted] BED NO.: 3 May 03 0630 [redacted]

PATIENT IDENTIFICATION: (b)(6)-2

DATE OF ORDER: 3 MAY03 TIME OF ORDER: 0700 HOURS

(b)(6)-2 [redacted]

1. CBC, CXR THIS A.M.
2. PT ON CALL FOR LEFT LEG DUPLEX ULTRASOUND

3 MAY 03/0730 [redacted]

NURSING UNIT: ROOM NO.: BED NO.:

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

PATIENT IDENTIFICATION

DATE OF ORDER: 3 May 03 TIME OF ORDER: 1500 HOURS (b)(6)-2

1. D/C Zovirax [redacted]

24°VS [redacted] 1ST AN 5/3/03 0045

(b)(6)-2

NURSING UNIT: ROOM NO.: BED NO.:

24°VS [redacted] 1ST AN 5/4/03 0100 [redacted]

PATIENT IDENTIFICATION: (b)(6)-2

DATE OF ORDER: [redacted] 5 May 03 TIME OF ORDER: 0710 HOURS

1. D/C PERCOCET, 20 IV
2. AUGMENTIN 250 mg
   AMOXICILLIN 250 mg PO TID
3. D/C IV
4. HEPARIN 5000 UNITS SQ BID
5. TYLOX 2 PO Q4-6° PRN PAIN

NURSING UNIT: ROOM NO.: BED NO.:

24°VS [redacted] 1ST AN 5/6/03 0045 [redacted]

(b)(6)-2

DA FORM 1 APR 79 1250 REPLACES EDITION [redacted] 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

[redacted]

NURSING UNIT: ICW2 | ROOM NO.: T | BED NO.: 4

DATE OF ORDER: 1400 5/6/03 | TIME OF ORDER: _____ HOURS | LIST TIME ORDER NOTED AND SIGN

XR AP & LAT (B) Humerus

(b)(6)-2 [redacted]

24 VS [redacted] 1400 AW 5/10/03 0325 [redacted] (b)(6)-2

Noted

4446

PATIENT IDENTIFICATION

(b)(6)-4

[redacted]

NURSING UNIT: ICW2 | ROOM NO.: T | BED NO.: 2

DATE OF ORDER: 5/12/03 | TIME OF ORDER: 0830 HOURS

- Remove Staple (L) Arm
- Remove sutures (B) Arm (b)(6)-2

[redacted]

(b)(6)-2

24° VS [redacted] 0800 14 May 03

PATIENT IDENTIFICATION

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

NURSING UNIT: Chest ✓ | ROOM NO.: done | BED NO.: [redacted]

DATE OF ORDER: 5/14/03 | TIME OF ORDER: 1900 HOURS

- NPO p̄ MN
- Start LR @ 100 cc/hr p̄ MN

[redacted]

(b)(6)-2

0155 05 May 03

PATIENT IDENTIFICATION

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 5/15/03 | TIME OF ORDER: _____ HOURS (b)(6)-2

Remove preop orders
Regular diet
D/C IV fluid when transport available.

[redacted]

(b)(6)-2

15 AW 15 May 03 1300

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. 4 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED (May) 25	26	27	28	29	30	1	2
25APR	[redacted]	Status: EPW	05	/	[redacted]						
			17	[redacted]							
25APR	[redacted]	vitals: q 4 0	05	[redacted]							
			17	[redacted]							
25APR	[redacted]	strict I/O's	05	/	[redacted]						
			17	[redacted]							
25APR	[redacted]	Diet NPO	06	/	[redacted]						
		~~sips if H2O prn~~	12	/	Δ'ed 27Apr03	[redacted]					
			18	[redacted]							
25Apr	[redacted]	Activity: Bedrest	07	/	[redacted]						
		- HOB ≥ 30°.	17	[redacted]	Δ'ed 26 Apr03						
25Apr	[redacted]	Incentive Spirometry	07	/	[redacted]						
		Q1° while awake	17	[redacted]							
25Apr	[redacted]	NGT to LIS	07	/	[redacted]						
			17	[redacted]	D/C 27Apr03	[redacted]					
25Apr	[redacted]	Foley to Gravity	07	[redacted]							
			17	[redacted]	D/C 27Apr	[redacted]					
25Apr 26Apr	[redacted]	(R) chest tube to	07	[redacted]							
		15cm suction H2O seal	17	[redacted]	D/C 27Apr	[redacted]					
25Apr	[redacted]	CXR Q am	05	/	[redacted]	D/C 29Apr03					
25Apr	[redacted]	2LNC O2 →	05	/	[redacted]						
		wean to RA	17	[redacted]	Δ'ed 27Apr03	[redacted]					
26APR	[redacted]	Activity: OOB in chair	05	/ /	[redacted]	Δ'ed 29Apr03					
		Q1D	17	/	[redacted]						
28APR 27Apr	[redacted]	Diet: clear liquid	06	/ /	[redacted]						
		Regular	12	/ /	[redacted]						
			18	/ /	[redacted]						

(b)(6)-2

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO
PCN

PRIMARY DIAGNOSIS: (1) (R) UE I+D & Ex Fix
(2) LUE I+D & Splint
(3) S/P Exp lab, Tube Thoracotomy

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

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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
25 Apr	[redacted]	Admit to ICU H2				[redacted]
25 Apr		condition: stable				
25 Apr		~~CXR QAM~~ error me				
26 Apr		CXR c 1800 (portable)	26 Apr	1800	[redacted]	
27 Apr		CXR now please	27 Apr	Now	0930	
27 Apr		NPO p MN	28 Apr	0000		
27 Apr		Repeat CXR 1400	27 Apr	1400	[redacted]	
29 Apr		CXR NOW			DNR	
1 May		CXR NOW	1 May	Now	0900	
1 May		Remove ABD. wound staples, place	1 May	Now	0930	
		steri-strips	/	/	/	

(b)(6)-2

(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
25 Apr	[redacted]	Reinforce arm														
		dressings PRN														
25 Apr		Call M.D. for														
	(b)(6)-2	T > 101.5, HR > 120,														
		SaO2 < 92%														
		chest tube output														
		> 200 cc/hr														

USAPA V1.00

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 27	28	29	30	1	2	3
27Apr	[redacted]	Wet-dry dressing	08	/	[redacted]					
		(L) chest wound	20	[redacted]						
		BID								
29 Apr		OOB to chair	05	/	/	/	[redacted]			
		4°/shift	17	/	/	[redacted]				
30 Apr		Chest PT - Focus to	05	/	/	/	/	[redacted]		
		(R) lower chest Q4°	17	/	/	/				
30 Apr	[redacted]	NT suction Q2°	05	/	/	/	/	[redacted]		
(5)(6)-2			17	/	/	/				

(5)(6)

ALLERGIES: ☐ YES ☐ NO

PCN

PRIMARY DIAGNOSIS:
(R)UE I&D c̄ ext. fixator SIP explap
(L)UE I&D c̄ splint

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

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Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo MAY Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
30 Apr	[redacted]	CBC now	30 Apr	NOW	0825	[redacted]
2 May	[redacted]	CBC NOW	2 May	DONE		[redacted]
2 May	[redacted]	TRANSFER TO JEW	2 May	DONE		[redacted]
2 May	[redacted]	PT CONSULT	2 May			(b)(5)-2
	(b)(5)-2					

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

USAPA V1.00

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

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 2	3	4	5	6	7	8	9	10	11	12	13	14	15
2 May 03	[redacted]	Diet Regular	6	/	[redacted]												
			11	/	[redacted]												
			17	[redacted]													
2 May 03	[redacted]	Wet to Dry Dressing Δ BID	10	/	[redacted]										See below		
			22	[redacted]													
2 May 03	[redacted]	Act as TOL	06	/	[redacted]												
			14	[redacted]													
			22	[redacted]													
10	[redacted]	wet→Dry dsg on	10	—	—	—	—	—	—	—	—	—	—	—	—	[redacted]	
		back Δ QD															
		-dsg Δ to (L) elbow QD															
		-dsg Δ & pincare to															
		(R) arm QD															
															13	14	15
15 May	[redacted]	DIET: NPO	06	/	/	/	/	/	/	/	/	/	/	/	/	/	[redacted]
			11	/	/	/	/	/	/	/	/	/	/	/	/	/	
			17	/	/	/	/	/	/	/	/	/	/	/	/	[redacted]	
		(b)(6)-2															
15 May	[redacted]	Diet: Regular	06	—	—	—	—	—	—	—	—	—	—	—	—	1	[redacted]
			11	—	—	—	—	—	—	—	—	—	—	—	—	1	
			17	—	—	—	—	—	—	—	—	—	—	—	—	1	

(b)(6)-2

(b)(6)-2

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO
PCN?

PRIMARY DIAGNOSIS: (b)(6)-2
S/P GSW to chest/arm/elbo [redacted]

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo May Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
2MAY	[redacted]	CONDITION STABLE = Transfer Order	2May03			[redacted]
	[redacted]	DX: S/P GSW to chest/arm/				
		elbow				
3MAY	[redacted]	CBC THIS AM	3MAY03	AM	DONE	[redacted]
3MAY	[redacted]	CXR THIS AM	3MAY03	AM	0825	[redacted]
3MAY	[redacted]	PT ON CALL FOR LEFT LEG	3MAY	—	11:00	[redacted]
		DUPLEX ULTRASOUND				
9	[redacted]	XR - AP & Lat (B) humerus	9MAY			[redacted]
13MAY	[redacted]	Remove Staples (L) Arm	13MAY	NOW	Done	[redacted]
13MAY	[redacted]	Remove Stitches (R) Arm	13MAY	NOW	Done	[redacted]
14	[redacted]	NPO - f MD	14	2359	Done	[redacted]
15	[redacted]	Resume Preop orders	15 May	1200		[redacted]
15	[redacted]	Regular Diet				
15	[redacted]	DC to jail when transport available	15May	Now	1600	[redacted]

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

USAPA V1.00

CLINICAL RECORD

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

Mo. 4 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 25	26	27	28	29	30	1	2	3	4
25 Apr	[redacted]	Ancef 1 gm IVPB	06	/	[redacted]								
		q 8°	14	/				D/C 27 Apr 03					
			22	/									
25 Apr	[redacted]	Heparin 5000 units	10	/	[redacted]								
		SQ BID	22	/									
25 APR	[redacted]	LR @ 125 cc/hr	05	/									
			17	[redacted]				D/C 1 May 03					
27 Apr	[redacted]	O2 - 10L face	05	/	/	/	[redacted]						
		mask	17	/	/	[redacted]		D/C 29 Apr					
29 Apr	[redacted]	O2 - via NC 2L	05	/	/	/	/	/	[redacted]				
			17	/	/	/	/	[redacted]					
	[redacted]	Zosyn 3.375mg	04	/	/	/	/	/					
		IV q 6°	10	/	/	/	/	/		D/C Times			
			18	/	/	/	/	/					
			22	/	/	/	/	[redacted]			30 Apr 03		
29 Apr	[redacted]	Zosyn 3.375mg	06	/	/	/	/	/	[redacted]				
		IV q 6°	12	/	/	/	/	/					
			18	/	/	/	/	/					
			24	/	/	/	/	/					
30 Apr	[redacted]	Albuterol nebs 0.5mg	02	/	/	/	/	/	/	[redacted]			
		Q4°	06	/	/	/	/	/	/				
			10	/	/	/	/	/					
			14	/	/	/	/	/					
			18	/	/	/	/	/					
			22	/	/	/	/	/					
1 May	[redacted]	Heplock IV	05	/	/	/	/	/	/	/			
			17	/	/	/	/	/	/				

ALLERGIES: ☐ YES ☐ NO
PCN

PRIMARY DIAGNOSIS:
S/P Ex Lap; Tube thoracotomy
(R) LE I&D & Ex Fix (L) LE I&D & Splint

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

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

(b)(6)-2

(b)(6)-2

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
29 Apr	[redacted]	Tylenol 975mg PO now			DONE	[redacted]
29 Apr	[redacted]	Zosyn 3.375mg ~~IV q6~~ 1st dose now			DONE	[redacted]
	.....					(b)(6)-2
01 May 03	[redacted]	Colace.				
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					

(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
25Apr	[redacted]	MSO4 2-8mg	26Apr 0410 5mg	26 Apr 1120	26 Apr 2mg	26 Apr 1250	26 Apr 1445	26Apr 4mg	26Apr 5mg	27 Apr 0545	27 Apr 0750 3mg	27Apr 1900 4mg	28 Apr 0750	28Apr 1600	28 Apr 0300 3mg	29Apr 0030 5mg	24APR 0300 3mg
.....	.....	IVP q1° prn pain	[redacted]	[redacted]	0954	[redacted] 2mg	[redacted] 2mg	[redacted] 1600	2140	3mg	[redacted]	[redacted]	3mg	3mg	[redacted]		
25Apr	[redacted]	Incpsire 0.25cc															
.....	.....	IV q6° prn N/V															
25Apr	[redacted]	Tylenol 975mg															
.....	.....	q4° prn fever															
25Apr	[redacted]	MSO4 2-8mg	29 Apr 0505 2mg IV	[redacted]	1 May 03 2230 2mg	2 May 03 0315 2mg	2 May 03 0445 3mg										
.....	.....	IVP q° prn pain	[redacted]														
.....	.....																
.....	.....																
.....	.....																
.....	.....																
.....	.....																

(b)(6)-2

USAPA V1.00

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 1	2	3											
1 May 03	[redacted]	Colace 1 PO BID 1st DOSE (b)(6)-2	10	/	[redacted]												
			22	[redacted]	(b)(6)-2												

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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 2	3	4	5	6	7	8	9	10	11	12	13	14	15
2May03	[redacted]	Heplock IV	6	[redacted]													
			14														
			23														
2May03	[redacted]	Albuterol NEB MDI Q4° Cont Chest PT & NEBS	02	[redacted]													
			06														
			10														
			14														
			18														
			22														
2May03	[redacted]	Zosyn 3.375mg IVPB Q6°	06	[redacted]													
			12														
			18														
			24														
2May03	[redacted]	Heparin 5000 U SQ BID	10	[redacted]													
			22														
2 May	[redacted]	Colace BID 100mg PO	10	[redacted]													
			22														
2May	[redacted]	Lovenox 70mg SQ Q12°	10	[redacted]													
			22														

D/C IV 3 May 03

D/C 5 May 03

D/C [redacted] 2 May 03 2100°

D/C 3 May 03

(b)(6)-2

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PCN?

PRIMARY DIAGNOSIS: S/P GSW to chest/arm

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

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

EPW

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED														
2May03	[redacted]	Morphine 2-8mg IVP Q2hr PRN PAIN	2May03 1600 5mg IVP	2May03 2200 4mg IVP	[redacted]	3May 0900 6mg IVP	[redacted]	3May03 1500 6mg IVP	[redacted]	3May 0030 6mg IVP	[redacted]	4May 0945	[redacted]	2May 1430 4mg IVP	5/4/03 5/4 204 5.03 6mg IVP	[redacted]	
2May03	[redacted]	Percocet I-II tabs PO Q4 PRN PAIN	4May03 1130 [redacted]														
2May03	[redacted]	Tylenol 650mg PO Q4° PRN	4May 0030 650 [redacted]	5/4 0400 [redacted]	5/5 0140 [redacted]	5/5 0100 [redacted]											
2May03	[redacted]	Inapsine 0.25cc Q6° PRN nausea															

(b)(6)

DIC 5 May 03

2-(9)(5)

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 5 Yr 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 5	6	7	8	9	10	11	12	13	14	15	16
3May03	[redacted]	Augmentin 250mg i	06	/	[redacted]										
		Amoxicillin 250mg	14												
		PO TID	22												
5May03	[redacted]	Heparin 5000 units	10	/	[redacted]										
		SQ BID	22												
14	[redacted]	LR@100cc/hr start	06	/	/	/	/	/	/	/	/	/	/	[redacted]	
	[redacted]	@ midnight 14May03	13	/	/	/	/	/	/	/	/	/	/		
			21	/	/	/	/	/	/	/	/	/	[redacted]		

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PENS

PRIMARY DIAGNOSIS: STP (GSW to chest/abdm)

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted]

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
5May03	- - - - -	Tylox 1 PO Q4-6°	5May03 1300 1	5May 1900 1	5May 2500 1	5May 2500 1	6May 0120 1 PO	6May 0540 1 PO	6May 0950 1 PO	6May 0630 1 PO	6May 0735 1 PO				
- - - - -	- - - - -	PRN PAIN													
- - - - -	- - - - -														
- - - - -	- - - - -	MSO4 Q-8mg IVP	5May03 3mg IV												
- - - - -	- - - - -	Q2hr prn pain													
- - - - -	- - - - -														
- - - - -	- - - - -														
- - - - -	- - - - -														
- - - - -	- - - - -														
- - - - -	- - - - -														
- - - - -	- - - - -														
- - - - -	- - - - -														
- - - - -	- - - - -														

6/6/2

USAPA V1.00

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 15 May
Time In:
Allergies:
Pre-op V/S: 106/64, 70, 20, 97.5
Procedures: Cast (R) arm
Remove fixator

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

OR Intake: Crystalloid 1100 Colloid ~~1100~~
OR Output: UOP Ø EBL Min
Meds/Times:

250 Fent
8mg04
5 vered

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds History

Time	1120	1125	1130	1135	1155	1210	1220
SaO2	100	99	100	100	100	96	96
FiO2							
Methods							
240							
220							
200							
180							
160							
140							
120							
100							
80							
60							
40							
20							
RR	23	15	22	22	20	20	18
T	95	95			96		96

Time									
Pain (0-10)									
LOS									

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1120 –	LR	2000cc	L Radial	[redacted]	

(b)(6)-2

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			2
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	9	10	12

Codes

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

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

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

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

PREPARED BY: [redacted] (b)(6)-2 CPT AP

DEPARTMENT/SERVICE/CLINIC: ICU 2

DATE: 15 May 03

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

[redacted] (b)(6)-4

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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1155		MSO4 1mg	IV		(b)(6)-2	[redacted]
1210		MSO4 2mg	IV			
1225		MSO4 2mg	IV			

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(R)arm	fingers	+ +	+	<3sec	Warm	Norm
15'							
30'							
45'							
60'							
90'							
D/C							

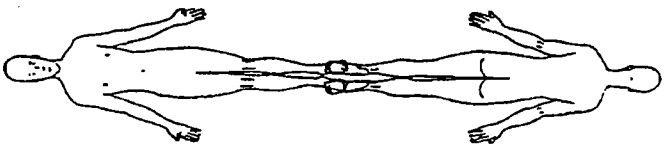
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(R)arm	cast	Ø
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
Tyme			

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1140	SR		

WAMC OP 173-E

NURSING NOTES

Arrived from OR. Drowsy but arouses to verbal/painful stimuli. Oral airway in place. SaO2 100% NF infusing. Cast to (R) arm. VSS. Sensation to (R) UE. Will cont. to monitor — [redacted] (b)(6)-2

Discharge Criteria:
Date: 15 MAY 03 **Time:** 1820 **PARS:**
BP: 111/56 **T:** 96 **HR:** 71 **RR:** 14 **Sa02:** 99
Pain Level at D/C (0-10):
Intake: Ø **Output:** Ø
Additional Data: MSO4 given still c/o pain
Transferred To: ICW
Report Given To: Lt [redacted]
Transferred Via: [redacted] Gurney Ambulance
Transferred B[redacted] 91WM2
Cleared IAW [redacted]
Charge Nurse Signatur[redacted] 91WM2
(b)(6)-2

ADMISSION AND CODING INFORMATION

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

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

3. REGISTER NUMBER						NAME (Last, First, Middle Initial)	4. PAY GRADE		5. SEX
9	10	11	12	13	14	15	16	17	18
[redacted]						(b)(6)-4 [redacted] CIV [redacted]			M

6. DATE OF BIRTH (YYYYMMDD)								7. AGE AT ADMISSION			8. RACE	9. ETHNIC BACKGROUND	RELIGION
19	20	21	22	23	24	25	26	27	28	29	30	31	
								2	5	4	X		UNK

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
N/A	46: UNK	1730	(b)(6)-4

14. FLYING STATUS			15. BENEFICIARY CATEGORY			16. ZIP CODE OF RESIDENCE								
47	48	49	50	51	52	53	54	55	56	57	58	59	60	61
			~~K~~	~~7~~	~~6~~ K78									

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: 0	ICU1	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
[redacted]		

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

(b)(6)-2

24. CLINIC SVC - ADMITTING				25. MTF TRANSFERRED FROM						26. DATE THIS ADMISSION (YYMMDD)					
87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102
A	B	C	A							0	3	0	4	2	5

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: S/P GSW to chest/ARM/elbow; BILATERAL ~~OPEN~~ HUMERUS FRACTURES
EX Lap

Dx: 81230
9750
8601

Dx: 9931
7916

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK
[redacted] CPT	[redacted]

DA FORM [redacted] MAR 80 EDITION OF [redacted]

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

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER: UD12858	2. NAME (Last, First, MI): EBW [redacted] (b)(6)-4			3. GRADE: —	ADMISSION REMARKS
4. SEX: M	5. AGE: unk	6. RACE: Z	7. RELIGION: MUS	8. LENGTH OF SVC: —	9. ETS: —	10. PREVIOUS ADMISSION: NO
11. FMP: 99	12. SSN: [redacted]		13. ORGANIZATION: (b)(6)-4		14. WARD: IC23
15. FLYING STATUS:	16. USG: —	17. DEPT/BEN: 28	18. BRANCH/CORPS: —	19. UIC/ZIP: —	20. TYPE CASE: NBI
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from ER			22. HOURS OF ADMISSION: 1800	23. CLINIC SERVICE: ABMA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: unk			25. TYPE DISPOSITION:	26. DATE OF DISPOSITION: 030503	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): unk			27b. TELEPHONE NO.: unk	28. DATE OF THIS ADMISSION: 030426	ADMITTING OFFICER
29. [redacted] ZWD				30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. [redacted] (b)(2)-2

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: Burn

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	7	7

36. Total Days All Facilites

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

DA FORM 3647, MAY 79 (b)(6)-2 (b)(6)-2 USAPPC V1.10

ADMISSION AND CODING INFORMATION

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

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

3. REGISTER NUMBER							NAME (Last, First, Middle Initial)	4. PAY GRADE		5. SEX
9	10	11	12	13	14	15	(b)(6)-4 EPW	16	17	18
[redacted]										M

6. DATE OF BIRTH (Y Y Y Y M M D D)								7. AGE AT ADMISSION			8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19	20	21	22	23	24	25	26	27	28	29	30	31	Muslim

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

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

14. FLYING STATUS			15. BENEFICIARY CATEGORY			16. ZIP CODE OF RESIDENCE								
47	48	49	50	51	52	53	54	55	56	57	58	59	60	61
			K	9	9									

17. UNIT LOCATION (State or Country Code)		18. MOS							19. TRAUMA	PREV. ADMISSION	
62	63	64	65	66	67	68	69	70	71	YEAR	☒ NO
									3		

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: 0 (b)(2)-2	ICW3	UNK
[redacted]	TY b2-2	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK
		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: UNK

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

24. CLINIC SVC - ADMITTING				25. MTF TRANSFERRED FROM						26. DATE THIS ADMISSION (Y Y M M D D)					
87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102
A	B	M	A							0	3	0	4	2	6

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

FOR LOCAL USE

DX: Burn

DX 9490
E899
Trauma 9
Inj 759
[redacted] (b)(6)-2

ADMITTING OFFICER (Signature [illegible] required)

[redacted] (b)(6)-2

SIGNATURE OF ADMITTING CLERK

[redacted]

DA FORM 2085, MAR 80

MEDCOM - 8237

(5)(6)-4

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER [redacted]	2. NAME (Last, F[redacted] EPW [redacted]		3. GRADE EPW	ADMISSION REMARKS
M [redacted]	RACE IRAQI	7. RELIGIO[redacted] UNKNOWN —	(5)(6)-4	10. PREVIOUS ADMISSION
11. FMP 99	12. SSN [redacted]	(5)(6)-4	13. ORGANIZATION	14. WARD ICU 2
15. FLYING STATUS —	16. RATING/ DSG —	17. [redacted]PT./ BEN K78	18. BRANCH/CORPS —	19. UIC/ZIP —
				20. TYPE CASE NBI

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: DIRECT FROM ER

22. HOURS OF ADMISSION: 2100

23. CLINIC SERVICE: ABAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: UNK

25. TYPE DISPOSITION: EPW CAMP

26. DATE OF DISPOSITION: 3MAY03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK

27b. TELEPHONE NO.: UNK

28. DATE OF THIS ADMISSION: 27APR03

ADMITTING OFFICER: DR. (5)(6)-2 [redacted]

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted]

30. DATE OF INTIAL ADMISSION

32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

(5)(2)-2

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

P/O GSW

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW TO (L) FLANK/CHEST

35. Total Days This Facility

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

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 [redacted] OR MEDICAL RECORDS OFFICER

[redacted] MAJ, MC

(5)(6)-2

[redacted]

DA FORM 3647, MAY 79 EDITION [redacted] OBSOLETE

MEDCOM - 8238

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

35-40 yo Iraqi evaced from FST s/p Ex lap (negative) + (L) chest tube placement x 2 s/p GSW to (L) chest.
Pt without complaints upon arrival.

PMH Ø PSH as above All Ø Meds Ø

PHYSICAL EXAMINATION

VS BP 121/73 HR 110 RR 19 Sa O_2 100% T 103.2
A+Ox3
Lungs CTA (B) 2 chest tubes present on (L)
RR nl S_1+S_2
Abd Midline incision dressed. Dressing c̄ mild serosanguinous staining Ø distended NTTP ØBS
EXT ØC/C/E palpable pulses in all 4 ext
Back 4x2 cm wound (L) lateral chest
2x1 cm wound (L) of spine mid back

Neuro Sensory/Motor intact in lower extremities

CXR - ØPTX
2 chest tubes present on (L)

12.3 / 10.7 / 33.6 / 172

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

A/ Iraqi ♂ s/p GSW to (L) chest. Stable at arrival to [redacted] (b)(2)-2
p̄ negative ex lap + CT^n placement @ FST.

P/ Admit to ICU 2 for observation + post op care
Antibiotics Ancef @ 8 hrs
Chest tubes to continuous suction

[redacted] PLAS INC USA	DATE 27 APR 03	IDENTIFICATION NO.	ORGANIZATION [redacted] (b)(2)-2
PATIENT'S IDENTIFICATION (*For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility*) (b)(6)-2		REGISTER NO.	WARD NO.

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

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

(b)(6)-4 [redacted]

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
27April03.	1350 Pt transfered to PACU via stretcher. Pt unconscious intubated c BVM support Resp 14-22. Pt placed on SIMV 14, 1:2 1:2. IV @ AC NACL 0.9% TKO @ Femoral Central line LR 100ml/hr. Dressing to (L) chest tube #1 and #2 patent attached to suction level 20. #2 dressing draining serous sangous fluid. Wound laceral (L) chest dressing draining serous. Wound to (R) upper back dressing draining serous drainage. Abdomenal dressing small amt of serous drainage. Foley draining clear straw colored urine. Bearhugger placed on pt. V/S monitored. EKG placed (b)(6)-7 [redacted]
	1356 Oral suction Cpt [redacted] NG placed (L) Nare gastric sounds present attached to suction low. (b)(6)-7
	1415 Pt becoming more alert gag reflex present. Pt extubated suction present oral airway removed. Pt placed on NRB 100% 5lpm via O2 concentrator. SpO2 100% - 98%.
	1420 Pt began to snore and gurgle. jaw thrust airway more improved. Elevated head.
	1425. Dressings to Chest tubes #1 and #2 and (L) lateral and back dressings reinforced c 4X4's and ACE wrap 6"
	1445 - Pt restrained c Kling wraparound wrists hands placed together on abdomen then to foot of bed. Pt becoming

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

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

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

PROGRESS NOTES
Medical Record

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

[redacted]

(b)(6)-4