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)*
18 MAY 03	DISCHARGE SUMMARY
	THIS 25 y/o O→ PRISONER PRESENTED HERE
	4 DAYS AFTER SUSTAINING A LOW ENERGY,
	NEUROVASCULARLY INTACT GUN SHOT FRACTURE
	OF THE LEFT PROXIMAL FIBULA. HE HAD RECEIVED
	NO TREATMENT PRIOR TO ARRIVAL. HE WAS
	AFEBRILE c̄ ~~N~~ WBC & HEALING WOUNDS
	S̄ SIGN OF INFECTION. HIS LEG WAS SPLINTED,
	HE WAS GIVEN TETNUS TOXOID & STARTED ON
	PROPHYLACTIC ANTIBIOTICS, THEN DISCHARGED,
	ON KEFLEX AND TYLENOL WITH CODEINE.
	FOLLOW UP AT ASMC IF IN CUSTODY, IRAQI
	FACILITY IF RELEASED.
	b(6)2 [redacted]
	LTC, MC ORTHOPEDIC SERVICE

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

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

REGISTER NO.	WARD NO.

[redacted] b(6)4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 May 03	2540 ♂ c/o wound to (L) Leg.
BP	
P	Pt limping. GSW (L) leg a few days ago, date unknown
R 12	(+) Language barrier / ~~-~~ interpreter available.
T	
Med:	PE: 2+ Edema LLE c̄ deformity
Alg:	of (L) fibula region. Healing wound present
	over same. ~~-~~ Erythema or ↑ warmth.
"PAIN STOP" (2) TABS	@ 1650 Sensation intact. Moves all
	toes. Dorsalis Pedis pulses palpable.
TAB Dextropropoxyphene 50mg + Paracetamol 325mg	
	(L) Tib/Fib X-RAY: Open Comminuted Fx
	(L) Fibula. c̄ displacement.
A	(L) Fibula - Open displaced, comminuted Fx.
	- Splint
	- Ancef 1gm IV
	- "PAIN STOP" as above
P	Evac to CSH
	for Orthopedic irrigation and treatment.
	b(6)2 [redacted]

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

[redacted] b(6)2

CPT, MC
Family Practice Clinic

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

[redacted] b(6)-4

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

USAF - 2 00

NSN 7540-01-075-3786

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

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS: EPW

CITY: | STATE: | ZIP CODE:

ARRIVAL

DATE *(Day, Month, Year)*: 17 MAY 05 | TIME: 1745

TRANSPORTATION TO FACILITY:

SEX: M

DUTY/LOCAL PHONE — AREA CODE: | NUMBER:

HOME PHONE — AREA CODE: | NUMBER:

AGE: 23

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: 0

ALLERGIES: NKDA

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: GSW to L leg 4 days ago

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☒ NON-URGENT

TIME: 1745

INITIALS: [redacted]

VITAL SIGNS

TIME	1745	1813				
BP	120/73	113/66				
PULSE	73	67				
RESP	16	16				
TEMP	98.3					
WT						

LAB ORDERS

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

X-RAY ORDERS

CXR PA & LAT/PORTABLE	C-SPINE
ACUTE ABDOMEN	LS SPINE
SINUS	HEAD CT
☒ ANKLE F/L	
☒ Tib/Fib AP	

ORDERS

☐ PULSE OX 99 99 ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1753	Tetanus				

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)*

EPW [redacted] b(6)4

DOB 1979 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

TEST RESULTS

CBC	WBC	SMAC		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

S. C/O GSW L-Leg 4 day ago
Med. history smokes & drinks

he was a restaurant owner some owed him money & he shot him Americans came to rest. said he had weapons

25 yo 0 Iraqi male s/p GSW 4 days ago. seen @ other care facility give Ancef & gm, splinted (L) Fib. comminuted Fx.
@1650

(D) lungs = (B) wheezing
(?) = RRR
ABD = ND NT NABS
rectal = guaiac neg

ext = (L) lower leg lac, TTP, distal pulse -

CONSULT WITH	TIME	ACTION
Ortho		

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNA[redacted]D STAMP

[redacted] b(6)2
MAJ, MC
FAMILY PRACTICE

DIAGNOSIS
(L) Fib GSW c̄ Fx

CODES [redacted]

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)
USAPA V1.00

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY															
POST-	DAY														
MONTH-YEAR	DAY	2120		18 MAY 03											
19	HOUR														
PULSE (O)	TEMP. F (°)														TEMP. C
	105°														40.6°
180	104°														40.0°
170	103°														39.4°
160	102°														38.9°
150	101°														38.3°
140	100°														37.8°
130	99°														37.2°
	98.6°														37.0°
120	98°														36.7°
110	97°														36.1°
100	96°														35.6°
90	95°														35.0°
80															
70															
60															
50															
40															
RESPIRATION RECORD		6		6											
BLOOD PRESSURE		78/60		104/60											
		80	96	97											
HEIGHT:	WEIGHT →														

(Centigrade Equivalents, for Reference only)

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] b(6)4

VITAL SIGNS RECORDS

Medical Record

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

[redacted] b(6)4

SPECIMEN/LAB RPT. NO.

HEMATOLOGY

URGENCY
- [X] ROUTINE
- TODAY [ ]
- [ ] PRE-OP
- STAT [ ]

PATIENT STATUS
- [ ] BED
- [ ] AMB
- OUTPATIENT [ ]
- [ ] NP
- [ ] DOM

SPECIMEN SOURCE
- [X] VEIN
- [ ] CAP
- [ ] OTHER (Specify)

PATIENT'S MED. RECORD

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

REQUESTING PHYSICIAN'S SIGNATURE: [redacted] b(6)2

REPORTED BY: MD / TECH

DATE: 18May03

LAB. ID. NO.

REMARKS: CBC Ly% 35.4

549-107

TEST(S)	SPECIMEN TAKEN																																	
	DATE	TIME A.M. P.M.	REQUESTED (X)	RBC COUNT	HEMOGLOBIN	HEMATOCRIT	MCV	MCH	MCHC	WBC COUNT	IMMATURE	NEUTRO-BANDS	NEUTROSEGS	LYMPHS	EOSINOPHILS	BASOPHILS	MONOCYTES	PLATELETS	RBC	SED. RATE	PLATELET COUNT	RETICULOCYTE COUNT	CLOTTING TIME	BLEEDING TIME	CONTROL	PATIENT	CONTROL	PATIENT	% ACTIVITY	RATIO	SICKLING TEST	LE PREP	
											WBC DIFF AND BLOOD CELL MORPH														PT	PTT						
		RESULTS		4.76	13.7	44.4	93.3	28.9	31.0	8.2											375												

HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41 CFR) 201-45.505

WARD/SECTION: EMT

REQUESTING PHYSICIAN: Dr [redacted] b(6)4

CHEMISTRY RESULT FORM

(Subject to the Privacy Act of 1974)

LAST, FIRST, MI.: EPW

DATE: 17MAY03

TIME: 183

SSN/PSEUDO SSN: [redacted]

[redacted]

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/l
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 25-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/l
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

[redacted]

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

TEST	RESULT	REF.
ALB	3.1	3.5-5.5 g/dl
ALP	59	26-84 u/l
ALT	17	10-47 u/l
AMY	25	14-97 u/l
AST	38	11-38 u/l
TBIL	0.7	0.2-1.6 mg/dl
BUN	7	7-22 mg/dl
CA++	8.4	8.0-10.3mg/dl
CHOL	118	100-200 mg/dl
CRE	1.0	0.6-1.2 mg/dl
GLU	109	73-118 mg/dl
TP	6.5	6.4-8.1 g/dl

[redacted]

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO2		18-33 mmol/l

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO2		18-33 mmol/l

[redacted]

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

[redacted]

TEST	RESULT	REF. RANGE
NA+	135	128-145 mmol/l
K+	4.0	3.3-4.7 mmol/l
CL-	103	98-108 mmol/l
tCO2	24	18-33 mmol/l

REMARKS:

REPORTED BY: b(6)4 [redacted]

DATE: 17MAY03

LAB ID NO.:

[redacted]

LAST C'D' DO NOT TA'F

Ward/Section: EMP	REQUESTING PHYSICIAN: Dr [redacted] b(6)2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
EPW	17 May	1825	[redacted] b(6)4

[redacted]

TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC	8.2	4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC	4.76	4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb	13.7	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	[redacted]		
Hct	44.4	42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV	93.3	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt	375	130-500 x 10^3 - verified	SG		N/A	Occ Bld		Negative
Lymph %	35.4	20.5-51.1%	Bld		Negative	H. pylori		Negative
[redacted]			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	[redacted]		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	[redacted]					
Sed Rate			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED		
Other			Directigen		Negative	ABO/Rh		

[redacted]

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

REMARKS:

REPORTED BY: b(6)4 [redacted]	DATE: 17 May 03	LAB ID NO.:

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
b(6)4 [redacted] Verified 8 Apr 11 18 May 03 OK			17 MAY 03 (2)	HOURS	
			ADMIT ICW C/O GRANULE		
			DX GS FX (L) FIBULA		
			COND FAIR		
			VS ROUTINE		
			ACT RESTRAINTS		
NURSING UNIT	ROOM NO.	BED NO.	NKA		
			REG DIET		
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
			KEEP LOCK	HOURS	
			ANCEF 7 GM IV Q8°		
			TYLOX 7-TIPO Q4-6° PRN		
			PAIN		
			b(6)2 [redacted]		
NURSING UNIT	ROOM NO.	BED NO.			
21° VS	[redacted]		1U/AN 5/18/03 OHS	LTC, MC ORTHOPEDIC SERVICE	
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
			18 MAY 03	0650 HOURS	
			D/C		
			ACT WB AS TOL		
			DIET REG		
			MEDS REFLEX 500 mg PO QID		
			TYLENOL 3 7-TIPO Q4-6° PRN		
NURSING UNIT	ROOM NO.	BED NO.	FILL IN ACT FACILITY PRN		
PATIENT IDENTIFICATION			DATE OF ORDER	TIME [redacted] HOURS	
NURSING UNIT	ROOM NO.	BED NO.			

Noted 9 0100 18 May 03 [redacted] b(6)2

b(6)2

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

MEDCOM - 9049

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 17	18	19
17 may	[redacted]	Vital Signs Routine	5	/	[redacted]	
			13	/		
			21	[redacted]		
17 may	[redacted]	Regular Diet	5	/	[redacted]	
			11	/		
			17	/		
17 may	[redacted]	Act: Restraints	5	/	[redacted]	
			13	/		
			21	//		

b(6)2

ALLERGIES: ☐ YES ☐ NO ✓ NKA

PRIMARY DIAGNOSIS: GSW Fx ① Fibula

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted] b(6)4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo / Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
5/18	[redacted]	Admit ICW C/O [redacted] b(6)2	18 May/03			[redacted]
	b(6)2					
5/18	[redacted]	Dx: GS Fx (L) Fibula	18 May/03			[redacted]
5/18	[redacted]	Condition: Stable FAIR	18 May/03			[redacted]

b(6)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 *(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										
9/17	[redacted]	Heplock IV	5	/	[redacted]											
	[redacted]		13	/												
	[redacted]		21	[redacted]												
9/17	[redacted]	Ancef + GM IV Q8°	6	/	[redacted]											
	[redacted]		14	/												
			22	[redacted]												

ALLERGIES: ☐ YES ☐ NO — NKA

PRIMARY DIAGNOSIS: GS Fx (L) Fibula

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._____ 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													
5/17	[redacted]	Tylox 1-2 PO														
- - - - -	- - - - -	Q4-6 PRN for pain														
- - - - -	- - - - -															
- - - - -	- - - - -															
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USAPA V1.00

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A 1 1 D 1	I Z	0 0 1 3 0 0 1	EPW [redacted] b(6)4	EPW	M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
	2 5 Y	X	9	UNKNOWN

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—	U	1745	—

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø	ICW2	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

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

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
2 4		Ø 3 Ø 5 Ø 8

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
A E A A		Ø 3 Ø 5 1 7

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

FOR LOCAL USE

DX: GS FX (L) FIBULA

ADMITTING OFFICER (Si[redacted] required) b(6)2 [redacted]

SIGNATURE OF ADMITTING CLERK b(6)2 [redacted] SPC, 91G10

MEDCOM - 9054

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER: 00,3124	2. NAME (Last, First, MI): EPLO # [redacted] b(6)4			3. GRADE: EPW	ADMISSION REMARKS
SEX: M	5. AGE: 25	6. RACE: —	7. RELIGION: —	8. [redacted] OF SVC: —	9. ETS: —
10. PREVIOUS ADMISSION: NO					
11. FMP: 99	12. SSN: [redacted]	13. ORGANIZATION: —		14. WARD: ICW#2	
15. FLYING STATUS: —	16. [redacted] OSG: —	17. DEPT./BEN: K78	18. BRANCH/CORPS: —	19. UIC/ZIP: —	20. TYPE CASE: WIA
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct From ER			22. HOURS OF ADMISSION: 1430	23. CLINIC SERVICE: AERA	
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: UNK			25. TYPE DISPOSITION: 05	26. DATE OF DISPOSITION: 030521	
27. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK			27b. TELEPHONE NO.: —	28. DATE OF THIS ADMISSION: 030518	ADMITTING OFFICER: DR. [redacted] b(6)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] b(2)2				30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

CAUSE OF INJURY

DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW (L) THIGH

Total Days This Facility

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

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] b(6)2

SIGNATURE OF PAD OR [redacted] b(6)2

DA FORM 3647, MAY 79

EDITION OF 1 AUG 78 IS OBSOLETE

MEDCOM - 9055

USAPPC V1.10

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
18MAY03 1617	PT Vitals taken T97.9 P64 R18 B/P 134/64 — [redacted] 91W b(6)2
18MAY03 1630	Pt admitted from EMT. VSS. AtOx3. Pain c̄ mvt, given 5mg MSO4 in EMT. W→D drsg applied in EMT on post (L) thigh CDI. (+) pulse, cap refil, sensation (L) foot, pt unable to voluntarily move (L) LE. O/W assessment WNL. Will monitor — [redacted] b(6)2
19May 0100	Assumed care of PT @ 2100. VSS. Pt. denies pain. AR Reg. BS ⊕ X4, Lungs c̄ ~~ITA~~. Drsng to (L) thigh C.D.I. will continue to monitor. — [redacted] 1477 AN. b(6)2
190600 May03	Pt is asleep but arousable. Airway is intact, lung sounds clear to all fields. Breathing is even and unlabored. Abd is soft, nontender, ↓ distention. BS⊕x4. Vnds spontaneously. FROM
0745 T97.5 P81	to (B) UE and (R) LE. (L) LE has ACE wrap to thigh. CDI. Neurovascularly intact to all extremities. IV flushes well & ↓ s/s of infection. — [redacted] 1477 AN b(6)2
R14 0900 BP 120/70	IV with hep lock 18g to left wrist — Spec [redacted] 91W 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. ICW2

#[redacted] b(6)4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
19 MAY 03	OP NOTE
	PREOP DX - GSW (L) THIGH
	POSTOP DX - SAME
	PROCEDURE - DPC (L) THIGH
	SURG [redacted] PT
	ANES LOCAL [redacted]
	FLUIDS 900 LR
	EBL MIN
	DRAINS PENROSE (L) POST THIGH
	CX Ø
	FINDINGS ST GSW (L) POST THIGH, MIN
	NECROTIC SKIN MARGIN Ø END INFECTION
	VIABLE MUSCLE. MIN GROSS DEBRIS. [redacted] b(6)2
	TO RW STABLE
19 MAY 03	Pt vitals taken BP 102/64 P. 90, R. 16, TEMP 98.4
1515	SPC [redacted] b(6)2
19 May 03	Pt [illegible] from OR / conscious sedation VSS. Resting Comfortably
1530	Will Monitor [redacted] b(6)2
19 may 03	VSS - pt. remains drowsy p̄ surgery - IV
2000	patent - dsg intact on (L) thigh, +2 pedal
	pulses in (L) foot [redacted] CB, A
20 may 03	Pt care assumed @ 2100. VSS, pt resting awaken by verbal stimuli b(6)2
0125	Pt has c/o small amount of pain in (L) thigh, no medication
	requested. Dressing on LLE CDI with slight edema noted in
	foot. Pt cannot wiggle toes in lle, and states he cant feel
	sensation in (L) foot. Pt has cap refill < 3 seconds, and even pulses

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
20 may 03 ~~1950~~ 2030	medicated for pain @ 1950 c̄ good results - VSS - dsg intact on (L) thigh. MD removed penrose drain this evening - can dc to EPW camp when transport available b(6)2 [redacted] CB AV b(6)2
20 May 03 2220	UOP 700cc CLEAR yellow fluid — DHC [redacted]
20 May 03 2230	Assumed care of PT @ 2100. VSS. PT c/o pain upon palpation (L) foot. Drsng to (L) thigh CDI. Pedal pulses 2+ c̄ Brisk cap refill. Pt. denies sensation on toes of (L) ft, denies ability to move toes (L) ft. HR Reg, Lungs CTA BS(+) XY. b(6)2 will continue to monitor. [redacted]
21 May 03 0700	Assumed Pt care @ 0500. Pt. A+O x3. Lungs CTA. (+) BS x4. VSS. AL (L) FA patent to flush. Drsng on (L) thigh CDI. Denies any c/o @ this time [redacted] b(6)2
21 May 03 1400	Assumed care @ 1300. VSS. A+O x3. Denies pain Drsg to (L) thigh CDI. O/W assessment wnl will monitor [redacted] b(6)2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
	in both feet. Lung sounds CTA with equal rise and fall b(6)2
	of chest, pulses palpable x4, bowel sounds present x4 quadrants. /
	Heplock @ L wrist flushes well, will continue to monitor. SPC [redacted] 91WM
20 MAY 03	Assumed pt care @ 0500: T 97.8 P 75 R 14 B/P 120/84
0630	SATS: 99 Pt. awake & oriented. (+) BS x 4. Hl (L) FA
	patent to flush. Dsng on (R) thigh CDI. c/o
	feeling no sensation in (R) foot. (+) Pulse palpable
	in all extremities. Will continue to monitor
	[redacted] b(6)2 91WM6
0900	Dsg Δ complete. Small blood drainage noted from
	site. Ø foul odor noted [redacted] b(6)2 91WM6
20 MAY 03	S LOCAL PAIN
1715	O. VSFA
	NVI
	WND WEAR & MOD SERIOUS DRAINAGE —
	PIN RUSE OUT
	A DOING WELL
	P. D/C TO MORROW

[redacted] b(6)2

ITC, MC

[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)

REGISTER NO.

WARD NO. ICW2

[redacted] b(6)4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
21 May 2345 Nursing cont.	pending. 18g PIV to (L) Wrist. (+) flush (-) Bkturn. (-) evidence infection, infiltration. Muscle strength good bilateral upper extremities and to (R) LE. (L) LE weak, (-) sensation (-) movement to toes and foot. (+) pulses dorsalis pedis, (+) cap refill ≤ 3 sec. No needs @ this time. Pt resting comfortably [redacted]
	LATE NOTE: 2230 Pt c/o (R) thigh pain. Tylox ĪTab po administered. Eval = EFFECTIVE [redacted] b(6)2
	0225: Pt sleeping quietly. No evidence of discomfort
22 May 03	0600 → Pt is a sleep but arousable. Airway is intact. Breathing is even and unlabored, lung sounds clear to all fields. BS(+)x4. Abd is soft, nontender, and 5 distention.
0550 T 98.1	Voids spontaneously. FROM to (B) UE and (R) LE. All extremities are neurovascularly
P 102	intact. LLE has limited ROM 2° pain at GSW site. Drsg to (L) thigh, posterior
R 14	is ACE wrap c̄ 4x4, and is CDI. IV to (L) hand is HL'd, flushes well c̄ s/s of b(6)2
BP 132/88	infiltration or infection. [redacted]
220900 May 03	Drsg to (L) posterior thigh Δ'd. Sutures have wound well approximated c̄ minimal b(6)2 drainage and no s/s of infection. Drsg replaced c̄ 4x4 and ACE wrap. [redacted]
	PT/ORTHO NOTE 1235 22 May 03
	S: 25 y/o ♂ c̄ GSW to (L) posterior thigh requests crutch training
	O: Pt supine. (I) c̄ bed mobility (I) sit ↔ stand. Walk c̄ crutches ~ 50 ft. Placed Pt back in bed
	A: good balance c̄ crutches
	P: Pt being evacuated to 581 ASMC
	G: Pt needs to WBAT (L) leg
	[redacted] b(6)2
	SPC 91WP1

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	D/C SUMMARY
21 MAY 03	25 Y/O O→ EPW C̄ ST GSW (L) POST THIGH 00A 15 MAY. ADMITTED 28TH CSH 18 MAY C̄ LOCAL WOUND CARE & ABX. 19 MAY UNDERWENT WOUND EXCISION & CLOSURE OVER DRAIN. POST OP COURSE UNREMARKABLE. DRAIN OUT POD1. D/C TO ASMC POD2 ON PO KEFLEX 500 QID & TYLOX ?-?? PO Q4-6° PRN PAIN.
	b(6)2
	[redacted] ITC, MC ORTHOPEDIC SERVICE
1319	Pt vital signs taken BP 120/76 P 77 T 98 b(6)2 R 16 SpO_2 97 — SPC [redacted] 91W
21 May 03	2110: Pt supine, awake alert & evidence gain → [redacted]
	2345: PA: Lung sounds clear throughout anteriorly. Chest movement equal bilaterally & symmetrical. FISZ present, regular; BS present, abdomen tender, nondistended. (+) Bandage - dressing to (R) thigh COI. (+) C/o gain. Peplox ? tab PO administered. [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)

REGISTER NO.	WARD NO

[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

NSN 7540-01-075-3786

b(2)2

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Patient)*	LOG NUMBER	TRE[redacted]
		RECORDS MAINT[redacted] AT	

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS: CPW/CIL

CITY | STATE | ZIP CODE

ARRIVAL

DATE (Day, Month, Year): 18 Ma 403 | TIME: 1430

TRANSPORTATION TO FACILITY: AMB

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: Pay'd / CEFDIN ~~[illegible]~~ 250 mg

ALLERGIES: none

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT

CATEGORY OF TREATMENT

☐ EMERGENT
☐ URGENT
☑ NON-URGENT

TIME: 1430

INITIALS: CEI

VITAL SIGNS

TIME	1430	1520			
BP	126/66	127/64			
PULSE	72	77			
RESP	[redacted] 18	18			
TEMP	98.3				
WT					

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1430	MSO4 5mg IV	CPT [redacted]	CPT [redacted]	1430	
1445	TETANUS .5ml, [illegible]	CP [redacted]	SSL [redacted]	1447	
			b(6)2		

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

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

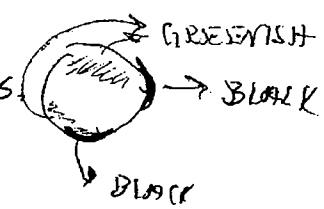
TEST RESULTS

CBC	WBC	SMAC		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

S: Gun Shot Wound to Left Upper Leg.
X3 days Last Meal & Drink 0400

O: ALERT, ORIENTED
PERRIA, EOMI
CARDIAC - S1, S2
LUNGS - CTA
ABDOMEN SOFT NDNT, BS(+) ACL QUADS
(L) UPPER POSTERIOR THIGH c̄ 1½ x 2 INCH WOUND c̄ BLACK BORDERS, GREENISH IN COLOR,
PULSES (+) EQUAL BILAT, COLOR GOOD, CAP REFILL <3 SECS



A/P: GSW (L) POSTERIOR THIGH
- WET TO DRY DS/2
- XRAY (L) LEG
- CONTINUE KEFLEX

CONSULT WITH	TIME	ACTION
DR. [redacted] b(6)2	~~1500~~ 1430	ASSESSED PATIENT

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP
CPT/DR/FNP b(6)2
[redacted]

DIAGNOSIS
GSW (L) THIGH / POSTERIOR

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

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: 23
HEIGHT: } unknown
WEIGHT:

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

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

4. PROPOSED SURGICAL PROCEDURE:
DPC Left thigh.

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition Good
Tobacco Ø ppd X___yrs. Body Piercing Ø Diabetes (Y) (N) ROM X LLE ASA/Motrin w/72 hrs (Y) (N)
ETOH Ø Implants Ø Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures "lose teeth" Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ 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~~. Conscious sedation
C. INTEGUMENT ✓ Potential impairment of skin integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement ✓ 3) Positional Aids ___ 4) Prosthesis ✓ 5) Pooling of Prep Solutions	Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	Utilize pressure preventing devices on OR table and accessories. Check for proper positioning and support to maintain good body alignment. Pad pressure points. Place ESU ground pad on non compromised skin surface area. Keep prep fluids from pooling.

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

EPW #[redacted] b(6)2

VERIFICATIONS AT HOLDING AREA:
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since 0800 ! Jewelry Removed
! UHCG/LMP ! Body Piercing Removed
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) (N)
! Family/Friend: Ø

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

10. OR NU[redacted]TIONS COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTION S NOTED.

[redacted] RN/RD 9MAY03 DATE

11. POSTOPERATIVE EVALUATION:
LEVEL OF CONSCIOUSNESS: ☐ A&O ☒ Drowsy ☐ Sleepy ☐ Intubated
LEVEL OF ACTIVITY: ☒ Moves All Extremities ☐ Moves Upper Extremities ☐ Transferred to liter with roller due to spinal

SKIN INTEGRITY: Bovie Pad Site: ☒ Clean and Dry ☐ Red ☐ N/A
DRESSING DRY & INTACT: (Y) (N)
BREATHING EASY: (Y) (N)

12. PR[redacted]VALUATION PREPARED BY (Sig[redacted] RN/RD
DATE: 9MAY03 TIME: 1035

13. POSTOPERATIV[redacted]PREPARED BY (Signature and Titl[redacted] RN/RD b(6)2
DATE: 9MAY03 TIME: 1490

REVERSE OF FORM 5179, JUN 91 MEDCOM - 9065 USAPA V1.0

MEDICAL RECORD

INTRAOPERA[illegible] DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA: LITTER BY: Anesthesia

2. PATIENT IDENTIFIED, RECORD [redacted] PROCEDURE
VERIFIED BY: 1LT [redacted] b(6)2

3. DATE: 19 May 03 TIME PATIENT ARRIVED IN SUITE: 1350

4. PATIENT IN ROOM TIME: 1350 NUMBER: 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:
UPOD 0800, NKDA.

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify) Pt. in lateral position, supported by bean bag on padded OR table. RUE on padded arm board <90°. Pillow between arms per pt comfort. Pillow between knees. Normal anatomic body alignment maintained.

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

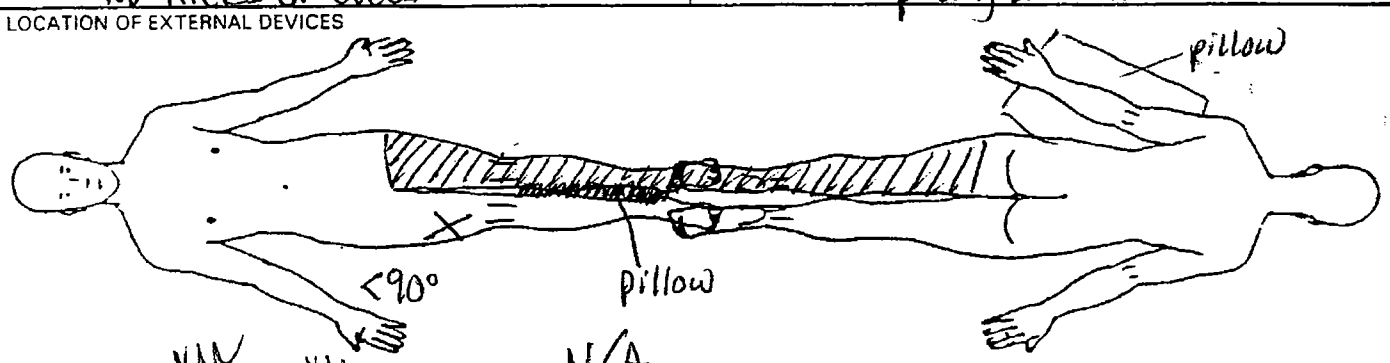
COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL [X] YES [ ] NO DR [redacted] b(6)2
DONE BY: [X] OR [ ] NURSING UNIT
METHOD: [ ] DEPILATORY [X] RAZOR [ ] CLIP
COMMENTS: No nicks or cuts.

PREP SOLUTION (Specify) Betadine/Betadine
SITE: Left leg BY WHOM:
SITE: circumferentially BY WHOM:
COMMENTS: No pooling or reaction noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND: X Ground Pad (KK) -- Safety Strap (KK) = = = Tourniquet (N/A)

Initial: SPC [redacted] 1LT [redacted]

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB b(6)2	CIRCULATOR b(6)2
Sponge	[X] Yes [ ] No	/	C	C	SPC [redacted]	1LT [redacted]
Needle Sharp	[X] Yes [ ] No					
Instrument	[ ] Yes [X] No					
Other	[ ] Yes [X] No					

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

EPW # [redacted] b(6)4

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

[X] ESU NO: #3 cut 30 coag 30
GROUND PAD: BRAND 3M
LOT NO: 2005-10 OT

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

[ ] BIPOLAR NO:

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

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

14. MEDICATIONS/ORDERS

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

b(6)2

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Xylocaine 1% c̄ Epi Lot 209130 Exp 4/04		INTRA-OP	LOCAL INJ.	mfr: AstroZeneca	Dr. [redacted]

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE [redacted] b(6)2

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 5/8 Penrose	2.	3.
SITE	1. Left Thigh.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs, kerlix

19. ADDITIONAL INFORMATION
Surgeon: Dr. [redacted], CRT [redacted] PT b(6)2
Anesthesia: MAJ [redacted] CRNA
Anesthesia Type: Conscious Sedation.

DA5179 Initiated

20. OPERATION(S) PERFORMED
DPC Left thigh

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU	1500	Litter c̄ O_2

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

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

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY		1	2	3	4					
POST-DAY										
MONTH-YEAR	DAY	18 MAY	19	20 MAY	21 MAY 03	22 May				
19	HOUR									

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

RESPIRATION RECORD RR

BLOOD PRESSURE

SpO2

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. TCW2

EPW # [redacted] b(6)4

T-3

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD — ANESTHESIA

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

DRUG	Units					
VERSED	(mg)	1	1	1	1	1
Fentanyl	(mcg)	50, 25, 25, 50, 25, 25				
MSO4	(mg)	4	2	2		
	( )					
	( )					
	( )					
VOLAT AGENT	% del					
	% e.t.					
AIR	L/Min					
N2O	L/Min					
O2	L/Min	3L NC				

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS: Reglan 1350 10mg IV

LINE site: L.R. ☐ Warmed — 100 — 900

☐ Warmed

☐ Warmed

☐ Warmed

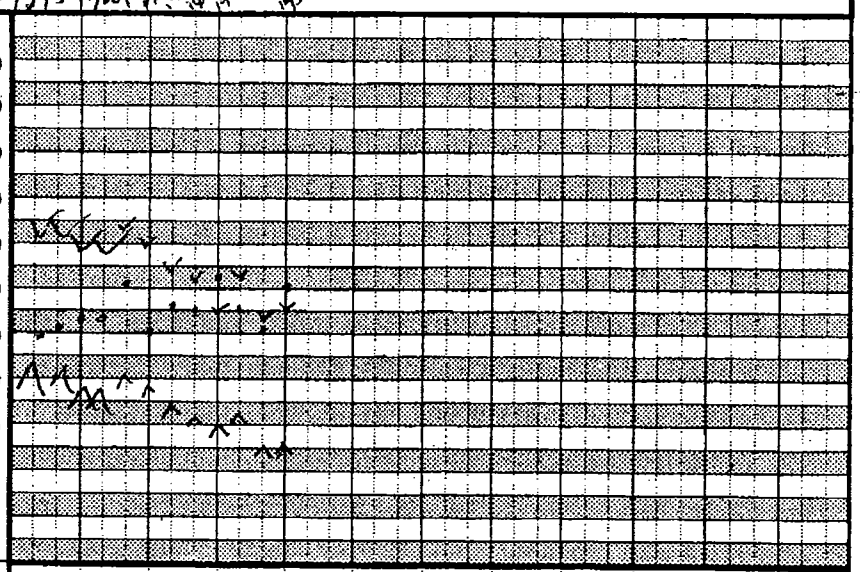
EST BLOOD LOSS

URINE –

TIME → 1345 1400 1415 1420 1425 1430 1435 1450

SYMBOLS: BP by cuff ∨ ∧ Heart rate ● Resp rate ⊘ BP (transduced) ⊥ TOURNIQUET T — ⊤ ANES– X-X PROC–⊙–Ø

220 200 180 160 140 120 100 80 60 40 20



VT – ml					
f – breaths/min	10	14	16	16	14 16
Peak inf pres / PEEP					
MODE– S(pon), A(ssist), C(on)	S	S	S	S	S S S S
BP/Auto Cuff	ET CO2 (torr)				
BP / oth	FIO2 (Frac or %)	7.21	7.21	7.21	7.21
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					

...rk with letters & symbols. ...plain under REMARKS

EVENTS Position →

TOTALS	TOTAL SEL
5mg	9oz
250mcg	
8mg	TOTAL URINE
	0

FLUIDS – SUMMARY

CRYSTALLOID–

COLLOID– 0

BLOOD– 0

REMARKS– Code drugs with numbers, events with letters

Local: 1% of Lacaine c Epi 1:100,000

10cc

RECOVERY AT

PACU ICU _____ (Specify)

OTHER ZIW #2

CONDITION: Stable

RESP– 14 SpO2– 97% RA

BP– 124/62 HR– 104

	Start	Room	End
ANES	1330	7350	1510
PROC	Ready	Begin	End
	1355	1410	1450

...CEDURES and CPT Codes: DPC (L) thigh

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

EPW # [redacted] b(6)4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

MAC / conscious Sedation

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

SURGEON [redacted] b(6)2

ANESTHE[redacted] MAJ CRNA

b(6)2

PROCEDURE LOCATION: OR #2

DATE: 19 May 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED ... Jan 99

MEDCOM - 9069

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

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 24 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: DPC (L) thigh
SURGICAL SERVICE: ortho
NPO SINCE: Brkfst 0700

ASA Physical State 1 2 3 4 5 E
WT: 50 KG/LB HT: ____ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: Ø
ETOH: ____
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Ancef Q8° NPO
( ) Tylox prn
( ) ____
( ) ____
( ) ____
( ) ____

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:			
Acuta/Chronic RF	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	
Hiatal Hernia	N	Y	
PUD/GERD	N	Y	
Endocrine System:			
Diabetes	N	Y	
Steriods	N	Y	
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	
Other	N	Y	
Gynecological :			
Pregnancy	N	Y	N/A
Other Significant Hx:			
	N	Y	
	N	Y	
Familial HX	N	Y	~~Pat~~
unknown			

ASSESSMENT
PAST SURGICAL/ANESTHETIC
None

PHYSICAL EXAMINATION
BP 122/70 HR 78 R 14 T 97.4
Pain Scale 0-10 ____ poor hygiene
HEENT - Teeth ____ Floor clup T
Trachea midline + mass
TMJ/Neck Erom
Oropharnyx Clear
Nares ____
CHEST: CTA
CARDIAC: S1 S2 S(m)
EXTREMITIES:
IV Access: #18 (L) Arm wrist
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since Brkfst 0700

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ ETT/RSI ~~{ } 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 patien[redacted] seems to understand and agrees. Questions answered.
Signed: [redacted] MAJ CRNA Date: 14 May 03 Time: 0845 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____
ICW 2 ALAA ERW [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.

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 1530 HOURS — LIST TIME ORDER NOTED AND SIGN

admit to JCW2

1. GSW (L) posterior thigh
2. X-ray (L) ~~HF~~ leg DONE
3. VS QS
4. Wet to dry dressing Δ QD
5. MSO4 2-4 mg IV q 4-6 hrs prn pain

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER — TIME OF ORDER _____ HOURS

6. Tylox 1-2 PO Q4-6 hrs prn pain
7. Activities bedrest - RESTRAINTS
8. Tylenol 1-2 PO Q 4-6 hrs prn temp
9. Contact ortho upon arrival for further orders

[redacted] [illegible] (CP[redacted]) 17 NP

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER — TIME OF ORDER Noted [redacted] b(6)2

18 MAY 03 2000 HOURS

ANCEF 1GM IV Q8°

[redacted] b(6)2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER — TIME OF ORDER

19 MAY 03 0805 HOURS

NPO

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

[redacted] 19 May 03 0800

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

MEDCOM - 9071

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.
ICW2	T	3

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

19 MAY 03 1500
ADMIT C/O EMAN VILLE ICW
DX - (L) THIGH GSW
COND - STABLE
VS MONITOR
ACT - ASCULATORS - EDW
NKDA
NPO DIET

PATIENT IDENTIFICATION

b(6)4

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW2	T	3

DATE OF ORDER — TIME OF ORDER — HOURS

HEP LOCK IV
MDS - ANCEF 1 GM IV Q8°
TYLOX 1-2 PO Q 4-6° PRN
MS 2 MG IV Q15' PRN UP TO
16 MG IN 4 HR
b(6)2 [redacted] b(6)2

note [redacted] ICTW [redacted] ORTHOPEDIC SERVICE

PATIENT IDENTIFICATION

SBP/S 0120 20 May 03 Delay

b(6)4

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW2	T	3

DATE OF ORDER — TIME OF ORDER — HOURS

20 MAY 03 0830

D/C TO ASMC
HEP LOCK 500 Q L.D
TYLOX 1-2 PO Q 4-6° PRN
b(6)2 [redacted] Noted Sent 21 May 0820

24° V done 19 0230 21 May 03

PATIENT IDENTIFICATION

b(6)4

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW2	T	3

DATE OF ORDER — TIME OF ORDER — HOURS

[redacted]

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. Hrs Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 18	19	20	21	22
16	[redacted]	VS Q Shift	5	[redacted]				
	b(6)2		13	[redacted]				
			21	[redacted]				
18	[redacted]	W→D Drsg ΔQD	10	[redacted]				
18	[redacted]	ACT→ Bed Rest	5	[redacted]				
			13	[redacted]				
			21	[redacted]				
19	[redacted]	~~NPO~~ Regular	06	[redacted]				
			11	[redacted]				
			17	[redacted]				
19	[redacted]	ACT - Restraints	5	[redacted]				
		EPW	13	[redacted]				
			21	[redacted]				

b(6)2

D/C'D

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
GSW (L) post thigh

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 9073

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
18	[redacted]	ADMIT ICW #2	18			[redacted]
18	[redacted]	X-RAY (E) log	18	DONE		[redacted] b(6)2
18	[redacted]	Contact ORTHO upon arrival	18		1600	[redacted]
19	[redacted]	ADMIT C/D [redacted] ICW: COND STABLE	19		1530	[redacted]
21	[redacted]	DC to ASMC w/ Tylox script.	21	Today		
	b(6)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 (MEDICATIONS)	Mo. 05 Yr. 03
	For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	

VERIFY BY INITIALING			INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION	
ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED
18 May 03	[redacted]	Ancef Q8 Tgm IV	[redacted]	18 / 19 / 20 / 21 / 22
		(cont 19 May)	16	[redacted]
			[redacted]	
19	[redacted]	HL: 1	5	[redacted]
			13	[redacted]
			21	[redacted]

ALLERGIES: ☐ YES ☐ NO	PRIMARY DIAGNOSIS:	ADDITIONAL PAGES IN USE:
NKDA	GSW Ⓔ Post Thigh	☐ YES ☐ NO
		PAGE NO.

PATIENT IDENTIFICATION:

EPW # [redacted] 6(6)4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED
18	[redacted]	MSO4 2-4mg IV Q4-6 hrs prn	D/C
18	[redacted]	Tylox 1-11 PO Q4-6 HRS PRN pain (cont 19 May)	1900 14 May 03 11 [redacted] / 21 May 03 2230 [redacted] / 21 May 2230 1 [redacted] b(6)2
18	[redacted]	Tylenol 1-11 PO Q4-6° prn temp	20 May 0845 11 [redacted] / 20 May 2000 11
19	[redacted]	MSO4 2mg IV Q 15° prn up to 16 mg in 4 hours	

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.)
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] b(6)4	16 17 EPW	18 M
0 0 1 3 1 2 4			

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	UNK
	2 5 4	X	9	

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

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

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49 N/A	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 X NO
I Z		9	

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72 Ø	ICW#2	UNK
		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK
NAME [redacted] b(2)2		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
Ø 5		0 3 0 5 2 1

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 E A A		0 3 0 5 1 8

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

FOR LOCAL USE

DX: 6SW (L) Thigh

Dx: 8900
E9912 Trauma-1
Px: 8345 Injury-450

b(6)2

b(6)2

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK
Dr. [redacted]	[redacted]

DA FORM 2985, MAR 89

MEDCOM - 9077

BATES PAGES MEDCOM 9078-9211 ARE NONRESPONSIVE AND HAVE BEEN WITHHELD IN THEIR ENTIRITY

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTRATION NUMBER: 0013190	2. NAME (Last, First, MI): EPW [redacted] b6					3. GRADE: EPW	ADMISSION REMARKS:
4. SEX: M	5. AGE: 23	6. RACE: X	7. RELIGION: UNK	8. LENGTH OF SVC:	9. ETS:	10. PREVIOUS ADMISSION: NO	
11. ZIP: 99	12. SSN: [redacted] b(6)		13. ORGANIZATION:			14. WARD: ICW 2	
15. FLYING STATUS:	16. RATE/DSG:	17. DEPT./BEN: 1478	18. BRANCH/CORPS:	19. UIC/ZIP:		20. TYPE CASE: N51	

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from E.R.

22. HOURS OF ADMISSION: 1450

23. CLINIC SERVICE: AEPR

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE:

25. TYPE DISPOSITION: D/C

26. DATE OF DISPOSITION: 31MAY03

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

27b. TELEPHONE NO.:

28. DATE OF THIS ADMISSION: 23MAY03

ADMITTING OFFICER:

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

30. DATE OF INITIAL ADMISSION:

31. SELECTED ADMINISTRATIVE DATA:

32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED:

33. CAUSE OF INJURY: RUNNING ATTACK ON US FORCES

☐ Check if Continued on Reverse

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

(R) FOOT GSW C OPEN FXS 4TH METATARSAL, NAVICULAR, INTERMEDIATE CUNEIFORM, AND MIDDLE CUNEIFORM

825.34
825.35
E991.1

PR
79.67

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	8	8

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER: D.C. [redacted]

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER: [redacted] b(6)2

DA FORM 3647, MAY 79 EDITION [redacted]

USAPPC V1.10

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

~30y 100% RADI EPW c (R) FOOT INJURY ?2° EXPLOSIVE DEVICE DURING ATTACK ON US FORCES YESTERDAY. DEBRIDED @ FST @ 0030.

PMH ?
PSH ?
NKA
HABITS ?
MS - ?

NO INTERPRETER AVAILABLE

PHYSICAL EXAMINATION

WAD.
CHEST CLR
[illegible]
[illegible]
EXT (R) LE FOUR PLANTAR WOUNDS CLEAN, FOOT INJ
[illegible]
[illegible]

XR AS PER [illegible]

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

A [illegible] OPEN MAGNETIC

P REDEBRIDEMENT IN O.R. AM

b(6)2

SIGNATURE OF PHYSICIAN [redacted]	DATE [illegible]	IDENTIFICATION NO.	ORGANIZATION

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

REGISTER NO.	WARD NO.

b(6)4

[redacted]

EPW

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

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

DATE	NOTES
28 APR 03 1730	CLS Pt admitted from EMT. S/P MVA @ FST. (R) Foot (U) Fx. Pt A+O x3, VSS, (B) CS CTA, (E) 35 x 4, RRR, (L) PIV ILR @ 75cc/hr. (R) LE drop splint CDI. (+) cap refill <3sec, (P) sensation limited out of Big toe, and 2nd toe. Unable to move toes 3-5. Resting comfortably pain normal. Will monitor [redacted] b(6)
2125:	Assumed pt care @ 2100. Pt. febrile @ 101° c̄ chills. Tylox given for pain. Pt. cooperative. Drsngs to (R) ft CDI. Pt. denies ROM toes (R) ft. (+) sensation, cap refill <3sec. ABD tender HR Reg, Lungs CTA, BS (+) x4. Will continue to monitor. —
29 APR 03 0530	OP NOTE [redacted] b(6)2 PRE & POST OP DX — OPEN FXS (R) MIDFOOT W/ BLAST INJ PROCEDURE DEBRIDEMENT (R) FOOT SURG EMANUEL ANES GREG VANDAM IVO 150 EBL 100 FLUIDS 1100 SPEC Ø ANALYS KENNIX CX Ø FINDINGS MOD NONVIABLE MUSCLE & GROSS METALLIC & SOIL CONTAMINATION TO PAN SURGE. [redacted] b(6)2

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST [redacted] | 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. 7C W2

[redacted]

EPW b(6)4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
24MAY03 0800	Pt. gone to OR via litter for I&D of (R) foot. [redacted] 2CT/AN
1115	Pt. back from OR via litter. Now resting comfortably in bed. (R) foot DSG appears clean & dry. Pt. c̄ small amt of pain, 4mg Morphine given. Vital signs stable: T 99.2, HR 98, sats 96% RA, BP 118/72, RR 12. Pt. ate 75% of lunch & tolerating it well. No other complaints @ this time. Will continue to monitor [redacted] 2CT/AN
24May03 1340	pt sleeping arouses to painful stimuli. Airway patent, lung sounds CTA, abd soft nondistended BS(+) x4 quads. LLE c̄ FROM strong (+) pulse. RLE c̄ splint wrapped c̄ ACE wrap. Scant amt of drainage noted on dressing around toes. IV infusing LR s̄ diff (+) s/sx of infiltration. BUE c̄ FROM strong (+) pulses. will cont to monitor [redacted] 91WM6
24May03 1630	New IV started (R) AC c̄ 18g by SPC [redacted], good blood return, site flushed well. IV (L) AC dc'd intact s̄ diff pt tol well [redacted] 91WM6
24May03 1730	pt having diff urinating foley cath inserted s̄ diff. 1400cc cl yellow urine drained. pt tol well. will cont to monitor [redacted] 91WM6
24May03 2030	Foley emptied 700cc cl yellow urine [redacted] 91WM6
24May03 2130	Pt resting comfortably in bed. PERRLA, neck supple c̄ FROM, mucous membranes pink. Moist & intact. BS clear bilaterally. Abd soft, nondistended. bowel sounds x4 quads. Foley catheter intact 300cc clear yellow urine emptied. ULE c̄ FROM, strong pulse, warm, brisk cap refill. RLE c̄ cast from knee to tips of toes. Old drainage noted to cast at toes. brisk cap refill to toes, no complaint of pain. [redacted] LT/MP

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

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

PROGRESS NOTES

DATE	NOTES
27 MAY 03 2930	POD$_2$ - 1 S SLEEPING ON ROUNDS O VSSA DSG & SPLINTS INTACT TOES WELL PERFUSED A STABLE P WND ✓, D/C ABX TO 48°
27 may 03 1845	VSS - IVF DC'd, SL patient - cast/dsg intact On (R) LE, cap refill <2 sec in (R) toes [redacted] b(6)2
27 May 03 2100	UOP 2500cc CLEAR yellow fluid → PPC [redacted] 9LW
27 may 03 2130	Pt care assumed @2100. VSS, alert and awake, pt has complaints of a small amount of pain in RLE. Lung sounds CTA, bowel sounds present x4, pulses present in UE and LE. Foley site intact, no complaints of pain at site. RLE dressing CDI, (+) sensation, ROM. Will continue to monitor. SPC [redacted] b(6)2 9LWM6
28 MAY 03 0530	Pt. asleep in bed easily arousable to voice. VSS temp 97.9, RR 20, P75, BP 110/64, sats 99%. cap refill in (R) toes <3 sec, dressing CDI. Bowel sounds hypoactive x 4 quadrants. Pt makes facial grimaces when lower

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. ICW2

EPW [redacted] b(6)4

PROGRESS NOTES
Medical Record

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

USAFA V1.00

STANDARD FORM 509 (REV. 5/1999) B4

ATE	abdomen palpated. Pt has no other complaints @ this time. All other assessment findings WNL. Will continue to monitor. [redacted] 2LT/AN
1125	New IV placed in (R) FA c̄ 20G. b(6)2 [redacted]
8MAY03	S LOCAL PAIN O VSSA ASG & SPLINT INTACT WELL PERFUSED A STABLE P SLNWC TOMORROW [redacted] MC, MC ORTHOPEDIC SERVICE b(6)2
28MAY03	Pt. vitals taken BP 102/60 P. 98, R. 20, Temp. 98.6
1330	SPC [redacted] b(6)2
28May03	assumed pt care @ 1300. VSS lung sounds CTA, abd.
1420	soft nontender (+) distention noted BS present. Foley cath to gravity draining cl. yellow urine. S̄ diff. LLE c̄ strong (+) pulse. RLE drising. CDI. IV LRA infusing s̄ diff. Will cont to monitor [redacted] 9WM6 b(6)2
2100	Pt alert. Foley to gravity c̄ clear yellow urine. ABD soft, non-distended. Pt denies pain. HR Reg, lungs CTA. cast to (R) LE intact. Caprefill <3sec (R) LE c̄ (+) sensation & (+) ROM. Will continue to monitor [redacted] 1LT/AN b(6)2
29MAY03	Pt sleeping in bed arrasable to voice. VSS: BP 115/80, P 75, RR 18, sats 98%, temp 99
0615	Pt he placed in (R) FA s̄ s/s of infection or infiltration. (R) feet dessing is CDI. Pt has no complaints @ this time. Will continue to monitor [redacted] 2LTA b(6)2

NOTES

DATE

LAST NAME | FIRST NAME | MIDDLE INITIAL | ID NUMBER

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

DATE	NOTES
29 May 03 1315	assumed pt care @ 1300, pt looking @ magazine. VS: O2 sats 98%, BP: 115/78, P: 94, R: 16. airway patent. lungs CTA, abd soft BS(+)x4. foley cath to gravity intact draining c̄ diff. RLE c̄ drsing CDI. pt able to wiggle toes. LLE c̄ FROM strong (+) pulse. BUE FROM c̄ strong (+) pulse. HL to RFA (+) S/Sx of infection noted. pt on EPW precautions, restraints bilat. (+) complaints voiced @ this time. Will cont to monitor. — b62 [redacted] 91WM6
29 May 03 1930	pt resting on et off thru out shift. (+) complaints voiced — [redacted] 91WM6
29 May 03 2040	500cc emptied from foley — [redacted] 91WM6 b(6)2
29 May 03 2130	POD 3 S NO C/O O USSA WINGS CLEAN c̄ MIN SEROSANG DRAINAGE SL CLOSED TOE CAST PLACED A ADMIT WELL P D/C ABX FILL & PULL TOMORROW b62

[redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO. TCW2

EPW # [redacted] b64

PROGRESS NOTES
Medical Record

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

USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
29 May 03 2200	Pt stable at this time VSS PERRLA. Lungs CTA Abd soft, non-tender bowel sounds x4 quads. Drsg and splint removed
b(6)-2	by Dr. [redacted]. Wound to (R) Foot healing well. Outside sutures well approximated, CDI. Bottom of foot T. loose sutures, oozing slightly. Site beefy red. Cast placed to (R) foot by SBT [redacted] Cast Covers to ST0 just below the knee. Unable to assess pulse or cap refill. Ø Complaint of pain at this time. Given MSO4 prior to procedure — [redacted] 1LT/AN b62
30 May 03 0445	Pt stable at this time. Slept through the night. Ø Complaints of pain. — b62 [redacted] 1LT/AN
	0640 Pt sleeping, easily aroused. Ø c/o pain at present
~~06~~	Lung CTA, (+) BS x4. Cast to (R) LE CDI. Popliteal pulse JT. Foley draining clear, amber urine 975cc out. — 1LT [redacted] AN
1220	UOP 250cc clr, amber urine. HL red, swollen, D/C. HL to (R) fa. — 1LT [redacted] AN
	b62

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

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

DATE	NOTES
30 May 03 1330	Pt vitals taken BP 108/60, P.90, R.16, Temp 98.9 SPC [redacted] b62
30 May 03 1915	VSS - cast intact on (R) LE, closed toe - foley dc'd p̄ 250cc sterile H_2O placed in bladder by Dr [redacted], pt. urinated 100cc p̄ foley pulled and 400cc ~ 1700 — b62 [redacted]
2200	VSS. AAO×3. PERRLA. Lungs clear bilat. Abd soft, non tender, bowel sounds ×4 quads. Cast to (R) LE. Cast covers toes to right foot, unable to assess cap refill or b(6)-2 pulses. Ø complaints at this time [redacted]
31 May 03 0430	Sleeping comfortably at this time. Percocet effective for pain management. VSS. Ø complaints at this time [redacted] 1LT/AN b62

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] b64

REGISTER NO. | WARD NO. ICW2

PROGRESS NOTES
Medical Record

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

USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
31 May 03	Pt sleeping, easily aroused. ∅ c/o pain @ present, VSS, lungs CTA, ⊕ BS x4. ⓡLE c̄ cast, CDI, unable to assess toes to ⓡLE, ↓ popliteal pulse to ⓡLE. Pt due to be D/c today. b(b)2 1LT [redacted], Any
31 May 03 1340	pt awake & alert. lung sounds CTA, abd nontender BS⊕ x4 quads. ⓡleg c̄ cast from knee down to foot. ⓛleg c̄ FROM ⊕ pulse. BUE c̄ FROM ⊕ pulses. ⊕ IV access noted. pt has d/c orders. ⊕ complaints voiced. pt on EPW precautions leather restraints bilat, will cont to monitor — [redacted] 91WMC b62

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

NSN 7540-00-634-4176

MEDICAL RECORD | AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
24 May 03 2230	Temp to 101.7F axillary ~~Orally~~. Pt given Tylox x2 tabs. Will recheck temp in 1 hr. b(6)2 [redacted] LT/AN
25 May 03 0130	Temp to 97' axillary ~~p~~ Tylox. 1200cc clear yellow urine emptied from foley. Pt sleeping comfortably ~~3~~ complaint b62 [redacted] LT/AN
0430	Pt sleeping comfortably at this time. Ø complaint of pain. 900cc clear yellow urine to foley. 75cc/hr LR to RAC IV site CDI Ø S/S infiltration. Ø new drainage noted to splint on (R) leg ~~c~~ b62 brisk cap refill to toes bilaterally [redacted] LT/AN
0745	Pt resting comfortably in bed. VSS: BP 115/70, P99, RR16, sats 100%, temp slightly ↑ @ 99.3. IV in (R) AC ~~c~~ no signs of infection or infiltration, LR @ 75cc/hr. Foley draining clear yellow urine ~~c~~ good output. (R) foot dressing has a small amt of red dried blood close to the toes. Cap refill in toes are <2 sec. Pt ~~c~~ no complaints @ this time. Will continue to monitor [redacted] LT/AN
25 MAY 03 0955	S SLEEPING b62 O TMAX 101.8, VSSA DSG & SPLINTS INTACT FOLEY PLACED 2° 1800cc RESIDUAL A URINARY RETENTION P FOLEY, REDRAIN TOMORROW [redacted] b62

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART. [redacted]	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP [redacted]	

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.) | REGISTER NO. | WARD NO. ICW2

#[redacted] b64

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)
1049	Pt c̄ urine output of 1000 cc from 0500 → 1049. [redacted]
1420	Pt vital signs taken BP 102/84 P 90 T 99.8 b62 R 16 SpO2 97% —— SPC [redacted] 91W
25May03 1425	VSS. pt resting c̄ eyes closed easily aroused to verbal stimuli. airway patent, lung sounds CTA abd soft BS⊕x4 quads. LLE c̄ FROM ⊕ pulse. RLE c̄ splint ~~cast~~ et ace wrap, drsing CDI. BUE c̄ FROM ⊕ pulses IV LCA infusing LL ∓ diff. ⊕ S/Sx of infiltration. pts temp 99.8, pt given ∴ Tylenol per prn orders. foley to gravity draining cl yellow urine. will cont to monitor —— [redacted] 91WM6 b(6)
25May03 2045	1200 cc cl yellow urine emptied from foley —— [redacted] 91WM6
25May03 21:10	Received pt. resting in bed. c/o of ↓ Abd pain. Palpated firmness over bladder. Foley drng cl yellow urine. Pt. repositioned. CPT [redacted] aware. 21:41. Pt. A+O. PERRLA⊕WNL. Skin W+D. LCA⊕ BS⊕x4. IV LR @ 75cc/hr patent L wrist. Foley patent ⊕PPP. Drsg to R LE C/D/I. Sm. amt. serosang. drng @ toes. Pt. can wiggle middle R toe. Feet B warm to touch + ⊕ sensation B feet. ∴ Percocet given for pain. Will cont. to mon [redacted] DLT/AN b62
Addendum	VS WNL see flow sheet [redacted] DLT/AN
23:20	400cc cl. yellow urine collected from foley [redacted] DLT/AN
26MAY03 0545	Pt. resting awake in bed. VSS: RR16, P82, T 97.4, BP [redacted]/70. Foley draining clear yellow urine. Pt makes facial grimaces when lower abdomen pressed on. IV patent c̄ no s/s infection or infiltration running @ LR 75cc/hr. Toes on R foot have cap refill < 3sec. Small amt of dried blood around toes on R foot. Pt. assessment otherwise WNL. No other complaints @ this time [redacted] DLT/AN b62
0730	Pt. NPO waiting for surgery this AM. ——

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STANDARD FORM 600 (REV. 6-97) BACK

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)
26MAY03 1000	Pt. gone to OR via litter. [redacted] b6
1230	Pt back from OR via litter. Pt. awake & alert c̄ no c/o pain. b6 Will continue to monitor. [redacted]
1315	Pt vital signs taken BP 118/68 R 14 b6 T 99.2° P 84 SpO_2 98% — SPC [redacted] 91W
26MAY03	Assumed care of Pt @ 1300. VSS. A+O x 3. LR @ 75ug (L) FA IV c̄ IV ABX. patent. BLS CTA. (+) BS x 4 (R) LE cast CDI. (+) sensation minimal mvt of toes (+) cap refill <3 sec. Pt given ii percocet for pain. Resting comfortably. FTG draining cyst. O/W [redacted] WNL Will Monitor
26May03 2145	Assumed pt care @ 2100. VSS, alert and oriented. IV @ LFA is running well, ∅ s/s infiltration or infection. Cast on RLE CDI, pt has (+) sensation, ROM, and capillary refill under 3 seconds. Pt had complaints of pain in RLE, ii percocet given. Lung sounds CTA, pulses palpable in UE, and LLE, bowel sounds present x4 quadrants. Will continue to monitor SPC [redacted] b62
27MAY03 0120	UOP 420cc CLEAR yellow PURD — [redacted] 91W
0355	UOP 150cc. Clear/yellow urine. [redacted]
27MAY03 0530 T 97.6 P 91 R 16 BP 108/74 SpO_2 98%	Assumed pt care @ 0500. Pt. A+O x 3. lungs CTA. (+) BS x 4. IV (L) FA patent. Dsing on (R) leg CDI. c/o pain to (R) leg. Will continue to monitor [redacted] 91WM6.

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE [redacted] b6	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

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

[redacted] b6

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)
27 May 03 1300	UOP: 840cc clear yellow urine [redacted] b(6) [redacted] glucose

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

Dr. [redacted] b(6)2 Lt, [redacted] b(6)2 b(6)2

NSN 7540-01-075-3786

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

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)* 23 MAY 03 | TIME 1450

TRANSPORTATION TO FACILITY: Ambulance

SEX: ♂

DUTY/LOCAL PHONE: AREA CODE | NUMBER

HOME PHONE: AREA CODE | NUMBER

AGE

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 INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☐ NON-URGENT

TIME: 1452

INITIALS: [redacted]

VITAL SIGNS

TIME	1450	1500			
BP	119/69	133/64			
PULSE	102	104			
RESP	16	16			
TEMP					
WT					

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

☒ PULSE OX 96, 100

☐ MONITOR

☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
	CBC, Met 8	Dr. [redacted]	[redacted]	1500	
	X-Ray Facesial	"	"	"	
	1000ml LR X 3	"	"	"	

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)*

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

b(6)4

[redacted]

Ancef 1gm EP

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: 27

HEIGHT:

WEIGHT:

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

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

4. PROPOSED SURGICAL PROCEDURE:
(R) foot I+D

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

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

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

[redacted]

b(6)4

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

6. PATIENT PROBLEMS AND NEEDS	PATIENT GOALS AND EXPECTED OUTCOMES	OR NURSING INTERVENTIONS
D. CIRCULATION X Potential for inadequate tissue perfusion due to: ____1) Intraoperative Mobility ____2) Positioning ____3) Existing Disease ____4) Safety Devices ____5) Hypothermia TQ use	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal puls[redacted]	o ~~Check for support stockings~~ or ace wraps. ~~If none, check with doctor~~ N/A o Check that safety straps are correctly applie[redacted] o ~~Offer pillow for under knees~~ N/A o ~~Place and take down legs from stirrups with slow bilateral motion~~ N/A o Check that rings and all body piercing has been removed. [redacted]
E. NEUROMUSCULAR CONTROL E.1. X Potential impairment of mobility due to: ____1) Pain X 2) Intraoperative Hazards ____3) Prosthesis X 4) Positioning X 5) Transfer pt. to/from OR table E.2. X Potential discomfort due to: X 1) Length of Surgery ____2) Positioning ____3) Arthritis	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary [redacted] physical discomfort.	o Monitor at time o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of [redacted] comfort while waiting for surgery. o Offer support (i.e., pillows, bath towels, etc.) for positioning. b(6)2
F. SPECIAL SENSES F.1. ____ Diminished visual perception due to being: ____1) Pre-Medicated ____2) W/O Glasses F.2. X Potential for decreased communication due to: ____1) Diminished Hearing X 2) Language Barrier F.3. ____ Potential injury due to dentures: ____1) Upper ____4) Caps ____2) Lower ____5) Crowns ____3) Bridges	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR tab[redacted] 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. [redacted] o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from _____ side. o Validate pt.'s understanding of verbal communication. o Verify removal of dentures.
G OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

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

[redacted], MAJ, AN b(6)2 24 MAY 03 DATE

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

12. PREOPERATIVE EVALUATION PREPARED BY (Sign [redacted] MAJ, AN b(6)2
DATE: 24 MAY 03 TIME: 0745

13. POSTOPERATIVE EVALUATION PREPARED BY (Sign [redacted] b(6)2, MAJ, AN
DATE: 24 MAY 03 TIME: 0940

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: 23

HEIGHT: } unknown
WEIGHT:

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

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

4. PROPOSED SURGICAL PROCEDURE:
Debridement Right Foot

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

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

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

EPW - [redacted] b(6)4

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

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	ø Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	ø Check for support stockings or ace wraps. If none, check with doctors. ø Check that safety straps are correctly applied. ø Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. ø 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	ø Pt. will be transferred to OR table without difficulty. ø Pt. will not experience unnecessary physical discomfort.	ø Have sufficient people available for transfer. ø Insure proper body alignment. ø Allow patient to lie in position of comfort while waiting for surgery. ø Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated 2) W/O Glasses F.2. ✓ Potential for decreased communication due to: 1) Diminished Hearing ✓ 2) Language Barrier F.3. Potential injury due to dentures: 1) Upper 4) Caps 2) Lower 5) Crowns 3) Bridges	ø Pt. will be made aware of surroundings prior to anesthesia induction. ø Pt. will be transferred safely to OR table. ø Pt. will be able to understand instructions. ø Minimize danger of injury during intraop period.	ø Introduce self. Keep pt. informed as to where he/she is and what is happening. ø Inform pt. in which direction to move and assist if necessary. ø Speak clearly and slowly. ø Address pt. from either side. ø Validate pt.'s understanding of verbal communication. ø Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

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

[redacted] 17/AN b(6)2 26 May03 DATE

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

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] 17/AN b(6)2
DATE: 26 May03 TIME: 0705

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] b(6)2
DATE: 26 May03 TIME: 1110

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

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: LITTER BY Anesthesia

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

3. DATE 26 May 08 TIME PATIENT ARRIVED IN SUITE 0933

4. PATIENT IN ROOM TIME 0933 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKDA. NPO p MN. Speaks only Arabic

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify) Pt. in supine position on padded OR table. BUE on padded armboards <90°. Hip roll under right hip. Safety strap across mid-abdomen.

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

COMMENTS: Normal anatomic body alignment maintained

8. SKIN PREPARATION

HAIR REMOVAL [ ] YES [X] NO

DONE BY: [ ] OR [ ] NURSING UNIT

METHOD: [ ] DEPILATORY [ ] RAZOR [ ] CLIP

COMMENTS: N/A

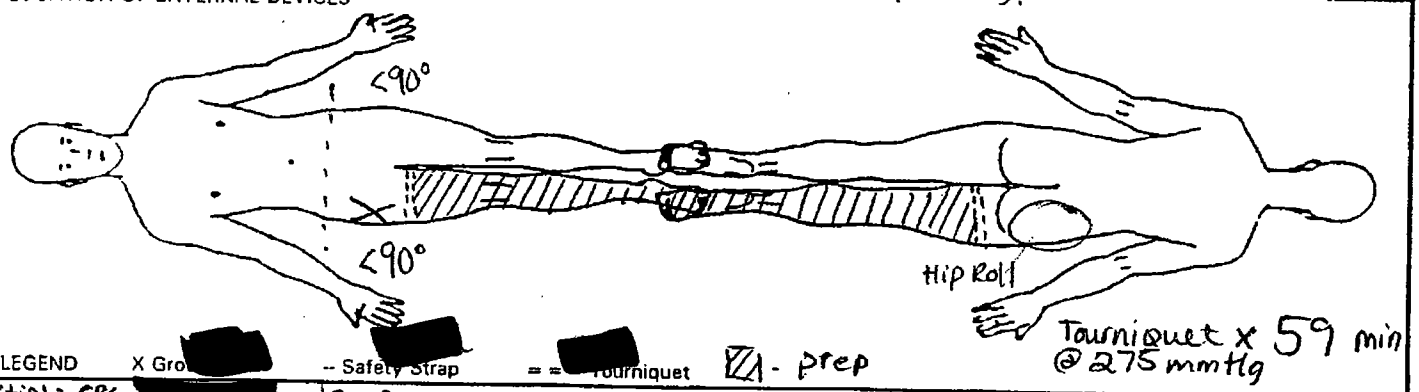
PREP SOLUTION (Specify) Betadine/Betadine

SITE: Right leg. BY WHOM:

SITE: circumferentially BY WHOM: ILT [redacted]

COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Gro[redacted] -- Safety Strap = = [redacted]ourniquet ⊠ - prep

Initial: SPC [redacted] ILT [redacted] b(6)2

C = Correct I = Incorrect

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

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

EPW [redacted] b(6)4

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

[X] ESU NO: #1 cut 30 coag 30

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
N/A					

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

OTHER ORDERS

	TIME	CARRIED OUT BY
N/A		

b(6)2

PHYSICIAN'S SIGNATURE [redacted]

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs, ABD, webril
Splint, ACE

19. ADDITIONAL INFORMATION
Surgeon: Dr. [redacted] b(6)2
Anesthesia: CPT [redacted]

Pt. arrived in OR c̄ Foley cath, draining clear yellow urine, monitored by anesthesia.

DA 5179 Initiated.

20. OPERATION(S) PERFORMED

Debridement Right foot.

21. PATIENT TRANSFERRED TO ICU2 TIME 1105 METHOD Litter c̄ O2

22. REGISTERED NURSE SIGNATURE [redacted] RN/AN b(6)2

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

MEDCOM - 9232

MEDICAL RECORD | **INTRAOPERA[illegible] 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], AN, 66E b(6)2

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

3. DATE 24 MAY 03 TIME PATIENT ARRIVED IN SUITE 0808

4. PATIENT IN ROOM TIME 0808 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: A&O x 3. ~~Con~~ errors [redacted] Restrained. Speaks Iraqi

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted], 91D b(6)2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ [redacted], AN, 66E b(6)2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) (B) arms abducted less than 90° on padded armboards

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

COMMENTS:

8. SKIN PREPARATION

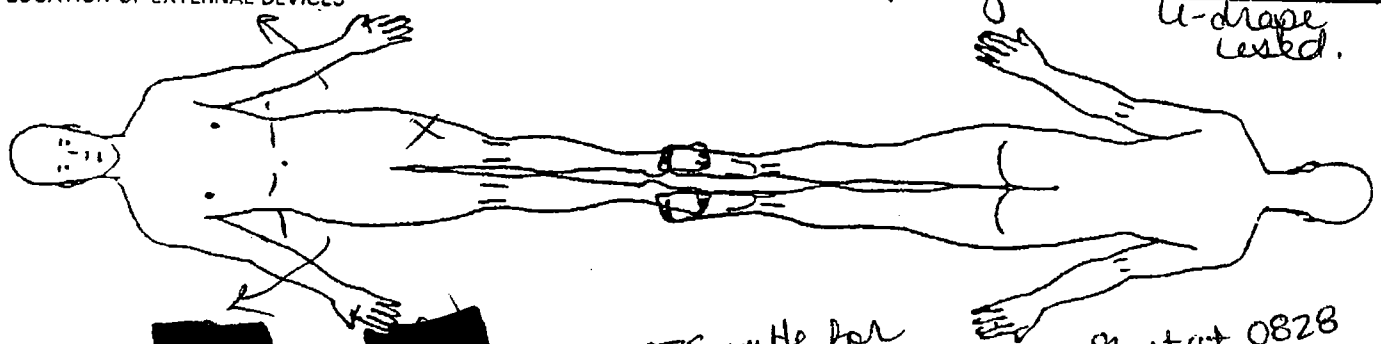
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION (Specify) Beta/Beta
SITE: RLE BY WHOM: [redacted]
SITE: BY WHOM:

COMMENTS: No pooling noted. Chux + 1015 U-drape used.

9. LOCATION OF EXTERNAL DEVICES



LEGEND X [redacted] -- [redacted] = = = Tourniquet 275mm Hg for 55 minutes Start at 0828 End at 0923 Init by [redacted]

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No		C [redacted]	C [redacted]	[redacted] b(6)2	[redacted] b(6) 55 12 23
Needle Sharp	☒ Yes ☐ No		C [redacted]	C [redacted]		
Instrument	☐ Yes ☒ No					
Other	☐ Yes ☒ No					

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

[redacted] EPW

b(6)4

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

☒ ESU NO: #1
GROUND PAD: BRAND VL REM
LOT NO:

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA MEDCOM - 9233 H IS OBSOLETE. USAPA V1.01

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS. SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

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, Kerlix, Cast, ABD Pads, Webril, Ace Wraps

19. ADDITIONAL INFORMATION

Dr. [redacted] b(6)2 MAJ [redacted], CRNA b(6)2

Bovie pad site post-op: CDI

Foley in place from ICW-2.

20. OPERATION(S) PERFORMED

I+D, Rt foot wound.

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU-2 b(6)2	0940	litter

22. REGISTERED NURSE SIGNATURE [redacted] MAJ, AN

REVERSE OF DA FORM 5179-1, OCT 8; USAPA V1.01

MEDCOM - 9234

MEDICAL RECORD b(6)2

INTRAOPER. ...OCUMENT

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

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

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

3. DATE 22 May 2003 TIME PATIENT ARRIVED IN SUITE 2155

4. PATIENT IN ROOM
TIME 2155 NUMBER N/A

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: [illegible]

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	SGT [redacted] CPT [illegible]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

[illegible]

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

COMMENTS: [illegible]

8. SKIN PREPARATION

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

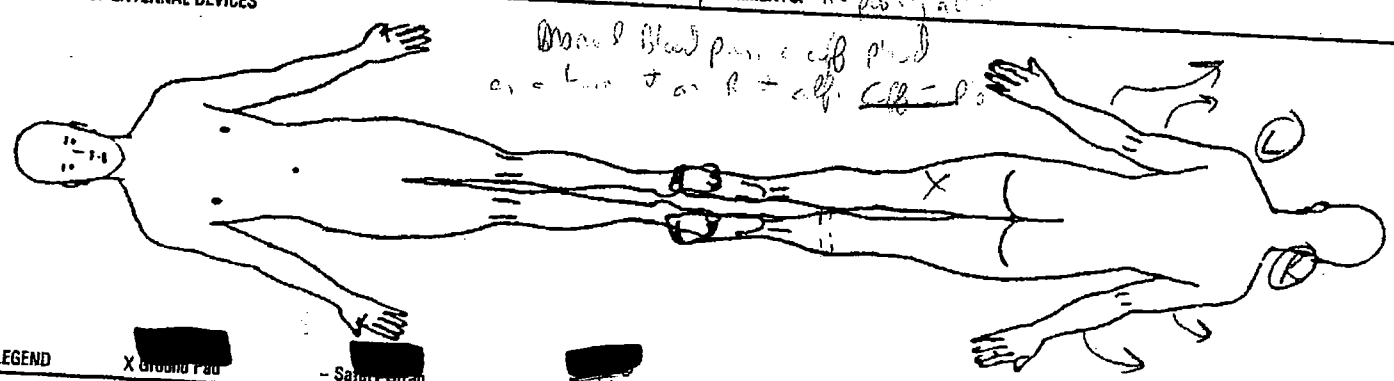
COMMENTS:

PREP SOLUTION *(Specify)* [illegible]
SITE: Right Foot/[illegible] BY WHOM: [illegible]
SITE: BY WHOM:

COMMENTS: [illegible]

9. LOCATION OF EXTERNAL DEVICES

Manual Blood pressure cuff placed [illegible] Cuff [illegible]



LEGEND X [redacted] – [redacted] --- [redacted]

10. COUNTS

C – Correct I – Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No		C	C	[redacted]	[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;)*

LOG# Epw [redacted]
SSAN# [redacted] b(6)4
NAME:

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

☒ ESU NO: FOW 00952
GROUND PAD: BRAND [illegible]
LOT NO: 0211[illegible]

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 517

MEDCOM - 9235

USAPA V1.01

13. PROSTHESIS, IMPLANTS [ ] YES [X] NO IF YES NAME: ID NUMBER; MAI

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION [X] YES [ ] NO, TYPE(S): 0.9% NS

OTHER ORDERS

	TIME	CARRIED OUT BY
b(6)2		

PHYSICIAN'S [redacted] LTC M

15. X-RAY IN OPERATING ROOM YES [ ] NO [X] IF YES, SITE

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES [ ] NO [X]

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

18. DRESSING/IMMOBILIZATION (Specify)

Kelly, Ace

19. ADDITIONAL INFORMATION

Surgeon - LTC [redacted]
Anesthesia - CPT [redacted]

Crystalloid: 2250
EBL: 350
UO: 2

23 MAY 03, Anesthesia block by CPT [redacted], Pt anxious, unable to sedate, non cooperative, GA + RSI c 200 Cricoid pressure, airway, ETT placed, esophageal, placement confirmed on more or less, blankets placed, taped, warm, drawers c software, drugs, glycopyrrolate, Ketamine, Valium, MgSO4, Succinylcholine, VSS throughout case, pulse oximetry: 118/65 105 100% Total: 3200 Dry Dry 135/77-100-16-100%, 37C

LOC#: [redacted]
SSAN#:
NAME:

20. OPERATION(S) PERFORMED

I&D Rt Foot

21. PATIENT TRANSFERRED TO Pat Lab b(6)2 TIME 1130 METHOD CH

22. REGISTERED NURSE SIGNATURE [redacted] CPT INS

REVERSE OF DA FORM 5179-1, OCT 87

MEDCOM - 9236

USAPA V1.01

511-119

MEDICAL RECORD

VITAL SIGNS RECORD

NSN 7540-

HOSPITAL DAY

POST-

DAY

MONTH-YEAR May 19 2005

DAY 23 24 25 26 27 28 29

HOUR

PULSE (O)

TEMP. F (•)

105° 104° 103° 102° 101° 100° 99° 98.6° 98° 97° 96° 95°

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

TEMP. C

40.6° 40.0° 39.4° 38.9° 38.3° 37.8° 37.2° 37.0° 36.7° 36.1° 35.6° 35.0°

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

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)

[redacted]

REGISTER NO.

WARD NO. ICW2

L(6)4

VITAL SIGNS RECORDS

Medical Record

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

EDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

DAY

H-YEAR	DAY	30 Nov	31 May
19	HOUR	1630	0540

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE: 108/76 | 120/74 | 122/80 | 100/85

SPO2: 99% | 98 | 99 | 99%

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICW2

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

Ward/Section: ICW2	QUESTING PHYSICIAN: [redacted] b(6)2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)		
LAST, FIRST, MI. EPW [redacted] b(6)4		DATE 25 MAY	TIME 1000	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	7.1	4.8-10.8 x 10^3
RBC	2.63	4.7-6.1 x 10^9
Hgb	7.5	14-18 g/dl (M) 12-16 g/dl (F)
Hct	24.0	42-52% (M) 37-47% (F)
MCV	91.4	80-94 fl (M) 81-99 fl (F)
Plt	226	130-500 x 10^3 verified
Lymph %	21.3	20.5-51.1%

(Hematology) Manual Differential

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

Blood Bank Unit Crossmatch
MUST SUBMIT SF [illegible] OF BLOOD REQUESTED

UNIT	TYPE	CROSSMATCH

REMARKS: CBC

REPORTED BY: b(6)2 [redacted]	DATE: 25 MAY	LAB ID NO.:

Ward/Section: ICW2

REQUESTING PHYSICIAN: [redacted] b(6)2

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

LAST, FIRST, MI. FPW [redacted] b(6)4

DATE 25MAY03 TIME 1000 SSN/PSEUDO SSN:

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

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

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

TEST	RESULT	REF. RANGE
GLU	95	73-118 mg/dl
BUN	4	7-22 mg/dl
CRE	0-8	0.6-1.2 mg/dl
CK	382	39-380 u/l (M) 30-190 u/l (F)
NA+	140	128-145 mmol/l
K+	3.7	3.3-4.7 mmol/l
CL-	105	98-108 mmol/l
tCO2	26	18-33 mmol/l

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO2		18-33 mmol/l

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

TEST	RESULT	REF. RANGE
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO2		18-33 mmol/l

REMARKS: Metabolic 8

REPORTED BY: b(6)2 [redacted]

DATE: 25MAY03

LAB ID NO.: