BATES PAGES MEDCOM 7174-8240 HAVE BEEN WITHHELD PENDING REVIEW

IDA: MEDCOM

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	b6-2
	cont 1445 more alert moving arms opening eyes. [redacted]
	1500 Airway patent SpO2 98% NC 4lpm V/S stable
	1530 Elevated pts head on blankets. Pt remains
	stable. Chest tubes draining to intermittent suction
	Foley draining clear straw colored urin. IV sites patent [redacted] b6-2
	1600 Pt remains stable becoming more alert trying to
	communicate. Gave pt. clock c waters on it for water [redacted] b6-2
	1730 - Pt awake c/o pain given Pain med. MS04 [redacted] b6-2
	1800 - Pt. sleeping V/S stable pt ~~[illegible]~~ removed from
	O_2. SpO2 94-96%. [redacted]
	1900 - intermittent sleep awake. c/o pain returned back b6-2
	to sleep.
	2000 - Pt prepare for transport via helicopter. ~~[illegible]~~
	Pain meds provided for trans [redacted]
	b6-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
27 APR 03 2045	Received pt via litter from ER in company of ER personnel. (NEURO) Alert and following commands. Appears to be in pain. PERL @ 3mm. Move all extremities x4. Equal handgrasp (B). (CV) Sinus tach 110's. S1S2. Peripheral pulses palpable x4. Febrile T-101.9 Dr. [redacted] aware. Tylenol was given at ER. Will keep monitoring. (RESP) On 10L via NON-REBREATHER O2 SATS 100%. CT x 2 on (L) chest. To cont. suction. Lungs clear ↓ on (L) side. Ø respiratory distress noted. (GI) NPO. BS absent. Midline abdominal incision with dressing draining bloody discharge that has not increased since early this evening. Abdomen soft tender to touch. (GU) Foley to gravity draining adequate amounts of clear yellow urine. (LINES) (L) AC with NS and (R) femoral with LR @ KVO. (SKIN) Dry & hot to touch. DSG to CT and ABD. Will keep monitoring for any changes. [redacted] b6-2
28 APR 03 0300	Dressing Δ on back done. Placed 4x4 on (B) wounds. Ø signs of infection. [redacted] sign b6-2

b(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)		REGISTER NO.		WARD NO.

[redacted] b6-4

PROGRESS NOTES
Medical Record

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

[redacted]

MEDCOM - 8242

LAST NAME	NAME	MIDDLE	ID NUMBER

DATE	NOTES
28Apr03	Stable overnight. CT to suction - on c/s now. W.H pull CT of [illegible] DC. Lowered Temp. Cont Abx
	[redacted] b6-2
	MATINMIX
28Apr03 1500	NN: Patient received at 0500. Neuro: Sleepy, opens eyes to voice, pupils 2mm reactive to light. Pain controlled c̄ 2mg MSO4 push Q 2°. Resp: lungs diminished bilaterally c̄ crackles in LLL and a distinct (L) pleural rub. Sats 96-100% on 2L NC. CV: HR 100-110, B/P stable low grade fever Tmax 100°, Pulses palpable in all extremities. GI: NPO, BS (+), GU: foley draining clear yellow urine. Skin: Abd dsg removed, staples OTA Ø drainage S/S of infection noted. (R) CT #1, (L) CT #2 dsg d'd. Entrance / Exit wounds dressed. Dressing to (R) fem cordis changed. Up to chair x 30 mins. IS Q 1-2°. Will continue to monitor - [redacted] (PT) RN b6-2
28 APR 03 1400	Received pt from outgoing nurse. Resting. Sleepy. Easy arousable. PERL @ 3mm. MAE x 4. Equal hand-grasping. (CV) ST ⊘ ectopy. S1S2. PPP x 4. ↓ deficit pulses. (RESP) O2 via N.C. @ 2L. Small crackles (B), lungs diminished on bases. O2SATS 99%. (GI) +BS. Abdomen with tenderness to touch. Still NPO. (GU) Foley out due to void @ 230cc. (Skin) Midline ABM, (L) chest wall bandage dressings intact. Will keep monitoring. [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

b6-2 USAPA V1.00

[redacted]

PROGRESS NOTES

DATE	
28 APR 03 2200	Pt temperature 101.9. [redacted] b6-2 modified. No action taking @ this time. Will continue using IS as ordered. [redacted] b6-2
29 Apr 03 1100	NN: Assumed care of patient at 0500. Neuro: patient opens eyes to voice / light touch. 2mg MSO4 given for flank pain. Resp: lungs sound diminished bilaterally c̄ crackles in (L) base. (R) CT to water seal, 10cc bloody drainage since 0500, 100cc overnight. Sato 96-100% on 2L NC. Will encourage IS, up to chair. CV: HR 90-110 B/P stable, skin warm / dry, afebrile. Pulses palpable. GI: large air bubble noted on cXray in stomach, patient had episode N/V last pm. Abd distended slightly firm and tender. NGT to LIS placed c̄ 100cc thin greenish return. GU: voiding spont 500-600 cc Q 4°. Skin: Staples mid line OTA, CT dsg intact, will Δ posterior 6580 dsg this pm. Will continue to monitor [redacted] b6-2 CPT/RN
29 Apr 03 1400	NN: Patient to chair x 30mins, bath / dsg Δ's done. IS x10. Tolerated well medicated c̄ 2mg MSO4. [redacted] b6-2 CPT/RN
30 APR 03	[illegible] 240 cc jello c̄ H2O c̄ MIV [redacted] b6-2

STANDARD [redacted] BACK
USAPPC V1.00

MEDICAL RECORD	PROGRESS NOTES
DATE	
29 APR 03 1730	Received pt. from offgoing nurse. (NEURO) Alert awake. PERL @ 2mm. MAE x4. 0 c/o pain @ this time. (RESP) 2 L NC. O2 SATS 98-100%. Lungs sounds ↓ (B) with small crackles @ (L) lower lobe. (CV) ST 0 ectopy PPP x4 0 edema Afebrile (GI) Abd soft slightly tender to touch. Active BS. (GU) Voiding adequate amounts of clear yellow urine. (IV) (R) femoral central line with IV @ 100 cc/hr. (SKIN) Midline abd incision open to air. CT over dressings d/ I. Dsg to GSW d/ I. Will keep monitoring. [redacted] b6-2
29 APR 03 2000	Pt up to the chair. Tolerating well. 0 complaints @ this time.
29 APR 03 2130	Pt back to bed after one hour and a half sitted up on chair. [redacted] b6-2
30 APR 03 1730	Received from offgoing shift. (NEURO) Alert awake and oriented. MAE x4. Equal hand grasp. PERL @ 2mm (RESP) RA O2SAT 95%. (B) lungs diminished @ bases. CT site with dressing. (CV) SR ectopy. PPP x4. afebrile. 0 edema noted. (R) AC heplock. (GI) Abdomen soft slightly tender to touch. Active BS x4 quadrant. (GU) Voiding spontaneously. (SKIN) Midline abd wound open to air. Dsg to (B) wounds in back. Will keep monitoring for any changes. [redacted] b6-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

[redacted] b6-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
26 Apr 03	
28 APR 03	MD Progress Note
	POD #1 s/p neg ex-lap + (L) CT placement x 2 s/p GSW
	CTs put to H_2O seal today. No PTX on follow up CXR
	+ CT #2 (anterior) just pulled. Pt's temp has trended down
	+ currently afebrile. VS normal. Adequate UO. No bowel
	sounds but abdomen soft. Hct 30.1 WBC 11.1.
	A/ Doing well POD #1. Resolved PTX.
	P/ Will D/C foley
	Continue Abx until 2nd CT pulled tomorrow
	Adv diet tomorrow
	b6-2 [redacted] MAJ MC, USA
29 APR 03	MD Progress Note
	POD#2 Tm 101.9 T. 99 HR 100's BP n/l Sa O_2 >95%
	Lungs (R) clear (L) inspiratory + expiratory wheezes
	Abd mildly distended, mildly TTP in LUQ, BR/G
	Scant distant BS
	EXT BCLE
	9.4 > 9.7 / 29.9 < 165 Chem 7 N/l Creat 1.1
	CXR Elevated (L) hemi-diaphragm c̄ enlarged stomach bubble. (L) CT in place ØPTX
	A/P Post op ileus - Will place NGT for decompression
	Will D/C CT today
	Afebrile but c̄ n/l WBC this am. Continue Abx
	until CT removed. Aggressive IS + Ambulation.
	b6-2 [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	SPONSOR'S SERVICE NUMBER (SSN)
			[redacted]

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MA[redacted] 9230

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.
	Mil Me CST	

[redacted]

b6-4

PROGRESS NOTES
Medical Record

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

[redacted]

LAST NAME	NAME	MIDDLE	ID NUMBER

DATE	NOTES
30APR03	MD Note
	POD#3 VSS AF 2nd CT removed yesterday. C/o thirst.
	Exam notable for ↓ BS bilat, Sats 100%. Post CT pull CXR ⊖ PTX.
	Abd soft, nontender, Bs present. Overall doing well. Will advance
	diet today + encourage IS + ambulation. [redacted]
	[redacted] MAJ, MC, USA
	b6-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

[redacted]

558-104

7540-01-075-371

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER | TREATMENT FACILITY

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

SEX: M

DUTY/LOCAL PHONE — AREA CODE | NUMBER

AGE: 22

HOME PHONE — AREA CODE | NUMBER

ARRIVAL

DATE *(Day, Month, Year)*: 27 APR 03 | TIME: 2040

TRANSPORTATION TO FACILITY: MEDEVAC

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			

MEDICAL HISTORY OBTAINED FROM

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS

ALLERGIES

CHIEF COMPLAINT

INJURY OR OCCUPATIONAL ILLNESS

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

HOW

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INITIAL SERIES ☐ YES ☐ NO

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☐ NON-URGENT

TIME

INITIALS

VITAL SIGNS

TIME	2040				
BP	125/73				
PULSE	110				
RESP	19				
TEMP	103.2				
WT					

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

✓ PULSE OX — b6-2 — ✓ MONITOR — ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
2040	25 cc IM Tetanus	[redacted]	[redacted]	2045	
2040	1 Gm IV ANCEF		b6-2	2045	
2040	1 Gm PO Tylenol			2045	

DISPOSITION: ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

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

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

[redacted] b6-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Doctor)*	TIME SEEN BY PROVIDER 27 Apr 03. 2030

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

S: Pt, 22yo Iraqi EPW s/p GSW @0400 this AM, seen @FST @ CT bilat 2 & Neg Ex Lap. Sent here for further mgmt. Sustained GSW to mid Back ~T6 & (L) Latissimus Dorsi

PMHx ∅
PSHx ∅
NKDA
∅ Meds.
? if Ancef/ortil given

O: WD WN in UAD. A&O ∅ Resp dist NonToxic Warm. Tem 103.2 ⊕
HEENT NM
Chest: (L) ant CT & (L) Lat CT ⊖ Air leaks ~400 cc Bld bilat
Abd: New Ex Lap incision. ⊖ Distention
Ext: wm. N/V intact. moves all 4's.
GU: Atraumatic ⊖ foley.

PCXR: 2 + (L) CT
Min small ptx.

12.3 / 10.7 / 33.6 / 172

T&S A⊕

P: Admit to ICU 2
CT mgmt.
Ancef 1gm IV
Tet .5 mL IM.

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVID[redacted] b6-2

DIAGNOSIS
GSW (L) Chest
S/P ⊖ Ex Lap.

CODE

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

[redacted] b6-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

STANDARD FORM 553 (REV. 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)

[redacted]

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY		1																	
POST-	DAY	27 APR03				27 APR													
MONTH-YEAR	DAY	1400	1415	1430	1445	1600	1630	1700	1800	1820	2000								
19	HOUR																		

PULSE (O) — TEMP. F (●)

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		

	1400	1415	1430	1445	1600	1630	1700	1800	1820	2000
RESPIRATION RECORD	14	20	36	36	30	30	30	24	24	
BLOOD PRESSURE										
FIO2	98		100		100		96			
HEIGHT: / WEIGHT→										
Chest #1	350/25				0		25/			
Chest #2	50/50				50		50/			
NS –										
LR –	75				75					
Urine –	2000				1200		1050			
O2	5L	4L			2L		[redacted]			

Record special data only when so ordered

b(6)-2

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

REGISTER NO.

WARD NO.

511-112

VITAL SIGNS RECORD

STANDARD FORM 511 (REV. 9-79)
Prescribed by GSA and Interagency Committee on Medical Records
FPMR (41 CFR) 101-11.806-8

PT'S NAME [redacted] ID# [redacted] DATE [illegible]

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP																	118/66	116/67	109/64	114/68	109/65	123/69	120/66	111/60
TEMP																		101.9		101.9		101.0		101.0
HR																	107	112	114	107	113	111	109	103
RR																	24	21	26	28	24	30	20	22
SA02																	100%	100%	100%	99	99	100	100	99
INPUT																								
PO																								
LRIV																	100	100/200	100/300	100/400	100/500	100/600	100/700	100/800
NGT																								
[redacted]																								
[redacted]																								
TOTAL																								
OUTPUT																								
URINE																	200	200/400	200/600	150/750	100/850	125/975	100/1075	100/1175
NGT																								
STOOL																								
CT #1															CT#1		225	225	225	250	250	250	250	255
CT #2															CT#2	225	25/250	25/275	25/300	35/335	15/350	25/375	15/390	10/400
																	225	225	225	25/250	0/250	0/250	0/250	5/255
TOTAL																								
BALANCE																								
[redacted]																								
															IN			800						
															OUT -			1830						

MEDCOM - 8251

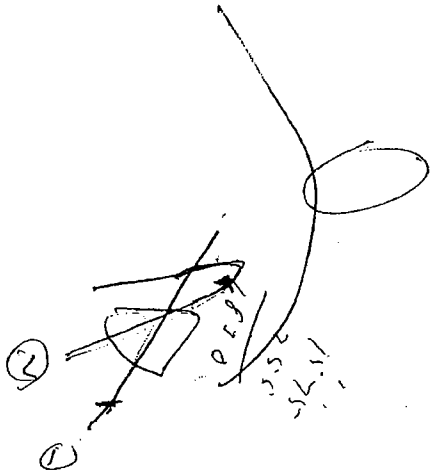
PT'S NAME: [redacted] b6-4 ID#: [redacted] b6-4 DATE: 28TH AMC 03 35 y/o

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP	119/58	122/63	124/64	119/64	111/62	106/68	115/68	108/67	115/66	111/68	119/64	124/60	119/65	113/62	109/63	111/64	110/62	127/69	127/63	124/65	125/66	124/64	127/67	113/64
TEMP	100.2				100.9				99.4				100.9	100.9				101.9	100.8			101.0		99.9
HR	103	104	101	103	103	104	112	111	105	110	107	104	111	109	119	112	189	119	106	111	115	112	101	100
RR	22	28	16	23	24	25	25	29	28	25	23	26	25	22	23	24	22	23	21	22	25	20	18	17
SA02	98%	98%	100%	100%	99%	99%	97%	99%	100%	100%	100%	98%	99	100%	99	98	99	97	100	100	100	100	99	98
INPUT																								
PO																								
LR IV	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
NGT																		50						
PB		50								50														
TOTAL																								
OUTPUT																								
URINE	100	600	225	225	250	250	150	150	100	100	200	200	100	D/C			550		DTW					550
NGT																								
STOOL																								
CT #1	5/265		10/10		25/35		5/40		0/40		30/70		0/70	5/75	0/75	0/25	0/330	20/350	5/355	10/365	5/370	0/370	5/375	5/380
CT #2	0/255		0/0		50/50		5/55		0/55		0/55		OUT											
EMESIS																						30		
TOTAL																								
BALANCE																								

IN 3150

OUT 3940

MEDCOM - 8252



ARGE BLUE	1412
ARGE BLUE	1412
ARGE POWDER FREE 900S	466
PACKED IN ORDER OF USE	125
G DBL LUMEN STER 50S	79
STERILE 18X26INCH 300S	214
POWDERED STER DISP 50S	88
SYN FIBER FILTER DISP50S	126
	55
SYRIN 24	12
	36
RBBR POWDER FREE 1000S	877
LOCK CHANNEL 120V60HZ	8
ROLLED 6IN X 4YD 36S	37
ARDOUS MATERIAL DISPOSAL	39
LES PER PACKAGE	2
	586
100FT 22MM CUFF DISP	55
S WIDE ROLLED	1353
	2590
	674
DERED STER DISP 50PR	293
L N-VNT IVAC	40
EP PLST GZ SPONGE	166
	6
3 STER DISP 100S	16
WIDE ROLLED	1353
EL	34
HYPO-ALLERGENIC 200PR	35
YELLOW ONE SZ FIT	49
ERILE DISP 2000S	247
TWT RBBR STER DISP50S	64
FOLD IN PAIRS	1
5 STER DISP 100S	44
IN DIA	262
EX GAUNTLET DISP100	14
7 DISP STER 50S	79
REEN 50S	8
ES PLAS STER48S	8
FILTER 82" LG 48S	20
	103
LE 18X26INCH 300S	214
IDE NYLON NONRIGID	578
	2
TIP STYLE DISP 50S	50
VDR STER DISP200PR	5
NEEDLE UNIT 50/PG	124
LE 12 PER BOX	1214
S	44
BLUE	1412
ERED FNGRS RBBR 200PR	79
POWDER FREE 900S	466

PT'S NAME: [redacted] b/e-4 ID#: [redacted] DATE: 29 APR 03

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP	116/70	118/65	116/64	110/60	117/69	123/66	113/67	114/62	111/64	118/61				111/61						118/70				
TEMP	99.3				990									99.6						99.1				
HR	98	98	104	100	98	102	98	99	102	100				103						98				
RR	20	18	15	16	18	15	16	19	19	18				18						14				
SA02	99	100	98%	98%	100%	98%	98%	98%	98%	99%				99						99%				
INPUT																								
PO																								
LR IV	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
NGT																								
[redacted]		30								50														
[redacted]																								
TOTAL																								
OUTPUT																								
URINE						580		[redacted]							560								450	
NGT								300		100	D/C													
STOOL																								
CT ACDNG	0/0		5/5		0/5		0/5		5/10		D/C													
CT TOTAL	380																							
TOTAL																								
BALANCE																								
[redacted]																								

IN 1100

OU 20

S/P GSW / Exp. Lap (neg) / CT placement

MEDCOM - 8254

) ROLLS	252
	1
M ID STER DISP 10S	1987
	15
NVENTED STER DISP 50S	99
WEIGHT 50PR	100
TY 60CU CM STER DISP20S	401
S 15X12IN 400S	22
F LARGE	31
PREPOWDERED STER100S	1448
ILE DISPOSABLE 20S	10
L BACKGROUND 20X4"	156
S	19
S	1020
DISPENSER PUMP 4S	1
YETHYLENE DISP 300S	228
5" BLADE DISP100S	5
	37
STERILE 6.0IN,100S	460
BOROSILICATE1000	16
ALC-FREE SIZE 6 200S	48
RESERVOIR CAP 50S	148
DPQ STER DISP 10S	150
D WILK.FRACT.CHILD.SE	2
R FREE LIGHTWEIGHT2S	43
	3
7 HDL CS 150S	29
ASTIC 400S	25
PROPYLENE BLOCK	2611
	23
L NON-VENTED 48S	1409
GREES 1000S	53
BIDEXTROUS RBBR100S	57
	24
	13
18S	100
RLESS QUICK DRYING	1
STER DISP 50S	548
LE 4IN X 4 YD 72S	203
ERIC I.S. 280S	12
BY 5 YARDS 12S	613
FLEX PLAS STER 20S	131
	87
NDL STER DISP60S	118
ERILE DISPOSABLE 50S	71
	12
5X2 INCHES	196
	20
PER PACKAGE	416
R STER 36S	413
NGE STER DISP 20S	7
ILE 4IN X 4 YD 72S	203

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ____ HOURS
TO ____ HOURS

TOTAL HOURS COVERED

DATE

INTAKE

~~ORAL~~ URINE OUTPUT

TIME	TYPE	AMOUNT	ACCUM TOTAL
0630	200 cc		

INTRAVENOUS

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

IRRIGATIONS (N/G, Bladder, etc.)

TIME	[redacted]			[redacted]	[redacted]
	BP	P	T	RESP	O2SAT
06	110/60	109	97°	18	93%
12	126/78	100	99.7	14	92%
18					
24					

BLOOD/BLOOD DERIVATIVES

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

~~OTHER INTAKE~~ Stool

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0630	x1 medium brown		
0930	x1 small liquid brown		

GRAND TOTAL INTAKE

USAPPC V1.00

[redacted] — b6-4

[redacted]

SPECIMEN/LAB RPT. NO.

MISC

EMT

URGENCY: ☐ ROUTINE ☐ TODAY ☐ ☐ PRE-OP STAT ☒

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

SPECIMEN SOURCE (Specify)

PATIENT'S MED. RECORD

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

REQUESTING PHYSICIAN'S SIGNATURE [redacted] b6-2

REPORTED BY b6-2 [redacted] MD TECH

DATE

LAB ID NO.

REMARKS

CBC

TEST(S) / SPECIMEN TAKEN — DATE 27 Apr 03 TIME 2045 A.M. (P.M.)

RESULTS	REQUESTED
WBC 12.3	
RBC 3.55	
Hgb 10.7	
Hct 33.6	
MCV 94.8	
MCH 30.3	
MCHC 32.0	
Plt 172	
Lymph % 11.4	

MISCELLANEOUS

557-107

STANDARD FORM 557 (Rev. 3-77) Prescribed by GSA/ICMR FIRMR (41 CFR) 201-45.505

TEST(S) / SPECIMEN TAKEN — DATE 4/28 TIME 0500 A.M. (P.M.)

RESULTS	REQUESTED	(X)
110	GLUCOSE	X
7	UREA N.	X
0.9	CREATININE	X
	URIC ACID	
135	SODIUM	X
3.5	POTASSIUM	X
97	CHLORIDE	X
26	CO_2	X
	PHOSPHATE	
	CALCIUM	
	TOTAL PROTEIN	
	ALBUMIN	
	GLOBULIN	
	ALKALINE PHOSPHATASE	
	ACID PHOSPHATASE	
	SGOT	
	LDH	
1691	CPK	X
	BILIRUBIN (TOTAL)	
	BILIRUBIN (DIRECT)	
	CHOLESTEROL	
	TRIGLYCERIDES	
	AMYLASE	
	LIPASE	
	PROFILE (Specify)	

REMARKS [redacted] Hematocrit

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

REQUESTING PHYSICIAN'S SIGNATURE [redacted] b6-2

REPORTED BY b6-2 [redacted] MD TECH

DATE

LAB. ID. NO.

b6-4 [redacted] ICU 2

CHEM 1

URGENCY: ☐ ROUTINE ☐ TODAY ☐ ☐ PRE-OP STAT ☐

PATIENT STATUS: ☐ BED ☐ AM ☐ OUTPATIENT ☐ ☐ NP ☐ DO

SPECIMEN SOURCE: ☒ BLOOD ☐ OTHER (Specify)

SPECIMEN/LAB. RPT. N

CHEMISTRY I 546-107

STANDARD FORM 546 (Rev. 8-77) PRESCRIBED BY GSA ICMR FIRMR (41 CFR) 201-45.505

PATIENT'S

TEST(S) / SPECIMEN TAKEN — DATE 4/28 TIME 0500 A.M. (P.M.)

RESULTS	REQUESTED	(X)
3.16	RBC COUNT	
9.7	HEMOGLOBIN	
30.1	HEMATOCRIT	
95.2	MCV	
30.8	MCH	
32.4	MCHC	
11.1	WBC COUNT	
	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
	NEUTRO-BANDS	
	NEUTROSEGS	
10.9	LYMPHS	
	EOSINOPHILS	
	BASOPHILS	
	MONOCYTES	
	PLATELETS	
	RBC	
	SED. RATE	
148	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PT CONTROL	
	PT PATIENT	
	PTT CONTROL	
	PTT PATIENT	
	% ACTIVITY	
	RATIO	
	SICKLING TEST	
	LE PREP	

REMARKS CBC

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

REQUESTING PHYSICIAN'S SIGNATURE b6-2

REPORTED BY b6-2 MD TECH

DATE

LAB. ID. NO.

b6-4 [redacted] ICU 2

HEMATOLOGY

URGENCY: ☐ ROUTINE ☐ TODAY ☐ ☐ PRE-OP STAT ☐

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

SPECIMEN SOURCE: ☒ VEIN ☐ CAP ☐ OTHER (Specify)

SPECIMEN/LAB RPT. NO.

HEMATOLOGY 549-107

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

PATIENT'S MED. RECORD

MEDCOM - 8257

bb-2

bb-4

TEST(S)

SPECIMEN TAKEN

DATE 4/28 TIME 0500 A.M. P.M.

REQUESTED

RESULTS

PT= 14.2 secs

PTT= 28.6 secs

PT PTT

REMARKS

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

REQUESTING PHYSICIAN SIGNATURE

REPORTED BY

bb-2

TECH

MD DATE

ICU 2

MISC

URGENCY: ROUTINE, TODAY, PRE-OP, STAT

PATIENT STATUS: BED, AMB, OUTPATIENT, NP, DOM

SPECIMEN SOURCE (Specify): Blood

SPECIMEN/LAB RPT. NO.

LAB ID NO.

MISCELLANEOUS 557-107

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

PATIENT'S MED. RECORD

bb-4

SPECIMEN TAKEN

DATE 4/29 TIME 0500 A.M. P.M.

RESULTS	REQUESTED	(X)
3.17	RBC COUNT	
9.7	HEMOGLOBIN	
29.9	HEMATOCRIT	
94.4	MCV	
30.6	MCH	
32.4	MCHC	
9.4	WBC COUNT	
	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
	NEUTRO-BANDS	
	NEUTROSEGS	
19.0	LYMPHS	
	EOSINOPHILS	
	BASOPHILS	
	MONOCYTES	
	PLATELETS	
	RBC	
	SED. RATE	
165	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PTT: CONTROL	
	PTT: PATIENT	
	[illegible]: CONTROL	
	[illegible]: PATIENT	
	% ACTIVITY	
	RATIO	
	SICKLING TEST	
	LE PREP	

CBC

REMARKS

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

REQUESTING PHYSICIAN SIGNATURE

REPORTED BY

bb-2

TECH 29 Apr 03

MD DATE

ICU 2

HEMATOLOGY

URGENCY: ROUTINE, TODAY, PRE-OP, STAT

PATIENT STATUS: BED, AMB, OUTPATIENT, NP, DOM

SPECIMEN SOURCE: VEIN, CAP, OTHER (Specify)

SPECIMEN/LAB RPT. NO.

LAB. ID. NO.

HEMATOLOGY 549-107

STANDARD FORM 549 (Rev. 7-78) PRESCRIBED BY GSA/ICMR FIRMR (41-CFR) 201-45 505

PATIENT'S MED. RECORD

bb-4

CHEM 1

SPECIMEN/LAB. RPT. NO.

URGENCY: ROUTINE, TODAY, PRE-OP, STAT

PATIENT STATUS: BED, AMB, OUTPATIENT, NP, DOM

SPECIMEN SOURCE: BLOOD, OTHER (Specify)

PATIENT'S MED. RECORD

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

REQUEST SIGNATURE bb-2

REPORTED BY bb-2

MD

TECH 29 Apr 03

LAB. ID. NO.

REMARKS Metlite

TEST(S)

SPECIMEN TAKEN DATE 4/29 TIME 0700 A.M. P.M.

REQUESTED	RESULTS	(X)
GLUCOSE	109	
UREA N.	18	
CREATININE	1.1	
URIC ACID		
SODIUM	136	
POTASSIUM	3.9	
CHLORIDE	98	
CO_2	31	
PHOSPHATE		
CALCIUM		
TOTAL PROTEIN		
ALBUMIN		
GLOBULIN		
ALKALINE PHOSPHATASE		
ACID PHOSPHATASE		
SGOT		
LDH		
CPK	233	
BILIRUBIN (TOTAL)		
BILIRUBIN (DIRECT)		
CHOLESTEROL		
TRIGLYCERIDES		
AMYLASE		
LIPASE		
PROFILE (Specify)		

546-107

CHEMISTRY I STANDARD FORM 546 (Rev. 8-77) PRESCRIBED BY GSA ICMR FIRMR (41 CFR) 201-45.505

516-108 NSN 7540-00-634-4156

MEDICAL RECORD | **OPERATION REPORT**

PREOPERATIVE DIAGNOSIS
Penetrating Trauma (Local / Fragments?) to Back / Left Lower chest with Left Hemopneumothorax — (open)

SU[redacted] MAJ, MC	FIRST ASSISTANT [redacted] MAJ, MC	SECOND ASSISTANT None	
[redacted], CPT	ANESTHETIC GEN		TIME BEGAN: 1210 TIME ENDED: 1350
[redacted] MAJ, AN	SCRUB NURSE [redacted] SGT, 91D	TIME OPERATION BEGAN 1210 Ira	TIME OPERATION COMPLETED 1350

b2

OPERATIVE DIAGNOSES
same. Negative abdominal exploration (No intra abd or diaphramatic injury)

DRAINS (Kind and number)
① Left Lat. Chest Tube ② L Ant. chest tube ③ NG tube

SPONGE COUNT VERIFIED
yes

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION
NONE

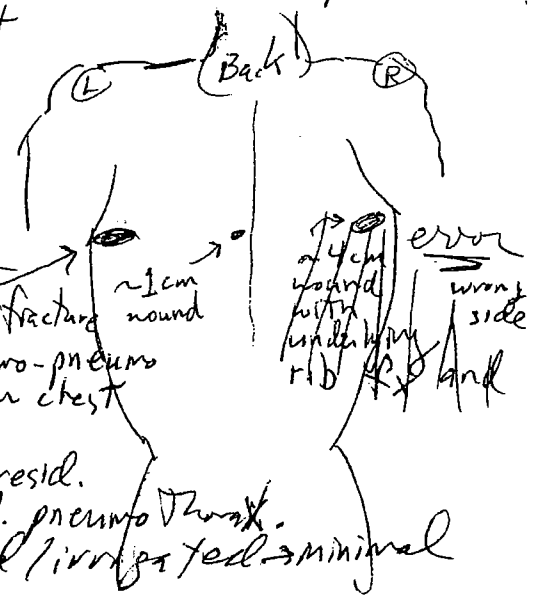
OPERATION PERFORMED
- (L) Chest tube (Lateral) - (R) Femoral Vein central line
- Exploratory Laparotomy
- (L) Chest tube, anterior

DESCRIPTION OF OPERATION (Type(s) of suture used, gross findings, etc.)

PROSTHETIC DEVICES (Lot no.) None

DATE OF OPERATION 27 Apr 03

(L) Lateral chest tube placed preop with return of ~ 200 cc blood/air. After Gen anest pt underwent ex lap to R/O intra/Abd injury/diapham injury → none found. (Pre-op BP Briefly in 80s systolic + pulse ~130) Abd closed with 1 PDS double stranded. (R) femoral vein central line placed intra-op due to difficult peripheral IV access. pericardium + pleura/diapham normal. Decreased Breath sounds on (L) and O2 sats in high-80s lead to placement of 2nd (L) anterior chest tube → small resid. pneumo appreciated. post-op CXR → no resid. pneumothorax. Back + (L) Lower lateral chest wounds explored/irrigated → minimal debridement of devitalized tissue.



SIGNATURE OF S[redacted] b6-2

DATE 27 Apr 03

PATIENT'S IDENTIFICATION [redacted] (Typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)

[redacted]

Never mind OK

REGISTER/I.D. NO.

WARD NO.

OPERATION REPORT
Medical Record

STANDARD FORM 516 (REV. 5-83)
Prescribed by GSA and ICMR, FPMR 101-11.806-8

USAPPC V1.00

Standard Form 517

CLINICAL RECORD — ANESTHESIA

ANESTHETIC(S) / HOURS

MSO4 / Versed / Etomidate / Succ / Rocu

Sa O2 / ISO O2 / OXYGEN / CO2 ABSORP.

LEVEL OF ANAL-ANES.

CODE: PULSE, RESP., B. P., ANES., OPER., TOURN.

FLUIDS: B BLOOD, N SALINE, G 5% G/W, DX EXPAND.

NUMBERS FOR REMARKS

IV FLUIDS

POSITION

AGENTS AND TECHNICS: GETA RSI induction Drawover ISO

INDUCTION

SATIS.

UNSATIS AND WHY.

REMARKS

1. to OR O2 per NRB FM @ 5LPM Monitors on NGT in place RSI induction ETsevo MAC 3 partial visualization BBS ETCO2
2. start of exlap
3. pt (R) lateral for wound exploration I&D
4. Ant chest tube placed Oside NGT and RDS
5. to X-Ray ETpulsox Ambu O2 @ 6LPM Then PACU on vent SIMV VS Vant adequate Suction extubated NRBM @ 5LPM Sa O2 100% 121/84 P-97 RR-20

Report to RN

ENDOTRACHEAL: SIZE 7.5 BLADE MAC3 ORO ✓ NASO CUFF ✓ PACK

REMARKS: ant airway, partial visualization

b6-2

OPERATION PERFORMED: ex lap; wound exploration I&D; (L) chest tube placement

TOTAL FLUIDS: LR 5500cc; 25% Alb 100cc

[redacted] MAJ/MC

[redacted] MAJ/MC

[redacted] b6-2

Signature of Anesthetist

RECOVERY

REFLEX IN O.R.

EMESIS

ASPIR.

EXCITEMENT

HYPOTENSION

OTHERS

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

EPOW

REGISTER NO.

WARD NO.

DATE 4/22/03

ANESTHESIA

Standard Form 517
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505
OCTOBER 1975

517-112

CLINICAL RECORD - DOCTOR'S ORDERS

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

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 1500 HOURS | LIST TIME ORDER NOTED AND SIGN

27 Apr 03 @ Post-op Orders - PACU
(1) Dx - s/p ex lap, (L) chest tubes x 2, wound drain
(2) Condition - guarded / Fair
(4) Diet - NPO, few sips ok if ↓ nausea
(5) IVF - LR @ 75 cc/hr
(6) O_2 - titrate for sats ≥ 90%
(7) foley, I + O's, Routine (L) chest tube care x 2 (Lateral + anterior)

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

(8) (R) femoral central venous line care - routine
(9) Activity bedrest, grad. mobilize
(10) chest tubes to 20cm suction @ all times
(11) Zeroform gauze/occlusive dressings to (L) chest & Back wound bid - re-enforce prn
(12) elevate HOB if tolerated

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

(13) 9m upright CXR if possible
(14) Ancef 1 gm IV q 8°
(15) MS O_4 0-15 } IV q 1° pm
Versed 0-5 } IV q 1° pm
Phenergan 12.5 - 25, IV q 6° pm nausea
Albuterol MDI # puffs q i d
Tordol 30 g IV q 6° x 48° if avail.

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

(16) H/H or CBC @ 1800 + @ 0700 tom.

b6-2

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b6-4 EPW

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 27 APR 03 TIME OF ORDER: 2100 HOURS

LIST TIME ORDER NOTED AND SIGN

- Admit to IC2
- Dx s/p GSW, negative X-lap, CT placement at FST
- Condition Fair
- VS q 1hr
- UO q 1hr
- I + O's q 1hr
- Activity: Bed rest. WB to chair c̄ assist

PATIENT IDENTIFICATION

[redacted]

b6-4 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

- in AM.
- DIET NPO
- LR @ 100 cc/hr IV
- Ancef 1 gm IV q 8 hrs. First dose @ 0500 AM. 28 APR 03
- CT x 2 to continuous wall suction
- Foley to gravity

PATIENT IDENTIFICATION

b6-4 [redacted]

Noted [redacted] AM b6-2 27APR03 2300

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

- R Femoral ~~A line~~ Central Line dressing/cleaning prn NAP
- MSO4 2-4 ~~gm~~ mg IV q 1-2 hrs prn pain NAP
- Phenergan 25 mg IV q 4-6 hrs prn
- ~~Tylenol 1000 mg po c̄ sips q 6 hrs prn fever~~ NA
- IS 10 x qhr while awake
- CBC + Metlite 8 q AM + PT/PM in AM
- CXR q AM

PATIENT IDENTIFICATION

b6-4 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

- Titrate sats to keep $S_c O_2$ > 92%
- Albuterol MDI II puffs QID
- Dressing Δ to wounds on back + to CTs BID.

[redacted] b6-2 [redacted] 0130 [redacted] MAJ, MC, USA

[redacted] 27APR03 2300

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b6-4

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 28 APR 03 TIME OF ORDER: 0834 HOURS

(1) CT put on water seal (dura)

(2) CXR @ 1030 (done) [redacted]

b6-2

LIST TIME ORDER NOTED AND SIGN: noted [redacted] 4/28

PATIENT IDENTIFICATION

[redacted]

b6-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 28 APR 03 TIME OF ORDER: 1649 HOURS

(1) D/C Foley DTV in 6 hrs. (done) [redacted] 9230 USA

b6-2

noted [redacted]

Urgent [redacted] 29 APR 03 0130

PATIENT IDENTIFICATION

[redacted]

b6-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 29 APR 03 TIME OF ORDER: 0705 HOURS

b6-2

(1) Place NGT to LIS ~~[illegible]~~

(2) CXR p NGT placed (done [illegible])

(3) Activity WB to chair c assist + limited walking under guarded supervision

noted [redacted] CPT/AN

[redacted] 9230 USA

PATIENT IDENTIFICATION

[redacted]

b6-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 29 Apr 03 TIME OF ORDER: 1400 HOURS

(1) VS to Q 6°

(2) I+O Q 6°

b6-2

noted [redacted]

Vo: maj [redacted]

CPT/AN

[redacted]

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b6-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 29 APR 03 TIME OF ORDER: 1652 HOURS

LIST TIME ORDER NOTED AND SIGN

1. CXR now please
2. D/C Ancef
3. D/C NGT
4. D/C AM labs

b6-2 [redacted]

[redacted] 9230

noted

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 30 APR 03 TIME OF ORDER: 0647 HOURS

1. Diet: Clears
2. D/C Q AM CXR
3. D/C ~~Toro~~ MSO4
4. Percocet 1-2 tab po Q4-6 hrs prn.
5. Please encourage IS
6. Decrease IVF to KVO when tol adequate po.

b6-2 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 30 APR 03 TIME OF ORDER: 1556 HOURS

1. D/C (R) Femoral line
2. Heplock IV
3. Ambulate TID c̄ gaurd
4. W-7D Dressings to back BID

[redacted] MAJ MC USA

[redacted] MAJ MC USA

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 1 MAY 03 TIME OF ORDER: 0625 HOURS

1. Regular diet
2. May transfer to ICW if bed available
3. May D/C from hospital pending PAD placement
4. Motrin 800 mg TID prn pain
5. Narrative summary on chart

b6-4 [redacted]

b6-2 [redacted] MAJ MC USA

noted [redacted] 1 May 03

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

b6-2

DATE
MO — YR —

NON-MEDICATION (NURSING TX)

MEDICAL RECORD — PROGRESS NOTES b6-2 (All Below)

ORDER DATE	CLERK/NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 27	28	29	30	5/1	2	3
27 APR 03	[redacted]	VS q 6°	05	/	[redacted]					
			17	[redacted]						
27 APR 03	[redacted]	I&O q 6° (I & O)	05	/	[redacted]					
			17	[redacted]						
27 APR 03	[redacted]	Activity: BED REST. OOB	05	/	[redacted]					
		TO CHAIR with ASSISTANCE	17	[redacted]						
		IN AM (4/28) may ambulate c̄ guard (limited walking)								
27 APR 03	[redacted]	DIET NPO - NGT to LIS	05	/	[redacted]		D/C 4/29			
			17	[redacted]						
27 APR 03	[redacted]	CT x 1 TO CONTINUOUS	05	/	[redacted]		D/C 4/29			
		~~wall suction~~ water seal	17	[redacted]						
27 APR 03	[redacted]	Foley to gravity	05	/	[redacted]		D/C 4/28			
			17	[redacted]						
27 APR 03	[redacted]	IS 10 x q hr while	05	/	[redacted]					
		AWAKE	17	[redacted]						
27 APR 03	[redacted]	CBC + Metlite q am	05	/	[redacted]		D/C 4/29			
27 APR 03	[redacted]	CXR Q AM	05	/	[redacted]			D/C		
27 APR 03	[redacted]	Titrate SATS to keep Sa_{O_2}	05	/	[redacted]					
		>92%	17	[redacted]						
27 APR 03	[redacted]	Dressing Δ to wounds on	05	/	[redacted]			Δ	3 APR 03	
		back + to CT's	20	[redacted]						
27 Apr 03	/	Diet / NPO / / /	10	/	/	[redacted]		Δ	3 APR 03	

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

[redacted] DX: S/P GSW / Neg X LAP / CT PLACEMENT at FST

PROGRESS NOTES
Medical Record

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

[redacted] b6-4

MEDCOM - 8265

NON-MEDICATION (NURSING TX)

b6-2

PROGRESS NOTES

MO: YR: b6-2

DATE	CLERK NAME	SINGLE ACTIONS	DATE TO BE DONE	TIME TO BE DONE	TIME DONE	INITIALS
27 APR 03	[redacted]	Admit to ICU 2	27 APR	Done		[redacted]
27 APR 03	[redacted]	Condition fair	27 APR	Done		[redacted]
27 APR 03	[redacted]	PT/PTT in AM	28 APR	0500	0500	[redacted]
28 APR 03	[redacted]	CT to waterseal, CXR @ 1030	28 Apr	1030	done	[redacted]
28 Apr 03	[redacted]	DTV @ 2300 (6 hrs)	28 Apr	2300	2100	[redacted]
29 Apr 03	[redacted]	CXray now	29 APR	1700	1715	[redacted]
		b6-2				

ORDER/ EXPIRE DATE	CLERK/ NURSE	PRN, ACTION, FREQUENCY	TIME/DATE COMPLETED
27 APR	[redacted]	Q FEMORAL CENTRAL LINE	
		DRESSING/cleaning PRN	

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

b6-2 (all)

b6-2 (ALL)

April / May

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	MAY 30	1	2	3	4	5	6	7	8	9	10	11	12	13
30 APR 03	[redacted]	Oral Care	06	/													
			12	[redacted]			DC			5/1		[redacted]					
			18	[redacted]													
30 APR 03	[redacted]	Please encourage	05	[redacted]													
		JS	17	[redacted]													
30 APR 03	[redacted]	Antibiotic TID =	06	[redacted]													
		guard	12	[redacted]													
			18	[redacted]													
30 APR 03	[redacted]	W → D Pressing	06	[redacted]													
		to back BID	18	[redacted]													
1 May	[redacted]	Regular diet	05	/ [redacted]													
			17	/													

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ___

PATIENT IDENTIFICATION: [redacted]

b6-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)					Mo APRIL/MAY Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
30 APRIL	[redacted]	D/C (R) Femral line	[redacted]	[redacted]	[redacted]	[redacted]	
3 MAY	[redacted]	May D/C to ICU if bed	ASAP				
	[redacted]	available, may D/C from					
	-----	hospital pending PAD placement					
	-----	(narrative summary on chart)					

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

USAPA V1.00

b6-2 ↓ (all)

b6-2

MEDICATION — MO: APR YR: 03

MEDICAL RECORD — PROGRESS NOTES

DATE ORDER	Clerk/ Nurse	Recurring Medications, Dose Frequency	HR	DATE DISPENSED 27	28	29	30	5/1	2	3	4
27 APR 03											
27 APR 03	[redacted]	LR @ 100 cc/hr IV	05	/	[redacted]			d/c'd			
			17	[redacted]							
27 APR 03	[redacted]	Ancef 1gm IV Q 8°	06	/	[redacted]			—			
		(First dose @ 0500 AM 28 APR)	14	/	[redacted]			D/C	4/29		
			22	/	[redacted]			—			
27 APR 03	[redacted]	Albuterol MDI II puffs	04	/	[redacted]						
		QID	10	/	[redacted]						
			16	/	[redacted]						
			22	[redacted]	[redacted]						
30 APRIL 03	[redacted]	Decrease IVF to KVO.	05	X	X	X	[redacted]				
		when tolerating adequate	17	X	X	X		NL IV —			
		P.O. LR 100cc/° ↓ Time 300cc KVO	T	[redacted]	on Ace			30 APRIL 03 KVO			

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

Allergies: NKDA

DX: S/P GSW/NEG X-LAP

CT PLACEMENT AT FST

PROGRESS NOTES

Medical Record

[redacted]

b6-4

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

MEDICATIONS

PROGRESS NOTES

DATE ORDER	Week/ Initials	Single Order, Pre-Operatives	Date to be Given	Time to be Given	Time Given	Initials

ORDER/EXPIRE DATE	CLERK/ NURSE	PRN Medication, Dose Frequency	TIME/DATE DISPENSED											
27 APR 03/	[redacted]/[redacted]	MSO4 2-4 mg IV Q	3 MG 2345 4/27	2 MG 0200 4/27	4 MG 0320 4/27	2mg 0600 4/28	2mg 1200 4/28	2mg 1400 4/28	2mg 2000 4/28	2mg 0800 4/29	2mg 1400 4/29	[redacted]		
	bb-2	1-2 hrs prn pain	[redacted]											
27 APR 03/	[redacted]/[redacted]	Phenergan 25 mg IV					bb-2							
		Q 4-6 hrs prn												
30 APR 03 0848	[redacted]/	Per cord 1-2 tsp P.O.	T											
		Q 4-6° prn	I											
		T = Time I = Initials M = MED E = Effect	M											
			E											
1 May 03	[redacted]	Motrin 800mg TID												
		pm pain												

STANDARD FORM 509 (REV. 7-91) BACK
USAPPC 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
27 Apr		Ancef 1 Gm IV q8 06 14 22		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

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														
		MS 5mg IV	4/27 1609	4/27 1730	4/27 2000												

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 2	[redacted]	[redacted] b6-4 EPW	EPW	

b6-4

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
	[redacted] 4	X	9	unk

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
—	—	9 9	0 0 0 [redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
EPW	U	2040	EPW

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
—	[redacted]	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø	ICU #2	

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND L[redacted] OF MEDICAL TREATMENT FACILITY [redacted]

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 3

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
A B A A		0 3 0 4 2 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

GSW ⓛ chest

Dx: 8751
E9912
Dx: 8345

b6-2

ADMITTING OFFICER (Signature, as required) [redacted] IMAJ, MC

b6-2

SIGNA[redacted]F ADMITTING CLERK [redacted] SPC, 91600

DA FORM [redacted] MAR 90

MEDCOM - 8273

b6-4

INPA[illegible] TREATMENT RECORD COVER SHE[illegible]

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

1. REGISTER NUMBER [redacted]	2. NAME (Last, First, MI) EPW [redacted] b6-4				3. GRADE EPW	ADMISSION REMARKS
4. SEX M	5. AGE [redacted]	6. RACE IRAQI	7. RELIGION UNKNOWN	8. LENGTH OF SVC —	9. ETS —	10. PREVIOUS ADMISSION
11. FMP 9930	12. SSN [redacted] 4		13. ORGANIZATION —			14. WARD ICW1
15. FLYING STATUS —	16. RATING/DSG	17. DEPT./BEN [redacted]	18. BRANCH/CORPS —	19. UIC/ZIP —		20. TYPE CASE BI
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION DIRECT FROM ER				22. HOURS OF ADMISSION 1600	23. CLINIC SERVICE AEAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE —			25. TYPE DISPOSITION EPW CAMP		26. DATE OF DISPOSITION 30 APR 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) —			27b. TELEPHONE NO. —		28. DATE OF THIS ADMISSION 28 APR 03	ADMITTING OFFICER [redacted] b6-2
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b(2)-2					30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

GSW

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: GSW (L) ankle

Dx: 891.0 E9912

35. Total Days This Facility

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

36. Total Days All Facilites

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

b6-2 SIGNATURE OF AT[illegible] [redacted] [illegible] PAD OR MEDICAL RECORDS OFF[illegible] [redacted] b6-2

34. FO[illegible] [redacted] [illegible], MAJ, MC

EDITION [illegible]

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

28 yo ♂ c̄ GSW from Tuzi commander 2 days ago. Brought here from outside survey

PMHx: ∅
PSHx: ∅
MOD: ∅
Allergies: NKDA

PHYSICAL EXAMINATION

HEENT: 2mm puncture (L) forehead. XR: ∅ Fx.
Ext: (L) ankle open wound

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

(A) GSW (L) ankle, forehead.
(P) oral ABX
pain control
PT for ambulation, D/C fetters

b6-2

SIGNATURE	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted]	4/28/03		

PATIENT'S IDENTIFICATION *(For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)*	REGISTER NO.	WARD NO.
EPW [redacted] b6-4		

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	b6-2
	1645: pt admitted to ICW from ER via litter; BP: 116/66 HR: 48 T: 99.0° POX: 98% RA [redacted]
28APR03@ 1934	HR 61 BP 121/61 R-16 98%RA T-98.5° oral — 567 [redacted] PIV MK-CPR
2132	U35. AO. PERRLA. 5, 5, 2. 1.5 clear. BS⊕X4. Tolerating PO med. Voiding light yellow urine, quantity sufficient. ⊕2 pulses in all extremities ⊕ankle DSG intact. ⊕ bruise contusion to 3/10 pain and ⊕ edema. Wait to month. — [redacted] b6-2
~~29APR03@0800~~	~~BP: 122/68 HR: 114 T: 102.0 RR: 18 98% RA~~
	BP: 110/56 HR: 67 T: 98.6 POX: 98% RA Neuro: A&O x3, PERRLA, strength & grasp equal bilaterally; no c/o pain, numbness, or tingling CV: NSR, RRR, cap Ref < 3sec, strong pulses x4 Resp: lungs CTA; GI/GU - ⊕ BS x4, abd soft, mild tender upon palpation Integ. dsg: CDI, skin - warm & dry - pt resting comfortably, will cont. to monitor [redacted] b6-2
29APR03	1800 - PT AFO X3. PERRLA SKIN WARM TO TOUCH. VSS - ON VS SHEET 511. LUNGS CLEAR TO AUSCULTATION WITH EQUAL RISE AND FALL BILAT. HEART SOUNDS NORMAL AND REGULAR. ACTIVE BOWEL SOUNDS IN ALL QUADRANTS. LLE - DRESSING CLEAN & INTACT. EDEMA NOTED. CAP REFILL <3 IN TOES. SKIN AROUND WOUND WARM. PULSES PALPABLE THROUGHOUT EXTREMITY. SWELLING NOTED IN (L) KNEE WITHOUT DISCOLORATION. PAINFUL TO TOUCH. PT GIVEN 50mg MORPHINE b6-2 FOR PAIN. WILL CONTINUE TO MONITOR THROUGHOUT — [redacted] SGT, USA
30 APR03	0355. PT GIVEN 50mg KETOROLAC PO. HAS SLEPT MOST OF THE b6-2 NIGHT WITH NO COMPLAINTS OF PAIN — [redacted] SGT, USA

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

EPW# [redacted] b6-4

PROGRESS NOTES
Medical Record

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

[redacted]

LAST NAME	FIRST NAME	MI	INITIAL	ID NUMBER

DATE	NOTES
30 Apr 03	pt Notes
Hx:	Crutch trng for ∅ known injury;
Exm:	supine c> sit (R) to EOB
	sit c> stand & crutches NWB (L) "2° pn"
	Amb 20' NWB (L) c̄ crutches level surface
	c̄ min LOB min Ax1
Diag:	Amb 20' min Ax1 NWB (L)
Tx:	cont trng x1
C:	(I) crutches - 1 day
	Deferred
	[redacted] b6-2 28 CSH
	CPT, SP
30APR03 0900	Pt AAOx3 PERRLA 3cm S1 S2 present PPP 4 extremities bilat equal/strong, BBS CTA c̄ equal chest wall expansion, bowels sound present 4 quad, voiding via BSC clear yellow urine, left ankle bandaged clean/dry, skin warm/dry/intact ∅ complaints at present, will continue to monitor.
	SGT [redacted] 91WM6 - LPN
30Apr03 1100	Pt D/C to FRW camp Supplies given. [redacted] CPT, AN
	b6-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

[redacted]

558-104

7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER | TREATMENT FACILITY

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS [redacted]

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)* 28 Aug 03 | TIME 1425

TRANSPORTATION TO FACILITY

SEX: M

DUTY/LOCAL PHONE — AREA CODE | NUMBER

AGE [redacted]

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: ϕ

ALLERGIES: ϕ

CHIEF COMPLAINT

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INITIAL SERIES ☐ YES ☐ NO

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☒ NON-URGENT

TIME

INITIALS

VITAL SIGNS

TIME	1435	1500				
BP	120/68	117/59				
PULSE	73	75				
RESP	14					
TEMP	98	100.9 RA				
WT		145				

LAB ORDERS

☒ CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT
URINE C&S	UA MSCC/CATH		CHEM:
BLOOD C&S X			MET 8
UA			

X-RAY ORDERS

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

ORDERS

☐ PULSE OX — bb-2 — ☒ MONITOR — bb-2 — ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1445	MSO4 5mg IV	[redacted]	CAPT [redacted]	1538	MSO4 5mg IVP
	Td 0.5cc IM		CAPT [redacted]	1546	MSO4 2mg IVP
1500	MSO4 5mg IV		CAPT [redacted]	1455	Irrigate wounds/clean
1531	2000 ml of LR @ TKO		CAPT [redacted]		

DISPOSITION: ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

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

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☒ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED | TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

[redacted] bb-4

FIF [redacted]

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

[redacted]

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

TEST RESULTS

CBC		SMAC		ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
WBC 8.9		137	102 / 9	SUP 02	PH	PO2	RESULTS	
H/H 13.6/42.3			89	PCO2	SAT	OTHER		
PLT 191		3.9	25 / 0.9					
PT				U/A	DIP		EKG INTERPRETATION	
APTT	BHCG	ETOH	GLU		MICRO			

PROVIDER HISTORY/PHYSICAL

Ortho

2846 ♂ "shot by Digu-forces" 2d ago. w/u by PSB, sent to CSH for debridement/OR eval
Pt c/o ① knee/ankle pain. c/o LBP ⊘F/C/N/V c/o ⓛ foot pain

O: A&O x4 — mod distress. VS
Heart: OP/A clear/RRR w/o MRG
Chest: CTA ⓑ
Wrist: ⊘ deformity
Abd: bowel sounds. Foley in place
Back: ⊘ stepoffs/bruising
Ext: ⊕ pain and ⊕ bruising ⓓ knee / ⓛ ankle ⊕ ⊘ edema ⊘ deformity

A/P: stable vital signs / complete workup

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP [redacted] b6-2

DIAGNOSIS
① GSW to ankle (ⓛ)
② Scalp laceration

CODES

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

[redacted] b6-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

[redacted]

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																
POST-	DAY															
MONTH-YEAR	DAY	29		30												
19	HOUR	17 20		6												

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE		115	122	110												
		57	65	57												
	Pox:	98% RA	99% RA	97%												
HEIGHT:	WEIGHT →															

Record special data only when so ordered

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

EPW# [redacted] 66-4

REGISTER NO.

WARD NO.

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

SPECIMEN TAKEN		
DATE 28Apr03	TIME 1500	A.M. / P.M.

RESULTS	REQUESTED	(X)
	ROUTINE	
yellow	COLOR	
1.025	SPECIFIC GRAVITY	
neg	UROBILINOGEN	
2+	OCCULT BLOOD	
neg	BILE	
large	KETONES	
normal	GLUCOSE	
neg	PROTEIN	
5.0	pH	
	MICROSCOPIC	
0-2	WBC	
250 full	RBC 10-20	
—	EPITH CELLS	
—	WBC (CASTS)	
—	RBC (CASTS)	
—	HYALINE (CASTS)	
—	GRANULAR (CASTS)	
few	BACTERIA	
—	CRYSTALS	
Large	MUCUS	
neg	NITRITE	
trace	bili	
	BENCE-JONES PROTEIN	
	HEMOSIDERIN	
	HCG	

REMARKS: UA

Acetest +/large

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

REQUESTING PHYSICIAN'S SIGNATURE: [redacted]

REPORTED BY: [redacted] b6-2

MD DATE: (ECH) 28Apr03

LAB. ID NO.

URINALYSIS

URGENCY: ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT

PATIENT STATUS: ☐ BED ☐ OUTPATIENT ☐ NP

SPECIMEN SOURCE: ☐ ROUTINE ☐ OTHER (Specify)

SPECIMEN/LAB RPT. NO

URINALYSIS 550-107
Standard Form 550 (Rev. 4-77)
General Services Administration and Interagency Committee on Medical Records FIRMR (41 CFB) 201-45.505

PATIENT'S MED. RECORD

[redacted] b6-4

TEST(S)		
SPECIMEN TAKEN		
DATE 28 NOV 03	TIME 1430	A.M. / P.M.

REQUESTED: CBC/MET 8/UA

RESULTS

WBC 8.9
RBC 4.35
Hgb 13.6
Hct 42.3
MCV 97.2
MCH 31.2
PLT 191
Ly% 12.5

REMARKS

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

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY

MD DATE

TECH

LAB ID NO.

MISC

URGENCY: ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT

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

SPECIMEN SOURCE (Specify)

SPECIMEN/LAB RPT. NO

NEOUS 557-107
17 (Rev. 3-77)
ISA/ICMR
01-45-505

PATIENT'S MED. RECORD

[redacted] b6-4

AMB F PT NO LO

28/04/03 14:56

REFERENCE RANGES: MALE

PATIENT #: [redacted]

METLYTE 8

DISC LOT #: 2402AA4

OPER #: 605 DR #: 001

SERIAL #: 0000100684

GLU	89	73-118	MG/DL
BUN	9	7-22	MG/DL
CRE	0.9	0.6-1.2	MG/DL
CK	590*	39-380	U/L
NA+	137	128-145	MMOL
K+	3.9	3.3-4.7	MMOL
CL-	102	98-109	MMOL
CO2	25	18-33	MMOL

INST QC: OK CHEM QC: OK
HEM 0 , LIP 0 , ICT 0

MEDCOM - 8281

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: EPW [redacted] b6-4

DATE OF ORDER: 28 Apr 03 TIME OF ORDER: 1600 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit MaW
2. Dx: Stargazer wounds to (L) ankle
   scalp wound
   (L) knee contusion
3. Stable
4. Allergies NKDA
5. Vitals bid

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

PATIENT IDENTIFICATION: b6-4 [redacted]

DATE OF ORDER: TIME OF ORDER: HOURS

6. Activity to walk as tol
7. D/c Foley
8. Diet regular
9. meds Tylox I-II tab po q 4-6° prn; Motrin 800 mg po tid
10. PT c/s to walk.

[redacted] 28 Apr 03 1600 b6-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: TIME OF ORDER: HOURS

11. Call IMOD on call upon pt's arrival

[redacted] b6-2

b6-2?

NURSING UNIT: Chart ✓ done | ROOM NO. [redacted] 2LS/AN | BED NO. 29APR03 0040

PATIENT IDENTIFICATION

DATE OF ORDER: 29 APR 03 TIME OF ORDER: HOURS

1. Keflex 500 mg po QID
2. Bacitracin dressing daily to (R) ankle wound

[redacted] b6-2

b6-2?

NURSING UNIT | ROOM NO. | BED NO.

Chart ✓ done [redacted] 4LS/AN | 30 APR03 0215 | 3 APR 03 DLIS

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
EPW # [redacted] 06-4				30 Apr 03	1030 HOURS	
				0/C to EPW Camp		Noted 30Apr03 [redacted] 06-2
NURSING UNIT	ROOM NO.	BED NO.				
ICW1				[redacted] 06-2		
PATIENT IDENTIFICATION				DATE OF ORDER	HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo Apr Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
28Apr	[redacted]	Admit ICW, cond. stable	28Apr		1640	[redacted]
28Apr	[redacted]	D/C foley	28Apr		1530	[redacted]
28Apr	[redacted]	PT C/S to walk	28Apr		Consult sent done	[redacted]
28Apr	[redacted]	Call I med on call upon pt's arrival	28Apr		1700	[redacted]
30Apr	[redacted]	D/C to EPW Camp	30Apr		done	[redacted]
	.....	b6-2				b6-2
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Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
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USAPA V1.00

b6-2

CLINICAL RECORD

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

Mo. 4 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 28	29	30
28Apr	[redacted]	Vitals BID	08	/	[redacted]	
			20	[redacted]		
28Apr	[redacted]	Activity to walk as tol	05 17	/	[redacted]	
			17 05		[redacted]	
28Apr	[redacted]	Diet Regular	08	/	[redacted]	
			12	/	[redacted]	
			18	[redacted]		
29Apr	[redacted]	Bacitracin dressing daily to (R) ankle wound		/	/ [redacted]	

b6-2

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: Scalp Wound
Shrapnel wounds to (R) Ankle
(L) Knee contusion

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

PATIENT IDENTIFICATION:
EPW # [redacted] b6-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

CLINICAL RECORD

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

Mo. 4 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 28	29	30
28 Apr	[redacted]	Motrin 800mg po TID	08	/	[redacted]	
	[redacted]	with food	18	[redacted]		bb-2
	.....		24	[redacted]		
29 Apr	[redacted]	Keflex 500mg PO QID	04	/	/ [redacted]	
	.....		10	/	/	
	bb-2		16	/	/	
	.....		22	/	/	

ALLERGIES: ☐ YES ☒ NO
NKDA.

PRIMARY DIAGNOSIS: Scalp wound ① Knee contusion
Shrapnel wounds to L ankle.

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

PATIENT IDENTIFICATION:
KPW # [redacted] bb-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. APR Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
	.....					
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Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
28Apr 1May	[redacted]	Tylox 1-2 tabs po	28 APR 2353	28 APR 0300												
.....	bb-2	q 4-6° prn	[redacted]	[redacted]	bb-2											
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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	A 1 1 D 1
2. MTF LOCATION (State or Country Code.)	[redacted]
3. REGISTER NUMBER	[redacted]
NAME (Last, First, Middle Initial)	EPW [redacted] b6-4 b6-4
4. PAY GRADE	EPW
5. SEX	M
6. DATE OF BIRTH (YYYYMMDD)	
7. AGE AT ADMISSION	[redacted] Y
8. RACE	X
9. ETHNIC BACKGROUND	9
RELIGION	unk
10. LENGTH OF SERVICE	—
ETS	—
11. FMP	99 20
12. SOCIAL SECURITY NUMBER	[redacted]
ORGANIZATION (Active Duty Only)	EPW
13. MARITAL STATUS	U
HOUR OF ADMISSION	1425
BRANCH / CORPS	EPW
14. FLYING STATUS	—
15. BENEFICIARY CATEGORY	[redacted]
16. ZIP CODE OF RESIDENCE	
17. UNIT LOCATION (State or Country Code)	[redacted] b(2)-2
18. MOS	—
19. TRAUMA	0
PREV. ADMISSION	YEAR: ; [X] NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	0
WARD	ICW 1
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	—
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	~~24~~ 04
22. MTF TRANSFERRED TO	
23. DATE OF DISPOSITION (YYYYMMDD)	20030430
24. CLINIC SVC - ADMITTING	AEAA
25. MTF TRANSFERRED FROM	
26. DATE THIS ADMISSION (YYYYMMDD)	20030428
27. LOCATION OF OCCURRENCE (Battle Casualty Only)	
28. MTF OF INITIAL ADMISSION	
29. DATE INITIAL ADMISSION (YYYYMMDD)	

FOR LOCAL USE

GSW (L) ankle

Trauma 9

Inj 569

891.0
873.42
E991.2

86.04
88.28

ADMITTING OFFICER (Signature, as required)

[redacted] b6-2 MAJ, MC

SIGNATURE OF ADMITTING CLERK

[redacted] b6-2 SPC, 91G10

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

INPATIENT TREATMENT RECORD COVER SHEET

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

REGISTER NUMBER: 12880	2. NAME (Last, First, MI): EPW [redacted] b6-4				3. GRADE: EPW	ADMISSION REMARKS
SEX: M	5. AGE	6. RACE: X	7. RELIGION: UNK	8. LENGTH OF SVC: NA	9. ETS: N/A	10. PREVIOUS ADMISSION
FMP: [redacted]	12. SSN		13. ORGANIZATION: N/A			14. WARD: EW
FLYING STATUS: NO	16. RATING/DSG: —	17. DEPT./BE: [redacted]	18. BRANCH/CORPS: b6-4	19. UIC/ZIP: —		20. TYPE CASE: NBI
SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from ER				22. HOURS OF ADMISSION: 1440	23. CLINIC SERVICE: AEAA	
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: UNK			25. TYPE DISPOSITION: DCA		26. DATE OF DISPOSITION: 030502	
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK			27b. TELEPHONE NO.: UNK		28. DATE OF THIS ADMISSION: 030428	ADMITTING OFFICER
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted]					30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

SELECTED ADMINISTRATIVE DATA [redacted] b(2)-2

☐ Check if Continued on Reverse

CAUSE OF INJURY

DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

I&D (L) Arm WND

Dx 891.0
881.02
E991.2

Proc 86.04
83.14

Total Days This Facility

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	5	5

Total Days All Facilites

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] b6-2 SI[redacted]AL RECORDS OFFICER

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

[illegible] GSW (L) UE & (R) LE
[illegible] c (R) leg compartment syndrome. Treated
c IVD & fasciotomies by PST last night

Pulse ✓
BMx: as above
NWSS ✓
Allergies NKDA

PHYSICAL EXAMINATION

AEON [illegible]
(L) UE: clean [illegible]
(R) leg [illegible] & calf fasciotomies; 2+ PT, DP

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

(A) GSW (L) wrist (R) leg c compartment syndrome
s/p fasciotomy
(P) Admit, wound care

b6-4

[redacted]	DATE 4/28/03	IDENTIFICATION NO.	ORGANIZATION
PATIENT'S IDENTIFICATION *(For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)*		REGISTER NO.	WARD NO.

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
4/27/03 2200	BRIEF OP NOTE: ORIF/GSW6
	PROCEDURE: ① ⓐ LEG & COMPARTMENT FASCIOTOMIES
	② ⓐ ANIST I&D
	PRE-OP DIAGNOSIS: GSW ⓐ ANIST ; ⓐ LEG ; ⓐ LEG COMPARTMENT SYNDROME
	POST-OP DIAGNOSIS: SAME
	SURGEON: [redacted] b6-2 ASSISTANT: [redacted] b6-2
	EBL: 150 cc
	FLUIDS: 1500 cc
	UOP: 800 cc
	TT: Ø
	POST-OP PLAN:
	① DPC ⓐ LEG (SKIN ONLY) WOUNDS in 4-5 DAYS
	② PT/DP DOPPLERS FLOW POST-OP [redacted]
	b6-2
	LTC ME
	V352

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

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

REGISTER NO. | WARD NO.

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

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

EDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
BAPR03	PT RECEIVED FROM PACU. A+O×3 PEERLA LUNG SOUNDS CLEAR
0256	TO AUSCULTATION Ø EXTRA HEART SOUNDS CAP REFILL <3 SEC ×4 EXT
VS	BS ACTIVE ×4 QUAD FOLEY DRAINING CLEAR, YELLOW URINE SITE CDI
P: 108/58	DRESSINGS CDI Ē MINOR DRAINAGE 4mg MSO4 GIVEN IV FOR
P: 60	PAIN. CONTINUE TO MONITOR [redacted] PFC 9WM4
R: 14	b6-2
T: 99.0	

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*		REGISTER NO.	WARD NO.

[redacted] b6-4

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

USAPA V2.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
1440 V&A	H&P See 558
	[redacted] b6-2
28Apr03 4/28/03	T-99.4 HR 103 BP 144/71 R-18 99% RA T 99.2 VSS. Tylenol PO med. Provided Tylenol for pain mgmt. ① Wrist PSG Δ. RUE elevated DSG intact. CMS intact. AO. PERRLA. LS clear. S1, S2. BS ⊕x4. FTG voiding light yellow urine quantity sufficient. Capillary refill <2 seconds bilaterally R&LLE. Provided light bath as ordered. Cont to monitor [redacted] b6-2
0730 29Apr03	BP: 122/68 HR: 132 T: 102.0 Pox: 98% RA — MD notified of temp, 975 of Tylenol given; Neuro: A&Ox3, PERRLA, equal strength, bilaterally, denies pain, numbness, or tingling CV: NSR, RAR, cap Ref <3 sec, strong pulses x4, Resp: lungs CTA, GI/GU - pt voids CS clear yellow urine via foley Integ: drsg: CDI, skin: warm & dry; IV patency, will cont to monitor — SPC [redacted] b6-2
0945 29Apr03 ~~1245~~	Neuro ✓ - PERRLA, A&Ox3, strength equal bilaterally, denies pain, numbness or tingling; differentiates between dull & sharp — [redacted] b6-2
1245 29Apr03	IV came out; New one started - [redacted] b6-2 came in & placed an 18g EG — [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.

EPW # [redacted] b6-4

PROGRESS NOTES
Medical Record

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

[redacted]

LAST NAME	NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
29APR03	1830. PT A+O x3, PERRLA, SKIN WARM TO TOUCH. VS ON VS SHEET SII. TEMP: 101.5. LUNGS CLEAR / EQUAL RRE AND FALL BILAT. HEART SOUNDS STRONG AND REGULAR - HR 118. HYPOACTIVE BOWEL SOUNDS IN ALL QUADRANTS. EDEMA NOTED IN ~~RRE~~ RLE. PULSE PALPABLE IN LOWER. DRESSING CLEAN + INTACT. CAP REFILL < 3. LUE HAS DRESSING - CLEAN + INTACT. PT COMPLAINS OF PAIN. GIVEN MSO4 IV IN AND TYLENOL 975 mg PO FOR ELEVATED TEMP. WILL CONTINUE TO MONITOR — [redacted] SGT, LPN b6-2
29APR03	2100- 450 cc WOP VIA FOLEY TO GRAVITY. DRSG A's COMPLETED ON ALL INCISIONS RLE AND LUE. WILL CONTINUE TO MONITOR — [redacted] SGT, LPN b6-2
29APR03	2130- PT TEMP: 99.8 RESTING COMFORTABLY — [redacted] SGT, LPN
29APR03	2230- PT GIVEN ANCEF 1gm. RESTING COMFORTABLY. — [redacted] SGT, LPN b6-2
30APR03	0045. PULSES PALPABLE IN ALL EXTREMITIES. CAP REFILL < 3. SKIN WARM TO TOUCH. WILL CONTINUE TO MONITOR THROUGHOUT — [redacted] SGT, LPN
30APR03	0250- PULSES PALPABLE IN ALL EXTREMITIES. DRSG SHOWS MINIMAL DRAINAGE / INTACT. CAP REFILL < 3. SKIN WARM TO TOUCH. EDEMA IN RLE STILL PRESENT AND HAS NOT GONE DOWN. TEMP: 100.4 GIVEN 975 mg TYLENOL PO. WILL CONTINUE TO MONITOR — b6-2 [redacted] SGT, LPN b6-2
30APR03	GIVEN 1gm ANCEF IV. PT RESTING COMFORTABLY. — [redacted] SGT, LPN
30 Apr 03	PT Note
4/2	Request crutch training & open fasciotomy;
T&M:	Dressing in place;
	min A x1 supine ↔ sit to EOB
	sit ↔ stand x1 & crutches
	Amb 40' & crutches NWB (R) & min LOB
	RTN supine (over →)

EPW [redacted] b6-4

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

MEDCOM - 8294

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
30 Apr 03	PT Note (Cont.)
Diag:	min 20B E crutch trng NWB (a)
Interv:	edu / crutch trn / 1x more
G:	(I) crutch - must Deferred [redacted] CPT, SF b6-2
30APR03 @0900	PT AAOX3 PERRLA 3cm, S1 + S2 present, ~~BS~~ AAP PAP x 4 extremts, BBS CTA ⊂ equal/chest wall expansion, bowel sounds hypoactive in all 4 quadrants, voiding via foley clear yellow urine ∅ distention noted, (L) wrist bandaged clean/dry (R) calf bandaged clean/dry, skin warm/dry, ∅ complaints @ present time, will continue to monitor. — SGT [redacted] WING-LPN — b6-2
30APR03 @0900	Ancef not given @ 1000, I.V. not working Anes. started new one — SGT [redacted]
30APR03	1715 - VS - B/P 125/63 HR 87, R 19, T: , POx: 99% RA PT A+O x3. PERRLA, SKIN WARM TO TOUCH/PINK. LUNGS CTA BILAT. HEART SOUNDS STRONG AND REGULAR, HYPOACTIVE BOWEL SOUNDS. DRSG'S LUE AND WRIST C,D,I. DRSG RLE C,D,I. USED INCENTIVE SPIROMETER x 20. WILL CONTINUE TO MONITOR THROUGHOUT — [redacted] SGT, LPN b6-2
30 APRIL 03	BW PT REFUSED MEAL. RESTING COMFORTABLY — [redacted] SGT, LPN
30 APR 03	1947 - MAJ HODGES REMOVED CLOT FROM PT'S CENTRAL LINE. LINE IS RUNNING AND ANCEF 1 gm FOR (60D) IS BEING GIVEN. PT. COMPLAINS OF Ø PAIN. WILL CONTINUE TO MONITOR — [redacted] SGT, LPN b6-2
30 APR 03	2035 - DRSG A'S DONE TO WOUNDS ON RLE + LUE. PT VOMITED

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.

EPW [redacted] b6-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	YELLOW BILE LOOKING LIQUID APPROX: 300cc. ENCOURAGED INCENTIVE SPIROMETER USE AND WATER INTAKE. WILL CONTINUE TO MONITOR THROUGHOUT — [redacted] SGT, LPN b6-2
30APR03 2200	PT VOMITED APPROX 200cc YELLOW BILE LOOKING FLUID. GIVEN 12.5mg PHENERGAN. PT COMPLAINS OF NOT BEING ABLE TO VOID. FEELS PAIN IN BLADDER AREA. ABLE TO EAT CRACKERS AND MILK. WILL CONTINUE TO MONITOR THROUGHOUT. — [redacted] SGT/LPN b6-2
30APR03 2230	PT OOB TO BATHROOM WITH CRUTCH ASSISTANCE. URINATED 500cc VIA BEDSIDE COMMODE. VSS B/P 132/74 HR 91 R 21 POX 98% TEMP 99.6 WILL CONTINUE TO MONITOR — [redacted] SGT, LPN b6-2
30APR03	2245 PT RECEIVED 1gm ANCEF IV — [redacted] SGT, LPN
01MAY03	PT AAOx3 PERRLA 3cm, S1+S2 present PPPx4 extremities, BBS wheezing on inspiration and expiration, bowel sounds present in all 4 quad, voiding via BSC clear yellow urine, skin warm/dry, dressing clean/dry, ø complications c present, will continue to monitor — SGT [redacted] SPAMS - LPN — b6-2
1May03 1337	Int Med on call Asked to assess patient for Δ in lung exam. Pt noted by LPN + RN to sound tight/wheezy. No recent CXR. No c/o cough/sputum. 15 s/p fasciotomy + I/D ⓡ wrist. Exam: Lungs clear ⓑ ø wheeze/rale or ronchi. Normal lung exam. No indication for further intervention c this time. Incidentally noted that ⓡ PIV IV catheter has dislodged. Would rec Δ to POS if ok w/ ortho Pt. b6-2 [redacted]

558-104

7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER | TREATMENT FACILITY

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

SEX

DUTY/LOCAL PHONE: AREA CODE | NUMBER

AGE

HOME PHONE: AREA CODE | NUMBER

ARRIVAL

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

TRANSPORTATION TO FACILITY

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

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

CURRENT MEDICATIONS

ALLERGIES

CHIEF COMPLAINT

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INITIAL SERIES ☐ YES ☐ NO

CATEGORY OF TREATMENT

☐ EMERGENT

☒ URGENT

☐ NON-URGENT

TIME: 1430

INITIALS: R

VITAL SIGNS

TIME	1435	1455			
BP	143/64	143/64			
PULSE	108	123			
RESP	22	20			
TEMP	101.2	101			
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 100% RA b6-2

☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1	1 L NS IV 125 ml/hr	[redacted]	14:45		
	~~tyrosine 30 c~~				
1445	975 mg Tylenol PO	[redacted]	1445		
	4 mg Morphine IV	[redacted]	1459		

DISPOSITION: ☐ HOME ☐ FULL DUTY

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

MODIFIED DUTY UNTIL

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

[redacted] b6-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

[redacted]

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

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

(R) Calf ADC w/Dry 4X4 / Ace Raps / ER Doc / (R) AC 18G
(L) forearm / Wet to Dry / ~~[illegible]~~ / Ortho Doc

Male EPW s/p (R) Leg Fasciotomy @ 2200 27Apr03

and ZFD (L) wrist bandaged. Sent Heo for

for the EMAC.

G: W, W, WD, A AOx3
Ext: (R) Edem / TTP / Tense @ Foot

(A/P) would check U/A ortho / ABX / pain control / EMAC

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

b6-4

PROVIDER SIGNATURE AND STA[redacted]

BOARD CERTIFIED EMERGENCY PHYSICIAN

DIAGNOSIS

(1) B/P @ Leg Fasciotomy
(2) S/P (L) Wrist ZFD

CODES

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

EMERGENCY CARE AND TREATMENT (Doctor)
Medical Record

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

[redacted]

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY 12L FIT SPEC

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted] b6-2

3. DATE 27 Apr 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 2052 NUMBER 24

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: EPW

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] b6-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] SGT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: on mesh litter

8. SKIN PREPARATION

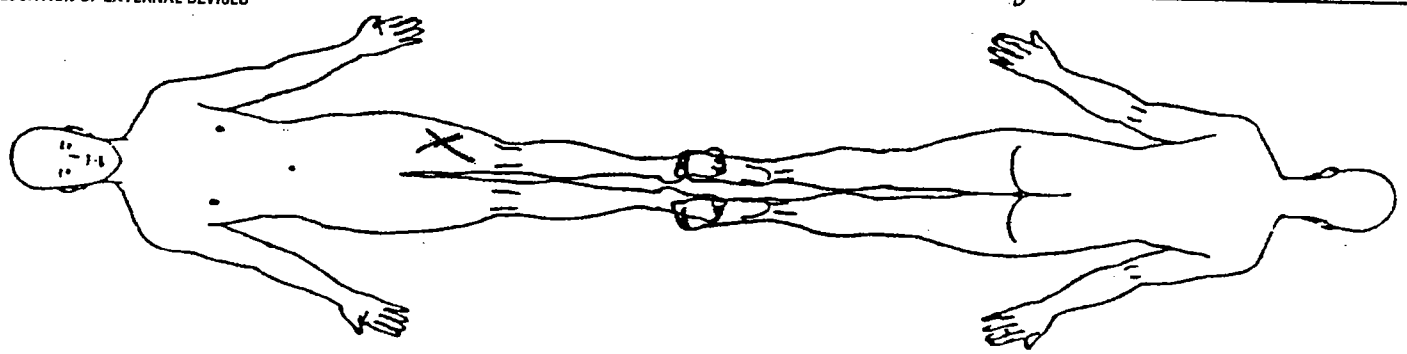
HAIR REMOVAL [X] YES [ ] NO
DONE BY: [X] OR [ ] NURSING UNIT
METHOD: [ ] DEPILATORY [X] RAZOR [ ] CLIP

COMMENTS: 0 nicks or cuts

PREP SOLUTION *(Specify)* Betadine / Betadine
SITE: Rt. Leg BY WHOM: CPT [redacted] b6-2
SITE: Lt. arm BY WHOM:

COMMENTS: D pooling of fluids

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap - - - Tourniquet

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB b6-2	CIRCULATOR b6-2
Sponge	[X] Yes	[ ] No			C	[redacted]	[redacted]
Needle Sharp	[X] Yes	[ ] No			C		
Instrument	[ ] Yes	[X] No				SPC	CPT
Other	[ ] Yes	[X] No					

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

LOG# [redacted] b6-4

SSAN#

NAME:

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

[X] ESU NO: Force 2 30/30
GROUND PAD: BRAND Conmed
LOT NO: 0211272

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

[ ] BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NaCL

OTHER ORDERS	TIME	CARRIED OUT BY
16 Fr Foley draining clear yellow urine	Intraop	SGT [redacted]

PHYSICIAN'S SI [redacted] b6-2 [redacted] LCMC

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

YES ☐ NO ☒

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 16 Fr Foley	2.	3.
SITE	1. L Bladder	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Rt Leg - 4x4, ABD, Kerlex

Lt leg - 4x4, Kerlex

19. ADDITIONAL INFORMATION

Surgeons: Dr. [redacted] > Leg b6-2
Dr. [redacted]

Dr. [redacted] - Ortho

LOG #

SSAN#

NAME: b6-2

2100 - Anesthesia per CPT Memorandum 6 FTA, 7 transfusion
Drawdown: 150 volume, 118/55 117 96%, VSS throughout
case. Crystalloid 1500 cc, EBL 150, UO: 600 cc
Drug: Ketamine, succinylcholine, Valium, MSO4, Cefazolin 1gm 2115, PT extubated, to RR [redacted] PT AW

20. OPERATION(S) PERFORMED

I & D Lt. arm wound, Fasciotomy Rt. leg

21. PATIENT TRANSFERRED TO [redacted] Post op TIME METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] CPT AW

REVERSE OF DA FORM 5179-1, OCT 87 b6-2 MEDCOM - 8300 USAPA V1.01

MEDICAL RECORD | **INTRAOPERATI[illegible]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 OR Staff

2. PATIENT IDENTIFIED/RECORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] 27, AN

3. DATE 2 May 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 0800 bb-2 NUMBER 2-1 #1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKA per interpreter

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] 910 bb-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] 662	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

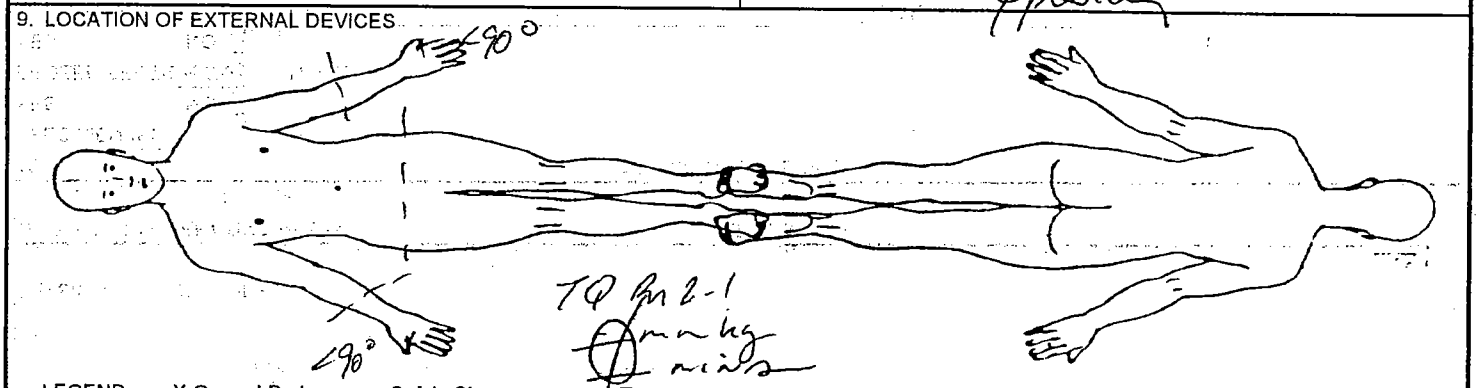
COMMENTS: (L) leg secured to table w sheet

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine/Betadine
SITE: (R) leg BY WHOM: CPT [redacted]
SITE: BY WHOM:
COMMENTS: (R) pooling

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes ☐ No	/				
Needle Sharp	☑ Yes ☐ No		C	C	[redacted] bb-2	Charlie
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] bb-4

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

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):
NACL

OTHER ORDERS	TIME	CARRIED OUT BY
Ø		

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
ACE

19. ADDITIONAL INFORMATION
WC
Surgeons: Olivieio
Anesthesia: Bierman
Anesthesia Type: Gen

Bovie Pad site intact pre-op Ø; post-op Ø Bovie Settings: Coag/Cut 20/20

20. OPERATION(S) PERFORMED

DPC Right Leg

21. PATIENT TRANSFERRED TO JCW TIME 0920 METHOD litter

22. REGISTERED NURSE SIGNATURE [redacted] CPT, AN

b6-2

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY		Apr	Apr	~~May~~	May	2 May			
POST-	DAY	29	30	1	1	2			
MONTH-YEAR	DAY								
19	HOUR	1830 22	1700 2000		1722	1722			

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE	131	136	128	140	125	132		132	136	120/58	135				
	65	73	61	64	63	67	144/57	73	84		72				
Pox:	99%RA	98%RA	97%	98%	99%RA	99%RA	106%	99%RA	100%RA	99%	99%RA				
HEIGHT: WEIGHT →											138				
											70				
											88				
											99%RA				

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.

EPW [redacted] b6-4

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

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]

ZPW # [redacted]

bb-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 28 Apr 03 TIME OF ORDER 1435 HOURS

LIST TIME ORDER NOTED AND SIGN

- ✓ Admit to FCW
- ✓ Dx: ~~Stab~~ (R) Leg Fasciotomy
- ✓ (L) wrist incision + Draining
- ✓ Condition Guarded
- ✓ Vitals: Mono/Vascular (R) Leg checks Q2°
- other vitals per Routine ✓
- ✓ Allergies: NKDA ✓

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER

Tylenol #3 75 mg p.o. Q6° for pain PRN (Next Dose @1800) bb-2

- ✓ Meds: IV Ancef 1 gm QID
- ✓ 4 mg MSO4 Q 4° prn pain ✓
- ✓ Consult: ortho for Eval of wrist fasciotomy
- ✓ Diet: Regular ✓
- ✓ Plan: Eval ASAP ✓
- ✓ Band Aide change BID ✓

[redacted] 2000 4/28/03

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

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

MAJ [redacted] BOARD CERTIFIED [redacted] PHYSICIAN

MD

bb-2

- ✓ Meds: Percocet 1 p.o. q 4° PRN ✓
- ✓ PT for gait training, ambulate to assist, WBAT ✓
- ✓ Nurs. wet to dry dressing's ✓

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

- ✓ qD (R) LE + (R) LE ✓

[redacted]

V.O. 1-2 mg Ativan IVP q2-4° prn for agitation 0305 4/29/03

[redacted] bb-2

bb-2

Chart checked [redacted] 21APR03 0200

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
EPW # b6-4 [redacted]	4/30/03	1200 HOURS	
	- D/C Foley		
	- Phenergan		Noted 4/30/03 1200 b6-2 [redacted]
NURSING UNIT: ICW 1 / ROOM NO.: Chart ✓ done / BED NO.: b6-2 [redacted]			

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
	U.O. 4/29/03	2100 HOURS	
	Phenergan 12.5-25 mg IV q 4-6° for N/V		
NURSING UNIT: ✓ done 0230 5/1/03 / ROOM NO. / BED NO.: b6-2 [redacted]			

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
EPW # [redacted] b6-4	01 MAY 03	1000 HOURS	
	✓ D/C change Ancef to CLINDAMYCIN 900 mg IVPB q 8°.		Noted Sent 1 May 03 1010 b6-2 [redacted]
NURSING UNIT / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
EPW b6-4 [redacted]	5/1/03	1400 HOURS	
	- D/C IV		
	+ D/C IV Atax		
	- Keflex 500 mg PO Q6		
	5/5/03 2000		
	NPO PMN		b6-2 [redacted]
NURSING UNIT: [redacted] / ROOM NO.: b6-2 [redacted] 7 AV / BED NO.: 2 May 03			

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: [redacted] b6-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 5/2/03 TIME OF ORDER: 1800 HOURS

- Stable
- Routine vitals
- D.O.B ambulate c assist
- Heplock IV
- Regular Diet
- Reinforce dressings PRN

LIST TIME ORDER NOTED AND SIGN: Noted Sent 2May03 1005

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

- T#3 [illegible] q4° PRN
- Keflex 500mg QID
- Demerol 50mg IV q4° pain through
- D/C to home when transport available

[redacted] b6-2 b6-2

PATIENT IDENTIFICATION: [redacted] b6-4

ICW #1 b6-2

NURSING UNIT: done | ROOM NO.: [redacted] ZLIAN | BED NO.: 3May 03

DATE OF ORDER: 5-2-03 TIME OF ORDER: 2252 HOURS

① Ambien 5mg PO now

[redacted] BOCMIST 4PTime b6-2

Noted 3May03 04[redacted] b6-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

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

MEDS

CLINICAL RECORD

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

Mo. APR Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 28	29	30	1	2
28	TA	Vitals: routine	6	[redacted]				
		(R)	14					
			22					
28	TA	(R) leg Neuro/vascular	AM 0500					
		& 2°	7					
			9					
			11					
			PM 1					
			3					
			5					
			7					
			9					
			11					
			AM 0100					
			3					
			0500					
28	TA	Diet: Regular	6					
			12					
			18					
28	TA	Bandage Δ BID	8					
			20					
28	TA	WTD DSG Δ's & D	10					
		(L) UE & (R) LE						
28	TA	PT for gait training,						
		ambulate, assist, WBAT	8					
			20					

b6 2

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION:

EPW # [redacted] b6-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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)~~ NON-MED			Mo. APR Yr. 03	
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
28	[redacted]	Admit ICU - Px: L leg @ Fasciotomy				[redacted]
	.....	@ Wrist incision & drainage				
	.....	Condition: Guarded				
28	[redacted]	Plan: EVAC ASAP	ASAP			
28	[redacted]	Consult: Ortho for eval of fasciotomy				
	.....	wounds				
30	[redacted]	D/C Foley	30Apr		1230	[redacted]
	[redacted]	Due to void	30Apr	1830	18	
1MAY	[redacted]	NPO P MN	1MAY	0000		[redacted]
	.....					
	.....					
	.....					
	.....					

b6-2

b6-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED													
.....	.....															
.....	.....															
.....	.....															
.....	.....															
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USAPA V1.00

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 5 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 2	3	4
2May	[redacted]	Routine Vitals	06	✓		
			14	[redacted]		
			22			
2May	[redacted]	OOB, Ambulate c̄ assist	05 17			
			17 05			
2May	[redacted]	Regular Diet	06			
			12			
			18			

b6-2

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: I&D c̄ DPC fasciotomy sites

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

#[redacted] b6-4

ACTION TIMES — USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*				Mo 5 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
2May	[redacted] b6	Stable	2May		noted	[redacted] b6-2
2May	[redacted]	D/C to home when transport available				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
2May	[redacted] b6	Reinforce dressings														
		prn														

USAPA V1.00

CLINICAL RECORD

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

Mo APR Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED (Mar 28, 29, 30, 01)
28APR03	[redacted]	Ancef 1 gm QID	4	[redacted] b6-2
		first dose @ 1800	10	
28APR03	[redacted]		16	D'd 1May 03
			22	
28APR03	[redacted]	Tylenol 975 mg P.O	04	[redacted] b6-2
		Q 6° for Pain and fever	10	
			16	4/29 @ 0113
			20	
1May	[redacted]	error ~~CH~~ Clindamycin 900mg	06	
		IVPB q 8°	14	D'd 1May 03
			22	
1May	[redacted]	Keflex 500mg po QID	06	[redacted] b6-2
			12	
			18	
			24	

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION: [redacted] b6-4

EPW # [redacted]

[redacted] b6-2

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. APR Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
~~28~~	[redacted]	~~Consult: Ortho per wal of combat wounds fracture~~ [redacted] b6-2				
1May	[redacted]	DC IV	1May		1415 done	[redacted] b6-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
~~28~~	[redacted]	Mg Cl 2gs q 4°	D	28APR	29APR											
			T	2157	1840											
			D	2mg	2mg											
			I	[redacted]												
			F/E	F	E											
~~28~~	[redacted]	Percocet/Tylox ii po q 4°	D	28APR	28APR	29APR	30APR	1MAY	1MAY	1MAY						
			T	1740	2150	0245	1200	1300	2030	2330						
			D	2	2	4	2	2	2	2						
			I	[redacted]												
			F/E	E	W	E		E	E	E						
~~28~~	[redacted]	Tylenol 975mg PO Q6 for fever and Pain	D	28APR	29APR	30APR	30APR	1MAY								
			T	1930	1840	0930	1400	0600								
			D	iii	iii	iii	iii	iii								
			F	[redacted]												
29	[redacted]	Ativan 1-2mg IVP q2-4° for agitation	29APR 0305													
			2 [redacted]	b6-2												
			E													
4/30	[redacted]	P. Narayan [illegible]														

b6-2

USAPA V1.00

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 5 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 2	3	4											
2May	[redacted]	Heplock flush q 8°	06	/													
			14	[redacted]													
bb-2			22														
2May	[redacted]	Keflex 500mg QID	06	/													
			12	[redacted]													
			18	[redacted]													
			24	[redacted]													

bb-2

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: I+D & DPC fasciotomy sites

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION: #[redacted] bb-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. 5 Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
5/2	[redacted]	Ambien 5 mg PO now			2255 5/2/03	[redacted] b6-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
2May	[redacted]	Tylenol #3 1-2	2MAY 1235	3May 0400												
	b6-2	po q4° prn	1	1	[redacted] b6-2											
2May	[redacted]	Demerol 50mg IV q4°														
		prn breakthrough pain														

USAPA V1.00

Blood ∅ EBL 150

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE: POST ANESTHESIA CARE UNIT FLOWSHEET

OTSG APPROVED (Date): 17 Jan 80

PROCEDURE: I/D (R) wrist, fx. leg (R) leg

PHYSICIAN: [redacted]

ANESTHESIA BY: [redacted]

Gen Spinal MAC Axillary
Local Bier Epidural Other

ALLERGIES:

AIRWAYS: Time DC'D

ETT Nasal Oral Trach

OXYGEN: Mask Nasal Prongs Face Tent Blow-By

Liter/min. 5 L/m %

ASA History

Cardiac Rhythm NSR

IV#1 LR Patent Infiltrated

Site (R) AC Rate 125 Gauge 18g

IV#2 Patent Infiltrated

Site Rate Gauge

66-2

Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	/												Extr: L R Upper Lower Pulse DP PT RAD
PRE-OP	/												Blanche Warm Pulse Moves Y N
2210	133/48	105	14	100%	36	0	2	2	0	2	6	O2@5L via MASK	Blanche Warm Pulse (+) 1625 Moves Y N
2220	117/52	104	14	100%	36	0	2	2	0	2	6		Blanche Warm Pulse Moves Y N
2230	86/46	96	10	88/70	36							ETT Tube Vent simul. IV	Blanche Warm Pulse Moves Y N
2300	96/59	109	10	99%									Blanche Warm Pulse Moves Y N
2330	115/76	91	10									TPEEP 10 100% O2	Blanche Warm Pulse Moves Y N
2340	102/76	86	15	100%									Blanche Warm Pulse Moves Y N
2400	123/61	119	15	100%	36	2	2	2	2	2	10	Vomited x 2, pharynx 12.5 ag IV	Blanche Warm Pulse Moves Y N
2430	146/64	99	13	100%	36							Airway bal Reasonable	Blanche Warm Pulse Moves Y N
0100	142/81	115	13	95%									Blanche Warm Pulse Moves Y N
0150	126/57	117	14	100%									Blanche Warm Pulse Moves Y N
0200	124/46	106	16	98%									Blanche Warm Pulse Moves Y N
0230	118/49	116	16	98%									Blanche Warm Pulse Moves Y N

POST ANESTHESIA RECOVERY SCORE "PARS"

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

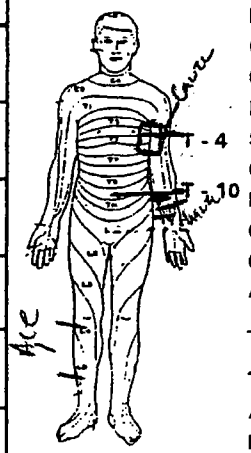
Activity - SAB or Subarachnoid Block
2--Moves all four extremities with control
1--Moves both upper extremities

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

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

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

Skin
2--[redacted]in color & temperature greater than 96°
[redacted]e, blotchy, dusky &/or temperature 95 - 96°
[redacted]&/or temperature less than 95°



DRESSING:	Status	Location
Gauze	Dry/Intact	(L) wrist/(R) Knee
Opsite		
Bandaid		
Steri-strips		
Collodian		
Peri-pad		
Coban		
Cotton Balls		
Ace Wrap	(R) Leg Dry/Intact	

TUBES AND DRAINS: Hemovac Foley NGT Chest Jackson-Pratt

(Continue on reverse)

[redacted]BY (Signature & Title): [redacted]SA/91W4M6 66-2

DEPARTMENT/SERVICE/CLINIC: [redacted]

DATE: 27 Apr 03

[redacted]DENTIFICATION (For typed or written entries give: Name—last, first, [redacted]e; date; hospital or medical facility)

[redacted] 66-4

SSAN#:

NAME:

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTICS STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

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

MEDCOM - 8315

ICAL RECORD-SUPPLEMENTAL MEDIC... DATA

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

REPORT TITLE

PRE-ANESTHETIC EVALUATION

The proponent is Dept of Surgery

OTSG APPROVED (Date) QI Appr 11 Dec 96

DATE OF PROPOSED SURGERY	AGE	WEIGHT	ALLERGIES (List react)	FAMILY HISTORY	Tob HX-	CONSULTATIONS (Check when completed)
2 May 03	[redacted]	70?	☒ NKDA	☐ NO ANES PROB	EtOH-	☐ 1
PROPOSED SURGERY	SEX	HEIGHT			DRUGS	☐ 2
I+D (R) [redacted]	M					☐ 3

PREVIOUS ANESTHESIA/SURGERY ☐ NO PROBLEM: I+D (R) leg, 27 Am (L) ARM

MEDICATIONS ☐ NONE * = ORDERED AS PRE-MED: Ancef, phenergan

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

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

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

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

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

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

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

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

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

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

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

- ☒ DENTURES
- ☒ CONTACTS
- ☒ PROSTHESIS

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

PHYSICAL EXAM: HR 120 BP 120/58 T RR

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

HEART:

LUNGS: ☐ CTAB

NEURO/BACK:

BLOCK SITE:

VASC ASSESS:

EXT/OTHER:

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

PFT

OTHER

PROBLEM LIST

ASA 1 (2) 3 4 5 E

☒ Counselled to remain NPO

PLAN
- ✓ General ___ MAC
- ___ Regional: ___
- ___ Block: ___
- ☐ Post Op ICU/Vent ☐ Awake Intubation
- ☐ Art Line ☐ CVP ☐ PA
- ☐ Special Techniques [redacted]

PREMED: [redacted]

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

PATIENT'S SIGNATURE: Jinahill Podane translator Need Records review

(Continue on reverse)

PRE[redacted] (Signature & Title) [redacted] NAT CRNA

DEPARTMENT/SERVICE/CLINIC REVIEWED BY:

DATE 2 May 03

b6-2

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

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

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700 PREVIOUS EDITION IS OBSOLETE

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

DRUG (Units)	08	x	30	x	09
VERSED (mg)	2.5				
Fentanyl (cc)				2	1
Propofol (mg)				150	
Succ (mg)				75	
Lidocaine (mg)				75	
VOLAT AGENT: Forane % del				1.0	.8
% e.t.					
AIR L/Min					
N2O L/Min					
O2 L/Min	8	5	5	2	

SPECIFY UNITS - MG/MCG/ML, "1" = CONSTANT INFUSION

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS → Rocuronium 0.2 g IV 0840 → 10 mg Reglan IV

IV site: LH ☐ Warmed; (R) hand ☐ Warmed; ☐ Warmed; ☐ Warmed

EST BLOOD LOSS

URINE -

TOTALS	TOTAL EBL
2.5	min
3	
	TOTAL URINE
	0

FLUIDS - SUMMARY

CRYSTALLOID-

COLLOID- 0

BLOOD- 0

REMARKS

Code drugs with numbers, events with letters

0805 - 0855 awaiting for surgery due to problems c electrical power.

ASA STATUS: 1 2 3 4 5 E

BODY WEIGHT: 70 KG LB

HEMATOCRIT:

INITIAL DATA: 120 / 50 120 (H)

TOURNIQUET CHECK: Y N

PATIENT: Y

Prior PROCEDURES: Y

TIME → 08 x 30 x 09

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

220 / 200 / 180 / 160 / 140 / 120 / 100 / 80 / 60 / 40 / 20

VT - ml				770-350	450	
f - breaths/min	16	16	16	7-7	10	
Peak inf pres / PEEP				19-		
MODE - S(pon), A(ssist), C(on)	S	S	S	C-S	S	
BP/Auto Cuff / ET CO2 (torr)				33	40	
BP/oth / FIO2 (Frac or %)	1.0	1.0	1.0	1.0	1.0	
ART line / SpO2 (%)	100	100	100	100	100	
Steth- PC/ES / ECG	SR	SR	SR	SR	SR	
Gas analyzer / TEMP-site						
N-M Block (T/4)						
Warming (blkt) / Conv warmer	Army Blkt.					

EVENTS with letters & symbols, Position in under REMARKS → a) Appp, Arms ∠90°

RECOVERY AT: 0925 ICW #1

PACU ICU _____ (Specify)

OTHER _____

CONDITION:

RESP- 12 SpO2- 100%

BP- 128/71 HR- 92

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0745	0805	0930
	Ready	Begin	End
PROC	0840	0855	0915

PROCEDURES and CPT Codes: DPC (R) Leg

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA

PATIENT IDENTIFICATION: Typed or written entries: Name, Grade/Rate, Medical facility: EPW [redacted] b6-4

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: SW1, ETOTI, atraumatic, cuff ↑, BBS, Eyes taped

SURGEONS: [redacted] b6-2

ANESTHETISTS: MAJ [redacted] RNA

PROCEDURE LOCATION: #2

DATE: 2 May 03

PAGE 1 OF 1

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

MEDCOM - 8317

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED *(Date)*

Date: 2 MAY 03
Time In: 0920
Allergies: NKA
Pre-op V/S: 136/84 100
Procedures: I&D & DPC fasciotomy sites

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid _____ Colloid _____
OR Output: UOP _____ EBL min
Meds/Times: _____

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds / History

Time	0920	0925	0930	0935	0950	1005	1020	1050	1120	1220						
SaO2	96	100%	100%	100%	99%	97%	97%	97%	98%	100%						
FiO2																
Methods																
240																
220																
200																
180																
160																
140																
120																
100																
80																
60																
40																
20																
RR	19	12	13	14	18	14	13	13	14	15						
T	97.4			98.5												

Time										
Pain (0-10)										
LOS										

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	1	1	1
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	1	1	1
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	~~10~~ 9	9	9

Codes

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

V/S
X = A-line BP
˙ = Cuff BP
= Pulse

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

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

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC

DATE 5/2/03

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

[redacted] 106-4

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete
USAPPC V2.00

MEDICATIONS None						
Allergies:						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

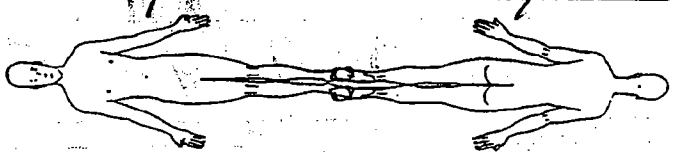
NURSING NOTES

NEUROVASCULAR							
Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	RLE	limited	+	P	B	W	PK
15'							
30'	RLE	limited	+	P	B	W	PK
45'							
60'							
90'							
D/C	RLE	limited	+	P	B	W	PK

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

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

DRESSINGS			
Time	Location	Type	Drainage
Adm	RLE	Kerlix & Ace	Ø
30'	RLE	Kerlix & Ace	Ø
60'	RLE	Kerlix & Ace	Ø
D/C	RLE	Kerlix & Ace	Ø



PACU OUTPUT			
Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?

Discharge Criteria:
Date: 5/2/03 Time: 1120 PARS: 9
BP: 130/70 T: 98.5 HR: 100 RR: 14 Sa02: 98%
Pain Level at D/C (0-10):
Intake: Output:
Additional Data: 18G HL via (R) hand patent
Transferred To:
Report Given To:
Transferred Via: W/C Litter Gurney Ambulance
Transferred By:
Cleared IAW Recovery Ro[redacted]
Charge Nurse Signature: [redacted]

b6-2

WAMC OP 173-E

Doctor's Orders—Post-OP 126th OP 4256

Nurse Complete	Dr.'s Select	DATE: TIME:
☐	☑	1. Admit to: ☐ OR ☐ PACU ☑ ICW ☐ Patient Holding
☐	☑	2. Diagnosis: s/p GSW to RLF/LUE
☐	☑	3. Condition: ☐ Critical ☑ Guarded ☐ Stable ☐ VSI ☐ SI
☐	☐	4. Allergies: See SF 558
☐	☑	5. Vitals: ☑ Unit SOP ☐ Notify Dr. for SBP < 90 or > 200, DBP < 50 or > 110, HR < 60 or > 110, RR < 8 or > 30, or Temp > 101°
☐	☑	6. Activities: ☑ Bed Rest, ☐ BRP, ☐ OOB ASAP w/ assist, ☐ Sit up and dangle when stable ☐ Other:
		7. NRSG:
☐	☑	a. Propaq monitor w/ Pulse-ox
☐	☐	b. O_2 to maintain SAT's above 94%
☐	☐	c. Maintain Vent settings at MODE=____ Vt=____ RR=____ PEEP= FIO_2=
☐	☑	d. ☑ Reinforce or ☐ Change dressing for bleed-through X1 then notify Dr.
☐	☑	e. I's & O's
☐	☐	c. Suction NT ETT PRN
☐	☐	d. CT to ☐ H_2O seal or ☐ Suction at ____
☐	☑	8. Diet: ☐ NPO ☑ Clear fluids as tolerated ☐ Other:
☐	☑	9. IV: ☐ NS or ☑ LR TRA 110 cc/hr ☐ DEXTRAN or ☐ Hespan X 500 cc bolus titrated then ____ cc/hr ☐ Albumin 100cc X ____ TRA ____ cc/hr ☐ When tolerating PO fluids, complete current fluid then SL.
☐	☐	10. BLOOD: ☐ T&S or ☐ T&C ____ units ☐ Transfuse ____ units ☐ PRBCs or ☐ Whole Blood
		11. Medications:
☐	☐	a. Tobramycin 300mg IV Q12hrs X | e ☐ Ceftriaxone 750 mg IV
☐	☑	b. Clindamycin 600mg IV | f ☐ PEN G 2 million Units IV
☐	☑	c. Cefazolin 1 gram IV @ 8° x 24°
☐	☑	d. Phenergan 12-25mg Titrate ☑ IV ☐ IM Q4hrs PRN nausea/vomiting
☐	☐	g. Droperidol 1mg ☐ IV ☐ IM X 1 PRN Nausea/Vomiting
☐	☑	h. MSO_4 1-3mg Titrate ☑ IV ☐ IM Q10min PRN Pain
☐	☐	i. Robinul 0.1mg IV X 1
☐	☐	j. Zantac 50 mg ☐ IV or ☐ IM or ☐ 6.25mg/hr infusion
☐	☐	k. Tetanus Immune Globulin
☐	☐	l. Toradol ☐ IV 30mg or ☐ IM 60 mg
☐	☐	m. Maintain sedation/paralysis w/ Rocuronium and MSO_4 PER SOP
☐	☐	12. LABS: a. iSTAT ☐ Glucose ☐ ABG ☐ BMP ☐ CMP
		13. Additional:
		Signature: [redacted] b6-2

LOG# [redacted] PT NAME: PT SSAN#

b6-4

10JAN03

MEDCOM - 8320

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	LR	1500	OR	EBL	150
			OR	Urine	600
TOTAL			TOTAL		

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

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

① Increase in T resp rate O2 Sats ↓ 70s. Lungs slight Rhonchi to upper airways. P [redacted] to vigorous stimuli. Anesthesia Pleased [illegible] of pt's condition. [redacted]

① Anesthesia 2330 [redacted] - called to PACU, pt desat ↓ SOx, BS crackles bilaterally, unresponsive, Reintubated pt [redacted] succ. 7.0 mg, Placed on vent 700 - 10 - PEEP 10 FiO2 1.0. sats ↓ 90s, albuterol via ETT x2, suctioned ETT [redacted] copious red secretions, MSO4 4 mg. [redacted] CPT AW

2350 - Anesthesia - Pt ex CO_2 ↑ SO2 on vent, fighting vent, CPAP trial [illegible] placed on T-piece, ET CO_2 ↓ ↑ 40, RR 14, pt tolerating [illegible], sats 100% will monitor until totally awakens. [redacted] CPT AW.

2[redacted]PA 03.0015 - Anesthesia - pt SV, RR T V, Pt [redacted], responsive, extubated & Suctioning oropharynx, Tol. well. [redacted] CPT AW

MEDICATION RECEIVED IN PACU/ICU

MEDICATION GIVE[redacted]	DRUG	DOSE	ROUTE	TIME	EFFECTIVENESS
[redacted]	Cmey	1gm	IVPB	2400	

DISPOSITION SUMMARY: Nursing Care Problems No.'s_____Resolved; No.'s_____Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status:_____ PAR Score_____ Safety Straps_____
Report given to_____. Patient released by Anesthesia_____
Time out_____ Nurses Signature:_____

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

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 [illegible]	I 2	[redacted]	EPW # [redacted] b6-4 b(6)-4		

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

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	U	K40	N/A

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
NO	[redacted]	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0 b(2)-2	ICW 1	
[redacted]		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYYYMMDD)
05		20030102

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
AEAA		20030428

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

FOR LOCAL USE

DX: I&D (L) Arm wound

Dx 891.0 881.02 E991.2

Proc 86.04 83.14

891.0 884.0 E991.2 Inj 450

86.59 Trauma

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK
[redacted] b6-2	[redacted] b6-2

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

b(6)-4

INPA[redacted]T TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER [redacted]	2. NAME (Last, First, MI) EPW # [redacted]			3. GRADE EPW	ADMISSION REMARKS
4. SEX M	5. AGE 23y	6. RACE —	7. RELIGION —	8. LENGTH OF SVC 7	9. ETS —
10. PREVIOUS ADMISSION NO					
11. FMP 99	12. SSN [redacted]	13. ORGANIZATION —		14. WARD Tow #2	
15. FLYING STATUS —	16. RATING/DSG —	17. DEP[redacted] BR[redacted]	18. BRANCH/CORPS —	19. UIC/ZIP —	20. TYPE CASE WIA.
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct From ER			22. HOURS OF ADMISSION 1440	23. CLINIC SERVICE AEMA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: UNK			25. TYPE DISPOSITION 05	26. DATE OF DISPOSITION 030525	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK			27b. TELEPHONE NO. —	28. DATE OF THIS ADMISSION 030524	ADMITTING OFFICER DR [redacted] b6-2
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted]				30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA b(2)-2

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: S/P I & C c̄ ex fx
(R) open Tib/Fib fx

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATT[redacted] b6-2 [redacted] OF PAD[redacted] MEDIC[redacted] RECORD[redacted] b6-2

DA FORM [redacted]

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

Ejected ♂ shot by US forces yesterday
Taken to BSI c̄ treated ī ex fix of open tib/fib.
Inj: (R) + (L) knee
pmHx: ∅
SHx: unknown
Meds: None
Allergies: NKDA (unknown)

PHYSICAL EXAMINATION

HEENT WNL

Ext: open wound (R) distal TIB/FIB, soft compartments
2+ DP/PT, ¢ pain ī passive stretch

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

(A) (R) Open TIB/FIB fx, BSW (E) knee
(P) Admit, repeat I+D in 24°

b6-2

SIGNATURE	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted]	4/26/03		

PATIENT'S IDENTIFICATION *(For typed or written entries give name last, first, middle; grade; date; hospital or medical facility)*	REGISTER NO.	WARD NO.

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

4/27/03 2330

BRIEF OP NOTE: ORATO

PROCEDURE: I&D (L) KNEE

I&D (R) KNEE

I&D (R) LEG & EX FIX of GSW TO TIBIA

PRE-OP DIAGNOSIS: GSW (R) & (L) LE's Deep TIB/FIB

POST-OP DIAGNOSIS: SAME

SURGEON: [redacted] b6-2

ASSISTANT: [redacted] b6-2 LIM

EBL: 150 cc

FLUIDS: 1000 cc

UOP: 900 cc

TT: 0

POST-OP PLAN:

(1) REPEAT I&D w/ 72°; CONSIDER ADDITIONAL FIXATION TO ADD STABILITY

[redacted] b6-2

USCMC
4352

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO.

LOG#: [redacted] b6-4

SSAN#:

NAME:

PROGRESS NOTES
Medical Record

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

USAPA V1.00

TAB TAB TAB TAB

RECORD OF ACUTE MEDICAL CARE

(Entries on this record should be restricted to further evaluation and treatment of complaint(s) screened)

DATE	2ND CARE LOCATION	TIME PATIENT ARRIVES	TIME ENCOUNTER BEGINS	TIME PATIENT LEAVES
27 APR 03				

1400L (5) IRAQ CPW Presents to BAS c̄ Shrapnel
B/P 130/80 wound to (R) Upper Arm, and Broken
P 80 tib/fib c̄ thru & thru GSW to (R)
R 20 leg. Wound is on medial aspect of leg
T 99.7 ~~O/E~~ PT ST shot x1.d. Pt x-ray demonstrates
SpO2 98 fx - tx'd at Iraqi Hospital.
~~AH~~ O/ NAD, WNWD ♂, A&Ox3
Sodium - VSS
1700L Phenergan 25mg IV - Talkative, moderate pain control.
Rt Lower leg - distal one third has medial
1747L MORPHINE 6mg through and through injury c̄ noted edema.
1807L Valium 5mg (P) Circulatory/Nervous intact. Noted malalignment
p̄ Iraqi splinting. anterior laceration
3cm x 2cm, posterior laceration 5cm x
3cm. (P) tibia/fibula involvement noted
with proximal leg manipulation. (P) ecchymosis
distal to Rt knee. 3cm lac. Symetrical.
.3cm symetric lac. distal to LT knee.
A) ~~GSW~~ Probable GSW c̄ tib/fib involvement.
P) 1) Betadine Scrub
2) Bacitracin & Bandage Wounds
3) "L & U" Splint - good Cap refill
4) Demerol 50mg IV 100mg wks

#3 Serial # [redacted]

SIGNATURE OF HEATH CARE PROVIDER	SIGNATURE OF MEDICAL SUPERVISOR	AUDITOR'S INITIALS AND DATE

SPECIAL INSTRUCTIONS

This form will be utilized in lieu of SF 600 (Health Record-Chronological Record of Medical Care) at the BAS level and above when care is initiated by an ADTMC screener. The record of acute, medical care will accompany the patient to the next level of care or remain in the BAS depending on disposition reached. This form will be filed in the HREC when evaluation and audit are completed.

TAB TAB TAB TAB

SCREENING NOTE OF ACUTE MEDICAL CARE

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

TIME PATIENT DEPARTS UNIT *(From DD Form 689)*	SCREENER LOCATION		
	TIME PATIENT ARRIVES	TIME ENCOUNTER BEGINS	TIME PATIENT LEAVES

DATE	SCREENER LOCATION	CHIEF COMPLAINT	DURATION

PATIENT RESIDENCE
( ) BARRACKS ( ) POST HOUSING
( ) OFF POST ( ) TRANSIENT

VITAL SIGNS
TEMPERATURE _____ ALLERGIES _____
PULSE _____ BP _____ RESP _____

FIRST VISIT FOR THIS COMPLAINT ( ) YES ( ) NO IF NO, WAS RETURN SCHEDULED/REQUESTED BY CARE PROVIDER?
( ) YES ( ) NO

ALGORITHM/CODE	ALGORITHM/CODE
ALGORITHM SUMMARY	ALGORITHM SUMMARY

COMMENTS *(Reasons for referral, method of referral, hospital appointments, self-care protocols, and patient instructions/precautions)*

5) IC LR RAC 20ga. - TKO
6) Anest° 1gm IV
7) motrin 800mg T/PO TID x 3d.
8) F/u for definitive care @ med tac.

[redacted] bo-2

PA-K

PATIENT'S IDENTIFICATION *(Use mechanical imprint if available, typed or written entries give: Name, SSN, Unit, Sex, Birthdate and Duty Phone)*

FINAL DISPOSITION
( ) I - PHYSICIAN STAT ( ) IV - SELF CARE PROTOCOL
( ) II - PA STAT ( ) V - HOSP CLINIC REFERRAL
( ) III - PA

AIDMAN'S SIGNATURE & CODE	AUDITOR'S INITIALS & DATE

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28APR03 @ 0115 VS BP: 110/61 P: 65 R: 18 T: 98.6	Pt RECEIVED FROM PACU Pt A+O x3. PERRLA Ø. EXTRA HEART SOUNDS LUNG SOUNDS CLEAR TO AUSCULTATION BS ACTIVE x 4 QUAD. LR RUNNING IN (L) AC @ 100cc/hr. Ø S/S INFECTION OR INFILTRATION. DRESSING CDI FOLEY DRAINING CLEAR YELLOW URINE. SITE CDI. CONTINUE TO MONITOR [redacted] PFC 9IWM6 bb-2
28 APR03 @ 1921	VS HR 107 BP 118/56 R-24 99% RAT-100.0°F-SGT [redacted] 9IWM6-CPN bb-2 (R) KF in DSG intact. (+) 2 pulse R & LLE, CNS intact. (+) 2 edema to (R) foot. Cap refill ≤ 2 sec R & LLE. AO. S1, S2. LS clear. BS (+) x4. Voiding light yellow urine quant sufficient. (L) breast DSG. dirty intact - chest placed. (L) HHV intact. Speaks English fairly well & understands fairly well. Unit to monitor - slight pain issue. Denies medication. [redacted] bb-2
29APR03 @ 830	BP: 117/57 — HR: 96 T: 99.5° Pox: 98% RA - Neuro: A & O x3, PERRLA, ~~RUE somewhat weaker than LUE~~ (R) extremities somewhat weaker than (R) side; pain 0/10 c/o numbness & tingling in (R) foot. MD notified CV: NSR, RRR, cap refill ≤ 3 sec strong pulses x4; Resp: lungs CTA GI/GU - (+) BS x4; abd. soft & non-t upon palpation; pt voids (+) S, clear yellow urine via Foley, Integ: drsg: CDI skin warm & dry - will cont to monitor [redacted] bb-2

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

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

[redacted] bb-4

EPW [redacted]

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

USAPA V2.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
~~24~~ 30Apr03	(Cont) Cap Ref ≤ 3 sec, strong pulses x4; Resp: lungs CTA; GI/GU - (+) BS x4, abd soft & nontender to touch; pt voids QS, clear, yellow urine via urinal; Integ: drsg - CDI, skin warm & dry. Will cont to monitor [redacted] bb-2
30 Apr 03	PT Note
Hx:	Request crutches trans (R) LE c̄ ex fix; ∅ problems c̄ getting up;
Tests:	Ex fix in place (R) LE
	(I) supine ↔ sit c̄ min A (R) LE x1
	(I) sit ↔ stand c̄ crutches min A x1 balance
	Amb 20' c̄ crutches NWB (R) c̄ min LOB
	NTN supine
Diag:	(I) crutches use c̄ min LOB
Interv:	edu / eval
	Cont crutch trn x1
G:	(I) crutch - 1 day
	Deferred [redacted] bb-2
	CPT, SP [redacted]
4/30/03	Pre Op Dx: open (R) TMS Fx B Ex
	Post op Dx: same
	Procedure: ORIF adjustment specified
	Surgeon: [illegible]
	Anesthesia: Spinal (Pelanquist)
	EBL ∅
	Fluids 500 cc
	Ca ∅ [redacted] bb-2

STANDARD FORM 509 (REV [illegible] BACK
USAFA V1.00

[redacted]

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
0945 29Apr03	Neuro ✓: A&Ox3, PERRLA, (R) side slightly weaker (L) than (R), differentiate between sharp & dull throught, denies pain; will cont to monitor — [redacted] bb-2
29Apr03 @1615	Neuro ✓: same as above; No Δ — [redacted]
29Apr03 1700	RLE Able to move Toes, ~~tiff leg~~ ERROR ~~sha~~, Able to feel as evidenced by running metal object up foot. Pt stated "dull and cold!" Denies Pain, numbness Tingling. — [redacted] PFC, LPN bb-2
29Apr03 1700	Pt Awake, A&O x3, PERRLA (+), Lungs CTA throughout S1, S2 present, HRRR. BS(+) x4 ~~quad~~ quads. RLE External Fixator Dsg CDI. ~~OR~~ LLE Curlix Dsg CDI. Pt Denies Pain Numbness tingling. — [redacted] PFC, LPN bb-2
29Apr03	2100 Mars - Neuro vascular ✓ - (R) LE weaker than (L) LE. R foot can sense Temp but unable to determine ~~sharp as~~ difference between sharp or Dull. All sensations appear to be sharp. Able to move (R) Foot toes. unable ~~to~~ Gross motor function of (R) foot. — [redacted] PFC, 91WMB bb-2
P 93 BP 111/59 O2% 98 T 98.1 R 16	24Apr03 0100 - NVJ RLE. Warm & Dry to touch, +2 pulse, Able to move toes, feels most pressures as sharp. — [redacted] PFC ~~911~~ 91W bb-2
30Apr03 0730	BP: 119/65 HR: 84 T: 98.6 SPO2: 100% RA Neuro ✓: A&Ox3, PERRLA, denies pain, c/o numbness through (R) leg, cannot differentiate between sharp & dull. Feels everything as sharp, (R) side ~~wa~~ slightly weaker than (L); CV: NSR, RRR,

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

bb-4

EPW # [redacted]

[redacted]

MEDCOM - 8330

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
2 May 03 0600	Pt awake & talking c̄ staff. VSS. HL (R) RC intact, non-tender. RLE drsg & External fixator intact. Ø drainage. Pulses +2. Brisk Cap. Refill. Skin warm & dry. RLE ↑ on pillow x1. medicated c̄ MSO4 2mg IVP for c/o pain approx 4/10. Will continue to monitor status. [redacted]
2 May 03 0830	Pt medicated c̄ Zyloc "II" tabs po for c/o pain. Will monitor for effect [redacted]
2 May 03 1230	Pt medicated c̄ Zyloc "II" tabs po for c/o pain 5/10. Will monitor for effectiveness. RLE ↑ on pillow x 1. Neuro intact. [redacted]
2 May 03 1400	Pt laughing & talking c̄ staff. Used BSC c̄ difficulty. VSS. Sat 97% [redacted]
2 May 03 1420	Medicated c̄ 4mg MSO4 IVP for breakthrough pain 5/10. Will monitor for effect. [redacted]
2 May 03 1600	Pt resting in bed. Neuro checks intact. +2 pedals. Brisk capillary refill. Moves toes c̄ difficulty. Kerlix, Ace wrap & fixator intact. Ø drainage. RLE ↑ on pillow x1. Denies pain @ this time. [redacted]
02 1930 May 03	Pt awake in bed. Peerla. Lungs CTA Bilat, Heart (S1,S2) bowels active x 4 quad. Abd soft nontender. pulses strong and equal x 4 extremities [redacted]
03 MAY 03 @ 0600	PT AAO x3 PERRLA 4mm S1 & S2 present PPP x4 Bilat equal/strong BBS CTA & equal clear w/ll exp pattern Bowel sounds present x4 quad voiding via urinal clear/yellow/urine, skin warm/dry, Ø complaints @ present will continue to monitor [redacted] NMC-CPN
03 May 03 @ 1310	c/o Generalized pain on a scale of 7 out of 10. [redacted] 2 Percocet PO given. Will continue to monitor. [redacted]

STAND[redacted] 09 (REV. 5/1999) BACK

USAPA V1.00

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
30 Apr 03	1500 - pt reached a par score of 10. He c/o slight ~~pt~~ ERROR numbness from hee) to toes. ~~pt~~ of affected leg. He is able to slightly move his toes. Pt taken off recovery. Will cont to monitor ——— SPC [redacted] b6-2
30 2140 APR03	PT Transfer from A-10 to B 3 Pt stable [redacted]
302P	b6-2
31 0100 APR03	Neuro check (R) foot differentiates sharp from dull stimuli in lateral and posterior sides of foot a stimuli. at great toe feels sharp. able to move toes on command. cap refill < 3 secs ——— [redacted] b6-2
1 MAY 2003 0900	Pt A&O x 3. lungs CTA. BS x 4. Tolerated Regular diet for breakfast w/ difficulty. RLE c̄ ace wrap and external fixator CDI. Pt states toes still slightly numb. + circulation and movement. Pt states pain today is different, its more with movement than constant. Pt ↑ ambulating to BR, Will continue to support & assess. ——— [redacted] NTAN ——— b6-2
01 1745 MAY03	PT awake and oriented. eyes perrla, lungs CTA bilat, Heart S1, S2, bowels hyperactive x 4 quad. abd soft nontender pulses strong and equal x (L)(R) radial (L) D.pedis. CMS intact in (R) LE. ——— [redacted] b6-2

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

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

REGISTER NO.

WARD NO.

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
4/1705 May 03	PT awake & verbal. Eyes Perrla. lungs CTA Bsa levels active x 4 quad. Heart (S1, S2) reg rate/rythm. abdom soft & nontender. Pulses equal x 4. CMS intact in (R) LE. — [redacted] bb-2
04 May 03	2125 IV in left forearm infiltrated. IV was reinitiated in (R) forearm using 18 guage catheter. The site was successfully flushed. — [redacted] SPC bb-2
05 May 03 @ 0700	Lying in bed. Awake and oriented X 3. Resp even and NL. Lungs clear. Heart (S1 S2) regular and strong. Abd soft and flat. Hypoactive BS X 4 quads. (R) dsg & dsg intact and pins present. Neuro intact. HL in (R) FA. Denies pain @ this time. — [redacted] CPT AN bb-2
	~~Transfer~~
	1345 c/o pain. Medicated c̄ iī Percocet PO. Will continue to monitor. — [redacted] CPT AN bb-2
5 May 03 1730	Pt Awake in bed. A&O x 3. PERRLA (+). Lungs CTAB. S1 S2 Present, HRRR. (+) BS X 4 quad. Abdomen soft Flat non tender. Last BM this AM. Voiding spont. onears clear yellow urine. HL in (R) FA. Drsg to ~~at~~ (R) LE External Fixator. unable to detect signs of infection ~~at~~ due to drsg. Drsg has serous fluid on posterior of leg about 2½" ~~at~~ by 3". Marked and dated. Denies Pain at this time will continue to monitor. — [redacted] FL LPN bb-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

03 May 03 @ 1655 Lying in bed talking c̄ medical staff. No distress noted. [redacted] CPT, AN b6-2

03 1745 May 03 Pt awake in bed clear speech eyes perrla, Lungs CTO bilat, Heart (S1 S2) reg rate/rythm. bowels active x 4. Abd soft nontender. pulses equal x 4 b6-2 extremities. [redacted] LT AN

03 2100 May 03 Dsg Δ by doc. no purulent drainage or redness/swelling b6-2 [redacted]

03 2230 May 03 IV infiltrated. IV reinitiated @ arm 18 ga [redacted]

04 May 03 @ 0715 Awake and oriented x 3. Resp even and ut. Lungs clear Heart rate 80-84, Regular Rhythm, Skin warm and dry, BS x 4 quads. Voiding clear yellow urine per urinal. + Radial and pedal pulses. (R) LE c̄ bandage and pins present. Sensation present (L) Heplock in FA. b6-2 [redacted] CPT, AN

0815 c/o pain. Medicated c̄ MSO4 2 mg IV Push. [redacted] CPT, AN b6-2

0845 Resting quietly. No further c/o pain. [redacted] CPT, AN b6-2

1010 OOB to commode. Passed large stool. Medicated c̄ 2 Percocet for c/o pain. [redacted] CPT, AN b6-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

Civ [redacted] b6-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
051800 May 03	Pt stumbled on way to bath room. May have jostled external fixator. CMS intact (R) LE. No bleeding noted on dressing (frank new bleeding). b6-2 [redacted] LT/AN
051810 May 03	Dr [redacted] notified - no further orders — b6-2 [redacted] LT AN
06 May 03 (R)	0515 Lying in bed awake and oriented x 3. Very talkative. (R) leg c̄ pins and dsg slightly elevated on a blanket. Neuro intact. Denies pain @ this time. Voiding freely clear yellow urine per urinal. Will continue to monitor. — b6-2 [redacted] CPT, AN
	0615 Asleep c̄ HOB ↑. — [redacted] CPT, AN
	0630 Awake. Resp even and NL. Lungs clear. Heart (S1S2) regular and strong + BS x 4 quads - Abd soft and flat. Radial and pedal pulses palpable. Ambulating on crutches - NWB on (R) LE. — b6-2 [redacted] CPT, AN
	0755 Dr [redacted] here. Update provided. Plan of care reviewed. Orders received. — [redacted] CPT, AN
	0905 C/o pain. Medicated c̄ ii Percocet PO as ordered. Refused bath @ this time. — b6-2 [redacted] CPT, AN
	1000 Very jovial. Talkative to staff and patients. Ambulated on crutches as ordered. — [redacted] CPT, AN
	1020 Pt refused Keflex. — [redacted] CPT, AN
	1545 Assessment remains unchanged. Will continue to monitor. — [redacted] CPT, AN
	1630 Partial bath and shampoo provided to patient. — [redacted] CPT, AN

b6-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

~~5/6~~

Transfer Summary.

5/5/03 This 6 [illegible] sustained an open fracture to his right tibia/fibula from a gunshot wound. His fracture has been stabilized with an external fixator and is well aligned. He will need continued local wound and pin site care and should remain non weight bearing for the next six weeks.

Open Wound posterior calf – daily damp to dry dressing Δ.

Pin sites – daily care with saline soaked Q-tips.

Fracture – non weight Right lower extremity x 6 weeks then repeat XRay & progressive weight bearing

Antibiotic Prophylaxis – Keflex 500mg BID

[redacted] b6-2

MAJ, MC
Orthopaedic Svc

5/5/3 1100 Pt able to move toe to ~~A~~ RLE. Lower extremity Pulses = bilat. Can move RLE Q Kn[redacted] dry to touch. [redacted] OFL, LPN

b6-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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MEDICAL RECORD	PROGRESS NOTES
DATE	
5/7/03 2225	VSS. A&O x3. Cont to verbalize english well. PERRLA. S_1, S_2. (+)2 pulses to include RLE pedal & dorsalis / tibialis. BS(+) x4. LS clear, equal AB. No c/o pain at this time. DSG to RLE clean, dry and intact. Ambulated x1 to bathroom w/o c/o pain. Cheerful mood. Cont to monitor. [redacted] bb 2
8 May 03	0720 = VSS & on graphic sheet. Assessment complete. Pt. A+O x3, Perrla, S_1, S_2, lungs CTAB, BS x4, good appetite - ate 100% of breakfast tray, pulses 2+ in ↑ & ↓ ext's, (R) leg has external fixator c̄ dsg. Ace Bandage over leg below knee C.O.I, Dsg Δ's Daily now, Neurovasc ✓ done = good sensation, CRT < 3 secs, 1+ edema to (R) foot, c/o of (0) pain at this time - medicated @ 0645 for pain 9/10 c̄ Tylox #1 tabs PO as ordered, bb-2 instructed to call for all needs. — [redacted] ZU/AN
	0720 = No IV access — [redacted] ZU/AN
8 May 03	1200 = Wet to dry Dsg Δ done, pt. given 2 Tylox tabs PO as ordered for pain R/T dressing Δ, covered ace wrapping over Kurlex dsg, neurovascular ✓'s good, (L) foot has some edema still. — bb-2 [redacted] ZU/AN
8 May 03	Addendum NOTE 1000 = pt. had BM x1 formed + brown. RP
8 MAY 03 1322	Pt awake in bed. Pt A&O x3. PERRLA(+), Hand grasp = bilat. ~~BS~~ Lung CTAB, S_1 S_2 Present, HRRR, (+)BS

(Continue on reverse side)

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

EIV [redacted] bb-4

PROGRESS NOTES
Medical Record

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PROGRESS NOTES

DATE	
6May03 1845	Pt resting in bed. A&O x3. LCTAB, BS+4. Tolerating Regular diet. No IV site. IV Abx Δ'd to PO Abx, will encourage pt to take it this evening. RLE dsg with some new drainage on ace wrap. Pt does not want it reinforced at this time. Pt ↑ ambulating well c̄ crutches. Will continue to monitor & support. — [redacted] INC AN — bb-2
6May03 0730	No Δ from previous assessment. Pt did take PO Abx on night shift. — [redacted] NT AN — bb-2
06May03 0545	Awake and oriented x3. Resp even and NL. Lungs clear. Heart (S1S2) Regular and Strong. Abd soft and flat. +BS x 4 quads. Radial and pedal pulses present. (R) leg c̄ pins and dsg present. Dsg c̄ old drainage present. Voiding clear yellow urine per urinal. c/o discomfort voiced. Will continue to monitor. — [redacted] CPT, AN — bb-2
0930	Complete bath c̄ ~~bowel~~ mouthcare done by pt. ~~Linen change~~ Pleasant and cooperative today [redacted] CPT,
0950	Medicated for c/o pain. — [redacted] PT, AN bb-2
1230	Asleep. No changes noted @ this time. [redacted] CPT, AN
7May03 1415	Pt awake in bed. ~~A&O x3~~ A&O x3. PERRLA, pins ~~3cm~~ ~~3x~~ mm in size. Lungs CTAB, S1S2 Present, HRRR, BS x 4 quads Abd. Soft Flat non Tender. (R) LE c̄ ex Fix, Dsg has bloody shaw 2 day old, marked and dated. ~~RLE~~ (R) Foot warm and dry, +2 pulse = bilat Lower extremities. Able to move (R) Foot & Toes. Denies Pain at this time — [redacted] PFL, LIN bb-2

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CIV [redacted] bb-4

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MEDICAL RECORD	PROGRESS NOTES
8 May 03	x4 quads, Lower Right extremity dressing CDI. Ex Fix CDI. Lower Extremity pulses = bilat. ~~warm~~ LRE Warm and dry to touch. Pt can move toes. Denies Pain at this time. [redacted] PFC LPN bb-2
8 May 03	VSS. No significant Δ's of assessment. Rested and ready d/c from hospital. cheerful mood and cont to help translate on ward. RLE Ex fix clean, dry and intact. ⊖ denies pain and ambulates well on own. [redacted] bb-2
9 May 03 @ 0530	All VSS; No Δ in assessment; neurologically intact, NSR, lungs CTA bilat; ⊕ BS x 4 pt voiding QS clear yellow urine via urinal; skin warm & dry; pins CDI - pt up and lib in a cheerful mood, will cont. to monitor [redacted] bb-2
9 May 03 1300	Pt awake verbal, ambulating, perrla, Lungs CTA Bilat, Abd soft non-tender. bowels active x 4 quad. Pulses equal strong x 4 extremities, [redacted] bb-2 AN
9 May 03 1345	Δ dressing to ⊕ LE c̄ pin care. 3 wounds 1: proximal Tibial region 1cm². applied bacitration; 2: Mid Tibial region 5-8 cm well approximated and satured. 3: 4 cm by 5 cm beefy red c̄ granulated tissue no purulent drainage note active bleeding when dressing removed wet-dry applied, bad color CMS intact [redacted] AN bb-2
10 May 03	VSS. No new Δ's. stable. [redacted] bb-2
10 May 03 @ 0530	RN attempted to complete nursing assessment. Pt refused by yelling @ nurse, throwing objects and

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.
Civ [redacted] bb-4		

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10 May 0300	[illegible] by being non-compliant. HN attempted to reason c̄ patient but very difficult to reason with. Lying in bed c̄ [illegible] — [redacted] b6 2
	0530 ⁊ Percocet PO given for pain. — [redacted] CPT, AN
	0600 Ambulating on crutches c̄ 2 soldiers in attendance. Transferred to ICW #2. Report given. Questions answered. — [redacted] CPT, AN
100930 May 03	Pt arrived to ward ambulatory c̄ crutches. Pt is awake, alert, Ox3. Airway is patent. b6 2 Lung sounds clear to all fields. Abd is soft, nontender, and c̄ distention. BS⊕x4. Tolerating PO well. Voiding spontaneously. (R) UE have FROM and good cap refill. (R) LE has ex fix c̄ ACE wrap. CDT. Pedal pulse is palpable c̄ limited movement. (L) LE has FROM and strong pulse. Pt ambulating by self c̄ crutches. — [redacted] AN b6-2
10 May 1316	PT vitals taken T98.4 P75 R20 B/P 118/86 — [redacted]
10 May 03 1410	Assumed pt care @ 1300. pt awake alert & Ox3. pt on RA lung sounds CTA bilat. abd soft ⊖ distention noted BS⊕x4 quads. (R) LE c̄ ex fix during Ad c̄ pin care c̄ ACE wrap. pedal pulses ⊕ LE c̄ FROM. ⊖ IV site noted. pt irritated stating "do not treat me like a child" talked c̄ pt & calmed him ↓. pt walking c̄ crutches. Doing well. will cont to monitor — [redacted] /WMC
pm May 03 1523	Pt D/C to ASMC. c̄ D/C instructions and [illegible] b6 2 MEDICATION — [redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	EPW [redacted] b6-4
5/10/03	Dx: Right Open TIB/FIB Fx s/p I+D ī external fixation Ambulatory Status: NWB (R)LE with crutches Care: once a day wet to dry dressing change and clean + dress pin sites with Q-tip and saline Follow up: Repeat x-ray ≈ 4 weeks. Ex-Fix will be removed as outpatient in 8-12 weeks. b6-2 [redacted]
9 MAY 03 1900	28 yo ♂ ī Dx of (R) open Fx to TIB/FIB. S/P I&D ī ext. fixation admitted to 581st patient hold to await evac to 28 CSH in the morning. Will monitor for Δ's — [redacted] b6-2
10 MAY 03 0750	No Change, Pt slept through the night No complaint of pain. BP 108/59 P 76 T 98 R 16 O2 sat 99% — [redacted] b6-2
10 MAY 03 0840	Pt is being D/C'ed to the 28th Cash Ura Sound evac. Pt is stable @ this time — [redacted] b6-2
11 MAY 03 0946	Pulse: 98, Resp 18, BP 100/70 [redacted] b6-2

(Continue on reverse side)

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

EPW # [redacted] b6-4

REGISTER NO.

WARD NO. CCW2

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
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PROGRESS NOTES

DATE	
RUA9 03	P.T. V.S. BP 114/72, P-78, RR-12, T 98.8, and SpO_2 99
13May03	Assumed pt care @ 0500. VSS T 97.5 P 76 R 16 B/P 104/68. Lungs CTA. ⊕ BSX4. Pt ambulated x 10 min. tolerated well. Drsng c̄ pins on R leg CDI [redacted] 1 mg 66-2
10:45	Pt. c/o pain. 2 tylenol #3 PO was given prn for pain as ordered — [redacted] 1 W 1 66 66-2
10:55	Dressing change + Rpr care complete [redacted] 1 W 1 66

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
11MAY03 1738	Assumed care of Pt @ 1800. VSS. (R)LE External Fixation site dressing D/O. W→D dsng site x2 reapplied. Both intact s/sx of infection. Pin care done. Flexlex dsng & Ace wrap reapplied. (+) sensation, ROM, caprefill <3sec in (R)LE. O/W assessment WNL. Will Monitor [redacted]
2025	Pt. A&O X3. HR Reg, Lungs CTA, BS (+) x4. Pt. affect (+). 66-2 Speaks good English. Ext. Fixator to (R) LE intact c̄ dsng CDI. Pedal pulses 2+, capr refill < 3sec. (+) ROM toes. 66-2 will continue to monitor. [redacted]
12MAY03 0022	P.T. VS are BP-12[redacted] T-98.5, P-71, SpO2-99, and BP 116/72. [redacted] 66-2
120550ly03	Pt asleep but arousable. Lung sounds clear to all fields. BS(+)x4. Tolerating PO but refusing to eat. Pt does not want to be here (hospital). Refuses to eat. Food will continue to be provided. Pt is neurovascularly intact to all extremities, c̄ limited ROM to (R)LE. Ex Fix and dsgs to (R)LE have minimal serosang drainage at this time. Pt ambulating c̄ crutches [redacted] 66 2 at this time. [redacted]
12May03 0655	PT vitals T 97.9 P58 R 14 BP 102/70 — Sp[redacted] 66 2
12 May 03 1400	Pt. vitals taken BP 120/60, P-84, R.20, Temp 99.0 SPC [redacted] 66-2

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.
CIV [redacted] 66-4 [redacted]		

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
13May0130	Pt care assumed @ 2100. VSS, Pt AOx3, pt has no complaints of pain. Pt is very cooperative. Dressing to RLE CDI. RLE (+) sensation, ROM, and cap refill <3 seconds. Lung sounds CTA with equal rise and fall of chest, pulses palpable x4, bowel sounds present x4. Pt has no other complaints at this time, will continue to monitor. SPC [redacted] 91WM6 — b6-2
13May03	1330 Pt c/o [redacted] 98.4° [redacted]
13May03 2000	dsg Δ done during last shift - pt given T#3 for pain in (R) LE & good results - takes own reflex BID — [redacted] b6-2
14May03 0200	Pt care assumed @ 2100. VSS, AOx3, pt has no complaints of pain. Dressing on RLE CDI, pt has (+) ROM, sensation, and capillary refill <3 seconds. Assessment WNL, will continue to monitor. SPC [redacted] b6-2 91WM6
14May03 0610	PT vitals T 96.8 P 58 R 20 BP 102/66 — [redacted] b6-2
14MAY03	Pt care assumed @ 0500. Pt. AxOx3. VSS. Lungs CTA - (+) BS x4. Very cooperative. Dsng and pins on (R) leg. CDI. Denies any discomfort @ this time — [redacted] b6-2

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
14 May 2105	: Assumed care of pt. Pt sitting in bed reading the bible. O_2 per RA
0200:	⊖ s/s of resp difficulties. ⊖ PIV. Pt denies pain @ this time. ® LE
VS: 106/68	External fixator in place. ⊘ drainage to dressing or around pins.
HR: 74	⊕ CDI. ⊕ sensation ⊘ movement all toes. cap refill ≤ 3 sec
RR: 16	good color, normal for race. ⊕ severely 1+. PA: S1S2 present regular
SpO2: 98% RA	cap refill ≤ 3 sec ⓛ indep. No other peripheral swelling to extremities.
T: 98.0°F	Radial pulses and ⓛ pedal pulse 2+. lung sounds clear, ⊘
	adventitious lung sounds. Chest movement symmetrical & equal.
	Abd soft, non-tender. ~~bowel~~ BS this PM. Pt encouraged to
	ambulate and ~~move~~ (error 'guy') remain active. Pt ambulating w/ crutches
	w/o assistance. ⊕ friendly, cooperative, good relationships
	w/ staff. 10.11 cont. to monitor. [redacted] b6 2
0025:	Pt sleeping quietly no evidence of distress [redacted] b6 -2
0026:	⊘ PIV in place [redacted] b6 -2
15 May 0400	T3 given for mild pain (5) at 0400. SPC [redacted] b6 -2
0430	UOP clear, yellow 375 out. [redacted] b6 -2
150700 May 03	Pt is awake, alert, O×3. Breathing is even and unlabored. Breath sounds ~~[illegible]~~ clear to all ~~unlabored to~~
	(B) lobes. ~~Abd soft, non-tender, b/t to pin to (L) LQ~~ Abd soft, non-tender, and ⊘
	distention. BS⊕×4. Voiding spontaneously. FROM to (B) UE and (L) LE. ROM limited to (R) LE
	by external fixator. Neurovascularly intact to all extremities [redacted] b6 -2
15 May 03 0900	Pt vitals T 97.5 P 84 R 12 BP 116/60 [redacted] b6 2

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

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* [redacted] b6-4 [redacted]

REGISTER NO.

WARD NO. 1CW 2

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)
15 May 03	1395. Pt cAOx4. ↓ obvious distress. Pt ambulatory c̄ crutches for 10 min in semi fowlers position. VTM @ this time. [redacted] SPC 91W b6 2
15 May 03 1700	Assumed care of Pt @ 1300. VSS. A&Ox3. Denies pain Ex Fix b6-2 drsg D, CDI. O/W assessment WNL. AMB x 3 to B/ [redacted]
15 May 03 2105	Assumed care of pt. Pt ambulatory around ward w/ crutches ⊘ evidence of difficulties ambulating w/o assist. Pt alert, oriented in good spirits. ⊕ LE Ex fix intact, ⊖ drainage to dressing ⊕ movement, ⊕ sensation, ⊕ capnfill ≤ 3 sec. big toe, Crutches @ BS when pt c̄ ambulate. S1S2 present, regular. Lung sounds clear. chest movement symmetrical, equal. Abd soft, non distended, ↓ BS x 4 q. Last BM yesterday 14 May. Pt voids in ward commode w/out difficulty. Musculoskeletal - intact, exception ⊕ LE. Radial, pedal - ↓ pulse. Pt. Will cont. monitoring [redacted] b6 2
16 May 03 1	0000 2400: Pt c/o pain to ⊕ L E around pain doctors to know. ∴ Tylenol #3 Po administered. Eval Pending [redacted] b6 2
	0200: Pt awake, c/o hunger. [redacted]
160530 May 03	Pt is awake, alert, Ox3. RN reports that pt was up all night. No c/o pain. Dsg Ex Rx to RLE is CDI. Pt is neurovascularly intact to RLE. Otherwise no abnormalities noted to pulmonary, cardiovascular, GI, or GU systems. [redacted] RAW
16 May 03 1415	Pt c/o pain. Given ∴ Tylenol #3 per pro orders. Will cont to monitor [redacted] 91WM b6-2
16 MAY 03 1445	Pt. VS taken BP 108/58, P. 68, R-16, Temp 98.6 SPC [redacted] b6-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
16May03 1545	S, pt up walking the hall. pt denies pain @ this time. lung sounds CTA, abd soft nondistended BS(+) X4 quads. VSS. (R)LE ext fixator c̄ drsng CDI. pulses (+) BLE. FROM. (-) IV access noted. will cont to monitor — b6-2 [redacted] 91WM6
16May03 2025	(-) complaints voiced. pt resting — b6 [redacted] 91WM6
2300.	Assumed care of PT @ 2100. Pt. A&O, (+) attitude: HR Reg, Lungs CTA, BS (+) x4. Pt. c/o pain in (R) LE. ⅋ Tylenol #3 given c̄ good results. Ext. Fixaten in place. (R) LE elevated ↑ Heart. Pulse 2+ x4 ext. Capre fill < 3sec in (R) LE. (+) ROM toes. Edema 1+ noted to (R) ft. Will continue to monitor. — b6-2 [redacted] CTRM
0515 May 03	Pt asleep but arousable. No c/o pain at this time. Airway is patent. Breath is even and unlabored, lung sounds clear to all fields. Abd soft, nontender, ~ distended. BS(+) x4. FROM and neurovascularly intact to (R) UE and (L) LE. (R) LE has ALE wrap and Ex-Fix from knee to toes. Drsg is CDI, LLE is neurovascularly intact. Pt expresses desire to leave Healthcare and claim d̄ comm̄d work. — b6-2 [redacted]
17 May 03 1345	Assumed care @ 1300. VSS. A+O x 3. C/o mild pain, withhold pain meds. (-) si/sx of distress. Will cont to monitor. — b6-2 [redacted]
18MAY03 1330	PT vitals taken T97.8 P79 R16 B/P 122/62 — b6-2 [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S SSN NUMBER (SSN or Other)
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PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.
[redacted] b6-4		

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17 May 03	1350. Pt supine in bed. Pt is CAOx3. ∅ obvious distress. Pt to PN on (R) leg. Pt ambulates ō crutches. b6-2
	VS 112/60 P 67 Reg T 98.6° R 16 (B) CTA [redacted]
17MAY03	2230 UOP 350cc CLEAR YELLOW FLUID → [redacted]
~~17 May~~ 18MAY03	0225 UOP 220cc CLEAR PALE YELLOW FLUID - [redacted] b6-2
17 May 03	2125: Assume care of pt. @ 2100: Presently pt is sitting up in bed speaking w/ staff. (R) A/O x3. (+) (R) Ex Fix intact, ⊖ drainage to dressing. (+) sensation, (+) good movement to all toes, color normal for race, (+) cap refill ≤3 sec. Pulse unable to palpate in ft dressing. No c/o pain. S1S2 present, normal, ⊖ swelling to non-injured extremities, (+) cap refill ≤3 sec U/L non-injured extremities, pulses 2+ Radially, (L) DP. Lung sounds clear. Pt encouraged cont activity throughout day. BS x 4q (+) BM x 1 17May, normal, soft, brown. Pt amb w/ crutches w/o assist. Pt needs more (+) voiding for WARD commode. [redacted] b6-2
TODAY	UOP 570
VS 114/60	
78	
RR 16	
98% RA	
T 97.8	
	2100: Pt c/o (R) Extremity pain. Tylenol #3 ii tabs PO administered. [redacted]
18 0515 May 03	Pt is alert and arousable. Pt has no c/o pain. Wound is covered ō ACE wrap, Ex-Fix intact. Drsg is CDI. BS (+) x 4. Tolerating PO well. Voids spontaneously. [redacted] b6-2
18 May 03 1335	Assumed care of Pt @ 1300. A+Ox3. VSS. Pain controlled ō tylenol. (R) LE Ex Fix Rt CDI. (+) sensation, cap refill <3 sec. O/W assessment WNL. Ambulating ō crutches [redacted] b6-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
19May03 2000	VSS - given Reflex as ordered - no c/o pain at this time - dsg Δ done c̄ pt. assistance, pink skin noted on wound on calf, pt care done - pt. cooperative throughout shift [redacted] b6-2
20May0045	Pt care assumed @2100. VSS, A&Ox3, [redacted] complaints of pain @2300, ∴ T3 given for relief. Dressing on RLE CDI. Lung sounds CTA, pulses palpable x4, bowel sounds x4 quadrants. SP[redacted] 9/WMC b6-2
20 MAY 03.	Assumed pt care @ 0800: T97.5 P 69 R 18 B/P 100/64 SATS 99%. Pt awake A&Ox3. Lungs CTA. BS x 4. Dressing on (R) leg CDI, slight edema in foot. Denies any c/o @ this time [redacted] b6-2 9/WM
20May03 1900	Assumed pt care @1300. VSS. pt A&Ox3. lung sounds CTA throughout, abd soft BS(+)x4 quads. LLE c̄ from c̄ strong (+) pulses. Doing to (R) leg d/d, stitches removed per Dr [redacted] slight edema noted to (R) foot. pt has been up walking c̄ crutches during this shift. (-) c/o pain voiced. Will cont to monitor [redacted] b6-2 9/WMC
20 May 03 2345	Assumed care @ 2400, Pt at that time alert, oriented ambulating on crutches around ward and outside to smoke. Pt accompanied by staff upon leaving ward. 2335: PA, SISR present, Regular. Lung sounds clear bilaterally, Abd soft, nontender, BS x 4 q, (+) c/o abd discomfort, states "I feel like I have to go, but can't" Last BM 19 May — pt states was watery. (Pt was offered ginger ale) Pt states he

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
19May03 0030	Assumed care of PT @ 2100. PT VSS. Pt. c/o not having crutches. PT A&O X3. HR Reg. Lungs CTA, BS (+) X4. ii Tylenol #3 given for pain. Will continue to monitor. [redacted]
190530 May 03	Pt is asleep but arousable. ~~No c/o pain at this time.~~ Pt c/o moderate pain. T#3 given as ordered. Array intact. Breathing is even and unlabored. Abd is soft, nontender, and ↓ distention. BS (+) x4. Voids spontaneously. Neurovascularly intact to all extremities. ROM to (R) LE and LLE. Limited ROM to (R) LE 2° Extrx. Extrx dsg is ACE, CDZ. Ambulates w/ crutches ↓ assistance. [redacted] bb 2
0745 T 97.1 P 74 R 14 BP 116/66	~~[illegible]~~
190900 May 03	Pt c/o "all his bones hurting him. T = 98° orally. No neurovascular [illegible] to all extremities. T#3 given earlier. [redacted]
19May	1410. 45 100% P 78 Reg R 66 (+) CTA T 97.7° Pt in supine position. Pt CAOX3. 0 C/O PN [redacted] SBC 2/LE [redacted] bb-2
19May03	ii Tylenol given per pain @ 1630 [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. ICW2

[redacted] bb-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 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
22 May 03	Assumed care of pt. @ 0500. Pt slept most of
BP 116/8	am. OOB to BR and to commode. Pt has ∅
T 98	c/o pain or discomfort. Lung CTA x 5 lbes, abd.
P 72	soft. Bowel sounds x 4 quads. Pulses palpable. [redacted] 86T
	bb-2 [redacted] RLWM
	Pt CAOX3. ∅ pleur distress. Pt on semi-fowler position.
	∅ c/o [redacted] this time. ∅ c/c v/s B/P 120/100 P 86 Reg R
	R16 (B) CTA T98.8° [redacted] SPC 9/W
22 May 03	dsg Δ d on (R) LE by pt., damp to dry c
1840	Kerlix, no ace wrap, pin sites covered c
	2x2's - VSS - no c/o pain - Dr [redacted]
	consulted on dsg Δ — bb-2 [redacted] RAN
22 May 03 0104:	Assumed care of Pt. Pt alert, oriented x3, ∅ c/o pain. (R)
	LE elevated, ex fix intact, no place ∅ drainage from pin
	sites. Dressing CDI. (+) 1+ swelling to (R) foot. 2+ dorsalis
	pedis pulse, cap refill ≥3 sec. (+) movement (+) sensation to
	foot & toes. Skin color normal for race, skin slightly dry, pt encouraged
	to use lotion. BP 152 pressure, regular. Lung sounds clear throughout.
	(+) abd soft, nontender, non distended, last BM 22 May 03 AM.
	(+) BS x 4q. Pt ambulates w/ crutches w/ out assist w/out difficulties.
	all needs met @ this time. [redacted]
0305:	Pt sleeping quietly - PT to cont section.

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED
			bb-2
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

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

#[redacted] bb-4

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
20 May 03 cont. 2345 NSig:	prefers to use Ketrine w/o use of other interventions. Pt encouraged to inform staff of bm c/or if discomfort persists. Pt stated understanding. (+) voiding in urinal commode clear yellow, no problems. Pulses biphasic w/L pedal/dp 2+. 1+ swelling to (L) LE (Below knee qal) +1 to foot. (+) movement (+) sensation, ↓ ROM to (L) f. Ex fix in place, bandages w/o drainage. No c/o pain. Cap refill ≤3sec.
	0300. Pt sleeping. No Evidence of discomfort b6-2 [redacted]
21 May 03	
0650 DT 97.6 P 70 R 14 BP 114/84	0739 Assume pt care @ 0500. VSS pt awake Alert and Oriented. No c/o pain @ this time. HR regular. Lungs CTA throughout. Bowel sounds active x4. pt c/o gas. No pain or tenderness on abd. palpation. Ex fix and ace wrap to Lt. pedal pse palpable. + sensation in toes. Pt amb w/ crutches. Requesting to smoke. Will continue to monitor. [redacted] WMC
1344	Vital Signs taken BP 118/74 P 92 T 98.8° R 18 Spo2 98 b6-2
21 May 03 2230	Pt alert and awake, vss, no complaints of pain. Lungsounds CTA, pulses palpable x4, Bowel sounds present x4 quadrants. LLE w/dressing and ex fix CDI. Pt has feeling and sensation to lle. Pt ambulated ∅ complaints on shift. Pt c/o slight abdominal pain and loose feces during bowel movements. Will continue to monitor. SP [redacted] 91WMC b6-2

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
23 May03	Assumed care of pt. @ 0500. Pt is resting quietly. Ø c/o pain or discomfort. Bowel sounds x 4 quads. b6-2 [redacted] 91WM6
23May03 1330	Pt resting c̄ Ø c/o pain or discomfort @ this time. Airway patent, lung sounds CTA throughout, abd soft nontender, nondistended, BS⊕x4 quads. ⊕RLE c̄ ext fixator. OTA around pin site, 1½" incision to LE ∃ sgns of infection noted, dressing to that area wrapped c̄ kerlix dressing, dressing CDI. ⊕LE c̄ FROM both extremities c̄ ⊕ strong pulses. ⊕RLE c̄ FROM strong ⊕ pulses. ⊕ IV access noted. b6-2 [redacted] 91WM6
23May 2300	Pt care assumed @2100. A+Ox3, VSS, no complaints at this time. Lung sounds CTA, pulses palpable x4, bowel sounds present x4 quadrants. RLE w/external fixation and dressing CDI. Pt ⊕ROM, sensation, and cap refill ≤3 seconds on RLE. No new complaints, will continue to monitor. SPC [redacted] 91WM6 b6-2
24 May03	Assumed care of pt @ 0500. Pt VSS. Lungs CTA. Bowel sounds x 4 quads. Ø distended abdomen. External fixation ⊕ ⊕ extremities. Ø signs of infection. Pt has Ø c/o pain or discomfort ⊕ this time. b6- [redacted] 91WM6

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. ZCW2

[redacted] b6

PROGRESS NOTES
Medical Record

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

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
24May03 1337	Pt vital signs taken BP 112/72 P 89 b62 T 97.2 R 16 ——— SPC [redacted] 91W
24 May 03 2200	Assume care @ 2100: Pt awake, sitting in bed talking with staff and other patients. @ a/a/o x3 denies pain @ this time. (R) LE ex fix intact, No drainage noted to gauze around pins. Skin color normal for race warm to touch. + edema to (R) ankle foot. @ sensation, (+) movement to foot and all toes. @ dry skin - pt encouraged to use lotion c̄ compliance noted s/p conversation. Ad ambulates w/o difficulty c̄ crutches. Physical assessment w/o anomalies S1S2 present regular, lungs and clear throughout, movement symmetrical c̄ equal. Abd soft non tender, @ BS x 4q. 2+ pulses bilat pedal and dorsalis pedis. cap refill <3sec (+)/(+) toe. Pt w/out needs, alert good spirits, monitoring to cont - G.J.
102/72 BP 82 HR 14 RR RA 99% SATS T= 96.8 Tax	0345: Pt awake sitting up in bed c/o "I feel pain in my back, all over like a cold is beginning." VS Taken, WNL. Dr [redacted] b62 notified Tylenol III taken 325 mg PO ordered and administered. Pt resting. Excel Pendleton ——— [redacted] b62
25 0500 May 03	Pt asleep but arousable. Denies pain at this time. Airway patent, breathing even and unlabored. Abd is soft, nondistended, and c̄ distention. BS (+) x 4. FROM to (B) UE and (L) LE. Neurovascularly intact to all extremities. (R) LE has ex fix, covered c̄ ACE [redacted] which is CDT. ROM to (R) LE is limited [redacted] Pt ambulates c̄ crutches [redacted] b62
1355	Pt vitals taken BP 118/80 P 97 T 97.8 R 14 SpO2 98 ——— SPC [redacted] 91W

STANDARD FORM [redacted] REV. 5/1999) BACK

USAPA V1.00

b6 -2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
25 May 03 1430	assumed pt care @ 1350. pt sitting ↑ in bed talking c̄ staff. Airway patent. lung sounds CTA throughout abd nontender et soft, BS⊕x4 quads. (R)LE c̄ ext fixator, drsing CDI ⊕ pulse, foot c̄ edema. (L)LE c̄ FROM ⊕ pulse. (B)UE c̄ FROM ⊕ pulses. pt voices ⊖ c/o pain or discomfort @ this time. Will cont to monitor — b6-2 [redacted] 91WM6
25 May 03 2200.	Received Pt. resting/sitting ↑ in bed. VS WNL. PE. Pt. A+O x3. PERRLA⊕WNL Skin PWD. JCA(B). BS⊕x4. (R)EXT Fix to ↓(R)EXT intact Drsg C/D/I. Pt able to move toes and flex (R) foot c̄ difficulty ⊕PPP(B) ⊖c/o pain @ this time will cont. to mon[redacted]UT/AN b6-2

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

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

REGISTER NO. | WARD NO.

CIV# [redacted] b6-7

PROGRESS NOTES
Medical Record

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

558-104

7540-01-075-371

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER | TREATMENT FACILITY

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 28 APR 03 | TIME: 1440

TRANSPORTATION TO FACILITY

SEX: M

DUTY/LOCAL PHONE — AREA CODE | NUMBER

HOME PHONE — AREA CODE | NUMBER

AGE: [redacted]

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

INJURY OR OCCUPATIONAL ILLNESS

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

HOW

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INITIAL SERIES ☐ YES ☐ NO

ALLERGIES: NKDA

CHIEF COMPLAINT: External fixater to (R) Leg, Bandage (R) Knee

CATEGORY OF TREATMENT

☐ EMERGENT
☐ URGENT
☐ NON-URGENT

TIME: 1440

INITIALS: [redacted] bb-2

VITAL SIGNS

TIME	1440	1450			
BP	123/70	123/70			
PULSE	104	95			
RESP	12	12			
TEMP					
WT	50kg	100			

LAB ORDERS

CBC/DIFF	AB[redacted]	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
500	10mg MSO4 given	[redacted]	bb-2		

DISPOSITION: ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

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

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name – last, first, middle; ID 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)

[redacted] bb-4 [redacted]

MEDCOM - 8356

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

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

S. Transfer from FAST team. See all notes. No new issues

O. Wound evaluated by Lt. [redacted] b6-2

A: ① s/p ⓡ tib/fib fx (bullet) & ex-fix .. NVI.
② s/p ⓛ knee I&D
③ s/p ⓛ LE I&D

P: Admit to ICW/orth. - Dr [redacted] b6-2

b6-2

CONSULT WITH	TIME	ACTION

DIAGNOSIS

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

[redacted] DO MAJ/MC

PROVIDER SIGNATURE AND STAMP

CODES

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

EPW [redacted] b6-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

[redacted]

558-103

(See Instructions on Back of this Sheet)

NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL DATE DAY	MONTH	YR.	TIME
12	06	03	1455

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

CURRENT MEDS. (Tetanus immunization and other data)

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES

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

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): Iraqi C.V

SEX: M

AGE:

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER

VITAL SIGNS			
TIME			
BP			
PULSE			
RESP.			
TEMP.			
WT. (Child)			

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

ORDERS	INITS.	TIME

ASSESSMENT/DIAGNOSIS

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

S: Find #0085 Iraqi civilian - here F/u X-rays s/p Ex Fix (R) LE s/p GSW; D/c 26 May 03

O: Amb NWB (R) LE c Ex Fix in place
New x-rays (R) LE (3 views)
D/w Ortho - films - 3 more wks then F/u new films

A: slow healing Tib/fib fx s/p GSW (R)

P: As above
F/3 wks, further new film
cont NWB (R) LE
D/w ER - stop 11 flex

C: Deferred

[redacted] bb-2
CPT, SC
28CSH

DISPOSITION (Check all that apply)
- HOME
- FULL DUTY
- QUARTERS: 24 Hrs. / 48 Hrs. / 72 Hrs.
- MODIFIED DUTY UNTIL: DAY / MONTH / YEAR
- REFERRED TO (Indicate clinic)
- EMERGENCY
- TODAY
- 72 HOURS
- ROUTINE
- ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
- IMPROVED
- UNCHANGED
- DETERIORATED

TIME OF RELEASE:

(CONTINUE ON SF 507, IF NEEDED)

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

[redacted] bb-4

SIGNATURE OF PROVIDER AND STAMP [redacted] CPT, SC 28CSH

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

bb-2

EMERGENCY CARE AND TREATMENT

MEDCOM - 8358

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

MEDICAL RECORD	**PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT** For use of this form, see AR 40-407; the proponent agency is The Office of the Surgeon General.
1. AGE: [redacted] HEIGHT: WEIGHT: 65kg	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): Metiepine - hives
	3. PREVIOUS SURGERY [ ] NO [X] YES (type): Tonsillectomy - OREF

4. PROPOSED SURGICAL PROCEDURE:

IKD / Adj. Ex Fix

5. ADDITIONAL INFORMATION:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to Surg procedure, long. barrier	✓ Pt. verbalizes any specific anxiety. ✓ Pt. exhibits relaxed body posture.	o Allow pt. to verbalize freely. o Explain OR environment and answer questions regarding surgery. o Offer comfort measures, (e.g., warm blanket, touch) o Explain all nursing procedures before they are done. o Remain with pt. whenever possible. o Maintain family interface.
B. AERATION ✓ Potential for respiratory dysfunction due to hx smoking 1½ ppd.	✓ PT. will be able to breathe without difficulty during immediate intra-operative phase.	o Offer to elevate head of litter or offer pillow. o Observe pt. while awaiting surgery for signs of distress o Assist anesthesia during intubation and extubation
C. INTEGUMENT ✓ Potential impairment of skin integuity due to positioning, pooling of prep fluid.	✓ PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	✓ Utilize pressure preventing devices on OR table and accessories. ✓ Check for proper positioning and support to maintain good body alignment. ✓ Pad pressure points. ✓ Place ESU ground pad on non compromised skin surface area. ✓ Keep prep fluids from pooling.

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

[redacted] b6-4 [redacted]

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to positioning, safety devices	✓ Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	✓ Check for support stockings or ace wraps. If none, check with doctors. ✓ Check that safety straps are correctly applied. ✓ Offer pillow for under knees. ~~Place and take down legs from stirrups with slow bilateral motion.~~ ✓ Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to sedation E.2. ✓ Potential discomfort due to positioning	✓ 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, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. ✓ Disminished visual perception due to being sedated F.2. ✓ Potential for decreased communictaion due to sedation, lang barrier F.3. Potential injury due to dentures. NONE	✓ 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 communications. ~~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. [redacted]S COMPLETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted] 30 Apr 03 DATE

11. POSTOPERATIVE EVALUATION:
bb-2

12. PREOPERTIVE EVALUATION PREPARED BY	13. PREOPERTIVE EVALUATION PREPARED
(S[redacted] bb-2 DATE: 30 Apr 03 TIME: 0745	BY (Signature and Title) [redacted] bb-2 DATE: 30 Apr 03 TIME:

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.0

MEDICAL RECORD — **INTRAOPER...VE ...UMENT**

For use of this form, see AR 40-66, the proponent age..., 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] b6-2

3. DATE 30 APR 03 TIME PATIENT ARRIVED IN SUITE 1150

4. PATIENT IN ROOM TIME 1150 NUMBER [redacted]

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:
NPO, Allergic to metephrine.

6. NURSING PERSONNEL

ASSIGNED SCRUB	[redacted] SPC	RELIEF SCRUB	
ASSIGNED CIRCULATOR	b6-2 [redacted] CPT [redacted] CPT	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

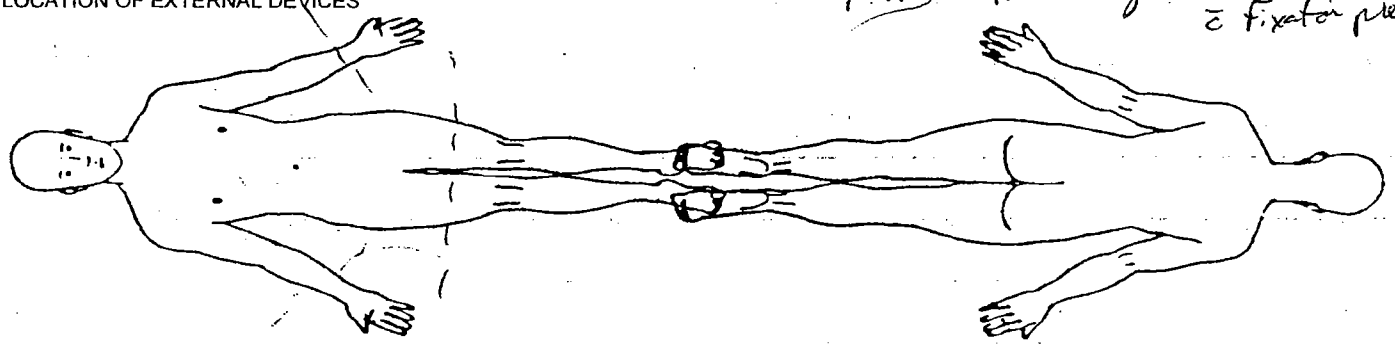
HAIR REMOVAL [ ] YES [X] NO
DONE BY: [ ] OR [ ] NURSING UNIT
METHOD: [ ] DEPILATORY [ ] RAZOR [ ] CLIP

COMMENTS:

PREP SOLUTION *(Specify)*
SITE: Beta/Beta BY WHOM: CPT [redacted]
SITE: (R) Tib/Fib BY WHOM: CPT [redacted] b6-2

COMMENTS: prepped upper thigh to foot; c̄ Fixator prepped

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap === Tourniquet

C = Correct I = Incorrect

b6-2

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	[X] Yes [ ] No				[redacted] SPC	[redacted] CPT
Needle Sharp	[ ] Yes [X] 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;)*

[redacted] b6-4

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

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

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

[ ] BIPOLAR NO: _____

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

Hoffman II Ex-fix Bar ↳ 5029-8-830X1 / CMS # 05 11301 Load

Upper insert 4920-1-010X2

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NACL

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE [redacted] b6-2

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

YES ☐ NO ☒

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs, Kerlix, Ace

19. ADDITIONAL INFORMATION

Surgeon: [redacted], MAJ b6-2

Anesthesia: [redacted], LTC

START 1125 END: 1155

20. OPERATION(S) PERFORMED

I & D (R) Tib/Fib / Ext. Fixator Adjustment

21. PATIENT TRANSFERRED TO ICW [redacted] b6-2 TIME METHOD gurney

22. REGISTERED NURSE SIGNATURE [redacted] CPT/AN

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

MEDCOM - 8362

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

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 124 FST Staff

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted] b6-2

3. DATE 29 Apr 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 2157 NUMBER 25

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: EPW

6. NURSING PERSONNEL

ASSIGNED SCRUB	SGT [redacted] b6-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

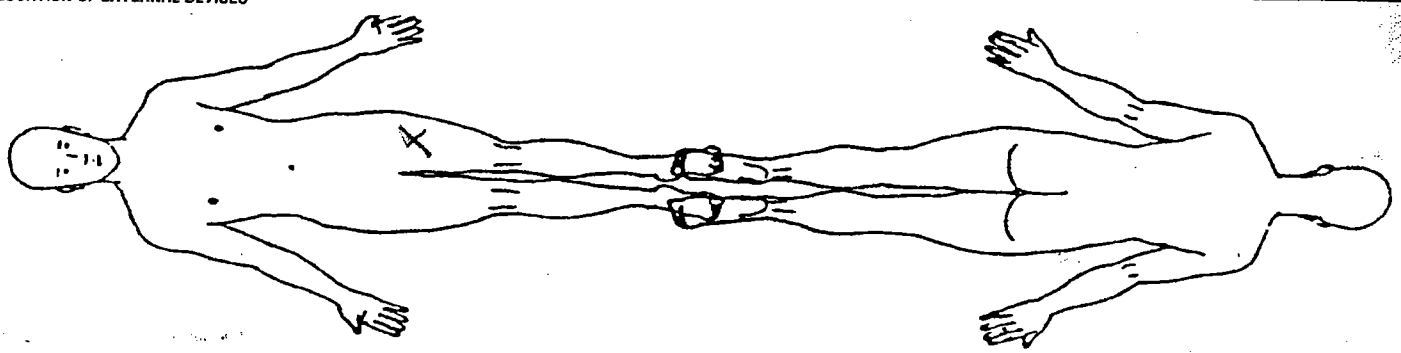
COMMENTS: on litter, blanket under head.

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Beta / Beta b6-2
SITE: Bilateral legs BY WHOM: CPT [redacted]
SITE: BY WHOM:
COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap - - - Tourniquet

10. COUNTS

C – Correct I – Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	[X] Yes	[ ] No			C		
Needle Sharp	[X] Yes	[ ] No			C		
Instrument	[ ] Yes	[X] No				SGT [redacted]	CPT [redacted]
Other	[ ] Yes	[X] No					

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

LOG# [redacted] b6-4

SSAN#

NAME:

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

[X] ESU NO: Force 2 30/30
GROUND PAD: BRAND Conmed
LOT NO: 0211272

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

[ ] BIPOLAR NO:

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

Hoffman II ex-fix
Ref # 4920-9-950
Lot # J327141

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NaCl

OTHER ORDERS	TIME	CARRIED OUT BY
16 Fr Foley draining clear yellow urine via gravity	Intraop	CPT [redacted] bb-2

PHYSICIAN'S SIGNATURE [redacted] bb-2 CPT ME

15. X-RAY IN OPERATING [redacted] IF YES, SITE

YES ☐ NO ☒

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	16 Fr Foley		
SITE	to Bladder		

18. DRESSING/IMMOBILIZATION *(Specify)*

4x4, Kerlex – Lt leg.

Xeroform, 4x8, ABD, Kerlex, Ace → Rt leg

19. ADDITIONAL INFORMATION

Surgeons: Dr [redacted] bb-2
Dr [redacted]
Dr [redacted]

Anesthesia [illegible]
BETAE Drawer
[illegible] 2225/2225/2225
[illegible] 2230/2232

Cefazolin 1gm
EPL 150
HO 800

Cl Fluid 1gm
Vallium 5mg
MSO4 15mg
Ketamine 70mg
Scop 100mg

LOG # [redacted] bb-4

SSAN# [illegible] - [illegible] - [illegible] - [illegible] - [illegible]

NAME: [illegible] - [illegible] - [illegible] - [illegible] - [illegible]

20. OPERATION(S) PERFORMED

I & D Lt leg wound. I & D, Ex-fix, Rt tibia

21. PATIENT TRANSFERRED TO	TIME	METHOD
12L FST Post-op		Litter

22. REGISTERED [illegible] [redacted] CPT AJ bb-2

REVE[illegible] [redacted]

USAPA V1.01

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																	
POST- DAY		Apr															
MONTH-YEAR	DAY	29	30	30		MAY 1		1 May		2 May				3 May			
19	HOUR	22	06	22		0600	15	22		6 14 22 17				22	MIDNIGHT 2115		

PULSE (0) / TEMP. F (°): 105°, 104°, 103°, 102°, 101°, 100°, 99°, 98.6°, 98°, 97°, 96°, 95°

PULSE (0): 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	RR	18		16		12	14R	12R		15	17/53	20/65		15/55	12	
BLOOD PRESSURE				98		118/60	110	128/58		47			123/57		114/72	
				12			78			80	12	18	15	13		
	SpO2	98%		99		98.5	99%	99		99%		92%	98%	98	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)*

TOAD 7

EPW [redacted] b6-4

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY

19 | HOUR

May 04 | 5 MAY 03 | 6 May 03 | 7 MAY | 8 MAY | 9 May | 10 MAY

PULSE (O) — TEMP. F (•) — TEMP. C

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

CW #[redacted] b6-4

STANDARD FORM 511 (REV. 7-95) BACK

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY

19 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

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.

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

[redacted] b6-4

MEDCOM - 8367

511-119 NSN 7540-00-634-4124

MEDICAL RECORD [redacted] VITAL SIGNS RECORD

b6-4

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY: 14 May, 15 May, 16 May, 17 May, 18 May, 19

May 15 2003 HOUR

PULSE (O) | TEMP. F (°) | TEMP. C

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD RR

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)*

[redacted] b6-4

REGISTER NO.

WARD NO. ICW2

T-1

VITAL SIGNS RECORDS

Medical Record

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

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] # [redacted] b6-4

CIV

b6-2

NURSING UNIT	ROOM	BED NO.
[redacted]	[redacted] 2LT AN	APR 31 03

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
4/30/03	1200 HOURS	
X XR - AP+LAT of (R) TIBIA		[redacted] b6-2
X Regular Diet		
X Pt for gait training NWB (R) LE		
X Resume Prehop M[redacted] b6-2		30 Apr/03 1220
X Routine Vitals		

PATIENT IDENTIFICATION

NURSING UNIT	ROOM	BED NO.
[redacted]	[redacted] 2LT AN	2 MAY 03

DATE OF ORDER	TIME OF ORDER	
01 MAY 03	1000 HOURS	
D CHANGE ANCEF to CLINDAMYCIN 900g IVPB q 8°		Noted + sent Mayo
[redacted] b6-2 IV/m LOWM [redacted] RC		[redacted] b6-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM	BED NO.
2AP V [redacted]	[redacted]	AN 0155 6MAY03

DATE OF ORDER	TIME OF ORDER	
5/5/03	0800 HOURS	Noted 5 May
D/C to ASMC		[redacted]
		b6-2 [redacted]

PATIENT IDENTIFICATION

CIV # [redacted] b6-4

NURSING UNIT	ROOM	BED NO.
ICW 2AP V	[redacted] b6-2	0400 03

DATE OF ORDER	TIME OF ORDER	
5/6/03	0800 HOURS	Sent + Noted
- D/C clindamycin		5/6/03 0835
- start Keflex 500mg BID PO		
- D/C heplock [redacted] b6-2		[redacted]

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
Civ # [redacted] b6-4			5/7/03	1430 HOURS	
			- Daily Dressing Δ's to Right leg. [redacted] b6-2		noted [redacted] 24
NURSING UNIT	ROOM NO.	BED NO.			
ICW	Alone @ 0012		5/8/03 [redacted] b6-2		

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
			5/9/03	1430 HOURS	
			XR - (R) TIBIA - 2V DONE [redacted] b6-2		noted [redacted] 24
NURSING UNIT	ROOM NO.	BED NO.			
Alone @ 0225		5/10/03	[redacted] b6-2		

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

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

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

CIV # [redacted] b6-4

NURSING UNIT: ICW 2 | ROOM NO. | BED NO.

DATE OF ORDER: 5/11/03 | TIME OF ORDER: 1300 HOURS | LIST TIME ORDER NOTED AND SIGN

- Admit ICW-2
- Stable
- Routine vitals
- Ambulate q 3°
- Regular Diet
- Refer 500mg BID po

PATIENT IDENTIFICATION

CIV # [redacted] b6-4

24°VS [redacted] b6-2

NURSING UNIT: ICW2 | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

T #3 Tiqo q4' pm

- Daily dsmp to dry during change a pm come to Right leg [redacted] b6-

5/12/03 0210

PATIENT IDENTIFICATION

CIV # [redacted] b6-4

ICW 2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 21MAY03 | TIME OF ORDER: 1500 HOURS

① ~~Kep~~ Kaopectate 2 tbls x 1 now.

V.O. [redacted] b(6)-2 [redacted] b6-2

24°VS 2300 23 May 03

PATIENT IDENTIFICATION

CIV # [redacted] b6-4

ICW 2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 5/25/03 | TIME OF ORDER: 1530 HOURS

XR - (R) leg 2V

[redacted] b6-2

25 May 1540

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] Verified 04/03 25 May 03

b6-4 [redacted]

NURSING UNIT | ROOM [redacted] BED NO.

DATE OF ORDER: 25 May 03 TIME OF ORDER: 0400 HOURS

VO DR [redacted] b6-2

(1) Tylenol 325 mg III (3) tabs PO

X 1 now

Taken by [redacted] b6 2

X Signature MD

DO 24 V done

LIST TIME ORDER NOTED AND SIGN

PATIENT IDENTIFICATION

b6-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDE [redacted] HOURS | b6-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

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

Doctor's Orders—Post-OP EPW[redacted] OP[redacted]

Nurse Complete	Dr.'s Select	
		DATE: 27 APR 03 TIME: 2320
☐	☒	1. Admit to: ☐ OR ☒ PACU ☐ ICW ☐ Patient Holding
☐	☒	2. Diagnosis: S/P I:D AND BY FIX @ LCG ; I:D @ LCG
☐	☒	3. Condition: ☐ Critical ☐ Guarded ☒ Stable ☐ VSI ☐ SI
☐	☐	4. Allergies: See SF 558
☐	☒	5. Vitals: ☒ Unit SOP ☐ Notify Dr. for SBP < ___ or > ___, DBP < ___ or > ___, HR < ___ or > ___, RR < ___ or > ___, or Temp > ___
☐	☒	6. Activities: ☒ Bed Rest, ☐ BRP, ☐ OOB ASAP w/ assist, ☐ Sit up and dangle when stable ☐ Other:
		7. NRSG:
☐	☐	a. Propaq monitor w/ Pulse-ox
☐	☒	b. O_2 to maintain SAT's above 94%
☐	☐	c. Maintain Vent settings at MODE=_____ Vt=_____ RR=_____ PEEP= FIO_2=
☐	☒	d. ☒ Reinforce or ☐ Change dressing for bleed-through X1 then notify Dr.
☐	☐	e. I's & O's
☐	☐	c. Suction NT ETT PRN
☐	☐	d. CT to ☐ H_2O seal or ☐ Suction at ___
☐	☒	8. Diet: ☐ NPO ☐ Clear fluids as tolerated ☒ Other: AS TO RCG
☐	☒	9. IV: ☐ NS or ☒ LR TRA 75 cc/hr ☐ DEXTRAN or ☐ Hespan X 500 cc bolus titrated then ___ cc/hr ☐ Albumin 100cc X ___ TRA ___ cc/hr ☐ When tolerating PO fluids, complete current fluid then SL.
☐	☐	10. BLOOD: ☐ T&S or ☐ T&C ___ units ☐ Transfuse ___ units ☐ PRBCs or ☐ Whole Blood
		11. Medications:
☐	☐	a. Tobramycin 300mg IV Q12hrs X | e ☐ Ceftriaxone 750 mg IV
☐	☐	b. Clindamycin 600mg IV | f ☐ PEN G 2 million Units IV
☐	☒	c. Cefazolin 1 gram IV q8° 24-08-16
☐	☒	d. Phenergan 12-25mg Titrate ☒ IV ☐ IM Q4hrs PRN nausea/vomiting
☐	☐	g. Droperidol 1mg ☐ IV ☐ IM X 1 PRN Nausea/Vomiting
☐	☒	h. MSO_4 1-3mg Titrate ☒ IV ☐ IM Q10min PRN Pain
☐	☐	i. Robinul 0.1mg IV X 1
☐	☐	j. Zantac 50 mg ☐ IV or ☐ IM or ☐ 6.25mg/hr infusion
☐	☐	k. Tetanus Immune Globulin
☐	☒	l. Toradol ☒ IV 30mg or ☐ IM 60 mg q8° 24-08-16
☐	☐	m. Maintain sedation/paralysis w/ Rocuronium and MSO_4 PER SOP
☐	☐	12. LABS: a. iSTAT ☐ Glucose ☐ ABG ☐ BMP ☐ CMP
		13. Additional:
		- FOLEY TO GRAVITY; CMPT; RECORD q SHIFT/PRN - @ PB/RO FILMS' in AM
		b6-2
		Signature: [redacted] LTC, MC

LOG# [redacted] PT NAME: PT SSAN#

b6-4

10JAN03

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

EPW

[redacted] b6-4

DATE OF ORDER: 28 Apr 03 | TIME OF ORDER: 1530 b6-2 HOURS | LIST TIME ORDER NOTED AND SIGN

✓ ① Adt: Orth. - D [redacted]

✓ ② Dx: multiple GSW ⓡ LE fx c ex-fix

✓ ③ Cat: stable

✓ ④ Vitals: c-sh pt

✓ ⑤ Act: MKA

✓ ⑥ Activity: bedrest

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

✓ ⑦ Nursing: dressing Δ by Orth. neurovascular ✓ b/l feet/L LE q4 hrs

✓ ⑧ Diet: ~~NPO~~ Regular ~~until further notice~~ NPO PMN

✓ ⑨ IV: ~~KVO (1R)~~ Heplock IV

✓ ⑩ Meds: morphine 2mg IV q4° prn pain ✓

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

b6-2

✓ ⑪ Other orders per Dr. [redacted] / Orthos

✓ ⑫ Ancef 1.0 gm IV q 8 hrs

next dose @ 1800 hrs today.. [redacted] b6-2 morphine Fr/ Sp on med

NURSING UNIT | ROOM NO. | BED NO.

✓ ⑬ Foley catheter to gravity

PATIENT IDENTIFICATION

DATE OF ORDER: 28 APR 03 | TIME OF ORDER: 2200 HOURS

✓ ① Tylox I-II po q4-6° prn pain.

[redacted] b6-2

b6-2

NURSING UNIT | ROOM NO. | BED NO.

Chart ✓ done [redacted] 28 APR 03 0030

Reviewed for Order, PT [redacted]

Medical Director

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

MEDCOM - 8374

b6-2

B3

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.	Month APR 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 28	29	30	1	2	3	4	5	6	7	8	9	10
28	[redacted]	Vitals: q shift	10	[redacted]												
			22													
28	[redacted]	Act: BR	10													
			22													
[redacted]																
28	[redacted]	Neuro V check feet/LE q 4°	05													
			09													
			1300													
			1700													
1			2100													
			0100													
28	[redacted]	Diet: Regular	6													
			12													
			18													
28	[redacted]	HLIV	6													03
			14													
			20													
[redacted]																
30.	[redacted]	PT for gait training NWB (R) LE	05													
			17													
7 May	[redacted]	Daily Dressing Δ to (R) Leg	13													

b6-2

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: Shrapnel Wound Fx/ RLE ExFix

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

EPW [redacted] b6-4
Civ

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

b6-2

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo APR Yr 03

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
28	[redacted]	Admit: Ortho - [redacted] b6-2 FCW				[redacted]
		Dx: MGSW ®LE fx c̄ ex-fix				
		Cond: stable				
28		NPO p MN b6-2	28APR			[redacted]
28		Ortho order per Dr. [redacted]				
30		Resume previous prop meds				
30		Xray - AP & LAT of ® tibia	30April	Today		
3May		N/C to ASMC		ASAP		
9May	[redacted]	XR - ® Tibia - 2V	9May	ASAP	5MAY03	[redacted]

b6-2

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

USAPA V1.00

Verify by Initialing		THE UTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo May Yr 2003
Order Date	Clerk Nurse	b6-2 SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
[redacted]	[redacted]	ADMIT ICW 2 : STABLE	11		1300	[redacted] b6-2

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
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USAPA V1.00

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 05 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 11	12	13	14	15	16	17	18	19	20	21	22	23	24
11	[redacted]	Routine Vitals	6	[redacted]													
			14														
			21														
11	[redacted]	AMBULATE Q 2°	6														
			14														
			21														
11	[redacted]	Regular DIET	6														
			11														
			17														
11	[redacted]	Daily Damp to Dry	18														
		Dressing Δ AND PIN CARE															
		TO (R) LE															

b6-2

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/P I&D & ex fix

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

QIV # [redacted] b6-4 [redacted]

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

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. 5 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 25	26	27
11	[redacted]	vitals routine	06	[redacted]		
			14			
			22			
			1			
11	[redacted]	ambulate @ 3°	06	[redacted]		
			14			
			22			
			1			
11	[redacted]	regular diet	06	[redacted]		
			14			
			22			
			1			
11	[redacted]	daily damp to dry	18	[redacted]		
		dsg Δ and pin	1			
		care to @ LE	1			
			1			

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/P I&D CC ex fix

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

CIV [redacted] b6-4

?

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

b6-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*				Mo _____ Yr 2003
Order Date	Clerk Nurse	b6-2 SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
25	[redacted]	X Ray R leg 2V	25 May	today	1600	[redacted] b6-2
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Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
- - - -	- - - - -															
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USAPA V1.00

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 5	6	7	8	9	10	11	12	13	14	15	16	17	18
1 May	[redacted]	Clindamycin	06	✓													
			14	✓													
			22	[redacted]													
6 May	[redacted]	Keflex 500mg BID PO	10	✓	[redacted]												
			22	✓													

b6-2

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: Shrapnel Wound Fx/ALE Ex Fix

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

~~EPW~~/LIV # [redacted] b6-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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													
28	[redacted]	MSO4 6mg IV q4°	A	5 May												
			T	2400												
			D	4mg												
			I	[redacted]												
28	[redacted]	Tylox 1-2 po q 4-6	A	5 May	6 May	6 May	6 May	6 MAY	6 MAY	7 May	7 May	7 May	8 May	8 May	5/8/03	5/8/03
			T	2000	0445	0905	1305	1830	2220	0400	0945	1515	2000	0240	0140	1200
			D	II	II	II	II	II	II	II	II	II	II	II	II	II
			I	[redacted]												
5/8	[redacted]	Tylox 1-2 po q 4-6°	D	5 May	5 May	5 May	5 May	5 May	7 May	7 May					(B)	(C)
			T	0112	0340	0701	0451	1845	2355	0530	1220					
			O	2	2	II	II	II	II	II	II TID					
			I	[redacted]												
							E									

USAPA V1.00

CLINICAL RECORD

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

Mo. APR Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED													
				28	29	30	1	2	3	4	5						
28	[redacted]	Ancef: 1GM IV q8°	6	[redacted]													
	.....	1st dose 1800 today	14	[redacted]													
	.....		22	[redacted]													
1 May	[redacted]	Clindamycin 900mg	06				[redacted]										
	.....	IVPB q8°	14														
	.....		22														
	.....																
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ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: Shrapnel Wound Fx / RLE Ex Fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

EPN [redacted] 66-4

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													
28	[redacted]	MsO4 6mg IV q 4°	D T	29Apr 1145	1May 1050	1May 1430	1May 2230	2May 0300	2May 0530	5/2 0600	5/2 1415	2May 2105	3May 0100	3May 0400	3May 1100	3May 1800
			D I	6mg	2mg	1mg	6mg	1mg	1mg	2mg	1415	3mg	3mg	3mg	3mg	1mg
			F/E		E	E	E	E	E	E	E	E	E	E	E	E
28	[redacted]	Tylox 1-2 po q 4-6°	D T	29Apr 0200	29Apr 1630	30Apr 0545	30Apr 1645	30Apr 2140	1May 0330	1May 0820	1May 1200	1May 1740	2May 2100	2May 0830	2May 1230	2May 1630
			P I													
			F/E	E							E				E	E
28	[redacted]	Tylox x 1-2 po q 4-6°	D T	2May 2245	3May 0300	3May 0900	03May 1310	03May 2010	04May 0115	4m 0715	4May 1010	4May 1705	4May 2100	5May 0430	5May 0945	5May 1415
			D I													
28	[redacted]	MsO4 6mg IV q 4°	D T	3May 1900	3May 2110	3May 2245	3May 0330	03May 0820	03May 1330	04May 1830	04May 2300	5May 0145	5May 1520	5May 1800		
			D I	3mg	3mg	3mg	3mg	3mg	3mg	3mg	3mg	3mg	3mg	4mg		

USAPA V1.00

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 5 Yr. 03

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

b6-2

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED												
				25	26	27										
11	[redacted]	Keflex 500 mg PO	07	[redacted]												
		BID	19													

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/P I&D C exc

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted] b6-4

CIV

[redacted]

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				Mo. May Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
25 May	[redacted]	Tylenol 325mg TII (3) tabs po x 1 now	25 May	0400	0400	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED													

USAPA V1.00

Verify by Initialing	THERA C DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. 5 Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
b-2 21May	[redacted]	Kaopectate ii tabs xi now.	21May	1500	1500	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
11	[redacted]	T#3 ii po Q4°	11May 1630 ii	12May 0230 ii	12May ½ po	12May ii 23	13May ii	13May 1845 ii	14May 0600 ii	14May 1250 ii		14May 2030 ii		15May 0400 ii		
		PRN	[redacted]													
b-2 11May	[redacted]	T#3 ii po q4° (recopied)	11May 0600 ii po	11May 1800 ii	12May 0400 ii	12May 0400 ii po	12May 1410	12May 2125 ii po	13May 0230 ii po	13May 0745 ii po	13May 0100 ii	[redacted]		14May 0400 ii po	14May 0930 ii po	
			[redacted]													
11May	[redacted]	T#3 ii po q4° (recopied)	11May 0930 ii po	12May 2300 ii	12May 1215 ii											
			[redacted]													

see below

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. 05 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 11	12	13	14	15	16	17	18	19	20	21	22	23	24
b6-2 11	[redacted]	Keflex 500mg BID PO	18 07	[redacted]													

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: SIP IBD c eaFix

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

CIU [redacted] b6-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

OR Cyc IN 1000 Blood

OR OUT FBL 150 URINE 500

OR MEDS

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE: POST ANESTHESIA CARE UNIT FLOWSHEET

OTSG APPROVED (Date): 17 Jan 80

PROCEDURE: [illegible]

PHYSICIAN: [redacted]

ANESTHESIA BY: [redacted]

Gen Spinal MAC Axillary
Local Bier Epidural Other

ALLERGIES: unk

AIRWAYS: Time DC'D

ETT Nasal Oral Trach

OXYGEN:

Mask Nasal Face Blow-By
Prongs Tent

Liter/min. 6 L/M %

ASA History

Cardiac Rhythm

IV#1 16 Patent Infiltrated
Site L Rate Gauge 16

IV#2 Patent Infiltrated
Site Rate Gauge

b6-2

Time	VITAL SIGNS B/P	P	R	O2SA	Temp	PAR SCORE Act	Resp	Circ	LOC	Skin	PARS	OTHER COMMENTS	Neuro-Vascular
PRE-OP	/												Extr: L R Upper Lower; Pulse DP PT RAD
PRE-OP	1/27	66	15	8	100	97	1	2	2	0	1	6	Blanche Pulse; Warm Moves Y N
2355	1/26	70	16			97	1	2	2	0	1	6	Blanche Pulse; Warm Moves Y N
2355	1/83	17	22	100		97	1	2	2	1	2	8	Blanche Pulse; Warm Moves Y N
0005	1/78	67	22	100		97	2	2	2	1	2	9	Blanche Pulse; Warm Moves Y N
0015	1/81	100	19	100		97	2	2	2	1	2	9	Blanche Pulse; Warm Moves Y N
0025	1/68	86	12	100		98	2	2	2	1	2	9	Blanche Pulse; Warm Moves Y N
0035	1/69	98	16	99		98	2	2	2	1	2	9	Blanche Pulse; Warm Moves Y N
0045	1/61	92	15	98		98	2	2	2	1	2	9	Blanche Pulse; Warm Moves Y N
0055	1/62	97	16	95		97	2	2	2	1	2	9	Blanche Pulse; Warm Moves Y N
	/												Blanche Pulse; Warm Moves Y N
	/												Blanche Pulse; Warm Moves Y N
	/												Blanche Pulse; Warm Moves Y N
	/												Blanche Pulse; Warm Moves Y N

POST ANESTHESIA RECOVERY SCORE "PARS"

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

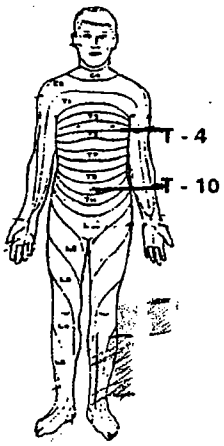
Activity - SAB or Subarachnoid Block
2--Moves all four extremities with control
1--Moves both upper extremities

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

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

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

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



DRESSING:	Status	Location
Gauze	Kling D/E	(L) Knee
Opsite		
Bandaid		
Steri-strips		
Collodian		
Peri-pad		
Coban		
Cotton Balls		
Ace Wrap	Dressing reinforced	
Ex-Fix	Splint	(R) Tibia

TUBES AND DRAINS: Hemovac Foley NGT Chest Jackson-Pratt

(Continue on reverse)

PREPARED BY (Signature [redacted]

b6-2

DEPARTMENT/SERVICE/CLINIC [redacted]

DATE 27 MAR 03

PATIENT'S IDENTIFICATION (For [redacted] give: Name--last, first, middle; grade; date; hospital or medical facility)

LOG#: [redacted]

SSAN#:

NAME:

b6-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTICS STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

FH MDA OP 132-11a (Revised) [illegible] 94

MEDCOM - 8389

b6-2

[redacted]

M AL RECORD-SUPPLEMENTAL MEDICAL DA

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

REPORT TITLE: **PRE-ANESTHETIC EVALUATION** — The proponent is Dept of Surgery

OTSG APPROVED (Date): QI Appr 11 Dec 96

30 APR 03

DATE OF PROPOSED SURGERY	AGE	WEIGHT	ALLERGIES (List react)	FAMILY HISTORY	Tob HX- 1½ PPD	CONSULTATIONS (Check when completed)
Open (R) tib/fib fx	29	65kg	~~☐ NKDA~~ Methepriine - hives.	☒ NO ANES PROB	EtOH- Social	☐ 1
PROPOSED SURGERY	SEX	HEIGHT			DRUGS	☐ 2
I+D / Adjust Ex Fix.	M					☐ 3

PREVIOUS ANESTHESIA/SURGERY ☐ NO PROBLEM: tonsillectomy as child.

MEDICATIONS ☐ NONE * = ORDERED AS PRE-MED: Ancef 1g q 8hr due 06. Allergy meds.

1. CARDIOVASCULAR	5. GI	9. MUSC-SKELETAL	NOTES
☒ No Pathology	☒ No Pathology	☐ No Pathology	☐ See Anesthesia Consult for more details.
☒ Angina	☐ Reflux	☐ Osteoarthritis	☐ Other Medical Conditions (List)
☐ MI	☐ Hiatal Hernia	☐ Rheumatoid Arthritis	
☐ Hypertension	☐ Other	☐ TMJ Disease	
☐ Low Exercise Tol	6. NEURO	☒ Other → Open (R) tib/fib fx.	
☐ Arrhythmia	☒ No Pathology	10. OB/GYN	
☐ CHF	☐ CVA	☒ Non-Preg	
☐ Valvular Disease	☐ Neuropathy	☐ Preg	
☐ CABG	☐ Seizures	☐ EGA	
☐ Periph Vasc Dis	☐ Other	G P	
☐ Other	7. ENDOCRINE	☐ Pre-eclampsia	
2. RESPIRATORY	☒ No Pathology	☐ Other	
☒ No Pathology	☐ Insulin-Dep Diabetes	11. PEDIATRIC	
☒ Asthma	☐ Non-Insulin-Dep Diabetes	☐ Normal Growth Dev	
☐ COPD	☐ Thyroid	☐ < 48 wks PCA	
☐ URI	☐ Steroids	☐ Congenital Defects	
☐ Other	☐ Other	☐ Cerebral Palsy	
3. RENAL	8. HEMATOLOGIC	☐ Other	
☒ No Pathology	☒ No Pathology		
☐ CRF/Renal Insufficiency	☐ Anemia	☐ DENTURES	
☐ Other	☐ Coagulopathy	☐ CONTACTS	
4. HEPATIC	☐ Sickle Cell Dis	☐ PROSTHESIS	
☒ No Pathology	☐ Hx Transfusion		
☐ Hepatitis	☐ Other		
☐ Cirrhosis			
☐ Other			

No seasonal allergies.

PHYSICAL EXAM: HR 94 BP 112/60 T 98° RR 16

AIRWAY: MP 1 (2) 3 4
Teeth Intact - chipped
ROM Full
TMD (FB) <2 2 3 (>3)

HEART: S1S2 RRR

LUNGS: ☒ CTAB

NEURO/BACK:

BLOCK SITE:

VASC ASSESS: (L) arm 20g.

EXT/OTHER:

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

PROBLEM LIST
1. Open tib/fib fx
2. Seasonal Allergies.
3. Smoker

ASA 1 (2) 3 4 5 E

☒ Counselled to remain NPO

PLAN
___ General ___ MAC
✓ Regional: SAB
___ Block:
☐ Post Op ICU/Vent ☐ Awake Intubation
☐ Art Line ☐ CVP ☐ PA
☐ Special Techniques
PREMED:

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

(Continue on reverse)

PR[redacted] CRNA

DEPARTMENT/SERVICE/CLINIC REVIEWED BY:

DATE 30 APR 03.

b6-2

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

EFW [redacted] ICW

[redacted] b6-4

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

[redacted] EDITION IS OBSOLETE

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

DRUG (Units)																		
Midazolam (mg)	2																	
Fentanyl (mcg)	100/50	50/25																
( )																		
( )																		
( )																		
( )																		
VOLAT AGENT % del																		
VOLAT AGENT % e.t.																		
AIR L/Min																		
N2O L/Min																		
SEM O2 L/Min	6	6	6	6														

SPECIFY UNITS - MG/MCG/ML. "1" = CONSTANT INFUSION

NGLE DOSE DRUGS-MARK ON GRID TH NUMBERS & ENTER IN REMARKS

IE site																	
☐ Warmed																	
☐ Warmed																	
☐ ~~Warmed~~																	
☐ Warmed																	
SES EST BLOOD LOSS																	
URINE -																	

S STATUS: 3845 E

Y WEIGHT: 70 KG LB

ATOCRIT:

IAL DATA: 102/50 94

UP CHECK: Y N

PATIENT: or CEDURE? Yes

E- 1106

TIME → 1100 X 1130 X 1200 X 1230 X 1300 X 1330 X 1400

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

220 200 180 160 140 120 100 80 60 40 20

VT - ml					
f - breaths/min	12	12	14	10	
Peak inf pres / PEEP					
MODE - S(pon), A(ssist), C(on)	S	S	S	S	
BP/Auto Cuff ✓	ET CO2 (torr)	Conversation			
BP/oth	FIO2 (Frac or %)	.21	.21	.21	.21
ART line	SpO2 (%)	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR
Gas analyzer	TEMP-site	Axi			
	N-M Block (T/4)	N A			
Warming blkt					
Conv warmer					

with letters & symbols. in under REMARKS

EVENTS Position → 9 a

TOTALS	TOTAL EBL
30	[redacted]
250/0	

TOTAL URINE: Ø

FLUIDS - SUMMARY

CRYSTALLOID- 500 LR

COLLOID- Ø

BLOOD- Ø

REMARKS

Code drugs with numbers, events with letters

(A) Pt in waiting area. ID VS, NPO VS, chart reviewed.

IV: 20, (D) wrist

(B) PT to OR, monitors placed

(E) SAB Portex kit lot # K148315 exp 2004-03

RECOVERY AT:

PACU ICU _____ (Specify)

OTHER _____

CONDITION:

RESP- SpO2- 100

BP- HR-

ANESTHESIA/PROCEDURE TIMES

	Start	Room	End
ANES	1000	1100	1210
	Ready	Begin	End
PROC	1108	1125	1155

OCEDURES and CPT Codes:

I&D / Adjust Ex Fix (R) tib-fib fx

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

BPW [redacted] ICW

b6-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks Pt sitting, area prep drape sterile c̄ betadine. 1.5 cc 1% lido for LAQ L4-5. 25g quincke placed through introducer. Ø heme or paresthesia, on 1st attempt. 12mg hyperbaric bupiV c̄ 25 mcg fent injected c̄ clear sweet c̄ ↑ level T6 @ 5 min

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

SURGEON: Dr [redacted] b6-2

ANESTHETIST: [redacted]

PROCEDURE LOCATION: OR #1

DATE: 30 Apr 03

PAGE 1 OF 1

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

MEDCOM - 8391

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 30 Apr 03
Time In: 1200
Allergies:
Pre-op V/S:
Procedures: I&D

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid ____ Colloid ____
OR Output: UOP N/A EBL Min
Meds/Times:

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds

History

Time	1205	1210	1215	1240	1310	1340
SaO2						
FiO2						
Methods						
240						
220						
200						
180						
160						
140						
120						
100						
80						
60						
40						
20						
P/X	100	100	100	100	100	
RR	18	20	20	18	18	
T	97.5	98.0	98.4	98.3	98.1	

Time						
Pain (0-10)						
LOS						

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC

DATE

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

[redacted] 66-4

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(R) LE	—	—	P	~~[illegible]~~	Warm	Pink
15'	(R) LE	—	—	P	Brisk	WARM	Pink
30'	(R) LE	—	—	P	Brisk	WARM	Pink
45'	(R) LE	—	—	P	Brisk	warm	Pink
60'	(R) LE	—	—	P	Brisk	Warm	Pink
90'	(R) LE	—	—	P	Brisk	Warm	Pink
D/C							

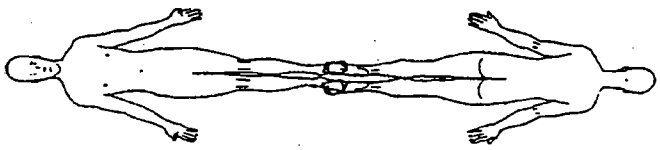
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(R) Leg	gauze & Ace	—
30'	(R) leg	gauze & Ace	—
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

Discharge Criteria:
Date: **Time:** **PARS:**
BP: **T:** **HR:** **RR:** **Sa02:**
Pain Level at D/C (0-10):
Intake:_____ **Output:**_____
Additional Data:_____
Transferred To:_____
Report Given To:_____
Transferred Via: W/C Litter Gurney Ambulance
Transferred By:_____
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:_____

b6-4

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

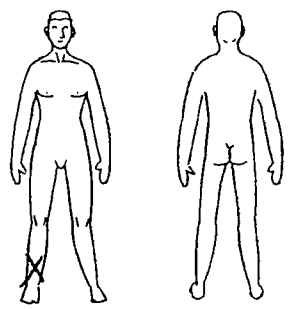
2. UNIT / UNITÉ

FORCE / ÉLÉMENT				NATIONALITY / NATIONALITÉ
A/T	AF/A	N/M	MC/M	

	BC / BC		NBI / BNC		DISEASE / MALADIE		PSYCH / PSYCH

3. INJURY / BLESSURE

FRONT / DEVANT — BACK / ARRIÈRE



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

GSW to [illegible]

[illegible]

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE

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

5. PULSE / POULS	TIME / HEURE	6. TOURNIQUET / GARROT		TIME / HEURE
107	1741	☐ NO / NON	☐ YES / OUI	

7. MORPHINE / MORPHINE		DOSE / DOSE	TIME / HEURE	8. IV / IV	TIME / HEURE
☒ NO / NON	☐ YES / OUI				

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

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

11. PROVIDER / UNIT / OFFICIER MÉDICALE / UNITÉ	DATE/DATE (YYMMDD)
CP: [redacted] 9[illegible] [redacted]	[illegible]0 Mar 03

b6-2

DD Form [illegible] [illegible] form replaces previous editions of DD Form 1380 and DD Form 1380 (TEST), which are obsolete.

DEC 91

U.S. FIELD MEDICAL CARD
FICHE MÉDICALE DE L'AVANT ÉTATS-UNIS

12. REASSESSMENT / RÉASSESSMENT				
DATE / DATE (YYMMDD) 15 May 03		TIME OF ARRIVAL / HEURE D'ARRIVÉE		
TIME / HEURE 1776				
BP / PS 125/70				
PULSE / POULS 112				
RESP / RESP 22 96				

DATE / TIME DATE / HEURE	13. CLINICAL COMMENTS / DIAGNOSIS INFORMATION MÉDICALE / DIAGNOSTIQUES
T: 98.6	
	14. ORDERS / ANTIBIOTICS (Specify) / TETANUS / IV FLUIDS DIRECTIVES MÉDICALES / ANTIBIOTIQUES (Spécifier) / TÉTANOS / IV FLUIDE

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

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

17. RELIGIOUS SERVICES / SERVICES RELIGIEUX				
		BAPTISM / BAPTISÉ		PRAYER / PRIÈRE
		ANOINTING / ONCTION		COMMUNION / COMMUNION
		CONFESSION / CONFESSION		OTHER / AUTRE

CHAPLAIN / CHAPELAIN	

DD Form 1380, DEC 91 (Back)

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	[redacted]	[redacted] b6-4	ENW	M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
	[redacted] 4	X	9	UNK

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
N/A	U	1440	N/A

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
N/A	[redacted]	

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
N/A	U U K		YEAR / X NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø	ICW # 2	UNK

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

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
Ø 5 (b(2)-2)		0 3 0 5 2 5

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
A E A A		0 3 0 5 2 4

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: S/p I&C c ex fx

(R) open Tib/Fib fx

823.92
884.0
891.0
E991.2

86.28
78.17

Dx: 823.90
880.03
891.0
E991.9

Proc: 78.17
77.17
88.29

Shrapnal wnd to (R) upper arm & Broken Tib/fib, GSW to (R) Leg

Inj	Trauma
443	1

ADMITTING OFFICER (Signature, as required) [redacted] b6 2

SIGNATURE OF ADMITTING CLERK [redacted] b6-2

DA FORM [redacted] MAR 80 [redacted]

IN[illegible]IENT TREATMENT RECORD COVER [illegible]ET

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

b6-4

1. REGISTER NUMBER [redacted]			2. NAME (Last-Fir[redacted]			3. GRADE —	ADMISSION REMARKS
4. SEX M	5. AGE —	6. RACE Z	7. RELIGION MUS	8. LENGTH OF SVC —	9. ETS —	10. PREVIOUS ADMISSION NO	
11. FMP —	12. SSN [redacted] b6-4			13. ORGANIZATION —		14. WARD [illegible]	
15. FLYING STATUS —	16. RATING/ DSG —	17. DEPT./ BEN 1748		18. BRANCH/CORPS —	19. UIC/ZIP —	20. TYPE CASE NBI	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from ER				22. HOURS OF ADMISSION 0125	23. CLINIC SERVICE AAAA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK				25. TYPE DISPOSITION ER Camp	26. DATE OF DISPOSITION 04 Nov 03		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK				27b. TELEPHONE NO. UNK	28. DATE OF THIS ADMISSION 01 May 03		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted]					30. DATE OF INITIAL ADMISSION		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DA[redacted] b(2)-2

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: (R) Foreign Injury

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	6	6

36. Total Days All Facilites

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

SIG[redacted]AL OFFICER [redacted] b6-2 SI[redacted]CORDS OFFICER

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A1 1D1	IZ	[redacted]	[redacted] b6-4	—	M

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

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
ZZZ	—	—	

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—	Z	0125	—

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
—	[redacted]	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0	IC02	N/A

		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
		N/A

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
Direct from ER	N/A

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
EPW Camp		030507

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
AAAA		030501

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

FOR LOCAL USE

DX: ① Forearm Injury

Dx: 9593
E9289

ADMITTING [redacted] (Signature, as required)	[redacted] ADMITTING CLERK
[redacted] b6-2	[redacted] b6-2

DA F[redacted] MAR 80 [redacted]

IENT TREATMENT RECORD COVER ET

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

1. REGISTER NUMBER [redacted]			2. NAME (Last, First, MI) UNK			3. GRADE —	ADMISSION REMARKS
4. SEX M	5. AGE [redacted]	6. RACE X	7. RELIGION UNK	8. LENGTH OF SVC —	9. ETS —	10. PREVIOUS ADMISSION NO	
11. FMP 99	12. SSN [redacted] b6		13. ORGANIZATION —			14. WARD TCW1	
15. FLYING STATUS NO	16. RATING/ DSG	17. DEPT./ BEN K78	18. BRANCH/CORPS —	19. UIC/ZIP —		20. TYPE CASE WIA	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct Admission from ER.				22. HOURS OF ADMISSION 2222	23. CLINIC SERVICE AAAA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK			25. TYPE DISPOSITION TRF TO ASMC		26. DATE OF DISPOSITION 5 MAY 2003		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK			27b. TELEPHONE NO. UNK		28. DATE OF THIS ADMISSION 1 May 2003		ADMITTING OFFICER DR. [redacted] b6-2
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b(2)-2					30. DATE OF INTIAL ADMISSION		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

Shot by an Iraqi soldier

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW (L) hand

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	4	4

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING [redacted] ICER [redacted] b6-2 SIGNATU [redacted] b6-2

DA FORM 3647, MAY 79 EDITION OF [redacted]

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

30 y/o (R) MD Iraqi civilian fighting for U.S. Shot 1 week ago by Iraqi soldier

PMHx: ∅
PSHx: ∅
Meds: ∅
Allergies: NKDA
Soc Hx: (R) TMA

PHYSICAL EXAMINATION

(2) wounds
Ext: wound distal radial wrist c̄ smaller palmar wound.

XR:

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

(A) Open, old STT fx's (2) wrist

(P) Admit OR in AM

b6-2

SIGNATURE [redacted]	DATE 3/1/03	IDENTIFICATION NO.	ORGANIZATION

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

[redacted] b6-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
5/1/03	2300: Pt. arrived to floor via litter from EMT. Pt. has ~~cast~~ prior dsng to (L) FA CDI. Cap refill <3sec, fingers warm, UTA pulse 2° dsng. HR Reg. Lungs CTA, BS (+) x4. Pt. denies pain @ this time. LR @ 125 cc/hr. to (R) AC. [redacted] bb-2 1CTAN
5/2/03	0515: Recieved report on Pt. Pt. awake, A+Ox3. IVLR infusing in (R) FA + patent. Dsg on (R) arm DI. Denies any discomfort @ this time [redacted] bb-2
2 may 03 1500	

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] bb-4

PROGRESS NOTES
Medical Record

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

[redacted]

MEDCOM - 8401

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
5/2/03	Brief Op Note
	Pre Op Dx: GSW (L) wrist
	Post Op Dx: same
	Procedure: ED open scaphoid, tourniquet triggered low
	Anesthesia: Axillary block
	Surgeon: Olivero
	EBL: 5
	Fluids: 500 cc
	TT: 40 min
	Post op Pl: IV Abx, return to OR 48° [redacted] bb-2
2 May 03 530	pt. returned from OR in stable condition S/P I&D (L) hand - no c/o pain - cap refill good in fingers, ROM adequate in (L) hand fingers - IV patent, HL - VSS - plan to return to OR in 48° [redacted] CRNA bb-2
2205	Received report on pt - assumed care. Pt awake sitting up in bed. PIV SL'd 18g (R) AC date of insertion unknown, ø evidence infection (+) flush ⊖ Blood return. Clindamycin 900 mg IV T x 30 min per pharm recommend. (+) movement to all digits in (L) hand. (L) arm bandaged, ⊖ bleeding noted. Sensation unable to determine r/t dressing barrier. Cap refill ≤ 3 secs.

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
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USAPA V1.00

[redacted] b6-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	pulse unable to palpate r/t cast. @ arm elevated, @ swelling pt to all fingers. Physical assessment WNL CV S1 S2 regular, pulm lungs clear throughout; BS present x4q. pt voiding clear yellow. @ BS urinal. Pt ambulates w/out difficulty Tol. Po intake [redacted] b6-2
2230	: Pt c/o pain Tylenol # 3 ii tabs Po administered pain eval pending [redacted] b6-2
3MAY03 0546	Vitals Signs taken BP 120/80 P78 T 96.9 R 14 [redacted] SPC [redacted] 91W b6-2
3MAY03 0548	Pt. Alert & oriented. Dsg to @ arm DI. Movement & sensation to @ hand. Ø distress noted. IV LR to @ FA patent. VSS. [redacted] b6-2 91WM6
3May03 1415.	Assumed care of Pt @ 1300. A+O x3. Bandage to (L) UE CDI. (+) sensation, cap refill <3sec, ROM (L) hand. Pt c/o pain, relieved by ii T#3. Pt very cooperative. O/W assessment WNL. Will cont to monitor [redacted] b6-2
4 May03 0100	Assumed pt care @ 2100. Pt A+Ox3, VSS. pt c/o pain in (L) hand, one T3 given for relief. Bandage to (L) UE CDI. All pulses palpable except for lve. LUE has good sensation and ROM, capillary refill ~~<2~~ SS <3 seconds and warm to touch. Pt c/o pain at wrist at 2140, T3 given for relief. Will continue to monitor. SPC [redacted] 91WM6 b6-2
4 May03	0520: Receive report on pt. Pt resting @ this time Ø signs of distress noted [redacted] 91WM6 b6-2

STANDARD FORM 509 (REV. 5/1999) BACK

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PROGRESS NOTES

DATE	
4 May 03	Assumed care of Pt @ 1300. VSS. Awaiting transport to OR
1320.	NPO since midnight. Will cont to monitor [redacted] b6-2
1400.	Pt to OR via stretcher c̄ CRNA [redacted] b6-2
1545	Pt returned from OR after recovery in PACU #2. VSS. Cast on (L) FA/Hand. (+) ROM of fingers (+) cap refill <3 sec (L) UE, b6-2 Denies pain O/W assessment WNL. [redacted]
1600	D/C IV (R) FA. Cath intact. Ass/sx of infection [redacted] b6-2 LTA
5/4/03 2350	Assumed care of pt. @ 2100. Pt. alert. Pt. c/o pain. Pt. given tylenol #3. HR Reg, Lungs CTA. Drsng to (L) FA CDI. Edema noted to (L) hand. Brisk cap refill, (+) sensation, warm to touch, pt able to wiggle fingers BS (+) x4. [redacted] LTAN b6-2
5 May 03	0820 Assume pt care @ 0500. Pt Alert. PERRLA S1S2 audible, regular. Lung sounds CTA. Bowel sounds x4 no c/o pain tenderness (-) distension. (R) Radial present strong regular pedal pulses present. (L) forearm dsg CDI able to wiggle fingers Edema noted of (L) hand. No c/o pain @ this time Kathite RN
5 May 03.	Assumed care of Pt @ 1300. VSS. Cast on (L) FA/HAND INTACT. (+) sensation, ROM of fingers, cap refill <3 sec (L) UE. +1 edema in (L) hand. Denies pain O/W assessment WNL. Will cont to monitor [redacted] b6-2
5 May 03	Pt CAOX3 c̄ clear lungs 4/5 B/P 117/72 R14 P72 T99.2 [illegible]
5 May 03 2115	Assumed care of pt @ 2100. Pt AOX3, VSS, w/o complaints of pain. Lungs sounds CTA with equal rise and fall of chest bilaterally. RUE, LUE, and RLE with palpable pulses. LUE has (+) sensation, with ROM of fingers. (L) forearm dressing CDI. Will continue to monitor. SPC [redacted] b6-2

STANDARD FORM 509 (REV. 7-91) BACK
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MEDICAL RECORD	PROGRESS NOTES
DATE	Transfer Summary.
5/5/03	This Iraqi male sustained a GSW to his left wrist x 2 wks ago. He fractured his left scaphoid, trapezium and trapezoid bones in his wrist. His wounds have been irrigated & debrided twice surgically and are now closed. He will need to be casted from 6-12 weeks total. He needs minimal care at present. In two weeks he should have a cast change and sutures removed from left wrist.
	[redacted] b6-2
	MAJ, MC Orthopaedic Svc
6May03 1900	VSS - no c/o pain - tolerating regular b6-2 diet - awaiting transport [redacted]
2300	Assumed pt care @ 2100. Pt vss, AOx3, no complaints of pain. Lung sounds CTA with equal rise and fall of chest, Bowel sounds present x4 quadrants. Dressing on LFA CDI. fingers + sensation, ROM, and capillary refill <3 seconds. Will continue to monitor.
7May03 0610	Vital signs taken BP 120/82 P70 T96.1 R16 b6-2 SPC [redacted] 911

(Continue on reverse side)

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

REGISTER NO.

WARD NO. ICW2

[redacted] b6-4

PROGRESS NOTES
Medical Record

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

DATE	
7 May 03	0730: Pt. A&O x 3, VSS. Dsg on (R) arm CDI. Denies any discomfort — [redacted] 4 ward —
7 May 03 1300	Assumed care of Pt @ 1300. VSS A&O x 3. Dressing (L) arm CDI. Denies pain. Up ad lib. O/W assessment WNL Will Monitor — [redacted]
7 May 03 1400	Pt vitals taken BP 102/70 P-88, R-20, Temp 98.6 SPO [redacted]
2130	Assumed care of PT @ 2100. PT. A&O. Pt c/o ∅ pain. HR Reg, lungs CTA throughout. BS (+) x 4. ↓ edema noted in (L) hand. cap refill < 3 sec. Pt able to wiggle fingers. Cast CDI. VTA pulse (L) hand 2° cast. — [redacted]
8 May 03 0730	Vital signs taken BP 122/72 P64 T96.8 R12 - SPO [redacted] —
080740 May 03	Pt is awake, alert, Ox3. Airway is patent. Breath sounds are clear to all fields. Abd is soft, nontender and ∅ distention. BS (+) x 4. Pt is voiding ∅ spontaneously. (R) LE + (R) UE has good cap refill, FROM, and strong pulses. (L) UE has splint c̄ ACE that is CDI. Pt has feeling to fingertips and can move thumb. Cap refill to (L) UE is brisk. Pt has no complaints at this time. Pt has no IV access — [redacted]
8 May 03 1330	Assumed pt care @ 1330. pt sitting ↑ in bed Awake & alert. lung sounds CTA bilat c̄ equal rise & fall of chest. abd soft, ∅ distention noted. BS (+) x 4 quads (L) forearm & hand c̄ cast. (+) ROM of fingers. ∅ complaint of pain @ this time. Will cont to monitor — [redacted]
8 MAY 03 1400	Pt vitals taken. BP 102/68 P. 96, R. 18, Temp, 98.4 SPO [redacted]
8 May 03 1900	pt resting ∅ complaints voiced — [redacted]

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
8May03 2040	pt resting c̄ eyes closed. ⊖ signs of distress [redacted] b6-2 noted @ this time [redacted] 91WM4
8 May 03 2115	Assumed care of pt. Pt resting quietly w bed. No evidence discomfort. ⊖ PIV, O_2 per RA. ⊖ Hand cast, ⊖ sensation ⊖ movement. 1+ edema to hand & digits. Cap refill ≤3 sec. color normal for race. Pt alert, oriented
02/22	pleasant and cooperative. CV: S1S2 present regular, ⊖ dyspnea
96	(error gw)
RR 14	~~color normal for race~~ ⊖ swelling of extremities. Resp: ⊖ RD
T: 96.8	⊖ evidence SOB, ⊖ cough, lungs clear throughout, chest
99%	movement symmetrical & equal. NSD; BS x 4 q, ⊖ pain, ⊖
	abd dist. GU: Pt using ward commode. Voq to monitor during shift. BLE muscle strength good, ambulates w/out assist. [redacted] b6-2 No apparent needs @ this time
	0200: Pt sleeping quietly [redacted]
	0410: ⊖ Δ's, pt cont. sleeping w/o evidence of discomfort [redacted] b6-2
09053 May 03	Pt's assessment unchanged from previous assessment. AROM to ⊖ LE and ⊖ UE, limited ROM to ⊖ LEs ~~at~~ ⊖ hand is neurovascularly intact. Pt denies pain. Tolerated PO well. [redacted] b6-2
0720	Vital signs taken BP 120/70 P90 T96.5 R12 SPO [redacted] 91
9 MAY 03	Pt vitals taken BP 110/62, P.96, R.20, TEMP 98.1
1400	SPO [redacted] b6-2
9 May 03	[redacted] a-ged-VSS-voiding & stooling S
2000	difficulty-tolerating regular diet-
	dsg intact on ⊖ hand [redacted] A b6-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO. IW2

[redacted] b6-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
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PROGRESS NOTES

DATE	
9 May 03 2140	Assumed care of pt 2100. Pt sitting up in bed, alert, oriented in good spirits (smiling) Ø evidence. (+) L FA cast, CD&I, unable to palpate radial A/T cast. Color normal for race. (+) sensation, (+) movement of digits. It swelling to hand. pt denies pain @ this time. CV: SR52 Regular (-) swelling to BLE, or generalized. cap refill ≤ 3 sec (R) hand. lung sounds clear Bilaterally (-) evidence, Resp diff. (+) BS x 4 q. pt tol PO Reg diet intake. Pt ambulates w/out assist. Pain control being monitored. [redacted] b6-2
	0155: Pt sleeping quietly. Ø evidence discomfort [redacted] b6-2
10 May 03	Assume care @ 0500. VSS. Lungs CTA. + BS x 4 quad.
0600	Cast on (R) arm CD&I. Denied any discomfort [redacted] b6-2
1320	Wake pt for VS. Pt CAOx3. Ø obvious distress (-) C/O PD. Pt state cold. Give pt another Blanket. VS BP 120/90, R 16 BCTA. P 93 R. T. 97.3° [redacted] SPC ECW b6-2
10 May 03	discharged to aircrew mb - VSS -
1530	discharged ambulatory [redacted] b6-2

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

558-104

7540-01-075-378

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER | TREATMENT FACILITY

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)* 01 May 03 | TIME 2120

TRANSPORTATION TO FACILITY Air Evac

SEX M

DUTY/LOCAL PHONE: AREA CODE | NUMBER

AGE [redacted]

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: None

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: today 010503 | COMPLETED INITIAL SERIES ☐ YES ☒ NO

CHIEF COMPLAINT: GSW 7day old (L) hand

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☐ NON-URGENT

TIME

INITIALS

VITAL SIGNS

TIME	2120				
BP	124/78				
PULSE	104				
RESP	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	

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
2151	Tetanus Ancef 1gm IV	[redacted]	bb-2		
2154	1000 ml LR				
2230	5mg morphine IV				

DISPOSITION: ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

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

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

EPW

[redacted] bb-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)

[redacted]

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

TEST RESULTS

CBC		SMAC		ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
WBC				SUP O2	PH	PO2	RESULTS fragments & Fx's of ~~Navicular~~ Scaphoid	
H/H				PCO2	SAT	OTHER		
PLT								
PT				U/A	DIP		EKG INTERPRETATION	
APTT	BHCG	ETOH	GLU		MICRO			

PROVIDER HISTORY/PHYSICAL

GSW 7 day old GSW (intraarticular). MSO4 10mg @ 1910
Ø other complications

(D) - a x O x 3 NAD
Lgs = CTA (P) ♡ = Reg ABD = NABS ND NT
Back = Ø injury Lower Ext = Ø Ext. Injury
(L) hand: Dorsal 3x4cm wound @ Radial distal point of D/C
• Palmar 1x1cm wound proximal to thenar eminence.

CONSULT WITH	TIME	ACTION	RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP
ortho			
			PROVIDER SIGNATURE AND STAMP [redacted] b6-2

DIAGNOSIS
GSW intraarticular (L) hand Fx.

CODES

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

[redacted] b6-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

[redacted]

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: [redacted] HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): NKDA 3. PREVIOUS SURGERY [X] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE:
(L) hand

5. ADDITIONAL INFORMATION: Last PO - 0630 this am Smokes
MSDS - Ø
Ø Family

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL X Potential for anxiety related to _____	✓ 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.
B. AERATION X Potential for respiratory dysfunction due to _____	✓ PT. will be able to breathe without difficulty during immediate intra-operative phase.	✓ Offer to elevate head of litter or offer pillow. ✓ Observe pt. while awaiting surgery for signs of distress ✓ Assist anesthesia during ~~intubation and extubation~~ Ax S/K c̄ sedation
C. INTEGUMENT X Potential impairment of skin integuity due to _____	✓ PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	✓ Utilize pressure preventing devices on OR table and accessories. ✓ Check for proper positioning and support to maintain good body alignment. ✓ Pad pressure points. ✓ Place ESU ground pad on non compromised skin surface area. ✓ Keep prep fluids from pooling.

9. PATIENT'S IDENTIFICATION (For typed or written entries give: Name- last, first, middle; grade; date; hospital or medical facility)
[redacted] 66-4

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

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

66-2 _____ [redacted] _____ 2 May 03 DATE

11. POSTOPERATIVE EVALUATION:

Pt AOX3

(L) Axillary block intact

begin daylight

TQ/SJW pulses clear

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title) [redacted]

DATE: 2 May 03 TIME: 1100 66-2

13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title) [redacted]

DATE: 2 May 03 TIME: 1350 66-2

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.0

MEDICAL RECORD — **INTRAOPER/ DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA litter BY OR Staff

2. PATIENT IDENTIFI [redacted] OCEDURE
VERIFIED BY [redacted] CRNA

3. DATE 2 May 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROO [redacted] b6-2 TIME 1235 NUMBER 2-1 of 4

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: Ø

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] b6-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Hand Table (L)

8. SKIN PREPARATION

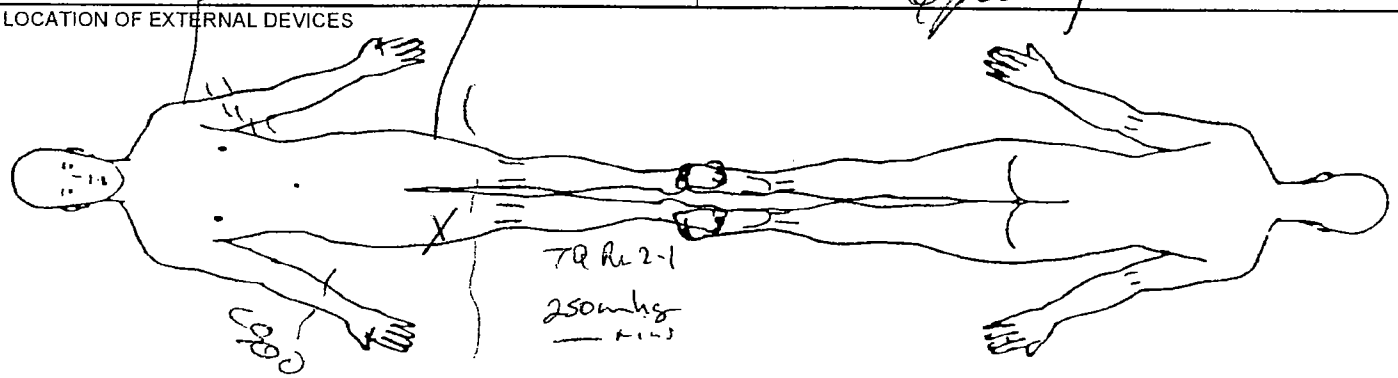
HAIR REMOVAL ☐ YES ☑ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine/Betadine
SITE: (L) arm BY WHOM:
SITE: BY WHOM [redacted]

COMMENTS: Ø grading

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes	☐ No				[redacted]	[redacted]
Needle Sharp	☑ Yes	☐ No		C	C		
Instrument	☐ Yes	☑ No					
Other	☐ Yes	☑ No					

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

[redacted] b6-4

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

☑ ESU NO: Rt 2-1
GROUND PAD: BRAND Valley Lab
LOT NO: 20494H 2195 20/20

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):
NACL

OTHER ORDERS	TIME	CARRIED OUT BY
Ø		

PHYSICIAN'S SIGNATURE [redacted] b6-2

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

TYPE/SIZE	1. Ⓛ hand	2.	3.
SITE	1. 2x2	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Phillips Kerlix splint Mat'l
ACE

19. ADDITIONAL INFORMATION
WC
Surgeons: [redacted], b6-2, Anesthesia: [redacted]
Anesthesia Type: Ax 5/4 c̄ sedation

Bovie Pad site intact pre-op Clear; post-op Clear Bovie Settings: Coag/Cut 20/20
Tourniquet Site intact pre-op Clear: post-op Clear
Tourniquet Time: Up 1752 Down____

20. OPERATION(S) PERFORMED
I & D Ⓛ hand

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU	1350	litter

22. REGISTERED NURSE SIGNATURE [redacted] RN, AN
b6-2

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

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA LITTER BY ANESTHESIA	2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] bb-2
3. DATE 4 may 03 TIME PATIENT ARRIVED IN SUITE 1321	4. PATIENT IN ROOM TIME 1330 NUMBER [redacted]

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: None, NPO ☆ MN. Ø complaints

6. NURSING PERSONNEL

ASSIGNED SCRUB	MAJ [redacted] AN bb-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ [redacted] AN	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* PT placed in OR bed. arms on Arm boards <90° strapped.

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

COMMENTS: STRAP ABOVE KNEES. WARM SHEETS USED.

8. SKIN PREPARATION

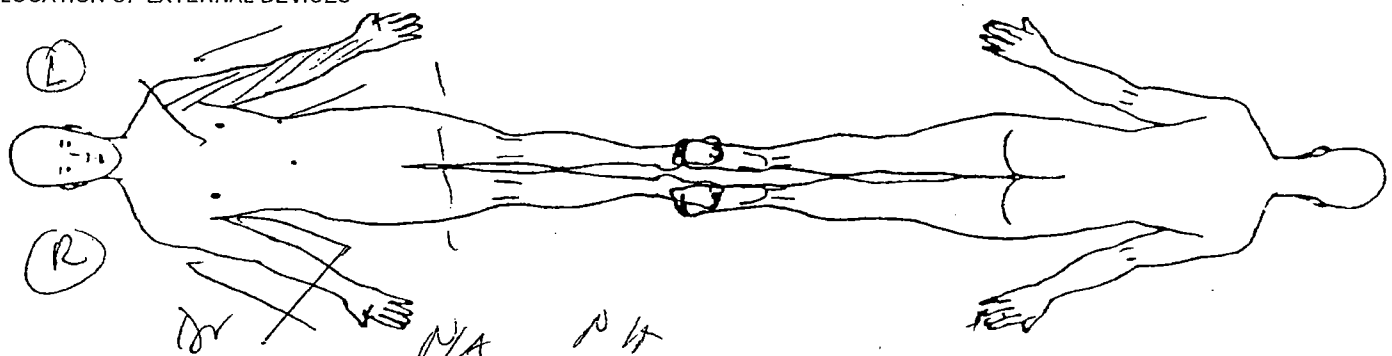
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* BETA / BETA
SITE: LEFT ARM BY WHOM: [redacted]
SITE: BY WHOM:

COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB bb-2	CIRCULATOR
Sponge	☒ Yes ☐ No		C	C	[redacted]	[redacted]
Needle Sharp	☒ Yes ☐ No		C	C		
Instrument	☐ Yes ☒ No				MAJ [redacted]	MAJ
Other	☐ Yes ☒ No					

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

EPW [redacted] bb-4

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

☐ ESU NO: _____
GROUND PAD: BRAND _____
LOT NO: _____

☐ ESU NO: _____
GROUND PAD: BRAND _____
LOT NO: _____

☐ BIPOLAR NO: _____

MEDICAL RECORD — **INTRAOPER/ OCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA LITTER BY ANESTHESIA	2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] b6-2
3. DATE 4 may 03 TIME PATIENT ARRIVED IN SUITE 1321	4. PATIENT IN ROOM TIME 1330 NUMBER [redacted]

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: None, NPO P MN. Ø complaints

6. NURSING PERSONNEL

ASSIGNED SCRUB	MAJ [redacted] AN b6-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ [redacted] AN	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt placed in OR bed. Arms on Arm boards <90° strapped.

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

COMMENTS: STRAP ABOVE KNEES. WARM SHEETS USED.

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

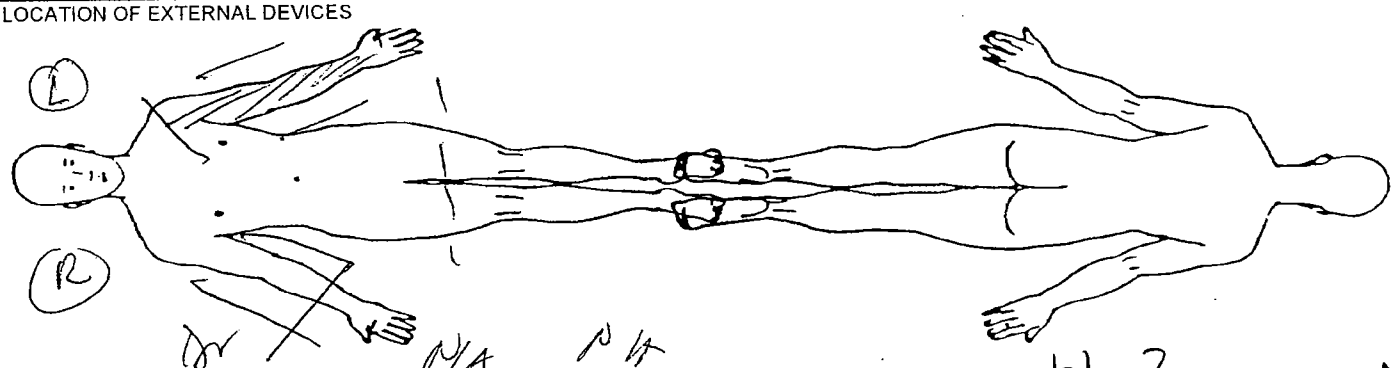
PREP SOLUTION *(Specify)* BETA / BETA

SITE: LEFT ARM BY WHOM: [redacted]

SITE: BY WHOM:

COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap N/A === Tourniquet N/A

b6-2

10. COUNTS

C = Correct I = Incorrect

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

EPW [redacted] b6-4

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

☐ ESU NO: _____

GROUND PAD: BRAND _____

LOT NO: _____

☐ ESU NO: _____

GROUND PAD: BRAND _____

LOT NO: _____

☐ BIPOLAR NO: _____

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

NS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE [redacted] b6-2

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

YES ☐ NO ☒

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*

fluff
Kerlix - Fiberglass
ACE Cast

19. ADDITIONAL INFORMATION

WC
Surgeons: [redacted] b6-2 Anesthesia: [redacted] Anesthesia Type: General

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

20. OPERATION(S) PERFORMED

I & D of (L) wrist wound.

21. PATIENT TRANSFERRED TO ICU TIME 1430 METHOD LITTER

22. REGISTERED NURSE SIGNATURE [redacted] b6-2

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY 8 MAR 03 9 10 May 03

19 HOUR 8 5

PULSE (0)	TEMP. F (°)	TEMP. C
	105°	40.6°
180	104°	40.0°
170	103°	39.4°
160	102°	38.9°
150	101°	38.3°
140	100°	37.8°
130	99°	37.2°
	98.6°	37.0°
120	98°	36.7°
110	97°	36.1°
100	96°	35.6°
90	95°	35.0°
80		
70		
60		
50		
40		

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD RR 12 18 16

BLOOD PRESSURE 100/70 120/70 120/70 106/72

SpO2 99 98

HEIGHT: WEIGHT →

Record special data only when so ordered

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

[redacted] b6-4

REGISTER NO.

WARD NO. ICW2

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY

MAY 2003 HOUR

PULSE (0)	TEMP. F (°)	TEMP. C
	105°	40.6°
180	104°	40.0°
170	103°	39.4°
160	102°	38.9°
150	101°	38.3°
140	100°	37.8°
130	99°	37.2°
	98.6°	37.0°
120	98°	36.7°
110	97°	36.1°
100	96°	35.6°
90	95°	35.0°
80		
70		
60		
50		
40		

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

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)*

[redacted] 06-4

REGISTER NO.

WARD NO. TCW2

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

CAL RECORD-SUPPLEMENTAL MEDIC A A

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

REPORT TITLE: **PRE-ANESTHETIC EVALUATION**
The proponent is Dept of Surgery

OTSG APPROVED (Date): QI Appr 11 Dec 96

DATE OF PROPOSED SURGERY	AGE	WEIGHT	ALLERGIES (List react)	FAMILY HISTORY	Tob HX- F 1 ppd	CONSULTATIONS (Check when completed)
2 May 03	[redacted]	210	☐ NKDA None	☐ NO ANES PROB ∅	EtOH- Pt drinks ½ bottle/week	☐ 1 ☐ 2 ☐ 3
PROPOSED SURGERY: I&D (L) wrist	SEX: M	HEIGHT			DRUGS	

PREVIOUS ANESTHESIA/SURGERY ☐ NO PROBLEM: 6

MEDICATIONS ☐ NONE * = ORDERED AS PRE-MED: 6 Clindamycin 900mg IVPB, Ancef 1gm IVPB, Maxipime

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

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

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

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

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

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

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

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

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

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

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

- ☐ DENTURES
- ☐ CONTACTS
- ☐ PROSTHESIS

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

PHYSICAL EXAM: HR 85 BP 128/78; 99 T 98.6 RR

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

HEART:

LUNGS: ☐ CTAB

NEURO/BACK:

BLOCK SITE:

VASC ASSESS: 185 (R) AC

EXT/OTHER:

Na	Cl	glu	ECG ☐ WNL
K	CO_2	BUN/Cr	
WBC 7.0	Hct 10.7/33.9	plts 301	
PT	PTT	βHCG	CXR ☐ WNL
ABG			

PFT

OTHER bb-2

PROBLEM LIST: Pt counseled for Anesthesia & interpreter. 0630 ate breakfast

ASA (1) 2 3 4 5 E

☐ Counselled to remain NPO

PLAN: Gen as B/U
____ General ____ MAC
____ Regional:
X Block: (L) Ax Block
☐ Post Op ICU/Vent ☐ Awake Intubation
☐ Art Line ☐ CVP ☐ PA
☐ Special Techniques
PREMED:

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

(Continue on reverse)

PRE[redacted] Title): CPT CRNA

DEPARTMENT/SERVICE/CLINIC REVIEWED BY: Anesthesia

DATE: 2 May 03

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

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

DA FORM 4700 PREVIOUS EDITION IS OBSOLETE

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

DRUG (Units)																		
Versed	(mg)	2			11	1												
Fent	(mcg)	50			50	50	50	50										
Prop	(mg)					100												
Sux	(mg)					100												
	( )																	
	( )																	
VOLAT AGENT	Forane % del					1.0	.5	.5 X										
	% e.t.																	
AIR	L/Min	RA	RA															
N2O	L/Min																	
O2	L/Min				6	2	2	2 – 10										

SPECIFY UNITS - MG/MCG/ML. "I" = CONSTANT INFUSION

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

IV site															
(R) arm LR	☐ Warmed				LL		1000								
	☐ Warmed														
	☐ Warmed														
	☐ Warmed														
EST BLOOD LOSS															
URINE -															

TOTALS	TOTAL EBL
5 kg	min
250	
100	TOTAL URINE
100	Ø

FLUIDS - SUMMARY
CRYSTALLOID- 500cc
COLLOID- Ø
BLOOD- Ø

REMARKS
Code drugs with numbers, events with letters

1145 Ax Block on ICW #2 Monitors Applied IV Set Ams Versed 50 mcg Fent Ax Block - 22g B Bevel (1½") Needle Trunk arterial Tech Ø paresthesia reported intermittent aspiration ⊖ q. 5 ml of local Ø S/Sx of systemic injection 5 ml inj region of muscle & cutaneous nerve 10 ml inj for wrist block
1235 Pt brought in room from ICW via litter. ⊕ monitors. PP parded, Ams < 90a
1245 Lunch relief/S1 LTC JSH
1250 RSI
1335 Pt awake extubated SO2 Pt transfer to ICW to 21 Report to
TQ↑ 1250 250 mtt
TQ↓ 1330
TTT - 40 min

PATIENT STATUS	TIME	1145	1200	15	30	45	1300	15	30	45	1400
2345 E	VT - ml					—	650	680	670	400	
WEIGHT: 70 KG LB	f - breaths/min					14	7	7	7	12	
HEMATOCRIT: 10.7 / 33.9	Peak inf pres / PEEP					—	16	16	16	—	
VITAL DATA: 128 / 78	MODE - S(pon), A(ssist), C(on)					S	C	C	C	S	
75	BP/Auto Cuff	ET CO2 (torr)					33	35	33	30	
WAKE-UP CHECK: Y N	BP/oth	FIO2 (Frac or %)	.21	.21		>.21	.67	.67	.66	.66	
PATIENT: Okay	ART line	SpO2 (%)	100	100		100	100	98	100	100	
Surgeon: 1230	Steth-PCWES	ECG									
	Gas analyzer	TEMP-site									
		N-M Block (T/4)									
	Warming blkt										
	Conv warmer										

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

220 / 200 / 180 / 160 / 140 / 120 / 100 / 80 / 60 / 40 / 20

↑ 250 Torr

[redacted] — O.K. Never mind!

4/4 TST

with letters & symbols. EVENTS
in under REMARKS Position →

RECOVERY AT: 1342
PACU ICU #2 (Specify)
OTHER
CONDITION: Stable
RESP- 12 SpO2- 100%
BP- 121/67 HR- 81

ANESTHESIA/PROCEDURE TIMES

	Start	Room	End
ANES	1145	1235	1345
	Ready	Begin	End
PROC	1240	1253	1335

PROCEDURES and CPT Codes:
I+D (L) wrist

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
Ax Block c̄ Mix 5 ml 0.1% Tetracaine & 1% 1:100 Epi Tap

PATIENT IDENTIFICATION: Typed or written entries: Name, Grade/Rate, Medical facility
EPW [redacted] (ICW)
bb-4

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments Simple Mask
SO ET 4 uncf DV Ø Trauma RSI
⊕ ETCO2 ⊕ BBS Secured ⊕ Ø Aus.

SURGEONS: Dr. [redacted] bb-2

ANES: [redacted] LAT CANA bb-2

PROCEDURE LOCATION: OR #2
DATE: 2 MAY 03
PAGE 1 OF 1

A FORM 7389, FEB 1998 MEDCOM - 8421 [redacted] PATIENT'S MEDICAL RECORD USAPA V1.00

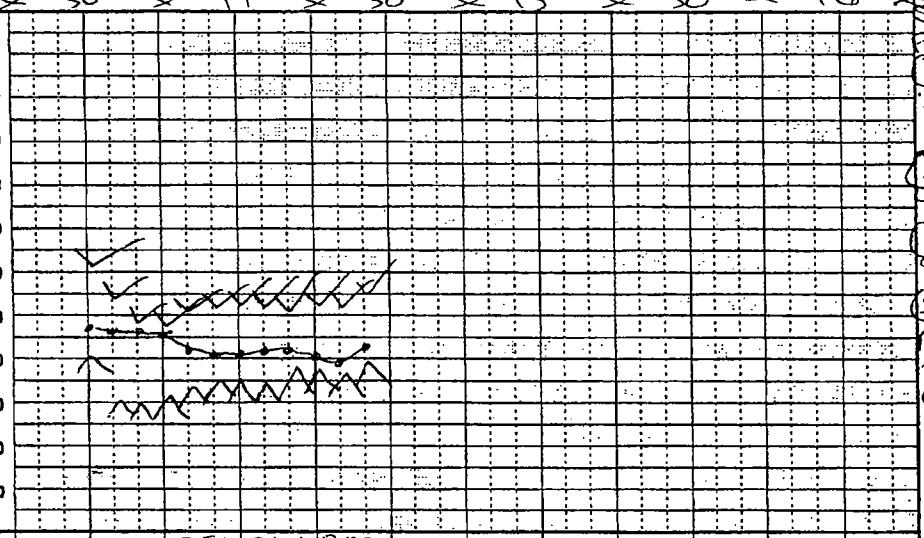
For use of ... ...l, see AR 40-66; the proponent agency is the OTS

DRUG (Units)														TOTALS	TOTAL EBL
midaz (mg)	3													3	min
propofol (mg)		200													
MSO4 (mg)		2	2	2/2	2									10	TOTAL URINE
( )															Ø
( )															
( )															
VOLAT AGENT Sevo % del		2.0	1.0	1.0	0.5X									FLUIDS - SUMMARY	
% e.t.														CRYSTALLOID- 500	
AIR L/Min															
N2O L/Min														COLLOID- Ø	
O2 L/Min		6-2	2	2	2-6										
NGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS		(1) (2)	(3) (4)											BLOOD- Ø	
IE site 20g RAC ☐ Warmed		NS			400	500								REMARKS	
☐ Warmed														Code drugs with numbers, events with letters	
☐ ~~Warmed~~															
☐ Warmed															
SES EST BLOOD LOSS		min													
URINE -		Ø													

✓ chart, ID, & pt. No interval change
(1) To room, SOC mons, preO2.
(2) Smooth IV indx & LMA placement.
(3) Ondansetron 4mg IV.
(4) Cleocin 900mg IVPB.
(5) LMA removed & trf to ICU for recovery. O2 2lpm via nasal prongs.

S STATUS 2345 E

TIME → x 30 x 14 x 30 x 15 x 30 x 16



Y WEIGHT: 70 (KG) LB
ATOCRIT: 34
IAL DATA: 123, 84 / 94
UIP CHECK: Y N
PATIENT: y
or CEDURE? y
E: 1300

VT - ml		200	250	340	300	
f - breaths/min		18	18	18	16	
Peak inf pres / PEEP						
MODE - S(pon), A(ssist), C(on)		S	S	S	S	S
BP/Auto Cuff	ET CO2 (torr)	34	34	36	34	36
BP/oth	FIO2 (Frac or %)	0.7	0.7	0.7	0.7	0.7
ART line	SpO2 (%)	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site available					
	N-M Block (T/4)					
Warming blkt						
Conv warmer						

with letters & symbols. in under REMARKS — EVENTS Position →

RECOVERY AT:
PACU ICU 2 (Specify)
OTHER comfortable
CONDITION: Good
RESP- 27 SpO2- 100
BP- 125/82 HR- 86

ANESTHESIA/PROCEDURE TIMES

	Start	Room	End
ANES	1310	1330	1440
	Ready	Begin	End
PROC	1340	1400	1425

OCEDURES and CPT Codes:
I & D Lt hand

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
GLMA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* Eyes taped, a+rauma #4 LMA, pmt, ⊕ETCO2, B/S ET B. Soft bite block.

IENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*
EPW [redacted] b6-4

SURGEON: [redacted] b6-2

ANES: [redacted] CRNA

PROCEDURE LOCATION: 2-1
DATE: 3/4/03
PAGE 1 OF 1

A FORM 7389, FEB 1998 MEDCOM - 8422 COPY 1 - PATIENT'S MEDICAL RECORD USAPA V1.00

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] bb-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 1 May 03 TIME OF ORDER: 2222 HOURS

1. Admit to ICW = ORTHO
2. Dx = ⊕ hand GSW ō Sephard Rt
3. Cond = Stable
4. VS = q shift
5. Allergies = NKDA
6. Act = Ab lib per SPW Protocol
7. Nursing = Dsg Care
8. Diet = Reg as tolerated
9. IV = heplock — LR @ 125 cc/hr
10. Meds = MSO4 2mg IV q 15 min up to 8 per hour PRN pain
11. Ancef 1 gm IV q 8° (2200 1st done) 6-14-22
12. Tylenol 325 mg ii po q 6° PRN pain

[redacted] bb-2 / [redacted] MAJ, MC FAMILY PRACTICE bb-2

PATIENT IDENTIFICATION

[redacted] bb-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 1 May 03 TIME OF ORDER: HOURS

1. D/C Ancef
2. Clindamycin 900 mg IV TID next dose 0600
3. NPO ~ midnight.

[redacted] bb-2 / [redacted] MAJ MC bb-2

PATIENT IDENTIFICATION

Ø38

NURSING UNIT	ROOM NO.	BED NO.
Chart ✓	[redacted] 0408	3 May 03

DATE OF ORDER: 5/2/03 1400 TIME OF ORDER: 24° VS [redacted] HOURS

1. up ad lib
2. stable — routine vitals
3. Heplock IV
4. Clindamycin 900 mg IV q 8°
5. T#3 ii q 3-4° PRN
6. Percocet 5/325 IV q 4° PRN breakthrough
7. Regular Diet

JTAN 5/1/03 2330 [redacted] bb-2 2 May 03 1530

24° VS [redacted] bb-2

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WH[redacted]

GO MEDCOM - 8423 710

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b6-4

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 5/3/03 TIME OF ORDER 2100 HOURS

- NPO 4 MN
- 5/4/03 1430
- Up ad lib
- Routine vitals
- D/c Clindamycin
- ~~Hydrocod~~ D/c IV
- T#3 PO 5-4 PRN pain

LIST TIME ORDER NOTED AND SIGN

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

- Dulcolax 10mg PR PRN constipation
- Regular Diet
- Celebrex 200mg QID
- XR - (L) wrist - 3 views in cast
- D/c in AM
- [redacted]

24° VS [redacted] 5/4/03 0100.

b6-2

PATIENT IDENTIFICATION

b6-2

24° V [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 5/5/03 TIME OF ORDER 0800 HOURS

- D/c to ASMC today.

5/5/03 2345.

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

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

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 5 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 1	2	3	4	5	6	7	8	9	10
5/1/03	[redacted]	VS Q shift (cont 4May03)	05	X	[redacted]								
			13										
			21										
5/1/03	[redacted]	Act = Ad lib per EPW protocol (cont 4May03)	05	X	[redacted]								
			13	X									
			21										
5/1/03	[redacted]	Dsg care	05	[redacted]									
			13										
			21										
5/1/03	[redacted]	Reg diet as tol. (Cont 4May03)	05	/	[redacted]								
5/2/03	[redacted]		13	/									
			21	/									

b6-2

Dc'd 12 May 03

ALLERGIES: ☐ YES ☐ NO	PRIMARY DIAGNOSIS:	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
NKDA	DX (L) hand GSW c̄ Siphoid Fx.	PAGE NO:

PATIENT IDENTIFICATION:

[redacted] b6-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 5 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
5/1	[redacted]	Admit to ICW = ortho	5/1	2 300		[redacted]
	-----	Stable.				
5/1	[redacted]	NPO P Midnight	5/2	0000		[redacted]
5/4	[redacted]	XR - (L) wrist 3 views in cast	5/4		1630	[redacted]
5/4	[redacted]	D/C in AM	5	AM		

Do 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. 5 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 1	2	3	4	5	6	7	8	9	10
5/1/03	[redacted]	LR @ 125cc/hr.	05	X	[redacted]								
			13	X									
			21	[redacted]									
5/1/03	[redacted]	Ancef 1 gm IVq 8° (2200 last dose	06	X									
			14	X									
			22	[redacted]									
5/1/03	[redacted]	Clindamycin 900mg IV TID next dose @ 0600	06	X	[redacted]								
			14	X									
			22	X									
			/										
2may	[redacted]	heplock IV	05	/	/	[redacted]							
			13	/	/								
			21	/									
4may	[redacted]	Keflex 500mg QID	10	/	/	/	/	[redacted]					
			18	/	/	/	/						
			14	/	/	/	/						
			24	/	/	/	/						

66-2

DC'd 2may03

DC'd 5/1/03

D/C 5/4/03

D/C IV 5/4/03

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: G SW @ hand & Xiphoid Fx.

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted] 66-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
5/1 5/9	[redacted]	MSO4 2mg IV q														
		15 min up to 8 per														
		hour PRN pain														
5/1	[redacted]	Tylenol 325mg ii														
		PO q 6° PRN pain														
2 may 5 may	[redacted]	Tylenol #3 ii	2 May 1815	2 May 2215	3 May 1300				3 may 03 2140	4 May 0215						
		4 may PO prn - pain q4°	[redacted]						[redacted]							
2 may 5 may	[redacted]	Demerol 50mg IM														
		q4° prn - breakthrough														

DC'd 2 May 03

USAPA V1.00

66-4

1. [redacted] | RANK / GRADE | MALE / HOMME | FEMALE / FEMME

SSN / NUMÉRO MATRICULE [redacted] | SPECIALTY CODE / GPM | RELIGION / RELIGION

2. UNIT / UNITÉ

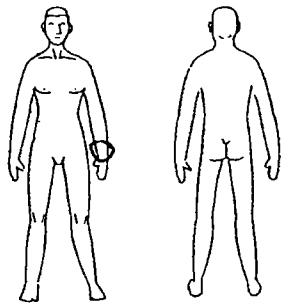
FORCE / ÉLÉMENT | NATIONALITY / NATIONALITÉ

A/T | AF/A | N/M | MC/M

BC / BC | NBI / BNC | DISEASE / MALADIE | PSYCH / PSYCH

3. INJURY / BLESSURE

FRONT / DEVANT | BACK / ARRIÈRE



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

GSW (L) wrist

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE

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

5. PULSE / POULS | TIME / HEURE

6. TOURNIQUET / GARROT: NO / NON [ ] YES / OUI [ ] | TIME / HEURE

7. MORPHINE / MORPHINE: NO / NON [ ] YES / OUI [✓] | DOSE / DOSE | TIME / HEURE

8. IV / IV | TIME / HEURE

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

GSW (L) wrist (Intra-articular)
x 7 days.
No TREATment
Morphine 10mg @ 1910

10. DISPOSITION / DISPOSITION

- RETURNED TO DUTY / RETOUR À L'UNITÉ
- EVACUATED / EVACUÉ
- DECEASED / DÉCÉDÉ

TIME / HEURE

11. PROVIDER / UNIT / OFFICIER MÉDICALE / UNITÉ | DATE/DATE (YYMMDD)

DD Form 1380, DEC 91 — *This form replaces previous editions of DD Form 1380 and DD Form 1380 (TEST), which are obsolete.*

U.S. FIELD MEDICAL CARD
FICHE MÉDICALE DE L'AVANT ÉTATS-UNIS

[redacted]

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 4 May 03
Time In: 1430
Allergies: NKDA
Pre-op V/S:
Procedures: I/D (L) HAND

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 500 Colloid
OR Output: UOP 0 EBL min
Meds/Times:

Zofran
10 MSO4
4 Zofran
Clocor given

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds

History

Time	1430	1435	1440	1445	1500	1515	1530
SaO2	100	99	100	100	98	100	97
FiO2		2L	2L	2L	RA		
Methods	NC	NC	NC	NC			
240							
220							
200							
180							
160							
140							
120							
100							
80							
60							
40							
20							
RR	10	12	12	12	13	12	
T	96						
Time	1430						
Pain (0-10)							
LOS							

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

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

(Continue on reverse)

[redacted] b6-2

DEPARTMENT/SERVICE/CLINIC: ICU 2

DATE: 4 May 03

PATIENT S[redacted] (Name — last, first, middle; grade; date; hospital or medical facility)

CPW #[redacted] b6-4

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(L)arm	+	+		B	W	P.
15'	"	"	"		"	"	"
30'	"	"	"		"	"	"
45'	"	"	"		"	"	"
60'	"	"	"		"	"	"
90'							
D/C							

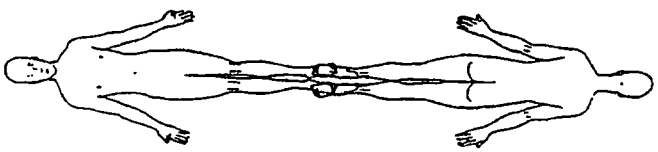
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L)hand	Ace	CDI
30'	"	"	"
60'	"	"	"
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1430	NSR		

WAMC OP 173-E

NURSING NOTES

1430: Arrived to ICU 2 for recovery. VSS. Drsg to (L) FA CDI. ØNIV Ø pain voiced. Onowsy but responds to verbal commands [redacted] b6-2 PTN

1530: No changes Ø pain ØNV Alert follow commands. IVF infusing VSS [redacted] b6-2

Discharge Criteria:
Date: 4MAY03 **Time:** 1530 **PARS:**
BP: 124/79 **T:** 96.8 Ax **HR:** 64 **RR:** 18 **SaO2:** 99% RA
Pain Level at D/C (0-10):
Intake: 200 NS **Output:** Ø
Additional Data:
Transferred To: ICU 2
Report Given To:
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: CPT [redacted] + HA [redacted] b6-2
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED *(Date)*

Date: 2 MAY 03
Time In: 1345
Allergies: NKDA / PPD
Pre-op V/S: P 89 78 BP 85 97 98.6
Procedures: I/D LEFT (H)

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 500 total Colloid
OR Output: UOP Ø EBL MIN
Meds/Times: CLIND / ANCEF

AX BLOCK
PROPOFOL
SUCCS
SUC VERSED
250 MCG FENT

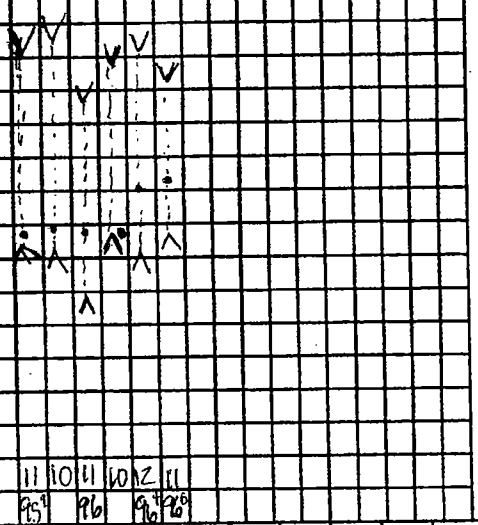
Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds

History

Time	1345															
SaO2	100	100	99	98	98	98	100									
FiO2	NC	RA	RA	RA	RA	RA	RA									
Methods	STC	RA	RA	RA	RA	RA	P									



RR	11	10	11	10	12	11										
T	98.1		96		98.6	98.6										
Time	1345	1500														
Pain (0-10)	Ø	Ø														
LOS																

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

V/S
X = A-line BP
˙ = Cuff BP
= Pulse

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

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

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

(Continue on reverse)

PREPARED BY: [redacted] ILT SN bb-2

DEPARTMENT/SERVICE/CLINIC: ICU#2

DATE: 2 MAY 03

[redacted] *or written entries give: Name – last, grade; date; hospital/medical facility)*

bb-4

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

Time 1345	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(L) Arm	+	+	P	B	C	NL
15'	(L) Arm	+	+	P	B	C	NL
30'	(L) Arm	+	+	P	B	C	NL
45'	(L) Arm	+	+	P	B	C	NL
60'							
90'							
D/C 1500	(L) Arm	+	+	P	B	C	NL

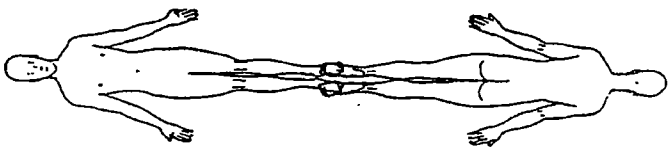
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 1345	(L) Arm	Kerlix & Bandage	Ø
30'			
60'			
D/C 1500	(L) Arm	Kerlix & Bandage	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

1500 Pt alert states mild pain by posturing. Neuro Intact. RESP CTA Bilaterally S1S2 Present. GI BS Present x4. Ø GAS GU Ø VOID. Skin Intact. Dressing to (L) Forearm and Hand Nothing Follow [redacted] b6-2

Discharge Criteria:
Date: 02 MAY 03 **Time:** 1505 **PARS:** 11, 11, 12
BP: 124/74 **T:** 96.6 **HR:** 73 **RR:** 11 **Sa02:** 99
Pain Level at D/C (0-10): MINIMAL
Intake: Ø **Output:** Ø
Additional Data:
Transferred To: ICW 2
Report Given To:
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: [redacted] b6-2
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:

,CAL RECORD-SUPPLEMENTAL MEDIC A

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

REPORT TITLE PRE-ANESTHETIC EVALUATION
The proponent is Dept of Surgery

OTSG APPROVED (Date) QI Appr 11 Dec 96

DATE OF PROPOSED SURGERY	AGE	WEIGHT	ALLERGIES (List react)	FAMILY HISTORY	Tob HX- (+)	CONSULTATIONS (Check when completed)
5/4/03	30	70	☒ NKDA	☒ NO ANES PROB	EtOH- Ø	☐ 1 ☐ 2 ☐ 3 N/A
PROPOSED SURGERY	**SEX**	**HEIGHT**			DRUGS Ø	
I&D Lt Hand	M	—				

PREVIOUS ANESTHESIA/SURGERY ☐ NO PROBLEM
2 May I&D Lt hand ax block (Failed block)

MEDICATIONS ☐ NONE * = ORDERED AS PRE-MED
Heplock IV T#3 PRN
Clindamycin IVPB

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

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

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

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

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

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

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

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

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

10. OB/GYN
- ☒ Non-Preg
- ☐ Preg
- ☐ EGA

G P
- ☐ Pre-eclampsia
- ☐ Other

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

- ☐ DENTURES
- ☐ CONTACTS
- ☐ PROSTHESIS

NOTES
☐ See Anesthesia Consult for more details.
☐ Other Medical Conditions (List)
NPO since MN

PHYSICAL EXAM: HR 72 BP 120/78 T 97.4 RR 14

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

HEART: RRR

LUNGS: ☒ CTAB

NEURO/BACK: N/A

BLOCK SITE: OK

VASC ASSESS: in place

EXT/OTHER:

Na	Cl	glu	ECG ☐ WNL
K	CO_2	BUN/Cr	N/A
WBC 7.0	Hct 34	plts 301	
PT	PTT	βHCG	CXR ☐ WNL
ABG			
PFT			
OTHER			

PROBLEM LIST
1. S/P GSW Lt wrist
2. Smoker
3. For I&D

ASA 1 (2) 3 4 5 E

☐ Counselled to remain NPO

PLAN
☒ General ____ MAC
~~Regional: ax c sedation~~
____ Block: ____
☐ Post Op ICU/Vent ☐ Awake Intubation
☐ Art Line ☐ CVP ☐ PA
☐ Special Techniques
PREMED: See record

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

(Continue on reverse)

PREP [redacted] (Rank, Title) ~~MAS~~ CRNA
bb-2

DEPARTMENT/SERVICE/CLINIC REVIEWED BY:

DATE 5/4/03

PAT [redacted] *DENTIFICAT* [redacted] *typed or* [redacted] *en entries give: Name—last, first, midd* [redacted] *grade; date; hospital or medical facility*
EPW [redacted] bb-4

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

HCN

DA FORM 4700 PREVIOUS EDITION IS OBSOLETE

Ø38

ADMISSION AND CODING INFORMATION

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

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

3. REGISTER NUMBER							NAME (Last, First, Middle Initial)	4. PAY GRADE		5. SEX
9	10	11	12	13	14	15	UNK	16	17	18
[redacted]								—		[redacted]

6. DATE OF BIRTH (YYYYMMDD)								7. AGE AT ADMISSION			8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19	20	21	22	23	24	25	26	27	28	29	30	31	
U	N	K						[redacted]		Y	X	9	Unknown

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—	46: U UNK	2222	— b6-4

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: Ø	ICW1	UNK
[redacted]		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK
		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: UNK

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

b(2)-2

24. CLINIC SVC - ADMITTING				25. MTF TRANSFERRED FROM						26. DATE THIS ADMISSION (YYYYMMDD)							
89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106
A	A	A	A							2	0	0	3	0	5	0	1

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

FOR LOCAL USE

Dx: GSW left hand

814.11
814.15
814.16
E991.2

Dx: 8822
E9912

Px: 7963

ADMITTING OFFICER (Signature as required)

DR. [redacted] b6-2

[redacted] b6-2

DA FORM 2[redacted]

USAPA V1.00

IN[illegible]NT TREATMENT RECORD COVER[illegible]

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

1. REGISTER NUMBER [redacted]	2. NAME (Last, First, MI) [redacted] b6-4			3. GRADE —	ADMISSION REMARKS
4. SEX M	5. AGE [redacted]	6. RACE X	7. RELIGION UNK	8. LENGTH OF SVC —	9. ETS —	10. PREVIOUS ADMISSION NO
11. FMP 99	12. SSN [redacted] b6-4		13. ORGANIZATION —			14. WARD ICW2
15. FLYING STATUS —	16. RATING/DSG —	17. BEN [redacted]	18. BRANCH/CORPS —	19. UIC/ZIP —		20. TYPE CASE WIA

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from the E.R.	22. HOURS OF ADMISSION: 2230	23. CLINIC SERVICE: AEAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: UNK	25. TYPE DISPOSITION: D/C HOME	26. DATE OF DISPOSITION: 6 May 2003	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK	27b. TELEPHONE NO.: UNK	28. DATE OF THIS ADMISSION: 1 MAY 2003	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] b(2)-2		30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DA[illegible]

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

Shot by Iraqi Soldier

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

815.10
882.2
E991.2

79.33
82.86
86.04
79.63

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	5	5

36. Total Days All Facilites

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

SIGNATURE OF A[illegible]

DA FORM [illegible] [redacted]

b6-2

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

29 y/o (R) HD of Iraqi cav. fighting for U.S. shot by Iraqi troops 1 week ago (R) Hand

PMHx: Ø
PSHx Ø
Meds Ø
Allergies NKDA

PHYSICAL EXAMINATION

Ext: Dorsal/palm wounds (R) hand and left stump

[redacted] bb-2

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

(R) Open stump arc Ex (R) Hand, chim
(B) To OR in AM

bb-2

SIGNA[redacted]	DATE	IDENTIFICATION NO.	ORGANIZATION

PATIENT'S IDENTIFICATION *(For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)*	REGISTER NO.	WARD NO.
[redacted] bb-4		

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

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AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
1 May 03 2230	29 yo ♂ civ EPW admitted to ward on stretcher accompanied by EOR staff.
BP: 116/56	Pt admitted for 7-day old gs trauma to (R) hand & (R) arm, & hand splint,
HR: 63	⊖ evidence of drainage, dressing clean dry intact; ⊕ movement, ⊕ sensation
RR: 16	to (R) fingers cap refill to (R) digit ≤3 sec, (R) middle finger healing lac, ⊖ evidence
SPO2: 93%	of infection. Radial pulse unpalpable r/t splinting. Pt denies pain at this
T: 97.4	time, ⊕ elevation. Physical assessment WNL. ⊕ PERRLA (R)/L eyes, 3mm in size;
	lung snds clear bilat throughout, pt on RA; CV: S1, S2 present regular
	⊖ edema noted peripherally. cap refill ≤3 sec, pulses radial (L) & dorsalis
	pedis (L)(R) bilaterally full, reg rhythm symmetrical ea 2+, Abd: ⊕ gurgles & 4 q's.
	Last BM unable to determine r/t language barrier. Pt has not voided
	since arrival to floor (error at) prop; MS: ⊕ firm muscles of bilat LE; (L) UE, ⊕ full ROM, ⊕ passive
	motion resistance remarkable to complete w/ MS assessment to (R) arm
	related to injury. 18g PIV to (L) AC intact, ⊕ flush ⊖ BR. ⊖ evidence
	infiltration; Pt alert, oriented, calm at this time, denies pain ⊖ evidence
	of discomfort. Will cont. to monitor — [redacted] b6-2
0030:	Clindamycin 900mg IV infused over 30 min per pharmacy ~~protocol~~ (error at)
	recommendation. LR @ 100 cc continue as maintenance fluid w/o evidence
	infiltration ~~Restraint to (L) arm in place~~ — [redacted] b6-2
2 May 03	0500: Received report on Patient. Resting @ this
	time w/LR infusing in (R) FA ∃ signs of infection. DSG
	on (R) arm DI. ∅ signs of distress noted. [redacted] b6-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S 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] b6-4

PROGRESS NOTES
Medical Record

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

[redacted]

AST NAME	FIR. ME	MIDD. AL	ID NUMBER

DATE	NOTES
5/2/03	Preop Dx
	Findings: Open (R) 5th arc Rx
	Postop Dx: Same + ant tear + flexor tear Zone III
	Procedure: I+D of wounds of hand
	Surgeon: Chavez
	Anesthesia: MAC
	Fluids: 300 cc
	Findings: I+D. Lac flexor tendon, palmar flexor tendon lac, comminuted 5th arc Fx
	Complications: 0
	Postop Plan: IV Abx, 48 hr return to OR [redacted]
	b6-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

[redacted]

PROGRESS NOTES

DATE	
5/4/03. 2250	Assumed care of Pt. @ 2100. HR Reg, Lungs CTA, BS (+) x4 Pt. c/o nausea. Ø emesis. Cool cloth placed on head, pt. given crackers, tol. well. Pt. c/o pain 5/10. Tylenol #3 given. Drsng to (R) UE CDI. Cap refill < 3sec. Fingers warm. Pt. unable to wiggle last 3 fingers (R) hand. UTA (R) radial pulse 2° drsng. Will cont. to monitor - bb-2 [redacted] AN
5May03 0512	Vitals signs taken BP 118/70 P60 T 98.4 R 14 SPC [redacted] 91W bb-2
5May03	0845 Assume pt care @ 0500. PERRLA. HR regular. Lungs Sounds CTA. Bowel sounds x4. no c/o pain tenderness no distension noted. (L) Radial pulse strong regular. (R) hand DSG CDI able to move thumb and pointer, unable to wiggle last three. Cap refil < 3sec hand warm to touch. pedal pulses present. L extremities full ROM. Heplock (L) arm flushed bb-2 free of s/s infection/infiltration. will continue to monitor [redacted]
5May03	1420 Pt CAOx3 w obvious distress. Pt ambulates [illegible] bb-2 VS B/P 112/72, P63 Reg T 97.7 R16 c/o [illegible] [redacted]
5May03 1430	Assumed care of pt @ 1300. VSS. Dressing on (R) UE CDI. Sticks on (R) UE fingers CDI. (+) sensation, ROM of fingers, cap refill < 3sec. (R) UE [illegible] Assessment WNL. Will bb-2 monitor [redacted]
5May03 2100	Assumed pt care at 2100. Pt A+Ox3, vss, complains of pain at a 1 in Right hand. Pulses palpable, pt has good ROM. Lung sounds CTA, with equal rise and fall of chestwall. Pt has (+) sensation, with capillary refill under 3 seconds. Pt

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