DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	⊖ S/S infection noted. Performed AROM ∃ difficulty. c/o pain x1 ii Tylenol given. ⊕ thigh ~~AE~~ sarcem AE wrap dsg C/D/I. Will cont. to mon. [redacted] RLT/AW (5)(6)-2
2030	DSG w/SD to ⊕ extremities done. RLE dsg-old c̄ scant amt serous drainag. ~~Both~~ Every 3 hrs wound well approximated c̄ healthy pink tissue noted. RLE ctl dsg c̄ scant amount greenish/yellow drainag noted. Wound c̄ healthy pink tissue well approx. noted. New WSD dsg applied. Both dsgs C/D/I. Pt. c/o pain to RLE ∃ Percocet given. Will cont to mon. [redacted] RLT/AW (5)(6)-2
010750 Aug 03	Nursing Assessment: Airway intact, breathing even and unlabored, ~~BS⊕x4~~ LS clear to all fields ⊕. Abd soft, nontender, ∃ distention, BS⊕x4. Urinates spontaneously. ROM to BLE and ⊕ UE, also neurovascularly intact, ⊕ LE has limited ROM to elbow ~~and hand~~ (active and passive). ROM to hand limited actively but FROM passively. Neurologically, unable to gain full movement of 1st through 3rd fingers of ⊕ hand and grip is weak. Neurovascularly intact [redacted] with the
4 Aug 03 1345	pt resting c̄ eyes closed, easily aroused to verbal stimuli. VSS. assessment findings WNL. RUE c̄ drsing CDI, steri strips intact, ⊕ sensation ⊕ pulse, slight movement. ⊕ thigh drsing CDI. ⊘ complaints voiced ⊕ this time. Will cont to monitor — [redacted] Trumble (5)(6)-2
7 Aug 03 2240	Rec'd c/o pt @ 21:00. Restraints x2 ⊕ wrist/ankle. VS WNL per flow sheet. Awake and alert in bed. Skin W/D. PERRLA ⊕ WNL. LCA ⊕. HRRS, S2 WNL. BS⊕x4. ⊕ PP ⊕. DSG ⊕ arm C/D/I. ⊕ thigh dsg C/D/I. ⊕ ROM ⊕ sensation ⊕ <3 sec cap refill to RU/RL exts digits. c/o pain x1 ∃ Percocet given. Will cont to mon. [redacted] RLT/AW (5)(6)-2

NSN 7540-00-634-4176

HEALTH RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE** | 600-108

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8 Aug 03	0620: Assumed pt care @ 0500. Pt. resting. Awaken easily. VSS. Assessment WNL. Pus. (R) elbo & dsing (R) thigh CDI. (+) movement & sensation below sites. Ø complaints @ this time. Will continue to monitor [redacted]
8 Aug 03 1345	Ipt care assumed @1300. Ipt awake & alert. VSS (b)(6)-2 RUE dsing CDI, steri strips intact (D) S/S of infection noted. LUE c̄ full ROM (+) pulses on UE. Lungs CTA and soft BS(+). (R) thigh dsing CDI (+) pulse (D) LE c̄ full ROM (+) pulse. (D) complaints voiced @ this time. Will cont to monitor (b)(6)-2 [redacted] Alvarez
8 Aug 03	Recd c/o pt @21:00. Restraints x 2 (D/D) ankles. VS WNL per FS. Awake and alert in bed. Amb x 15 min c̄ difficulty. PERLA (+) WNL. ICA (+). HRRS, S2 BS (+) x 4. ABD soft/non-tender. (+) PP (R). to RE's (+) sensation (+) ROM (+) <3 sec cap refill (+) warm to touch. c/o pain x 1 p̄ AROM performed ii Tylenol given. W→D dsg's d/d. Old dsgs for both wounds to RUE and RLE c̄ scant amt. yellow/green drainage. Both wounds well approx c̄ pink healthy granulation tissue present. Tolerated procedure well. New dsgs applied C/DI. Will cont to mon. Steri strips to RUE intact incision well approx c̄ S/S infection [redacted] 2ET AN
0300	C/O pain ii Tylenol given [redacted] 2ET AN (b)(6)-2

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

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9 Aug 03	0540: Assumed pt. care @ 0500: VSS. Alt x3. Lungs CTA. (+) BSXG. (+) Pulses x4. Pain on (R) thigh & (R) elbow CDI. Denies any complaints @ this time — [redacted] 9 Aug 03
	(b)(6)-2

558-103

(See Instructions on Back of this Sheet) (b)(2)-2

EMERGENCY CARE AND TREATMENT
(Medical Record)

NSN 7540-01-075-3786

TREATMENT FACILITY [redacted]

LOG NUMBER

ARRIVAL — DATE: DAY 14, MONTH 07, YR. 03 — TIME 1425

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

CURRENT MEDS. (tetanus immunization and other data): Ø

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: PCN

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code): EPW # [redacted] (b)(6)-7

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): [redacted]

SEX: M — AGE:

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER

VITAL SIGNS			
TIME	1425		
BP	113/63		
PULSE	105		
RESP.	16		
TEMP.	99.8		
~~WT. (Child)~~	98°(-		

12

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

ORDERS	INITS.	TIME
X-rays rt thigh	[redacted]	
tetanus		1431
4MSO4		1430

ASSESSMENT/DIAGNOSIS

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:

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)

Fragi S/P GSW to Rt forearm - thigh. Bleeding controlled
AT/O x3. VSS. HRRR. Lungs CTA (B). Abd soft & flat non-tender
Pulses present distal to injury

S: Shot in (R) forearm + (R) thigh last night. No pain [redacted] c̄ EPW. (b)(6)-2

O: (R) forearm - (+) swelling of proxl-mid forearm. (+) GSW over radial head begin c̄ exit on medial aspect of forearm. Compartments - soft
Radial + ulnar pulses 2+. - ↓ sensation median nerve distribution
X-ray (R) forearm - (+) comminuted fx prox. radius - unable to do "ok" sign - ant. interosseous nerve injury.
- able to extend wrist.

(R) proximal femur - (+) ant. entrance c̄ post-lat exit
- compartments soft
- able to flex knee to 90° / hip to 90°
- DP/PT pulses - 2+
- able to wiggle toes.
X-rays - (-) fx

LCx - CMS
Heart RRR ∅ (A)
Abd - soft
Back - nontender.

143 / 107 / 8
40 / 95 / 113 / 1.2

11.2 / 12.9 / 43 / 344

A: (1) GSW c̄ fx (R) proximal ~~ulna~~ radius
(2) GSW (R) femur (-) fx
(3) median nerve injury 2° to #1

P: Recent Log Anal @ 1300 hrs today.
Ortho admit for wash out & fixation.

(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] (b)(6)-7

[redacted] (b)(6)-2

NAME OF PROVIDER AND ID STAMP: MJ(P) MC

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up): Ft/Splint

[redacted] (b)(2)-2

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

INSTRUCTIONS FOR COMPLETION OF THE EMERGENCY CARE AND TREATMENT FORM

NOTE: This form will be used to record all care rendered to patients in the Emergency Room and will be used in lieu of ***all*** locally prepared emergency room forms. This form is not a substitute for line of duty, accident/injury or third party liability forms, but it may be used as a basis for completing those forms.

1. Complete form for each patient entered on Emergency Room Log.
2. Complete all parts of form.
3. Enter patient's log number from Emergency Room Log.
4. Check appropriate condition in "category" block based on following definitions:
   Emergent—A condition which requires immediate medical attention and for which delay is harmful to the patient; such a disorder is acute and potentially threatens life or function.
   Urgent—A condition which requires medical attention within a few hours or danger can ensue; such a disorder is acute but not necessarily severe.
   Non-Urgent—A condition which does not require the immediate resources of an emergency medical services system; such a disorder is minor or non-acute.
5. Use SF 522, Request for Administration of Anesthesia and for Performance of Operations and Other Procedures, to obtain authorization for any necessary procedures.
6. Orders: Provider enters orders; i.e., CBC, UA, etc. The person completing the action enters the time and his/her initials at the time of completion.
7. Give "Patient's Copy", containing instructions, to patient, sponsor (NOK) or person accompanying patient, except when patient is admitted.
8. File original in patient's treatment record (i.e., Military Health Record, Outpatient Treatment Record or Inpatient Record) as applicable.
9. Establish a treatment record for any patient who does not have a record. File and maintain treatment record in accordance with appropriate directives.

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: 35

HEIGHT:

WEIGHT:

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

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

4. PROPOSED SURGICAL PROCEDURE:

I & D Rt elbow + Rt thigh

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition write of
Tobacco Ø ppd X___yrs. Body Piercing N/A Diabetes (Y) (N) ? ROM ASA/Motrin w/72 hrs (Y) (N)
ETOH a little Implants N/A Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures Ø Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

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

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

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

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

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

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

[redacted] MAJ AN (b)(6)-2 14 Jul 03 DATE

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

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Titl[redacted] MAJ AN
DATE: 14 July 03 TIME: 1630

13. POSTOPERATIV[redacted]ARED BY (Signature and Title)[redacted] MAJ AN
DATE: 14 Jul 03 TIME: 1750

MEDICAL RECORD

INTRAOPERA[illegible] DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA: Litter BY: Amo. Staff

2. PATIENT IDENTIFIED, RECORD [redacted] AND PROCEDURE VERIFIED BY: [redacted] CPT / AN

3. DATE: 17 Jul 03 TIME PATIENT ARRIVED IN SUITE: ICW → OR.

4. PATIENT IN ROOM TIME: 0730 (b)(6)-2 NUMBER: 21 / 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKDA. NPOD MN.

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted] ORT (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT. [redacted] (OBG)	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

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

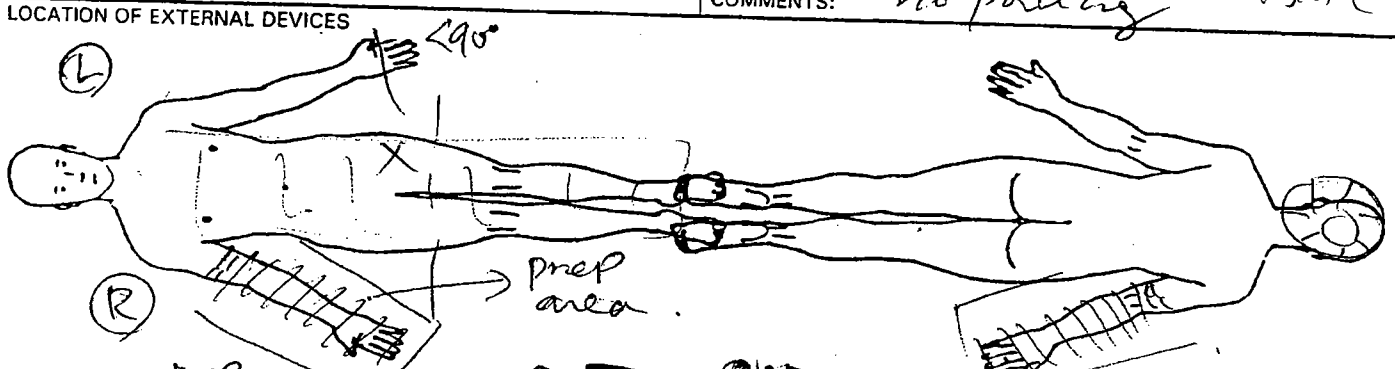
COMMENTS: (B) arms to padded arm board <90°, Body alignment maintained. Two arm board used to Right side.

8. SKIN PREPARATION

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

PREP SOLUTION (Specify): Betadine S/Sol
SITE: (R) arm BY WHOM: CPT [redacted]
SITE: ~ BY WHOM: ~ (b)(6)-2
COMMENTS: no pooling

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap

Dr [redacted] @250mmHg total time: 170 minutes (b)(6)-2

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes	☐ No	/				
Needle Sharp	☑ Yes	☐ No		C	C	SSG [redacted]	CPT, [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] (b)(6)-7

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

☑ ESU NO: Valleylab #4
GROUND PAD: BRAND Polyhesive II
LOT NO: 65706.

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

0092:30 / out: 30

13. PROSTHESIS, IMPLANTS ☑ YES ☐ NO MEDCOM - 14649 IER; MANUFACTURER

"Synthes"
Minifragset
Lot #03183D2

Screws: Cortex 202.00X(2.7mm)
18mm — 1
20mm — 6
24mm — 1

Plate 242.33
242.08

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
None		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*

flutts. plaster splint
Kerlix xeroform
webril
Ace

19. ADDITIONAL INFORMATION

Dr. [redacted]
LTC [redacted] (CRNA)
(b)(6)-2

20. OPERATION(S) PERFORMED

ORIF (R) Radius.

21. PATIENT TRANSFERRED TO ICU TIME See Anes. Record METHOD Litter

22. [redacted]ISTERED N[redacted]URE [redacted] CPT/AN

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

(b)(6)-2

MEDICAL RECORD

INTRAOPERA[illegible] DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: [illegible] BY anesthesia

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

3. DATE 14 JUL 03 TIME PATIENT ARRIVED IN SUITE 1645

4. PATIENT IN ROOM TIME 1645 (b)(6)-2 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: unable to speak/understand english language

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted] (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	Maj [redacted] 1715-EOC

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS: w/hip bump.

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION (Specify) Betadine scrub/sol'n

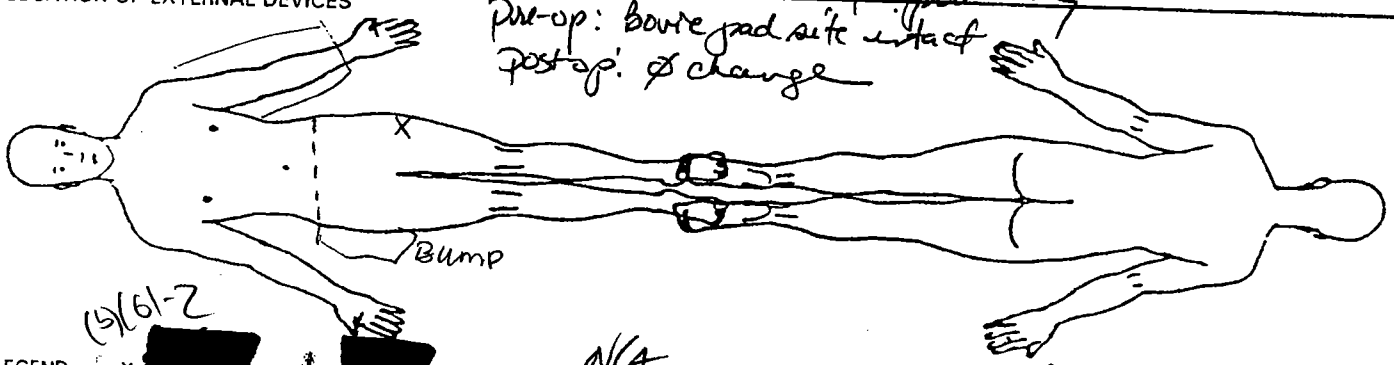
SITE: (R) forearm BY WHOM [redacted]

SITE: (R) upper leg BY WHOM [redacted]

COMMENTS: Ø pooling (b)(6)-2

9. LOCATION OF EXTERNAL DEVICES

Pre-op: Bovie pad site intact
Post-op: Ø change



(b)(6)-2 [redacted]

LEGEND X Ground Pad -- Strap = = = Tourniquet N/A

Initial [redacted] C = Correct I = Incorrect Initial! [redacted] (b)(6)-2

10. COUNTS

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

[redacted] (b)(6)-4

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

Cut: 30 coag: 30

☒ ESU NO: 4 Valleylab

GROUND PAD: BRAND Valleylab

LOT NO:

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO

MEDCOM - 14651

ER; MANUFACTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

YES ☐ NO ☒

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*

Kerlix
fluffs
ace wrap

19. ADDITIONAL INFORMATION

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

Anesthesia: [redacted]

WC I

20. OPERATION(S) PERFORMED

I+D Rt arm + leg

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU 2	1745	Litter

22. REGISTERED NURSE SIGNATURE

[redacted] MAJ

REV[redacted] 5179-1, OCT 87

USAPA V1.01

(b)(6)-2

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR Aug 19

DAY: 4 5 6 7 8 9 10

HOUR

PULSE (O) — TEMP. F (°) — TEMP. C

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

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**

MEDCOM - 14653

511–119 NSN 7540–00–634–4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 28, 29, 30, 31, 1, 2-3, 3-4

19 | HOUR

PULSE (O) | TEMP. F (•) | TEMP. C

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

(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. ICW2

EPW #[redacted]

(b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL REC...

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR July 03 | DAY 21 22 23 24 25 26 27

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

HEIGHT: | WEIGHT →

Spo2

Record special data only when so ordered

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

REGISTER NO.

WARD NO. 1CW2

[redacted] (5)(6)-4

STANDARD FORM 511 (REV. 7-95) BACK

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR July DAY 14 15 16 17 18 19 20

19 2003 HOUR

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

TEMP. F	TEMP. C
105°	40.6°
104°	40.0°
103°	39.4°
102°	38.9°
101°	38.3°
100°	37.8°
99°	37.2°
98.6°	37.0°
98°	36.7°
97°	36.1°
96°	35.6°
95°	35.0°

PULSE (O)	
180	
170	
160	
150	
140	
130	
120	
110	
100	
90	
80	
70	
60	
50	
40	

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

EPW

[redacted] (b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR July DAY 14

19 2003 HOUR 1 6 8 0

PULSE (0) | TEMP. F (°)

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° A	35.6°
90	95°	35.0°
80		
70		
60		
50		
40		

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE 150/100

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.

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

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 14657

MEDICAL RECORD

VITAL SIGNS RECORD

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

(Centigrade Equivalents, for Reference only)

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

Ward/Section: EMT

TESTING PHYSICIAN: [redacted] (b)(6)-2

LAST, FIRST, MI.

DATE: 14 Jul 03 TIME: 1440

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

SSN/PSEUDO SSN: [redacted] (b)(6)-7

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		
ALP		
ALT		
AMY		
AST		
TBIL		
BUN		
CA++		
CHOL		
CRE		
GLU		
TP		
TES		
GLU		
BUN		
CRE		
CK		
NA+		
K+		
CL-		
tCO2		

```
======= PICCOLO =======
14/07/03            14:47
REFERENCE RANGE:      MALE
PATIENT #: [redacted] (b)(6)-7
GENERAL CHEMISTRY 12
DISC LOT #: (b)(6)-2 3082AA4
OPER #: [redacted]  DR #: 000
SERIAL #: [redacted]
.......................
ALB   3.2*  3.3-5.5   G/DL
ALP   74    26-84     U/L
ALT   89*   10-47     U/L
AMY   36    14-97     U/L
AST   63*   11-38     U/L
TBIL  0.6   0.2-1.6   MG/DL
BUN   8     7-22      MG/DL
CA++  8.6   8.0-10.3  MG/DL
CHOL  187   100-200   MG/DL
CRE   1.2   0.6-1.2   MG/DL
GLU   113   73-118    MG/DL
TP    6.8   6.4-8.1   G/DL

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
		73-118 mg/dl
		7-22 mg/dl
		8.0-10.3 mg/dl
		0.6-1.2 mg/dl
		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
		18-33 mmol/l

(Piccolo) Liver Panel Plus

RESULT	REF. RANGE
	3.3-5.5 g/dl
	26-84 u/l
	10-47 u/l
	14-97 u/l
	11-38 u/l
	0.2-1.6 mg/dl
	5-65 u/l
	6.4-8.1 g/dl

(Piccolo) Electrolyte

	RESULT	REF. RANGE
NA	143	128-145 mmol/l
K	4.0	3.3-4.7 mmol/l
CL	107	98-108 mmol/l
tCO2	25	18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
CWS	14 Jul 03	

[redacted] (b)(6)-7

Ward/Section

LAST, FIRS

TEST

WBC

RBC

Hgb

Hct

MCV

Plt

Lym

G

Se

B

L

(b)(6)-2

Ward/Section: EMT	ESTING PHYSICIAN: [redacted]	LATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: # [redacted] (b)(6)-4	DATE: 14 Jul 03	TIME: 1440	SSN/PSEUDO SSN: [redacted] (b)(6)-4

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE: 14 Jul 03	LAB ID NO.:

[redacted] (b)(6)-4

For MEDICAL RECORD - ANESTHESIA
this form, see AR 40-66; the proponent agency is OTSG

Allergy: PCN

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

DRUG	(Units)																		
Versed	(mg)	2																	
Fent	(mcg)	100	50																
Lido	(mg)	20																	
Propofol	(mg)	170																	
Succs	(mg)	100	Regular	10															
	( )																		
VOLAT AGENT	Forane del	2	2	2															
	% e.t.																		
AIR	L/Min																		
N2O	L/Min																		
O2	L/Min	—	3	2	8														

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

FLUIDS

LINE site																			
LR (L) FA	☐ Warmed																		
	☐ Warmed																		
	☐ Warmed																		
	☐ Warmed																		

LOSSES

EST BLOOD LOSS																			
URINE -																			

TOTALS: 2mg, 150mcg, 20mg, 170mg, 100/70mg

TOTAL EBL: 25 cc

TOTAL URINE:

FLUIDS SUMMARY

CRYSTALLOID- 450 cc.

COLLOID-

BLOOD-

PHYS STATUS: 1 2 3 4 5 (E)

BODY WEIGHT: 75 (KG) LB

HEMATOCRIT:

INITIAL DATA

BP- 146/84

HR- 96

EQUIP CHECK

OK?- (Y) N

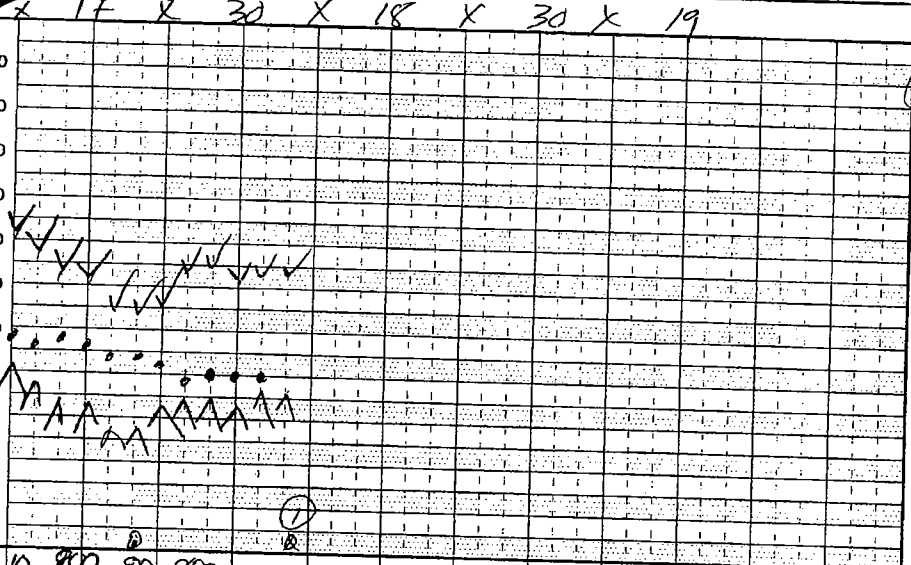
PATIENT RECHECK

OK for PROCEDURE?

TIME- 1630

TIME → 1617 1630 1718 1730 1819

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



VENTIL

VT - ml	10 800	800	800		
f - breaths/min	10	10	9	16	
Peak inf pres / PEEP	18	18	19		
MODE - S(pon), A(ssist), C(on)	S-C	C	C	S	

MONITORS/ACCESSORIES

☒ BP/Auto Cuff	☒ ET CO2 (torr)	36 34	30	29	39	
BP/oth	☒ FIO2 (Frac or %)	.83	.84	.84	.84	
ART line	☒ SpO2 (%)	98	100	100	98	
Steth- PC/ES	☒ ECG	SR	SR	SR	SR	
Gas analyzer	☒ TEMP-site SKIN	36.4	37.2	37.2		
	N-M Block (T/4)					
Warming blkt						
Conv warmer						

Mark with letters & symbols, explain under REMARKS — EVENTS Position → Supine @ Bilat arms on padded boards @ angles < 90° Prone

REMARKS

Code drugs with numbers, events with letters

1620. IDed pt in ICW2 & spoke to pt thru interpreter

(1) Pt extubated when awake & Reflexes returned Sustained airway no problems

TO ICW 2 Stable, awake & talking Report to Cpt [redacted]

(b)(6)-7

RECOVERY AT

PACU (ICU 2) (Specify)

OTHER

CONDITION: RA 98%

RESP- 16 SpO2- 92%

BP- 131/81 HR- 100

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1620 1630	1640	1748
	Ready	Begin	End
PROC	1652	1712	1742

PROCEDURES and CPT Codes:

Ieo (R) leg (thigh) @ (R) Arm (b)(6)-7

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

EPW ICW2

[redacted] (b)(6)-7

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

[redacted] / OGT

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments placed one attempt DLX1 MAC 3 Atraumatic ⊕ bilat BS ⊕ ETCO2 modified RSI c sellick #8.0 ETT @ 22cm

SURGEONS:

[redacted] (b)(6)-7

ANESTHETISTS:

[redacted]

PROCEDURE LOCATION: OR #1 Ind

DATE: 14 July 2003

PAGE OF

DA FORM 7389, FEB 1998

MEDCOM - 14663

COPY 1 - PATIENT'S MEDICAL RECORD

USAPA V1.00

Al: PCN II ? HTN

MEDICAL RECORD - ANESTHESI

For this form, see AR 40-66; the proponent agen e OTSG

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML. "I" = CONSTANT INFUSION	0730	0800	30	0900	30	1000	30	TOTALS
Versed (mg)	2.5							
Fentanyl 50μ/(cc)	2	1 1						
Lidocaine/Propofol (mg)	20/150					1	2	8cc
Zofran (mg)	50							
Drugs/Reglan (mg)	1.25/10			10	10	10	10	
Morphine (mg)			5	5				
VOLAT AGENT Forane % del	X1.5	1	1	1.2	1.5	2	1.5	1.5 1.5 1.5 1.5 1.5 1.5
% e.t.								
AIR L/Min	LABETOLOL mg			5	5			
N2O L/Min								
O2 L/Min	6	2	2	2	2	2	2	2 2 2 2 2 2
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS								

FLUIDS	0730	0800	30	0900	30	1000	30	TOTAL EBL
LINE site LR ☐ Warmed	300	350	500	550	600	700	950	100
☐ Warmed								TOTAL URINE
☐ Warmed								Ø
☐ Warmed								
LOSSES: EST BLOOD LOSS								10cc
URINE -								

FLUIDS SUMMARY
CRYSTALLOID- LR 1300
COLLOID- Ø
BLOOD- Ø

REMARKS
Code drugs with numbers, events with letters
Prep PIV NAD
agrees to GA
for Rt Arm Surgery
OR, O2, monitor
stable IV induction

PHYS STATUS: 1 (2) 3 4 5 E

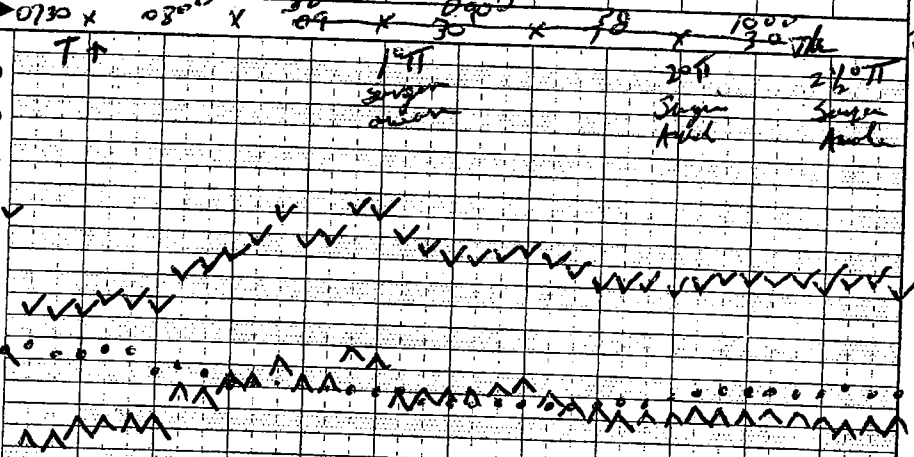
BODY WEIGHT: 75 (KG) LB

HEMATOCRIT: 42.4

INITIAL DATA: BP- 154/96 HR- 92

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? Y/NO TIME- 0720



VENTIL	0730	0800	30	0900	30	1000	30	1030	1100	30	1200
VT - ml	730	730	750	760	770	800	760	750	780	790	780
f - breaths/min	8	8	7	7	7	7	7	7	7	7	7
Peak inf pres / PEEP	21	21	21	21	21	21	21	21	21	21	21
MODE - S(pon), A(ssist), C(on)	C	C	C	C	C	C	C	C	C	C	C
X BP/Auto Cuff / X ET CO2 (torr)	33	32	30	30	31	30	31	32	32	32	32
BP/oth / X FIO2 (Frac or %)	.7	.7	.7	.7	.7	.7	.7	.7	.7	.7	.7
ART line / X SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES / X ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer / X TEMP-site A.O	36.8	36.7	37.0	37	37.1	37.3	37.4	37.6	37.7	37.8	37.8
X N-M Block (T/4)	4	0	0	1	3	1	3	3	3	3	4
Warming blkt											
Conv warmer											

RUE Tourn @ 255
↑ @ 0786
↓ @ 1046
TT. 170 min

Mark with letters & symbols, explain under REMARKS — EVENTS Position → 9/T → Head/Neck Neutral

RECOVERY AT
PACU ICU _____ (Specify)
OTHER _____
CONDITION:
RESP- SpO2-
BP- HR-

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0720	0730	
	Ready	Begin	End
PROC	0740	0800	

PROCEDURES and CPT Codes:
Rt Elbow ORIF

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GA easy mask, vent, 3MAC O2x1, gas I nitrous, 8.0 ETT

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
@ 24 cm lips B=B, +ETCO2, G.B.B.

PATIENT IDENTIFICATION: Typed or written entries: Name, Grade/Rate, Medical facility
ICW2
#[redacted]
(5)(6)-4

SURGEONS: [redacted] (5)(6)-2

ANESTH[redacted] LTC CRNA

PROCEDURE LOCATION: OR2
DATE: 17 JUL 03
PAGE 1 OF 2

DA FORM 7389, FEB 1998 MEDCOM - 14665 COPY 1 - PATIENT'S MEDICAL RECORD USAPA V1.00

II ? HTN
Al: PCN

MEDICAL RECORD - ANESTHES

For this form, see AR 40-66; the proponent agen ie OTSG

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION													
DRUG	(Units)	1030	x	1100	x	30	x	1200	x	30			
PROPOFOL	(mg)			10/10/10/10									
ZEM	(mg)												
	( )												
Fentanyl 50 mcg	(cc)												
	( )												
LABETOLOL	(mg)			5									
VOLAT AGENT	% del	1.5	-1 X										
	% e.t.												
AIR	L/Min												
N2O	L/Min												
O2	L/Min	2-	2-4	-6									
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS													

FLUIDS													
LINE site LA	☐ Warmed	1000	-1100	-1300									
	☐ Warmed												
	☐ Warmed												
	☐ Warmed												
LOSSES	EST BLOOD LOSS												
	URINE -												

TOTALS	TOTAL EBL
	TOTAL URINE

FLUIDS - SUMMARY
CRYSTALLOID-
COLLOID-
BLOOD-

REMARKS
Code drugs with numbers, events with lettters
T↓ @ 1046
OP suite
SV extubated awake to ICU #2 for PACU

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 75 (KG) LB

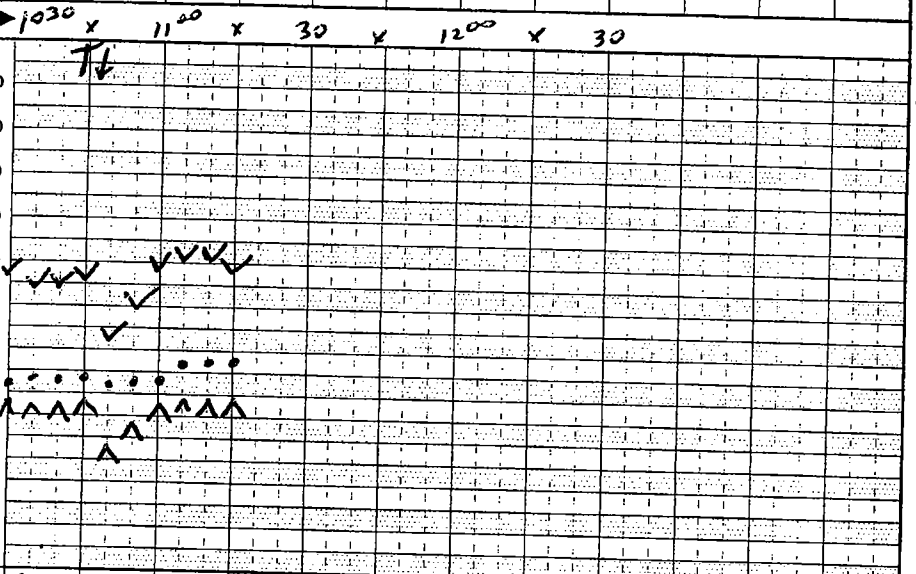
HEMATOCRIT:

INITIAL DATA:
BP-
/
HR-

EQUIP CHECK
OK?- Y N

PATIENT RECHECK
OK for PROCEDURE?
TIME-

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



VENTIL	1030	1100	1200	1230
VT - ml	810	860	520	460
f - breaths/min	7	7	6	8
Peak inf pres / PEEP	21	21		
MODE - S(pon), A(ssist), C(on)	C	C	S	S

MONITORS/ACCESSORIES		1030	1100	1200	1230
X BP/Auto Cuff	X ET CO2 (torr)	32	33	55	52
BP/oth	X FIO2 (Frac or %)	.7	.7	.7	.7
ART line	X SpO2 (%)	100	100	100	100
Steth- PC/ES	X ECG	SR	SR	SR	SR
Gas analyzer	X TEMP-site P.O.	38	38	37.7	
	X N-M Block (T/4)	4	4 T&T	0 FADE	
Warming blkt					
Conv warmer					

RECOVERY AT 1120
PACU (ICU) #2 (Specify)
OTHER PAS 10
CONDITION: ~ 12m
RESP- 12 SpO2- 95%
BP- 153/90 HR- 106

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES			1130
	Ready	Begin	End
PROC			1120

Mark with letters & symbols, explain under REMARKS EVENTS *Position* → off → pressure pts OK. Tilt 10

PROCEDURES and CPT Codes:

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*
ICU 2
H[redacted]
(5)(6)-4
(5)(6)-2

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
SEE PG 1

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

SURGEONS: [redacted]

ANESTHETISTS: [redacted]

PROCEDURE LOCATION: OR 2
DATE: 17 JUL 03
PAGE 2 OF 2

ANESTHESIA PLAN OF CARE PRE[illegible]EDURAL ASSESSMENT (Sedation/[illegible]thesia)

Age 36 DAYS MOS YRS Sex () MALE () FEMALE

PROPOSED PROCEDURE: [illegible]
SURGICAL SERVICE: Ortho / Gen
NPO SINCE: _____

ASA Physical State 1 2 3 4 5 E
WT: 75 (KG/LB) HT: _____ IN.
ALLERGIES: NKN.

HABITS:
TOBACCO: (–)
ETOH: little
DRUGS: Ad

CURRENT MEDICATIONS:
( ) = ordered as premed

() Tetanus
() MSO4 4mg @1430
() Ancef 1gm @1300
()
()
()

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

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

11.2 / 12.9 / 42.4 / 344

143 / 107 / 8 / 113
40 / 75 / 1.3

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	
Angina	N	Y	
MI	N	Y	
CVA	N	Y	
Other	N	Y	
Pulmonary System:			
Asthma	N	Y	
Bronchitis/URI	N	Y	
COPD	N	Y	
Other	N	Y	
Renal System:			
Acute/Chronic RF	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	
Hiatal Hernia	N	Y	
PUD/GERD	N	Y	
Endocrine System:			
Diabetes	N	Y	possible New?
Steriods	N	Y	
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	
Other	N	Y	
Gynecological :			
Pregnancy	N	Y	N/A
Other Significant Hx:			
	N	Y	
	N	Y	
Familial HX	N	Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC

PHYSICAL EXAMINATION
BP 136/63 HR 105 R 16 T 99
Pain Scale 0-10 _____
HEENT - Teeth Front (R) poor Dentition
Trachea _____
TMJ/Neck MP III
Oropharnyx _____
Nares _____
CHEST: _____
CARDIAC: _____
EXTREMITIES: _____
IV Access: (L) FA.
Ulnar Filling: _____
BACK: _____
OTHER: _____

NPO Since _____

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

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

The patient/legal (b)(6)-2 [redacted] to understand and agrees. Questions answered.

Signed: [redacted] CRNA Date: 14 July 2003 Time: 1630 Hrs

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

Signed: _____ Date: _____ Time: _____ Hrs

Patient Identification: (Ward) _____

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

SEDATION KEY:

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

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age ~40 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: ORIF (R) Elbow S/P GSW Rt thigh & forearm
SURGICAL SERVICE: Ortho
NPO SINCE: 2400

ASA Physical State 1 (2) 3 4 5 E
WT: 75 (KG/LB) HT: IN.
ALLERGIES: ~~NKDA~~ PCN

HABITS:
TOBACCO: denies
ETOH: Ø
DRUGS: Ø

CURRENT MEDICATIONS:
( ) = ordered as premed

() MSO4 IV PRN
() Ancef IV q6°
()
()
()
()

PREMEDICATIONS:
None Yes (@ _____ Hrs) /CC
_____ · _____ mg IV IM PO
_____ · _____ mg IV IM PO
_____ · _____ mg IV IM PO

LABORATORY STUDIES:
HB/HCT: 12.9 / 42.4
U/A:
OTHER:

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	? Borderline
Angina	N	Y	
MI	N	Y	
CVA	N	Y	
Other	N	Y	
Pulmonary System:			
Asthma	N	Y	
Bronchitis/URI	N	Y	
COPD	N	Y	
Other	N	Y	
Renal System:			
Acute/Chronic RF	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	
Hiatal Hernia	N	Y	
PUD/GERD	N	Y	
Endocrine System:			
Diabetes	N	Y	
Steriods	N	Y	
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	
Other	N	Y	
Gynecological :			
Pregnancy	N	Y	
Other Significant Hx:			
	N	Y	
	N	Y	
Familial HX	N	Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC
I&D both wounds 1975 (easy tube)

PHYSICAL EXAMINATION
BP 148/78 HR 68 R 16 T. 96
Pain Scale 0-10 sleeping
HEENT - Teeth poor
Trachea ML
TMJ/Neck MP II
Oropharnyx FROM
Nares N/A
CHEST: CTAB
CARDIAC: RRR
EXTREMITIES:
IV Access:
Ulnar Filling: N/A
BACK: N/A
OTHER: N/A

NPO Since 2400

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

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

The patient/leg[redacted]derstand and agrees. Questions answered.
Signed: [redacted] CRNA Date: 7/17/03 Time: 0645 Hrs

POST-ANES[redacted]ON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER
(b)(6)-2
Signed: _____ Date: _____ Time: _____ Hrs

Patient Identification: (Ward) ICW2

[redacted] (b)(6)-4

SEDATION KEY:

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

WAMC Form 2300 (Revised) 15 Mar 01 MCXC-DOS

PATIENT RECORD COPY

Previous edition is obsolete
☆ U.S. GPO: 2002-729-283

IDENTIFICATION

04 Aug 03 2245

V.O.

Tylenol 650mg PO PRN [redacted] noted

q4h (b)(6)-2 2245 4 Aug 03

Dr [redacted]

24 Vanessa Patrick McNamara

IDENTIFICATION

8 Aug 03 1610

D/C to GPW camp

B2D w → D unit's

wound healed (b)(6)-2 [redacted] noted

[redacted] 8 Aug 1615

UNIT ROO BED NO.

IDENTIFICATION

UNIT ROO BED NO.

IDENTIFICATION

UNIT ROO BED NO.

IDENTIFICATION

UNIT RO BED NO.

FORM 1 APR 79

CLINICAL RECORD - DOCTOR'S ORDERS

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

[illegible] RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM [illegible] USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

#454

[redacted]

DATE OF ORDER: 18 Jul

TIME OF ORDER: 1100 A

- Pro-med for dsg Δs c 2-10 mg MSO4 IV
- BID w → D Dsg Δ (R) thigh to include packing of both wounds [redacted] MAJ [redacted]

WARD UNIT: ICW2 | ROOM NO. [redacted] | BED NO. (b)(6)-2

24° Chasty [redacted] 1LT/AN 19July03 0200 (b)(6)-2

PATIENT IDENTIFICATION: 24° V's [redacted]

TIME OF ORDER: 1LT/AN 7-24-03 0030

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

DC Ancef

Keflex 500mg PO ~~QIA~~ ~~TID~~ QS QS 910

V.O. Dr. Guinn [redacted]

WARD UNIT: ICW #2 | ROOM NO. | BED NO. | (b)(6)-2

- QD Dsg Dsg (R) c/bv
- bag 2n BID c/bv → hand

[redacted] MAJ [redacted]

PATIENT IDENTIFICATION | DATE OF ORDER | TIME OF ORDER

WARD UNIT | ROOM NO. 24°V's | BED NO. 2200 26 July [redacted] (b)(6)-2

PATIENT IDENTIFICATION | DATE OF [redacted] | TIME OF ORDER

30 July 03 1600

V.O. Remove staples et steristrip

Dr. [redacted] 91WMC

(b)(6)-2 noted [redacted] 91WMC

30 July 03 1600

WARD UNIT | ROOM NO. 24°V's | BED NO. 2200 30 July [redacted]

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

PATIENT IDENTIFICATION [redacted]

DATE OF ORDER 18 JUL 03 TIME OF ORDER 2330 HOURS

Verapamil 60mg PO ~~&FNN~~
BP Q20 x 6 then
resume PRN Pulse

noted [redacted]

NURSING UNIT 1CW2 ROOM NO. BED NO.

PATIENT IDENTIFICATION [redacted] (b)(6)-2

[redacted]

DATE OF ORDER ~~14 JAN 7-15-03~~ 0030 TIME OF ORDER 191[redacted] HOURS (b)(6)-2

15 July 03

① NPO > MN

noted [redacted]

9HWM6 15 July 03 1914

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

PATIENT IDENTIFICATION 24 V's [redacted]

9HWM6 7-16-03

[redacted]

DATE OF ORDER 16 Jul TIME OF ORDER 1740 HOURS

NPO p MN (b)(6)-2
OR in AM

noted [redacted] 9HWM6 1756

MAT [redacted]

NURSING UNIT 1CW2 ROOM NO. BED NO. 1

24° V Pulse 17 July 03

[redacted]

DATE OF ORDER 17 July TIME OF ORDER 1130A HOURS

- Post op s/p ORIF (R) elbow
Resume prior orders (+):
- Regular diet
- 2-3 pillow elevation strictly
* 72°
- NV checks RUE q 1 x 24 hrs, 1 shift
- BID w/ D Ds[redacted] (b)(6)-2
^ (R) thigh
18 inches

noted [redacted]

24° V a (b)(6)-2 [redacted] MA[redacted]

(b)(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER (HOURS)	LIST TIME ORDER NOTED & SIGN
			Admit Ortho S/P GSW (R) elbow, (R) thigh vitals routine Activity BR Diet NPO IVF D5 1/2 NS + 20 KCl @ 125 cc/h meds Percocet 1-2 po q 4 PRN	
NURSING UNIT	ROOM NO.	BED NO.		
PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER (HOURS) MSO4 2-5 mg IV q 2 PRN Phenergan 12.5 mg IV q 4 PRN [redacted] MAJ (b)(6)-2	
NURSING UNIT	ROOM NO.	BED NO.		
PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER (HOURS) Post-op NS/P 2 D (R) elb & thigh vitals routine Activity As tolerated Diet Regular IVF D5 1/2 NS + 20 KCl @ 125 cc/h hep lock when taking PO meds Percocet 1-2 po q 4 PRN MSO4 2-5 mg IV q 2 PRN	
NURSING UNIT	ROOM NO.	BED NO.		
PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER (HOURS) Phenergan 12.5 mg IV q 4 PRN Ancef 1 g IV q 6 (b)(6)-2 [redacted] MAJ	
NURSING UNIT	ROOM NO.	BED NO.		

[redacted] 24° V's [redacted] 1CTAN 715-03 0030

(b)(6)-4

the proponent agency is the Office of The Surgeon General. M.O. 1 July YR 2003

RIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 14	15	16	17	18	19	20	21	22	23	24	25
14	[redacted]	VS Routine	5	[redacted]											
			13												
			21												
14	[redacted]	Act As Tol	5	[redacted]											
			13												
			21												
14	[redacted]	Diet Regular	6	[redacted]											
			11												
			17												
17	[redacted]	2-3 pillow elevation Strictly x 72°	5				[redacted]								
			13												
			21												
17	[redacted]	NV checks @ VE Q2 x24 then Q shift.	5				[redacted]								
			13												
			21												
17	[redacted]	BID w 7D dsng @ thigh	10												
			22												
7R	[redacted]	BID w 7D D&Δ (R) thigh to include packing of both wounds	10												
			22												

(b)(6)-2

(b)(6)-2

SEE Δ

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/p I+D (R) calf + thigh

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

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

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIME

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. USA

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo July Yr 2003

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
14	[redacted]	B/P Q2° x 6 hr then Routine	14 July	2330	—	[redacted]
15	[redacted]	NPO p̄ MN	16 July	2400	2400	[redacted]
16	[redacted]	NPO p̄ MN for OR IN AM	17 July	2400	2400	[redacted]
17	[redacted]	S/P I&D (R) elbow	17 July	1247	1247	[redacted]
30	[redacted]	Remove Staples & Steristrip	30 July	Done	Done	[redacted]
	(b)(6)-2					(b)(6)-2

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

-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)					Mo _____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
8 Aug 03		D/C to EPW camp BID w-D until wound heals					

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

MEDCOM - 14684

the proponent agency is the Office of The Surgeon General. MO. ___ YR 2003

RIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 26	27	28	29	30	31	1	2	3	4	5	6	7
14	[redacted]	VS Routine	5	[redacted]												
			13													
			21													
14	[redacted]	act as tol	5	[redacted]												
			13													
			21													
14	[redacted]	Diet Regular	6	[redacted]												
			11													
			17													
17 ~~14~~	[redacted]	NV checks RUE Q Shift	5	[redacted]												
			13													
			21													
17	[redacted]	BID W→D Drsing Δ (R) thigh to include packing of both wounds	10	[redacted]												
			22													
26	[redacted]	Drsg Δ to (R) elbow qd	10	[redacted]												
26	[redacted]	ROM (passive & active) to (R) elbow ~~BID~~ and hand BID	10	[redacted]												
			22													

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: 9/P I & D (R) elb + thigh

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIME

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

(5)(6)-2

(5)(6)-2

DA FORM 4677, 1 OCT 78 — EDITION OF 1 DEC 77 MAY BE USE — USA

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. 07 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 14	15	16	17	18	19	20	21	22	23	24	25	26	27
14	[redacted]	D5½NS +20KCL	5	/	[redacted]												
	------	@125cc/hr (HL)	13														
	------	when tol P.O.	21														

14	[redacted]	Ancef 1 gram IV	04	/	[redacted]												
	------	Q 6°	10	/													
	------		16	/													
	------		22														

7-8	[redacted]	Pre-med for Dsng	10	X	X	X	X	[redacted]									
	------	ASA 2-10mg MSO4 IV	MSO4					5mg	Pnc	6mg	5mg	4mg	5	5	5mg	5mg	6
	------	BID	22					[redacted]									
	------		MSO4					6mg		5mg	5mg	10mg	5mg	5mg	5mg	5mg	5mg

20	[redacted]	Keflex 500mg PO TID QID	06	—	—	—	—	—	—	—	—	—	—	—	—	—	[redacted]
	------		12	—	—	—	—	—	—	—	—	—	—	—	—	—	[redacted]
	------		18	—	—	—	—	—	—	—	—	—	—	—	—	—	[redacted]
	------		24	—	—	—	—	—	—	—	—	—	—	—	—	—	[redacted]

	------																

(5)(6)-2

(5)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P I+D (R) ell + thigh

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

EPW

[redacted] (5)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. July Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
14	[redacted]	Nexapanel 60mg PO x 1 now	14 July	2130	NOT AVAILABLE	
	(b)(6)-2					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
14	[redacted]	Percocet 1-2 po	14 July 2140	15 July 0145	15 July 0255	15 July 0355	17 July 1423	17 July 1810	17 July 2200	18 July 0515	18 July 2040	19 July 0145	19 July 1300	19 July 0135	19 July 1100	19 July
		Q4° PRN	0220	0145	0255	0355	1423	1810	2200	0515	2040	0145	1300	0135	1100	0300
14	[redacted]	MSO4 2-5mg	14 July 2045	15 July 0005	15 July 0330	15 July 0440	15 July 0710	15 July 1100	15 July 1900	15 July 2215	16 July 0215	16 July 0415	16 July 0100	16 July 2115	17 July 0230	17 July 1305
		IV q 2° PRN	3mg IV	5mg IVP	5mg IVP	5mg IVP	5mg			5mg	4mg	4mg	5mg	5mg	4mg IVP	5mg IVP
14	[redacted]	Phenergan 12.5	19 July 2010	20 July 0000												
		mg IV Q4° PRN	5mg	[redacted]												
14	[redacted]	MSO4 2-5mg	17 July 2250	18 July 0145	18 July 0400	18 July 1030	20 July 0721	20 July 1400								
		IV q 2° PRN	5mg IV	5mg IVP	5mg IVP	5mg IVP	4mg	4mg								
14	[redacted]	Percocet 1-2 po q 4°	24 July 0220	25 July 0220	25 July 0145	25 July 0145	25 July 1-46	25 July 1-46								
		prn	1-2 po	1-2 po	1-2 po	1-2 po	[redacted]									

(b)(6)-2

(b)(6)-2

USAPA V1.00

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 28	29	30	31	1	2	3	4	5	6	7	8	9	10
14 July	[redacted]	IV HL	05	[redacted]													
			13	[redacted]										DC'd			
			21	[redacted]													
18 July	[redacted]	Premed for Dsg D	10	[redacted]										Mg 13	[redacted]		
		E 2-10mg MSO4	MSO4														
		BID	22	[redacted]													
			MSO4														
26 July	[redacted]	Keflex 500mg PO	06	[redacted]													
		QID	12	[redacted]													
			18	[redacted]													
			24	[redacted]													

(b)(6)-2

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P I/D @ elb & thigh

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

EPW

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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													
14 July	[redacted]	Percocet 1-2 PO	28 July 0900 T	28 July 1800 T	28 JUL 2000 05	29 July 0000 T PO	30 July 1400	31 July 0535 T PO	31 July 1215 T PO	31 July 1943	1 Aug 1042 T PO	1 Aug 1605 T	5 Aug 1615 T PO	5 Aug 0? T	5 Aug 0845 T PO	6 Aug 0143 T PO
.....	[redacted]	Q4° PRN	[redacted]													
14 July	[redacted]	MSO4 2.5mg IV q2°														
.....	.....	PRN														
14 July	[redacted]	Phenergan 12.5 mg														
.....	.....	IV Q4 PRN														
04 Aug	[redacted]	Tylenol 650mg PO	2215 4 Aug T PO	0000 5 Aug T PO	01:26 6 Aug T PO	7 Aug 0920 T PO	7 Aug 1112	8 Aug 0035 T PO								
.....	.....	PRN q4°	[redacted]													
6 Aug	[redacted]	Percocet 1-2 PO	Aug 6 05:20 T PO	7 Aug 0942 T PO	7 Aug 2033 T PO											
.....	.....	Q4° PRN	[redacted]													
.....	.....															
.....	.....															
.....	.....															

(b)(6)-2

(b)(6)-2

USAPA V1.00

#454

Recopied

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 8	9	10	11	12	13	14	15	16	17	18	19	20	21
8/Aug	[redacted]	VS Routine	5	[redacted]													
			13														
			21														
8Aug	[redacted]	Acti-as tol	5														
			12														
			21														
8Aug	[redacted]	Diet Regular	07														
			12														
			17														
8Aug	[redacted]	NV ✓'s RUE q Shift	15														
			13														
			21														
8Aug	[redacted]	BID w→D dsg Δ's	10														
		Bthigh to include posterior	22														
		of both wands ✓															
8Aug	[redacted]	DSG Δ to ® elbow	10														
		q D ✓															
8Aug	[redacted]	Rom (Passive + Active)	08														
		to ® elbow and hand	20														
		BID															

(b)(6)-2

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P I/D ® elb. + thigh

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

EDW

[redacted]

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

USAPA V1.00

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														

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

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: 14 Jul 03
Time In: 1745
Allergies: NKA
Pre-op V/S: _____
Procedures: 1st Lt R hip + Bone
Anesthesia Type (Circle)): (General) Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 450 cc Colloid _____
OR Output: UOP Ø EBL 25cc
Meds/Times: _____

150 mg Ulcer
EL
MSO4
Ancef
Tetanus

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds

Time	1745	1750	1800	1815	1830	1845	1900
SaO2	98	99	99	100	100	95	95
FiO2	RA	RA	100	100	100	RA	RA
Methods		NC	NC	NC	NC	NC	

History

240							
220							
200							
180							
160						✓	
140		✓	✓	✓	✓		✓
120	✓						
100		•	•	•			
80	•				•	•	•
60	^		^	^		^	^
40		^			^		
20							
RR	16	18	18	20	14	15	17
T	98						

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

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	1	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	1
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.	10	11	11

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

(5)(6)-2 PREPARED BY (Signature & Title) [redacted] CPT/AD

(Continue on reverse)

DEPARTMENT/SERVICE/CLINIC: PACU 2

DATE: 14 JUL 03

Name - last, first, middle; grade; date; hospital or medical facility)

[redacted] (5)(6)-4

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

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

USAPPC V2.00

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1830		MSO4 3mg	IV			[redacted]
						(b)(6)-2

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(R)leg	+	+	A	B	W	PK
15'	(R)leg	+	+	+	B	W	PK
30'	(R)leg	+	+	+	B	W	PK
45'	(R)leg	+	+	+	B	W	PK
60'							
90'							
D/C							

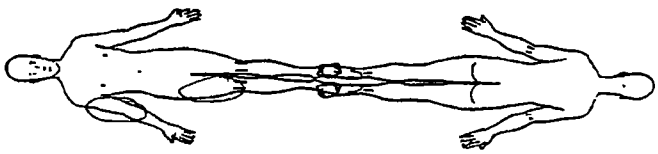
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(R)leg	ace bandage	small
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

Pt arrived on unit for recovery s/p I&D of (R)arm and (R)leg. Very groggy but responds to verbal stimuli. Lungs CTA bilaterally c̄ O2 sats @100% on 10L NRB. NSR c̄ HR in high 90's (+) palpable pulses. (+)BS x4 quads. Able to move all extremities. Will continue to monitor [redacted] (b)(6)-2

Discharge Criteria:
Date: 14 Jul **Time:** 1900 **PARS:** 11
BP: 148/84 **T:** 99.6 **HR:** 92 **RR:** 16 **Sa02:** 98%
Pain Level at D/C (0-10):
Intake: 0 **Output:** <0
Additional Data:
Transferred To: ICW 2
Report Given To: [redacted] (b)(6)-2
Transferred Via: W/C [redacted] Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Recovery Room SOP B-3 [redacted]
Charge Nurse Signature [redacted]

ASA #2

HTN

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: 17 Jul 03
Time In: 1130
Allergies: PCN
Pre-op V/S: BP 94 92
Procedures: open reduction Gibson

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

OR Intake: Crystalloid LR 1300 Colloid 100 Ent
OR Output: UOP 0 EBL 100
Meds/Times: Propofol Reglan labetalol 25

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

Pre Op Meds / History

Time								
SaO2	99	99	99	99	99	99	99	99
FiO2	RA	RA	RA	RA	RA	RA	RA	RA
Methods								
240								
220								
200								
180								
160		✓						
140			✓	✓	✓	✓	✓	
120								
100								
80								
60								
40								
20								
RR	18	20	16	18	18	18	20	
T	97.3						97.2	
Time								
Pain (0-10)				3/10				
LOS								

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

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

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	0	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	✓	✓	
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	7	9	10

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

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC: ICU #2

DATE: 17 Jul 03

[redacted] (b)(6)-4

Name – last, date; hospital or medical facility)

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

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) Arm	+	+	✓	B	W	PK
15'	R Arm	+	+	✓	B	W	PK
30'	"	"	"	✓	"	"	"
45'	"	"	"	✓	"	"	"
60'	"	"	"	✓	"	"	"
90'	—	—	—	—	—	—	—
D/C	"	"	"	"	"	"	"

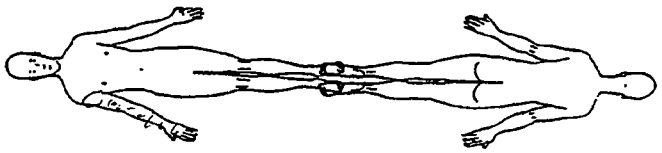
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(R) Arm	Ace & Splint	Ø
30'	(R) Arm	Ace & Splint	Ø
60'	(R) Arm	Ace & Splint	Ø
D/C	"	"	"



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

Pt easily arousable upon arrival unable to follow commands though Sats 99-100% 4L O2. A+O x 1 VSS. 1200. Pt Awake, verbal following commands. Sats 96-99% RA. Able to cough & Deep Breath. Neuro checks to extremities WNL. Pt c/o unable to urinate. [redacted] LPN -

(b)(6)-2

Discharge Criteria:
Date: 17 July 03 **Time:** 1732 **PARS:** 10
BP: 142/80 **T:** 98.3 **HR:** 101 **RR:** 18 **Sa02:** 99
Pain Level at D/C (0-10):
Intake: Ø **Output:** Ø
Additional Data: Ø
Transferred To: ICW2
Report Given To: Lt.
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Recovery Ro
Charge Nurse Signature: [redacted]

(b)(6)-2

ADMISSION AND CODING INFORMATION

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

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

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
Z Z Z Z Z Z Z Z	3 5 Y	X	9	UNK

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—	Z	2000	—

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø	1CW2	UNK

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
UNK	UNK

(b)(2)-2 [redacted] MEDICAL TREATMENT FACILITY Baghdad

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

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

GSW (R) forearm & (R) thigh

T: 9 Dx: 81315 AR: 7932
Inj: 569 8900 8688
9571
E9912

ADMITTING OFFICE [redacted] (b)(6)-2 SIGN [redacted]

DA FORM 2985, MAR 89

USAPPCV1.0

ADMISSION AND CODING INFORMATION

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

30. AGE AT DISP	31. AUTOPSY Y / N	32. UNDERLYING CAUSE OF DEATH / SEP	33. RESIDUAL DISABILITY	34. DO NOT USE - DATA FILLER #1	35. CAUSE OF INJURY
117 118 119	120	121	122 123 124	125 126 127 128 129 130 131 132 133	134 135 136

36. FIRST DIAGNOSIS *(Principal Diagnosis)*	37. SECOND DIAGNOSIS	38. THIRD DIAGNOSIS
137 138 139 140 141 142 143 144	145 146 147 148 149 150 151 152	153 154 155 156 157 158 159 160
39. FOURTH DIAGNOSIS	40. FIFTH DIAGNOSIS	41. SIXTH DIAGNOSIS
161 162 163 164 165 166 167 168	169 170 171 172 173 174 175 176	177 178 179 180 181 182 183 184
42. SEVENTH DIAGNOSIS	43. EIGHTH DIAGNOSIS	
185 186 187 188 189 190 191 192	193 194 195 196 197 198 199 200	

44. FIRST PROCEDURE *(Principal Diagnosis)*	45. SECOND PROCEDURE	46. THIRD PROCEDURE
210 202 203 204 205 206 207 208	209 210 211 212 213 214 215 216	217 218 219 220 221 222 223 224
47. FOURTH PROCEDURE	48. FIFTH PROCEDURE	49. SIXTH PROCEDURE
225 226 227 228 229 230 231 232	233 234 235 236 237 238 239 240	241 242 243 244 245 246 247 248
50. SEVENTH PROCEDURE	51. EIGHTH PROCEDURE	
249 250 251 252 253 254 255 256	257 258 259 260 261 262 263 264	

52. NUMBER OF DIAGNOSTIC FIELDS CONTAINING CODES	53. NUMBER OF PROCEDURAL FIELDS CONTAINING CODES	54. PRIMARY PROVIDER SPECIALTY CODE	55. BLOOD USAGE Y / N
265 266	267 268	269 270 271	272
0 0	0 0		

(b)(6)-4

ID: [redacted] #.

WB

14-07-03
, 14:49

			Patient Limits	
WBC	11.2 H	x10^3/uL	4.5	10.5
RBC	5.15	x10^6/uL	4.00	6.00
Hgb	12.9	g/dL	11.0	18.0
Hct	42.4	%	35.0	60.0
MCV	82.3	fL	80.0	99.9
MCH	25.0 L	pg	27.0	31.0
MCHC	30.4 L	g/dL	33.0	37.0
Plt	344.	x10^3/uL	150.	450.
LY%	20.3 *L	%	20.5	51.1
LY#	2.3 *	x10^3/uL	1.2	3.4

1. LAST NAME, FIRST NAME / NOM ET PRÉNOM: F&W J 11931 | RANK / GRADE | MALE / HOMME | FEMALE / FEMME

SSN / NUMÉRO MATRICULE | SPECIALTY CODE / GPM | RELIGION / RELIGION

2. UNIT / UNITÉ

FORCE / ÉLÉMENT | NATIONALITY / NATIONALITÉ: Iraqi

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
- [X] WOUND / BLESSURE
- NECK/BACK INJURY / BLESSURE AU COU/AU DOS
- BURN / BRÛLURE
- AMPUTATION / AMPUTATION
- STRESS / TENSION
- OTHER (Specify) / AUTRE (Spécifier)

(1) Open (R) proximal radius fx.
(2) Soft tissue wnd (R) thigh
(3) Probable (R) ulnar n. injury

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE

- [X] ALERT / ALERTE
- VERBAL RESPONSE / RÉPONSE VERBALE
- PAIN RESPONSE / RÉPONSE À LA DOULEUR
- 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

Ancef 1g @ 1300
No other injuries seen on 2° survey

10. DISPOSITION / DISPOSITION

- RETURNED TO DUTY / RETOUR À L'UNITÉ
- [X] EVACUATED / EVACUÉ (1)(6)-2
- DECEASED / DÉCÉDÉ

TIME / HEURE: 1400

11. PROVIDER [redacted]

DATE / DATE (YYMMDD): 14 JUL 03

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

INPATIENT TREATMENT RECORD COVER SHEET

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

(b)(6)-4

1. REGISTER NUMBER [redacted]			2. NAME (Last, First, MI) EPW [redacted]			3. GRADE —	ADMISSION REMARKS
4. SEX M	5. AGE —	6. RACE Z	7. RELIGION MUS	8. LENGTH OF SVC —	9. ETS —	10. PREVIOUS ADMISSION NO	
11. FMP 99		12. SSN [redacted]		13. ORGANIZATION —		14. WARD JCW2	
15. FLYING STATUS —	16. USG —	17. DEPT./BEN R78		18. BRANCH/CORPS —	19. UIC/ZIP —	20. TYPE CASE NBI	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from ER				22. HOURS OF ADMISSION 0053	23. CLINIC SERVICE AAAA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK				25. TYPE DISPOSITION EPW Camp	26. DATE OF DISPOSITION 030715		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK				27b. TELEPHONE NO. UNK	28. DATE OF THIS ADMISSION 030715		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] Dachau					30. DATE OF INTIAL ADMISSION		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINIS[redacted]

(b)(2)-2

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: (R) humerus fx. 812.40

E 819.9

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING [redacted] SIGNATU[redacted]

DA FORM 3647, MAY 79 EDITION OF 1 AUG 76 IS OBSOLETE USAPPC V1.10

(b)(6)-3

AUTHORIZED FOR LOCAL REPRO

DICAL RECORD

PROGRESS NOTES

DATE	NOTES
7.15.03 0300	Pt. to ICW#2 from EMT ambulatory. VSS. Pt. c/o pain to (R) arm c palpation. Neuro checks to (R) arm WNL. Drsng & sling to (R) arm CDI. IVF infusing to (L) AC @ TKO. IV site cleaned, op-site applied. HR Reg, Lungs CTA, BS (+) X4. Pt. NPO for poss. Surgery in A.m. Will cont. to monitor [redacted] (b)(6)-2 [redacted] CTA
15 July 0545	Pt care assumed @ 0500. Pt sleeping, aroused by verbal stimuli. Lung sounds CTA, pulses (+) x4, bs (+) x4 quads. Pt c dsg and sling over rue, both cole (+) pulse, sensation, and ability to move fingers in rue. HL in lue, cap, flushes well. Pt to have hanging arm cast applied @ 0700, will continue to monitor. (b)(6)-2 [redacted] awmc
15 July 0620	chart reviewed (EMT hx) by 5-3, SSG Harris. Because pt has EPW tag A1197 CC 0412722 will be tx as EPW. Upon release to 115th MP Co for their determination. (b)(6)-2 [redacted] LTC, a
15 July 03 1500	assumed care @ 1300 - VSS - no c/o pain - neuro V's WNL in (R) hand, hanging cast in place - SL d'c'd - pt. awaiting d/c to EPW camp [redacted]

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

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

'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. ICW 2

EPW

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (RE
Prescribed by GSA/ICMR FPMR (41CFR) 101-11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
13Jul03 1100	pt. d/c'd to Echo camp via helicopter c hands bound & amb-escort [redacted] (b)(6)-2

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp): EMT

LOG NUMBER:

ARRIVAL DATE			TIME	TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)	CURRENT MEDS. (tetanus immunization and other data)	HISTORY OBTAINED FROM
DAY	MONTH	YR.		☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify) AIR	Ø	☒ PATIENT ☐ OTHER (Specify)
4	JUL	03	0030			ALLERGIES: NKDA

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): (L) ARM PP

SEX: M AGE: 29

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

02.03

VITAL SIGNS			
TIME	0031		
BP	144/99		
PULSE	95		
RESP.	16		
TEMP.	98.5		
WT. (Child)			

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

ORDERS	INITS.	TIME
Xray (R) Arm		
CBC Platelet -		
LYTES PT PTT -		

ASSESSMENT/DIAGNOSIS: (R) Humerus Fx

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: Ward 1

CONDITION UPON RELEASE
- ☒ IMPROVED
- UNCHANGED
- DETERIORATED

TIME OF RELEASE: 0200

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)

TIME SEEN BY PROVIDER: 0035

Ø Allergies

29 y/o ♂ s/p (MVA) injury 4-5 days ~~7-14 days~~

Ago. Released from Iraqi jail today then Iraqi hospital said they wouldn't help so he went to U.S. Air Station got xrays + meds and sent home here. Pt 5 other complaints

G: WD, WN, NAD, AAOx3
E: CTAB ⊘ r/r/rales
C: RRR ⊘ m/r/g
Ext: NVI, ⊕ pain c̄ ROM wrist/Elbow

Pmh - ⊘
PSH - ⊘
Fm - ⊘

516 / 16.6 / 53.4 / 267
3.7 / 3.1 / 10 / 1.1 / 98
PT/PTT 14/23

(R) Humerus
(R) Distal 1/3 Humerus Fx
(R) Radius
UE splint

Ortho to see - Dr. [redacted] (5)(6)-2 wants Xrays (L) Arm AM in AM

(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] EPW

(5)(6)-4

SIGNATURE OF PROVIDER AND ID STAMP

[redacted] 76T

[redacted] medications ordered, any limitations and follow-up plans)

(5)(6)-2

EMERGENCY CARE AND TREATMENT

MEDCOM - 14704 Copy

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

NSN 7540-00-634-4176

600-108

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
15 Jul 03 1215	D/c Summary 29 y/o Iraqi ♂ 4-5 c s/p (L) humerus fx. Seen in ER & placed in hanging arm cast by Dr [redacted] (b)(6)-2 (P) D/c to EPW camp Needs F/u XR ~ 6 wks [redacted] MAJ [redacted] (b)(6)-2

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

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY

July 18 2003 HOUR

PULSE (0)	TEMP. F (°)	TEMP. C (Centigrade Equivalents, for Reference only)
	105°	40.6°
180	104°	40.0°
170	103°	39.4°
160	102°	38.9°
150	101°	38.3°
140	100°	37.8°
130	99°	37.2°
	98.6°	37.0°
120	98°	36.7°
110	97°	36.1°
100	96°	35.6°
90	95°	35.0°
80		
70		
60		
50		
40		

RESPIRATION RECORD

Record special data only when so ordered

BLOOD PRESSURE

HEIGHT: WEIGHT [redacted]

(b)(6)-2

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

[redacted] EPW

(b)(6)-4

REGISTER NO.

WARD NO. ICW

VITAL SIGNS RECORDS

Medical Record

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

Ward/Section: EMT	REQUESTING PHYSICIAN: Dr [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] (b)(6)-7	DATE 15 JUL 03 / TIME 0044	SSN/[redacted]N:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^6

ID: [redacted] (b)(6)-4
MR: [redacted]
15-07-03
00:56

			Patient Limits	
WBC	9.2	x10^3/uL	4.5	10.5
RBC	5.66	x10^6/uL	4.00	6.00
Hgb	16.6	g/dL	11.0	18.0
Hct	53.4	%	35.0	60.0
MCV	94.4	fL	80.0	99.9
MCH	29.4	pg	27.0	31.0
MCHC	31.2 L	g/dL	33.0	37.0
Plt	267.	x10^3/uL	150.	450.
LY%	18.2 *L	%	20.5	51.1
LY#	1.7 *	x10^3/uL	1.2	3.4

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT	14.6	9.8-13.6 secs
APTT	23.8	21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

(b)(6)-2

Ward/Section: EMT	[E]STING PHY[redacted]	[CHEM]ISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI [redacted] (b)(6)-4	DATE 15JUL03 / TIME 0044	SSN/PSEUDO SSN: [redacted] (b)(6)-4

(i-STAT)			(Piccolo) Chemistry 12			(Piccolo) Metabolic Panel		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Na		138-146 mmol/L	ALB		3.5-5.5 g/dl	GLU		73-118 mg/dl
K		3.5-4.9 mmol/L	ALP		26-84 u/l	BUN		7-22 mg/dl
Cl		98-109 mmol/L	AL[T]		10-47 u/l	CA^{++}		8.0-10.3 mg/dl
		7.31-7.45	AM[Y]					0.6-1.2 mg/dl
		35-45 mmHg (art) 41-51 mmHg (ven)	A[ST]					128-145 mmol/l
		80-105 mmHg (art) N/A (ven)	T					3.3-4.7 mmol/l
		23-27 mmol/L (art) 24-29 mmol/L (ven)						98-108 mmol/l
		22-26 mmol/L (art) 23-28 mmol/L (ven)						18-33 mmol/l
		95-98%						
		(-2) – (+3) mmol/L						
		10-20 mmol/L						
		1.12-1.32 mmol/l						
		8-26 mg/dl						
		70-105 mg/dl						
		0.7-1.5 mg/dl						
		38-51% PCV						
		12-17 g/dl						

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

(Piccolo) Electrolyte		
TEST	RESULT	REF. RANGE
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

[Che]mistry — REF. RA[NGE]

i-STAT EC8+

Pt: [redacted] (b)(6)-4

Pt Name: ___________

Glu________98 mg/dL
BUN________10 mg/dL
Na_________140 mmol/L
K__________3.7 mmol/L
Cl_________107 mmol/L
TCO2_______31 mmol/L
AnGap______7 mmol/L
Hct________51 %PCV
Hb*________17 g/dL
*via Hct
pH_______7.366
PCO2______52.1 mmHg
HCO3_______30 mmol/L
BEecf______4 mmol/L

Sample T...

15JUL03 00:54

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

Physician: ____________

Ser# [redacted]

Ver: JAMS046A
CLEW A93

==== PICCOLO ======
15/07/03 00:55
REFERENCE RANGE: MALE
PATIENT #: [redacted]
GENERAL CHEMISTRY 12
DISC LOT #: 3082AA4
OPER #: [redacted] (b)(6)-2 DR #: 000
SERIAL #: [redacted]

ALB	3.7	3.3-5.5	G/DL
ALP	89*	26-84	U/L
ALT	75*	10-47	U/L
AMY	41	14-97	U/L
AST	56*	11-38	U/L
TBIL	0.8	0.2-1.6	MG/DL
BUN	7	7-22	MG/DL
CA++	9.6	8.0-10.3	MG/DL
CHOL	176	100-200	MG/DL
CRE	1.1	0.6-1.2	MG/DL
GLU	107	73-118	MG/DL
TP	7.6	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK
HEM 1+, LIP 0, ICT 0

DATE: ID NO.:

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

EPW

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

15 July 03 | 0052 HOURS

Admit ICW #1

Dx: (1) Humerus Fracture

Condition: Stable

vitals: per Routine

ANI NKDA

Meds: 4mg MSO4 IV Q2-4° prn PAIN

12.5mg phenergan IV Q4° prn NAUSEA vomit.

PATIENT IDENTIFICATION

(b)(6)-2 [redacted] 7-15-03 0320

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

HOURS

Diet: NPO -

Activity: Bedrest

Plan - AE per ~~ortho~~ Dr [redacted]

- Ortho tech - needs to put on a hanging Arm CAST after 0700.

[redacted] 2/2 65

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

(b)(6)-2

7-15-03 0324:

V.O. Dr. [redacted] [redacted]

(1) Reg Diet

(2) D/C IVF

(3) Percocet 1-2 PO Q4-6° PRN pain

[redacted] 47AM

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

15 Jul 03 1215

- D/C to EPW Comp

(b)(6)-2

[redacted]

MAJ [redacted]

NURSING UNIT | ROOM NO. | BED NO.

the proponent agency is the Office of The Surgeon General. MO. 7 YR 2003

RIFY BY INITIALING			INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION												
ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED											
				15	16	17	18	19	20						
7.15	[redacted]	Vitals per routine.	S	[redacted]											
			13												
			21												
7.15	[redacted]	NPO	7												
			11												
			17												
7.15	[redacted]	Bedrest	5	[redacted]											
			13												
			21												
7.18	[redacted]	Reg diet	7	[redacted]											
			11												
			17												

(b)(6)-2

(b)(6)-2

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: (R) humerus fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

#[redacted]

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIME

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 7 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
7-15	[redacted]	Admit to ICW #2	7-15	0245	0245	AB
		(b)(6)-2 Stable.				
7-15	[redacted]	As per Dr. [redacted] ortho tech	7-15	0700		
		needs to put on a hanging				
		arm cast after 0700				

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

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. 7 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 15	16	17	18
7/15	[redacted]	HCIV	5	[redacted]			
	(b)(6)-2		13				
			21				

D/C 15 Jul 03

ALLERGIES: ☐ YES ☑ NO

PRIMARY DIAGNOSIS: @ humerus fx.

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	Mo. 7 Yr. 03

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
7-15	[redacted]	4mg MSO4 IV Q2-4°	[redacted]												
		PRN pain.													
7-15	[redacted]	12.5mg Phenergan IV													
		Q4° PRN nausea,													
		vomiting.													
7-15	[redacted]	Percocet 7-½ PO													
		Q4-6° PRN	[redacted]												

(b)(7)-2

USAPA V1.00

1. LAST NAME, FIRST NAME / NOM ET PRÉNOM	RANK / GRADE	MALE / HOMME FEMALE / FEMME
[redacted]	SPECIALTY CODE / GPM	RELIGION / RELIGION

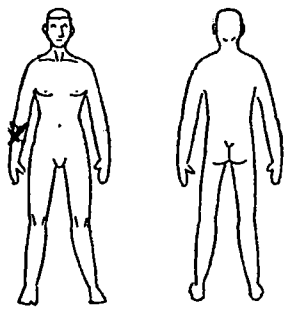
2. UNIT / UNITÉ

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
- [x] OTHER (Specify) / AUTRE (Spécifier)

(R) distal humerus

fx

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE

- [x] 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 [X] 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

- MORPHINE GIVEN at 2251 10mg
- Posterior splint

10. DISPOSITION / DISPOSITION		TIME / HEURE
	[ ] RETURNED TO DUTY / RETOUR À L'UNITÉ	
	[ ] EVACUATED / EVACUÉ	2224
	[ ] DECEASED / DÉCÉDÉ	

11. PROVIDER / UNIT / OFFICIER MÉDICALE / UNITÉ	DATE/DATE (YYMMDD)
(S)(61-7 [redacted]	030714

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

12. REASSESSMENT / RÉASSESSMENT

DATE / DATE (YYMMDD)	TIME OF ARRIVAL / HEURE D'ARRIVÉE
03 07 14	

TIME / HEURE	2249	2300		
BP / PS	118/98			
PULSE / POULS	83			
RESP / RESP	30			

DATE / TIME DATE / HEURE	13. CLINICAL COMMENTS / DIAGNOSIS INFORMATION MÉDICALE / DIAGNOSTIQUES
	14. ORDERS / ANTIBIOTICS (Specify) / TETANUS / IV FLUIDS DIRECTIVES MÉDICALES / ANTIBIOTIQUES (Spécifier) / TÉTANOS / IV FLUIDE

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

16. DISPOSITION / DISPOSITION		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)

1. DATE AND TIME OF CAPTURE	2. SERIAL [redacted]	A
12 July 03 0065		
3. NAME [redacted]	4. DATE OF BIRTH 1 JUN 75	
5. [redacted]		
7. UNIT OF EPW [redacted]		
[redacted] LOCATION OF CAPTURE (grid coordinates)		
MB 385875		
10. CIRCUMSTANCES OF CAPTURE TCP Curfew DWI	11. PHYSICAL CONDITION OF EPW Injured	12. WEAPONS, EQUIPMENT, DOCUMENTS Car papers

(b)(6)-4

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

2nd MODERATE [redacted]

[redacted]

DECEASED [redacted]

Mass Casualty Incident Tag
©Eastern PA EMS Council - 1997

(A) (P)

TIME	2140		
AGE		SEX	M
LUNGS	Good		
PULSE	108		
RESP.	22		
B.P.	110/70		
A	V	P	U

Patient Name (if known) (b)(6)-4 [redacted]

Notes/Treatment Poss. broken (R) Arm
Request X-RAY (R) ARM

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
A 1 1 D 1	I Z	[redacted]	(b)(6)-4 EPW [redacted]	—	M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
—	—	Z	9	Muslim

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

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

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
—	N 7 6	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72 O (b)(2)-2	ICU 2	

[redacted] MENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
[redacted] South		

21. TYPE OF DISPOS[redacted]	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
EPW Camp		0307 15

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
AAAA		0307 15

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: (R) humerus fx

Dx 81220
E887
proc 9353
Trauma 9
INJ 989

(b)(6)-2 [redacted]

ADMITTING OFFICER (Sig[redacted] required)	SIG[redacted] OF ADMITTING CLERK
[redacted]	[redacted]

DA FORM 1056, MAR 80 EDITION OF MAY 75 IS

(b)(6)-2

INPATIENT TREATMENT RECORD COVER SH

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

1. REGISTER NUMBER [redacted]			2. NAME (Last, First, MI) UNK EPW [redacted]			3. GRADE EPW	ADMISSION REMARKS
4. SEX M	5. AGE 32y	6. RACE X	7. RELIGION MUSLIM	8. LENGTH OF SVC —	9. ETS —	10. PREVIOUS ADMISSION NO	
11. FMP 99			12. SSN [redacted]	13. ORGANIZATION —		14. WARD FCW2	
15. FLYING STATUS NO	16. DSG		17. BEN K78	18. BRANCH/CORPS —	19. UNC/ZIP —	20. TYPE CASE WIA	

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: DIRECT FROM ER

22. HOURS OF ADMISSION: 0700

23. CLINIC SERVICE: AGAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: UNK

25. TYPE DISPOSITION: D/C TO CAMP

26. DATE OF DISPOSITION: 28 JUL 03

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

27b. TELEPHONE NO.: UNK

28. DATE OF THIS ADMISSION: 17 JUL 03

ADMITTING OFFICER

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

30. DATE OF INTIAL ADMISSION

31. [redacted]

32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

(b)(2)-2

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

Shot by US soldier after loading & firing his AK-47 @ US soldier

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: S/P I&D (L) ARM/THIGH GSW WASHOUT — 812.10

881.10

877.1

E991.2

86.05

79.31

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	12	12

36. Total Days All Facilities

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. [redacted]	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER

DR [redacted] / WYNN [redacted]

DA FORM 3647, MAY 79

USAPPC V1.10

(b)(6)-2

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

82 yo Iraqi [illegible]
multiple GSW

Shot at US troops
(L) shoulder (L) forearm
(L) Buttocks

[illegible]
[illegible]
[illegible]
NKDA

PHYSICAL EXAMINATION

[illegible]
[illegible]
[illegible]
[illegible]
[illegible]

(L) [illegible]
[illegible]
(L) [illegible] (L) [illegible]
[illegible]
[illegible]

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

A | (L) [illegible], multiple GSW

P | (L) multiple [illegible] / Poss [illegible] [illegible]

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

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

REGISTER NO.	WARD NO.

(5)(6)-2

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

CAL RECORD

AUTHORIZED FOR LOCAL REPRO

PROGRESS NOTES

NOTES

0800 17 July 03

Pt care assumed @ 0800, transferred from emt. VSS, pt c̄ c/o pain in lue, no meds ordered. Lung sounds CTA c̄ equal rise and fall of chest, hrr, bs hyporactive. Pt admitted c̄ LR@100cc/hr to rtKA, running s̄ s/s infiltration or infection. IV @ R external jugular dc'd p̄ 1000cc LR. Pt c̄ foley to gravity, 2400cc CYU, light urine. Two wounds on buttocks covered c̄ 4x4. Dsg on lue intact, some bloody drainage. Pt npo to surgery today. Continue to monitor. [redacted] allum6

Phys

Orno of Note

(b)(6)-2

Prep Dx [illegible]

[illegible] MP TAT [illegible]

p. [illegible] [illegible]

[illegible]

EBL 400cc

TTO

TPAW stable

Plan) [illegible] [illegible] in 48°

(

[redacted]

(b)(6)-2

SHIP TO SPONSOR

LAST | SPONSOR'S NAME | FIRST

SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

REGISTER NO

WARD NO

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509
Prescribed by GSA/ICMR (FPMR 41 CFR 101

TE	NOTES
7Jul03 1700	assumed care @ 1300, pt. to Surgery and returned ~1600, S/P I&D (L) arm/thigh GSW washout - LR @ 100cc/hr infusing into (R) AC, site patent - dsg on (L) upper arm marked @ 1700, dsg on buttock CDI, dsg on back CDI - lungs CTA (B) - (+) BS - Foley to gravity draining CYU [redacted] c/o pain @ this time — (5)(6)-2 [redacted] BAN
8Jul03 2330	UOP 5000cc CYU — (5)(6)-2 [redacted] 4W
7 July 03 2330	Pt - awake & alert & any complaints @ this time. HR Regular, Lung sounds clear bilat, bowel sounds clear bilat. (L) shoulder DSG slightly saturating c̄ bright red blood, noted on tape. DSG to upper back & (L) hip c̄ small amt of bloody drainage noted. HL to (R) FA flushes well c̄ 3cc NS c̄ S/S of infection. Pt. c̄ full ROM in (L) hand, (+) sensation, <3 sec cap refill, minimal ROM in (L) arm. All other assessment findings WNL. Foley draining clear yellow urine. Will continue to monitor (5)(6)-2 [redacted] 24 AM
18 July 03	0700 - Pt alert lying in bed. VSS, temp 99.4. Grave Tylenol for bowgade & mild pain. Lungs CTA, HR reg, BS (+). Pulses (+) & strong bilat to ↑ & lower extremities. Dsg reinforced to (L) shoulder. Dsg to hip intact c̄ old drainage. Pt c̄ full ROM in (L) hand, (+) sensation, cap refill <3 sec. Voiding [redacted] at this time. Will continue to monitor — [redacted]
	0715 - Foley intact draining dark amber (5)(6)-2 urine — [redacted]

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

PROGRESS NOTES

DATE	NOTES
18 July 03	1200 - Dsg Δd to (L) hip. Sutures intact. (b)(6)-2 [redacted] 2L+N
18 JUL 03	- Received PT Alert + oriented. VSS. Lung sound are clear Bilateral c̄ no difficulty Breathing. BS x 4. Good Pulse never function on All extremity. HR R. Hep lock to (R) Forearm is CDI. Flushes well. Dressing to Rear (R) Shoulder drainage Light smart of Blood. Will change dressing. Will continue to monitor PT for comfort. [redacted] PN (b)(6)-2
18 July 2025	- PT dressing was bright red 1½ inch in diameter, MD Gaper was notified. Dressing change to (L) Arm was done. PT is to be NPO After midnight for surgery. Will continue to Monitor. SLT [redacted] PN (b)(6)-2
19 July 03 0130	Pt. asleep in bed. HR Regular, ~~##~~ Lung sands clear bilat, bowel sands (+) x 4 quads. DSG to (L) shoulder, (L) hip, (L) wrist CDI. (L) arm in sling, digits c̄ full ROM, <3 sec cap refill, (+) sensation. HL in (R) FA flused well c̄ 3cc NS s̄ s/s of infection. All other assessment findings WNL. Pt. s̄ complaints @ this time. Will continue to monitor. Pt. NPO since MN. (b)(6)-2 [redacted] 2L/AN
	0530 - Pt alert, temp 99.4. VSS, lungs CTA, BS (+), HL to (R) forearm. Dsg intact to (L) shoulder c̄ old drainage. Dsg to (L) hip CDI. Foley patent

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

SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] (b)(6)-4

REGISTER NO.

WARD NO. ICU

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (R
Prescribed by GSA/ICMR FPMR (41CFR) 101-1

	FIRST NAME	MIDDLE INITIAL	ID NUMBER

TE	NOTES
	C

cont. — draining amber urine. Voiding ∅ complaints at this time. O/c to OR. Will cont to monitor — [redacted] Flatt

(b)(6)-2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
19July03 1500	- Received PT From DACO Alert + oriented to verbal command. VSS. Breath sounds are Bilateral c̄ ⊖ difficulty Breathing. BS x4 c̄ no abdominal distention or rebound tenderness PT has Good Pulse motor Sensory c̄ Good ROM to all extremity. Skin is warm + Dry. Drsg to (L) Shoulder is DSI. No s/s of infection noted. JP draining 10cc of bright red blood noted. Drsg to (L) Gluteus maximus is dry + INTACT. Drsg to rem neck is DSI. PT has 4 Foley to Gravity c̄ clear yellow urine. PT has IV LR @ 100 c/hr on (R) hand Flushing well + INTACT. PT is resting well in bed + will continue to monitor.
(b)(6)-2	[redacted] LPN
19July03 2000	- PT is resting in bed ⊖ c/o pain or discomfort. (b)(6)-2 [redacted] LPN
19July03 2330	Pt. awake & alert in bed. HR Regular, Lung sounds clear bilat, bowel sounds (+) x 4 quads. Foley draining clear orange colored urine. DSG to upper back, (L) shoulder & (L) outer thigh CDI. JP draining dark red bld., 30cc removed from bulb suction. Pt. c̄ c/o pain, 4mg MSO4 given. HL to (R) FA flushed well c̄ 3cc NS c̄ s/s of infection. VSS temp slightly ↑ @ 101.2, ii tylenol given. All other assessment findings WNL. Pt. c̄ other complaints @ this time. Will continue to monitor. (b)(6)-2 [redacted] RN
0530.	JP output 10cc bright red bloody drainage - [redacted]
0600	Pt. care assumed @ 0500. VSS. Pt c/o pain (L) shoulder, ii Percocet given. Drsg to (L) shoulder CDI. (L) ↑ext. pulses 2+ c̄ ⊕ sensation ⊕ rem strong grip, brisk cap refill. Drsg to (L) Buttock also CDI

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

[illegible] OP / [illegible]

prep Dx: (P) 3pt prox thum
OSW Fx

Pt [illegible] ORIF

[redacted] (b)(6)-2
BBC SOUC
TTQ
JP Drain
Pts: Antibiotic Reduction
Gable Fracture

Dr COLEMANS
Pain Rom
To EPW Can 10-21 Days

(b)(6)-2
[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.

PROGRESS NOTES
Medical Record

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

[redacted]
(b)(6)-4

7540-00-634-4176

HEALTH RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE** | 600-108

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
21July03	1240 15cc red tinged fluid from [redacted] (b)(6)-2
21July03	-Assumed PT care. VSS. Lung sounds clear bilateral
1305	35x4. Drsg to (L) shoulder clean dry + intact, JP drained, Ø cc @ start of shift. Drsg to (L) thigh is CDI. HL to (R) hand flushes well c̄ 3cc NS. (+) ROM on All extremity. Will cont to monitor PT. [redacted] (b)(6)-2
21July03	- D/C HL and restarted in (R) arm. Flushes well. Will
1850	cont to monitor [redacted] (b)(6)-2
21July03	Pt. awake & alert in bed. JP to (L) shoulder draining clear red tinged
2300	fluid. (L) hand c̄ full ROM, (+) sensation, cap refill < 3sec. HL in (R) FA flushed well c̄ 3cc NS5 s/s of infection. (L) arm +2 edema. HR Regular, Lungsounds clear bilat, bowel sounds (+) x 4 quads. Pt. c̄ complaints @ this time. Will continue to monitor. (b)(6)-2 [redacted] RN
22 Jul	Assumed care of pt @ 0500. Pt resting quietly. VSS. Lungs CTA. BS x 4 quads. Abd flim. Bandage to (L) shoulder - dry and intact. JP drain to (L) shoulder draining dk red drainage. Ø c/o pain/ discomfort. Will continue to monitor. — [redacted] SGT CPN (b)(6)-2
22July03	Assumed PT care. PT resting in bed c̄ Ø c/o pain. VSS. Lungs CTA. BS x 4. Bandage to (L) shoulder with c̄ 1¾ inch diameter blood stain. Will cont to monitor PT. [redacted]

ENT'S IDENTIFICATION (Use this space for Mechanical at) (b)(6)-2 ICW

[redacted] (b)(6)-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7-20-03 0300 cont...	HR Reg, lungs CTA, ABD soft c̄ BS(+)XY Foley to gravity draining CYU. JP bulb to (L) shoulder patent, draining bright red bloody drainage. HL to (R) hand intact c̄ s/s infection. Will cont. to monitor. (b)(6)-7 [redacted] CTA/AN
7-20-03 1300	- Assumed Pt care. Pt is alert + oriented x3. Dresg to (L) Shoulder CDI. No s/s of infection. JP drained 20cc of bright red blood. Breathsounds clear bilateral, BS x4. HL to (R) FA Flushes well c̄ No s/s of infection. VSS. Pt has BS x4. Foley draining dark yellow urine. Good PMS on all extremity. Will continue to monitor Pt. [redacted] LPN (b)(6)-7
7-20-03 1930	- D/C Foley as per MD Quin order. [redacted] LPN
21 July 03 0030	Pt. awake & alert in bed c̄ c/o pain. HR Regular, Lungsounds clear bilat, bowel sounds (+) x 4 quads. VSS. Dsg to (R) shoulder, upper back & (L) hip CDI. JP to bulb suction draining clear red tinged fluid. HL in (R) FA flushed well c̄ 3cc NS c̄ s/s of infection. Pt. voided 150cc orange colored clear urine. Pt - c̄ complaints @ this time. All other assessment findings WNL. Will continue to monitor. [redacted] DCT/AN
0415	15cc red tinged fluid drained from JP (b)(6)-7 [redacted]
21 July 03	0620 Assume pt care @ 0500. pt awake and alert no c/o pain @ this time VSS. HR reg. Lungs CTA. Abd soft BS x4. Dsg to (L) Shoulder c̄ JP drain CDI+I draining red fluid. Dsg to upper back and (L) hip CDI+I. Sm cyst noted to Lower back soft to touch. HL to (R) FA no s/s redness/infiltration c̄ flush - Will continue to mon [redacted] (b)(6)-7

NSN 7540-00-634-4176

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

AUTHORIZED FOR LOCAL REPRODUCTION

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
22 July 03 1900	- Reinforced dressing to (L) shoulder. Small amount of bright red blood noted. Will cont to monitor. (b)(6)-2 [redacted] CPW
22 July 03 2300	Pt care assumed @2100. VSS, no c/o pain at this time. Lung sounds CTA, pulses palpable x4, bs(+) x4 quads. Dsg on LUE CDI, reinforced by prior shift. Dsg on (L) buttock c̄ bloody drainage noted, reinforced. Pt c̄ IV ABX. No new complaints continue to monitor. (b)(6)-2 [redacted] 91WM6
23 July 03 0815	Pt. awake & alert up completing AM care. DSG to upper back (R) arm, & (L) upper thigh D/C'd, all wounds s̄ s/s of infection. (L) arm in sling, +1 edema, (+) sensation, limited ROM, cap refill <3sec. HR Regular, Lung sounds clear bilat, bowel sounds (+) x4 quads. IV in (R) FA flushed well c̄ 3cc NS s̄ s/s of infection. All other assessment findings WNL. Pt. s̄ complaints @ this time. Will continue to monitor. (b)(6)-2 [redacted] OUT/AN
23 July 03 1300	- Assumed Pt care, Lungs are clear bilateral. BS x4. Dressing to (L) shoulder CDI. (L) elbow has small edema noted. HL to (R) forearm flushed well c̄ 3cc of NS. Will cont to monitor. Pt is resting comfortably in bed. [redacted] CPW (b)(6)-2

HOSPITAL OR MEDICAL FACILITY

SPONSOR'S NAME	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
	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. ICU2

EPW # [redacted] (b)(6)-7

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)
7.23.03 2300:	Pt. care assumed @ 2100. VSS. HR Reg, lungs CTA, BS (+) x4. Pt. denies pain. Drsngs to (L) UE CDI. Staples to (L) shoulder OTA ~~S~~ S/S infection. Neuro checks (L) UE WNL. Will cont to monitor. (b)(6)-2 [redacted]
24 July 03 0700	Pt. awake & alert sitting up in bed eating breakfast. DSG to (L) UE CDI, limited ROM, <3 sec cap refill (+) sensation, radial pulses present, incision well approximated. DSG to (L) hip Δ'd, wound ~~S~~ S/S of infection. HR Regular, bowel sounds (+) x4 quads, Lung sounds clear bilat. Pt. ~~S~~ complaints @ this time. All other assessment findings WNL. Will continue to monitor. HL in (R) EA ~~S~~ S/S of infection. [redacted] (b)(6)-2 [redacted]
1000	New IV placed in (R) bicep
24 July 03 1300	- Pt is Awake & Alert. VSS. Lung sounds clear B. bilat. BS x4 (+) ROM on all extremity c̄ Good Pulse motor function on all extremity. BS x4. Dressing to (L) UE CDI. DSG to hip CDI c̄ ⊖ S/S of infection. Will cont to monitor [redacted] (b)(6)-2 Cpl.
25 July 0140	Pt care assumed @ 2100. VSS, pt awake and alert ~~S~~ c/o pain, 1 percocet given @ 0000. Lung sounds CTA, pulses (+) x4 bs (+). Pt ambulated x1, BM x1. Dsg's on LE CDI, both dsg's to hip/buttock CDI. IV @ (R) arm TA running IV ABX no S/S infiltration. Will cont to monitor. [redacted] (b)(6)-2 Alumno
25 July 03 0550	Pt. asleep in bed easily aroused to verbal stimuli. HR Regular, lung sounds clear bilat, bowel sounds (+) x4 quads. Diagnal incision on (L) shoulder well approximated ~~S~~ S/S of infection. DSG to (L) shoulder CDI. DSG to (L) hip Δ'd, wounds ~~S~~ S/S of infection. Pt. c̄ very limited ROM in (L) arm, pulses palpable, slight edema noted, (+) sensation,

STANDARD FORM 600 (REV. 6-97) BACK

FPI. LEX. Printed on Recycled Paper

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)*
25 July 03 0550	cap refill <3sec. HL in (R) bicep ∃ s/s of infection. Pt. ∃ complaints @this time. All other assessment findings WNL. Will continue to monitor. (b)(6)-2 [redacted] JLT/AN
1430	Pt Stable at this time. VSS. AAO×3 PERRLA. Lungs CTA bilaterally, ∅ resp distress. VSR. Abd soft, non-tender, bowel sounds active × 4 quads. Strong pulses and brisk cap refill × 4 extremities. (L) arm immobile, sutures CDI. Drsg intact. ∅ complaints (b)(6)-2 [redacted] LT/A
1945	Pt ⊤ large formed BM to BR. Pt states he has not gone in 6 days, requesting colace. Will speak ⊤ MD on rounds [redacted] LT/A
2218	Pt. Care assumed @ 2100. VSS ⊼ temp 100.8 A. HR Reg, lungs CTA, BS(+) x4. Drsng to (L) shoulder CDI, staples OTA∃ s/s infection. Neurovascular checks (L) ↑E WNL. Drsng to (L) buttock CDI. Will cont to monitor. (b)(6)-2 [redacted]
26 July 03 0532	Pt. awake & alert in bed. HR Regular, lungsounds clear bilat, bowel sounds(+) x 4 quads. Incision on (L) shoulder well approximated, 2 wounds on shoulder ∃ s/s of infection. (L) radial pulse palpable, capreFill <3sec, (+) sensation, full ROM in hand, limited ROM in (L) arm, no swelling noted. HL in (R) bicep ∃ s/s of infection. Pt. ∃ complaints @ this time.

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. 1CW2

[redacted] (b)(6)-4

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
26 July 03 0532	all other assessment findings WNL. Will continue to monitor. [redacted] (b)(6)-2 [redacted]
0915	New IV placed in (L) hand (b)(6)-2 [redacted]
1430	Pt stable at this time. AAOx3. PERRLA. Lungs CTA bilaterally, Ø resp distress. NSR. Abd soft, non-tender, bowel sounds active x4 quads. (L) shoulder dsg x2 CDI. Staples CDI open to air. assessed by Dr [redacted] (b)(6)-2 to D/C dry and repeat x ray. Ø complaints [redacted]
2130:	Pt. care assumed @ 2100. VSS. Ø complaints. HK Reg, lungs CTA, BS ⊕ x4. HL to (R) hand intact S/S infection. Drsngs to (L) shoulder CDI, staples OTA S S/S Infection. (L) TF ⊂ pulses 2+, ⊕ ROM but ↓, ⊕ sensation, brisk cap refill. will cont. to monitor. (b)(6)-2 [redacted]
27 July 03	NURSING ASSESSMENT: Assumed care of pt. Airway intact, breathing even and unlabored, LS clear to all fields (B). Abd soft, nontender, ⊖ distention. BS ⊕x4. Voids spontaneously. ROM and neurovascularly intact to RUE and (B) LE. LLE has limited ROM 2° pain (kept in sling) and is neurovascularly intact. IV in (L) hand flushes well S/S ⊖ S/S infection. [redacted] (b)(6)-2 [redacted]
27 July 03 1300	- Assumed PT care. PT had a moderate fever of 100.5 F. ~~Tylenol~~ Tylenol were given. PT Breath sounds are clear Bilateral. BS x4. ⊕ ROM on all extremity. Good PMS on all extremity. Drsg to (L) shoulder CDI. Stapler are CDI ⊂ ⊖ S/S of infections. Will cont to monitor Temp. [redacted] (b)(6)-2

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)*
25 July 03 0550	cap refill <3sec. HL in (R) bicep ∃ s/s of infection. Pt. ∃ complaints @this time. All other assessment findings WNL. Will continue to monitor. (b)(6)-2 [redacted] /AN
1430	Pt stable at this time. VSS. AAOx3. PERRLA. Lungs CTA bilaterally, ∅ resp distress. NSR. Abd soft, non-tender, bowel sounds active x 4 quads. Strong pulses and brisk capr refill x 4 extremities. (L) arm immobile, sutures CDI. Drsg intact. ∅ complaints (b)(6)-2 [redacted] /AN
1945	Pt ∃ large formed BM to BR. Pt states he has not gone in 10 days, requesting colace. Will speak ∃ MD on rounds (b)(6) [redacted] /AN
2218	Pt. Care assumed @ 2100. VSS x̄ temp 100.8 A. HR Reg, lungs CTA, BS (+) x4. Drsng to (L) shoulder CDI, staples OTAJ s/s infection. Neurovascular checks (L) UE WNL. Drsng to (L) buttock CDI. Will cont to monitor. (b)(6)-2 [redacted]
26 July 03 0632	Pt. awake & alert in bed. HR Regular, lungs and clear bilat, bowel sounds (+) x 4 quads. Incision on (L) shoulder well approximated, 2 wounds on shoulder ∃ s/s of infection. (L) radial pulse palpable, capr fill <3sec, (+) sensation, full ROM in hand, limited ROM in (L) arm, no swelling noted. HR in (R) bicep ∃ s/s of infection. Pt. ∃ complaints @ this time.

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. 1CW2

#[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

NSN 7543-00-634-4175

MEDICAL REC

CHRONOLOGICAL RECORD OF

DATE | SYMPTOMS, DIAGNOSIS, TREATMENT, TREATMENT | CARE

[redacted]

(5)(6)-2

HOSPITAL OR MEDICAL

SPONSOR'S NAME

PATIENT'S IDENTIFICAT

EDW

[redacted]

(5)(6)-4

RECORD OF MEDICAL

NSN 7540-01-075-3786

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

TEST RESULTS

CBC		SMAC				ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
WBC 20.7		138	105	6		SUP 02	PH	PO2	RESULTS CXR - ∅ pneumo (+) Bullet LAT - (+) Bullet in soft tissue (L) Shoulder - (+) Humerus Fx	
H/H 13.6/		3.6	25	143	1.0	PCO2	SAT	OTHER		
PLT 127						DIP			EKG INTERPRETATION ABD: ∅ Fx / ∅ Fx Pelvis ∅ Fx :	
PT 14						U/A WNL				
APTT 23		BHCG	ETOH	GLU		MICRO				

PROVIDER HISTORY/PHYSICAL

32 y/o ♂ who was shot (3) times c̄ 9mm ≈ 4 hrs ago. the perp had an AK47 that was confiscated then returned to him. after he was given it back he loaded it and fired on the soldiers who gave it to him. Arrived via Aerovac

6: WD, WN, NAD, A&Ox3

H: NCAT, PERRLA, EOMI, S/P ⊖

Ni ∅ neg (+) FB/Exit superior back/neck

L: ⊖ ⊖ ⊖ ⊖ ⊖ ⊖ ⊖ ⊖ ⊖ ⊖ ⊖ ⊖ ⊖ ⊖ ⊖ ⊖

A/P

Ext: (+) thigh + thigh (L) Distal Forearm

(+) (L) Arm deform/bleed/+, NVI, FABRM

ABD: soft, NT, no ⊕BS, ∅ peritoneal sign

PMH - ∅
PSH - ∅
Im ~~OTA~~?

FST Exam
Neg

(b)(6)-2

CONSULT WITH	TIME	ACTION
[redacted]		to OR
[redacted]	C/E Areal	

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP [redacted] 2265

DIAGNOSIS
(1) GSW (L) Arm c̄ Humerus Fx
(2) GSW (L) Buttock.
(3) GSW (L) Forearm

CODES (b)(6)-2

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

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

NSN 7540-01-075-3786

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

PATIENT'S HOME ADDRESS OR DUTY STATION			ARRIVAL	
STREET ADDRESS			DATE *(Day, Month, Year)* 17 Jul 03	TIME 0530
CITY	STATE	ZIP CODE	TRANSPORTATION TO FACILITY medevac	

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

CURRENT MEDICATIONS	INJURY OR OCCUPATIONAL ILLNESS				EMERGENCY ROOM VISIT	
none	ITEM	YES	NO	WHEN *(Date)*	DATE LAST VISIT	24 HOUR RETURN ☐ YES ☐ NO
	IS THIS AN INJURY?			WHERE	TETANUS	
ALLERGIES	INJURY/SAFETY FORMS				DATE LAST SHOT	COMPLETED INTITIAL SERIES ☐ YES ☐ NO
NKda	HOW					

CHIEF COMPLAINT GSW

CATEGORY OF TREATMENT		VITAL SIGNS					
☐ EMERGENT	TIME 0532	TIME	0535				
☒ URGENT	INITIALS [redacted] (b)(6)-2	BP	149/81				
		PULSE	120				
		RESP	17				
☐ NON-URGENT		TEMP	97.6				
		WT	185 (93)				

LAB ORDERS					X-RAY ORDERS		
☒	CBC/DIFF	ABG	☒ PT/PTT	☒ BHCG/URINE/BLOOD/QUANT	☒	CXR PA & LAT/PORTABLE	C-SPINE
	URINE C&S	UA MSCC/CATH		☒ CHEM: 12C lytes		ACUTE ABDOMEN	LS SPINE
	BLOOD C&S X					SINUS	HEAD CT
						ANKLE R/L	
					X	Shoulder, L	

ORDERS

☒ PULSE OX ☒ MONITOR ☒ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
0540	NS IV 1000mlx	[redacted]	[redacted]	0540	
0545	CXR PA/LAT			0550	
0540	Labs			0544	
0556	Foley Catheter			0602	

DISPOSITION	DISPOSITION QUARTERS/OFF DUTY	PATIENT/DISCHARGE INSTRUCTIONS
☐ HOME ☐ FULL DUTY	☐ 24 HRS. ☐ 48 HRS. ☐ 72 HRS. (b)(6)-2	
MODIFIED DUTY UNTIL	RETURN TO DUTY	

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

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

#[redacted] (b)(6)-7

[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)
USAPA V1.00

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: 21 yrs.

HEIGHT:

WEIGHT:

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

3. PREVIOUS SURGERY [ ] NO [✓] YES (type):
Removal of Bullet from (L) Shoulder wound Washout (L) Shoulder

4. PROPOSED SURGICAL PROCEDURE:
ORIF (L) Shoulder

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

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

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

Epw # [redacted] (6)(6)-4

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

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

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

(4)(6)2 [redacted] LPT/AN 19 Jul 03 DATE

11. POSTOPERATIVE EVALUATION: SKIN INTEGRITY: Bovie Pad Site: ☐ Clean and Dry ☐ Red ☐ N/A DRESSING DRY & INTACT (Y) (N)

LEVEL OF CONSCIOUSNESS: ☐ A&O ☐ Drowsy ☐ Sleepy ☐ Intubated BREATHING EASY: (Y) (N)

LEVEL OF ACTIVITY: ☐ Moves All Extremities ☐ Moves Upper Extremities ☐ Transferred to litter with roller due to spinal

12. PREOPERATIVE EVALUA[redacted] PREPARED BY (Signature and Title [redacted] LPT/AN

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title)

DATE: 19 Jul 03 TIME: 0900 (4)(6)-2 DATE: TIME:

REVERSE OF FORM 5179, JUN 91

USAPA V1.0

MEDICAL RECORD | **INTRAOPERA...E 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: Cart BY Amb & OR Staff
2. PATIENT I[redacted] AND PROCEDURE VERIFIED BY [redacted] CPT/AN
3. DATE 17 Jul 03 TIME PATIENT ARRIVED IN SUITE 1 CW → OR
4. PATIENT IN ROOM TIME 1335 (b)(6)-2 NUMBER 2-1/4

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKDA, NPOP MN

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] (1st Tech) (b)(6)-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

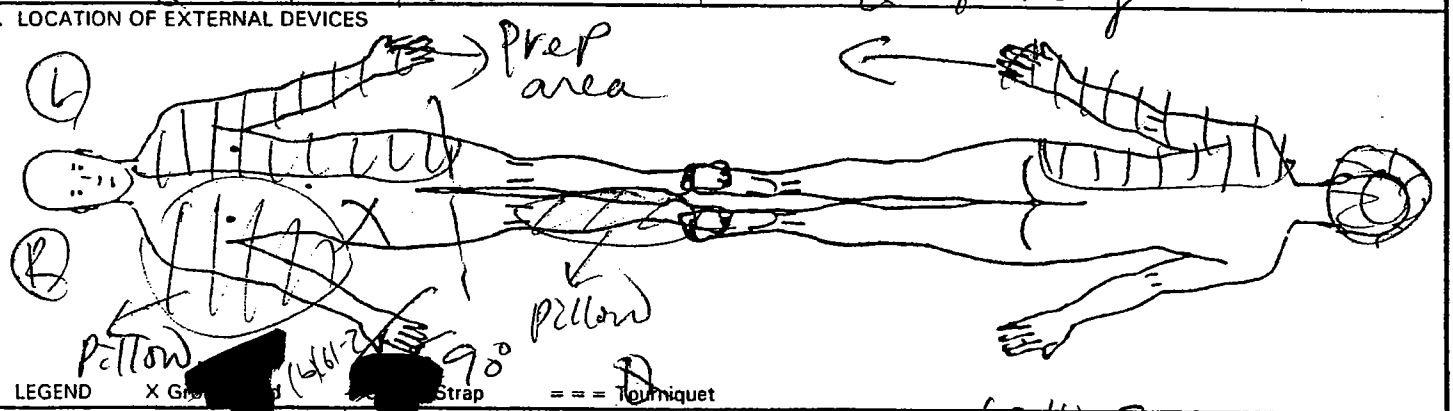
COMMENTS: Bean Bag used for position. Pillow under Rt arm & between knee

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Betadine S/sol
SITE: (Lt) Hip BY WHOM:
SITE: (Lt) Side & Arm BY WHOM: CPT. [redacted] (b)(6)-2
COMMENTS: ⊗ Poultry

9. LOCATION OF EXTERNAL DEVICES



C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes ☐ No					
Needle Sharp	☑ Yes ☐ No		C	C	PFC [redacted]	CPT. [redacted]
Instrument	☐ Yes ☑ No					
Other	☐ Yes ☑ No					

(b)(6)-2

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

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

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

☑ ESU NO: Valley Lab #4
GROUND PAD: BRAND Polyhesive II
LOT NO: 012

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

Cont: no | Cut: 30

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):

0.9% saline

OTHER ORDERS

	TIME	CARRIED OUT BY

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

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 ☐

	1.	2.	3.
TYPE/SIZE	1/2" Iodoform	penrose	
SITE	Back & Hip	Shoulder	

18. DRESSING/IMMOBILIZATION *(Specify)*

fluffs 4x8
Kerlix
Ace Tape

19. ADDITIONAL INFORMATION

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

20. OPERATION(S) PERFORMED

Removal of Bullet from (L) Hip & Washout (L) Side wd and (L) Shoulder.

21. PATIENT TRANSFERRED TO ICU TIME See Anes. Record METHOD Litter

22. [redacted] NURSE SIGNATURE [redacted] SPC (AN).

REVERSE [redacted] USAPA V1.01

(b)(6)-2

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

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Litter BY Amb. OR Staff

2. PATIENT IDENTIFIED, RECORD REVI[redacted] AND PROCEDURE VERIFIED BY [redacted] CPT/AN

3. DATE 19 Jul 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 1003 (b)(6)-2 NUMBER 2-1 / 3

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKDA. NPO pMN.

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] ORT.	RELIEF SCRUB	SSG [redacted] (1FST) ~~1215~~
ASSIGNED CIRCULATOR	CPT. [redacted]	RELIEF CIRCULATOR	CPT [redacted] (1145-1230)

(b)(6)-2

7. POSITION AND POSITIONAL AIDS (Specify) Beach chair position.

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

COMMENTS: Roll under (L) Shoulder. Pillow under knee, Body alignment maintained. (R) arm to @ side.

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☑ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS: Ø

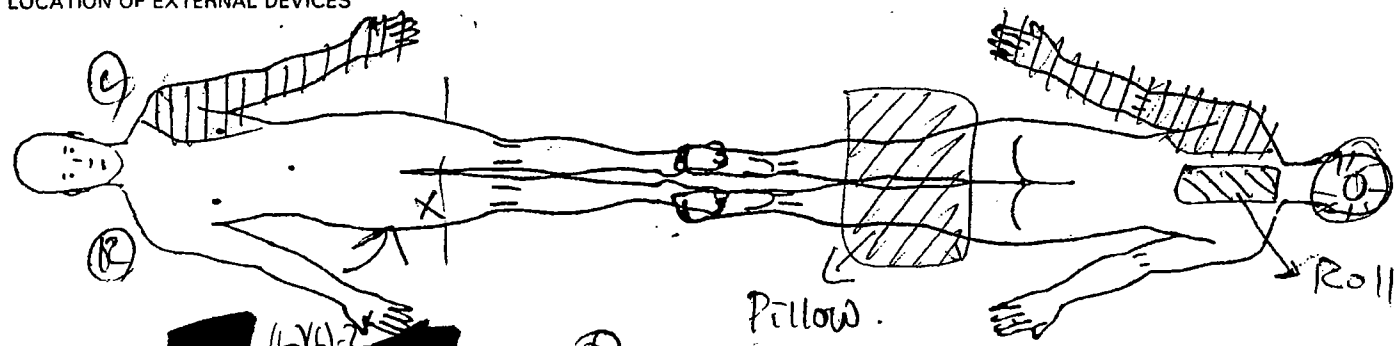
PREP SOLUTION (Specify) Alcohol / Betadine sol

SITE: (L) Shoulder BY WHOM: CPT [redacted]

SITE: (L) arm BY WHOM:

COMMENTS: Ø Pooling

9. LOCATION OF EXTERNAL DEVICES



LEGEND X G[redacted]ad -- Sa[redacted]p = = = Tourniquet (b)(6)-2

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes ☐ No	/	C	C	SPC [redacted]	CPT. [redacted]
Needle Sharp	☑ Yes ☐ No					
Instrument	☐ Yes ☑ No					
Other	☐ Yes ☑ No					

(b)(6)-2

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

EPW # [redacted]

(b)(6)-7

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

☑ ESU NO: Valley Lab #X000450

GROUND PAD: BRAND polyhesive II

LOT NO: 68936.

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

Coag: 230 / Cut 230

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

Synthes Large Frag Set
Plates + Screws
CMS # 06191 01/0319202

4.5 mm Cortex Screws
30 mm x 2
42 mm x 1
46 mm x 1
50 mm x 1

T-Plate
240.05 X 1

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):

0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☑ NO ☐ C-ARM IF YES, SITE (L) Shoulder

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. 10mm J.P	2.	3.
SITE	1. (L) Shoulder	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

fluffs 4x8
ABD's
Tape

19. ADDITIONAL INFORMATION

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

20. OPERATION(S) PERFORMED

ORIF (L) Shoulder

21. PATIENT TRANSFERRED TO (b)(6)-2 1 cu TIME See Anes. Record METHOD Litter

22. [redacted] (AN)

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 17, 18, 19, 20, 21, 22, 23

19 | HOUR

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

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)

PULSE (O): 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

~~WARD NO.~~

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

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR July 03 DAY 24 25 26 27 28

19 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° 98.6° 37.2° 37.0°

120 98° 36.7°

110 97° 36.1°

100 96° 35.6°

90 95° 35.0°

80

70

60

50

40

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

O2 Sats →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICW2

[redacted] (b)(6)-4

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

Ward/Section: Emt

(b)(6)-7

ESTING [redacted]

C STRY RESULT FORM
(Subject to the Privacy Act of 1974)

LAST, FIRST [redacted] (b)(6)-4

DATE 17 July 03 TIME 0535

SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-1		
Drug of Abuse		

REMARKS:

1-STAT EC8+

Pt: [redacted] (b)(6)-4

Pt Name:_____

Glu_____139 mg/dL

BUN_____8 mg/dL

Na_____138 mmol/L

K_____3.6 mmol/L

Cl_____105 mmol/L

TCO2_____25 mmol/L

AnGap_____13 mmol/L

Hct_____43 %PCV

Hb*_____15 g/dL

*via Hct

pH_____7.327

PCO2_____45.3 mmHg

HCO3_____24 mmol/L

BEecf_____-2 mmol/L

Sample Type_:

17JUL03 05:50

Oper: [redacted] (b)(6)-7

Physician:_____

Ser# [redacted]

Ver: JAM5046A
CLEW A93

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl

======= PICCOLO =======

17/07/03 05:52

REFERENCE RANGE: MALE

PATIENT #: [redacted] (b)(6)-7

GENERAL CHEMISTRY 12

DISC LOT #: 3082AA4

OPER #: [redacted] (b)(6)-7 DR #: 000

SERIAL #: [redacted]

ALB	3.5	3.3-5.5	G/DL
ALP	73	26-84	U/L
ALT	18	10-47	U/L
AMY	60	14-97	U/L
AST	24	11-38	U/L
TBIL	0.5	0.2-1.6	MG/DL
BUN	6*	7-22	MG/DL
CA++	8.4	8.0-10.3	MG/DL
CHOL	140	100-200	MG/DL
CRE	1.0	0.6-1.2	MG/DL
GLU	143*	73-118	MG/DL
TP	6.7	6.4-8.1	G/DL

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

REPORTED BY:	DATE:	LAB ID NO.:
[redacted] (b)(6)-7		

17 July 03

(b)(6)-2

Ward/Section: Eur	R	[redacted]	LA ORY RESULT FORM (Su... to the Privacy Act of 1974)
LAST, FIRS[redacted]		DATE: 17 July	TIME: 0335	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10³

(b)(6)-4

Re Do

[redacted]

Urinalysis

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

CSF

Cell Count	
Other	
Directigen	Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT	13.8	9.8-13.6 secs
APTT	23.6	21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] **DATE:** **LAB ID NO.:**

(b)(6)-2

(b)(6)-2

Ward/Section: EMT	ORDERING PHYSICIAN: Dr. [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] (b)(6)-7	DATE 17 Jan 03 / TIME 0623	SSN/PSEUDO SSN: [redacted] (b)(6)-7

(Hematology) CBC

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

Urinalysis

TEST	RESULT	REF. RANGE
Color	Yel	N/A
App	Clear	N/A
Glu	Neg	Negative
Bili	Neg	Negative
Ket	Neg	Negative
SG	1.020	N/A
Bld	Neg	Negative
pH	6.0	N/A
Prot	Neg	Negative
Urob	0.2	0.2-1.0
Nit	Neg	Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	DATE: 17 Jan 03	LAB ID NO.:

(b)(6)-2

ICW2

EPW # [redacted] (b)(6)-7

[redacted] 2L7 m.

(b)(6)-2

18JUL03 0350

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		1.8-10.8 x 10³
RBC		
Hgb		
Hct		
MCV		
MCH		
MCHC		
Plt		
Neut		
Band		
Lymph		
Atyp		
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Baso		
Immat		

Urinalysis

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] (b)(6)-2 **DATE:** 18JUL03 **LAB ID NO.:**

(b)(6)-2

Ward/Section: [redacted] REQ [redacted]

LABORATORY RESULT FORM
(Subject: the Privacy Act of

(b)(6)-7

DATE: 200603 TIME: 0330 SSN: [redacted]

(b)(6)-7

TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10³	Color		N/A	RPR		Negative
RBC			pp		N/A	Mono		Negative
Hgb			u		Negative	[redacted]		
Hct			li		Negative	Source		
MCV					Negative	Gram Stain		
[redacted]			G		N/A	Occ Bld		
			ld		Negative	H. pylori		Negative
			H		N/A	Micro Parasites		
Segs			rol		Negative	Malaria		
Bands			Urob		0.2-1.0	O & P		
Lymph			lit		Negative	Other		
AWP		Imm	Leuk		Negative	[redacted]		
RDW			HCG		Negative			
Volph								
Hgb		42-52% (M) 37-47% (F)	[redacted]			[redacted]		
Hematocrit								
Rate			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED		
Other			Directigen		Negative	ABO/Rh		

[redacted]

TEST	RESULT	REF. RANGE	UNIT	TYPE	CROSSMATCH
PT		9.8-13.6 secs			
PTT		21-34 secs			
Digoxin		<2.0 ng/ml			
[redacted]		<10 ng/ml			
[redacted]					

REPORTED BY: [redacted] DATE: LAB ID NO:

(b)(6)-2 20dec03

MEDCOM - 14747

ANESTHESIA PLAN OF CARE ... PROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 32 DAYS MOS YRS

Sex (✓) MALE ( ) FEMALE

PROPOSED PROCEDURE: Debridement removal/Possible OR (LUE)

SURGICAL SERVICE: Ortho

NPO SINCE: 2200 16 Jul 03

ASA Physical Status 1 2 3 4 E

WT: 85 (KG/LB) HT:

ALLERGIES: NKDA

HABITS:

TOBACCO: Ø

ETOH: Ø

DRUGS: Ø

CURRENT MEDICATIONS:

( ) = ordered as premed

( ) N/A

( )

( )

( )

( )

( )

PREMEDICATIONS:

None Yes (@ _____ Hrs) /CC

_____ . _____ mg IV IM PO

_____ . _____ mg IV IM PO

_____ . _____ mg IV IM PO

LABORATORY STUDIES:

HB/HCT: _____ / _____

U/A: _____

OTHER: _____

T/PTT 3.8/23.6 17 Jul 03

15.5 3.8 41.3 123

130 105 8

3.6/23 139

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	
Angina	N	Y	
MI	N	Y	
CVA	N	Y	
Other	N	Y	
Pulmonary System:			
Asthma	N	Y	
Bronchitis/URI	N	Y	
COPD	N	Y	
Other	N	Y	
Renal System:			
Acute/Chronic RF	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	
Hiatal Hernia	N	Y	
PUD/GERD	N	Y	
Endocrine System:			
Diabetes	N	Y	
Steriods	N	Y	
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	
Other	N	Y	
Gynecological :			
Pregnancy	N	Y	
Other Significant Hx:			
	N	Y	
	N	Y	
Familial HX	N	Y	

ASSESSMENT

PAST SURGICAL/ANESTH: N/A

O-A hx GEA

Coupl.

PHYSICAL EXAMINATION

BP 142 HR 90 R ___ T ___

Pain Scale 0-10 ___

HEENT - Teeth: Intact

Trachea: M

TMJ/Neck: FROM

Oropharynx: Cl 2, 3/6 Tr.

Nares

CHEST: BBS+/CTA

CARDIAC: S1S2 ⊖

EXTREMITIES: GSW (L)UE/buttock

IV Access: #18 (R) A/C

Ulnar Filling: ___

BACK: ___

OTHER: ___

NPO Since 2200 16 Jul 03

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): _____ ~~{ } General:~~ Mask Intubation

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

The patient/le[redacted]d and agrees. Questions answered. (b)(6)-2 per Translator "Bill"

Signed: [redacted] Date: 17 Jul 03 Time: 2200 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)

[ ] NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: _____ Date: _____ Time: _____ Hrs

SEDATION KEY:

1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance necessary.
3. DEEP SEDATION/ANALGESIA Patient responds purposefully following repeated or painful stimulation. Airway assistance ...

Patient Identification: (Ward) _____

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

ICW 2

ESTHESIA PLAN OF CARE P... ROCEDURAL ASSESSMENT (Sedation-anesthesia)

32 DAYS MOS (YRS)

Sex (X) MALE ( ) ~~FEMALE~~

POSED PROCEDURE: ORIF (L) SHOULDER

GICAL SERVICE: ORTHO

SINCE:

ASA Physical State (1) 2 3 4 5 E

WT: 85 (KG) LB HT: ___ IN.

ALLERGIES: NKDA

ITS:

BACCO: Ø

ETOH:

DRUGS:

RENT MEDICATIONS:

ordered as premed

NA

MEDICATIONS:

e Yes (@ ___ Hrs) /CC

___ · ___ mg IV IM PO

___ · ___ mg IV IM PO

___ · ___ mg IV IM PO

ORATORY STUDIES:

HCT: 13.1 / 40.6

18 July

IER:

PCT 227

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

DENIED

Cardiovascular:		
Hypertension	N Y	
Angina	N Y	
MI	N Y	
CVA	N Y	
Other	N Y	
Pulmonary System:		
Asthma	N Y	
Bronchitis/URI	N Y	
COPD	N Y	
Other	N Y	
Renal System:		
Acute/Chronic RF	N Y	
Gastrointestinal:		
Hepatitis	N Y	
Hiatal Hernia	N Y	
PUD/GERD	N Y	
Endocrine System:		
Diabetes	N Y	
Steriods	N Y	
Thyroid	N Y	
Neurological:		
Seizures	N Y	
Neuropathy	N Y	
Other	N Y	
Gynecological :		
Pregnancy	N Y	
Other Significant Hx:		
	N Y	
	N Y	
Familial HX	N Y	

ASSESSMENT

PAST SURGICAL/ANESTHETIC

ORIF (L) A

Ø COMPLICATIONS

PHYSICAL EXAMINATION

BP ___ HR ___ R ___ T ___

Pain Scale 0-10 ___

HEENT - Teeth ___

Trachea WNL

TMJ/Neck FROM

Oropharnyx MP 2

Nares ___

CHEST: CSA

CARDIAC: S_1 S_2

EXTREMITIES:

IV Access: (R) A

Ulnar Filling: ___

BACK: ___

OTHER: ___

NPO Since Prior To MN

ESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ___ { ✓ } General: Mask Intubation

ORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to ussed with the patient/[redacted] (b)(6)-7

patient/[redacted] and agrees. Questions answered.

ned: [redacted] Date: 19 July 03 Time: 0540 Hrs

T-ANESTHESIA EVALUATION AND NOTE (NON ASU)

NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

ned: ___ Date: ___ Time: ___ Hrs

SEDATION KEY:

1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is n necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may

ent Identification: (Ward) ___

[redacted] (b)(6)-7 ICW_2/ICU_2

MEDICAL RECORD - ANESTHESI

For [illegible] of this form, see AR 40-66; the proponent agenc[illegible] the OTSG

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

DRUG (Units)																		
Versed																		
Fentanyl	mcg	100	50			100												
Lidocaine	(mg)	10																
Zemuron	(mg)	5																
propofol	(mg)	180			10													
Sch	(mg)	100																
Propenidyl	(mg)	0.625																
VOLAT. AGENT	Sevoflurane	Sevo	3	1.2	1.2	1.2	1.2	1.2	.8	.8								
		% e.t.																
AIR		L/Min																
N2O		L/Min																
O2		L/Min	6	2	2	2	2	2	2									

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

FLUIDS

LINE site																		
(R) AC RL	☐ Warmed																	
	☐ Warmed					100												
	☐ Warmed																	
	☐ Warmed																	

LOSSES

EST BLOOD LOSS																		
URINE -																		

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 85 (KG) LB

HEMATOCRIT: 13.8/41.3

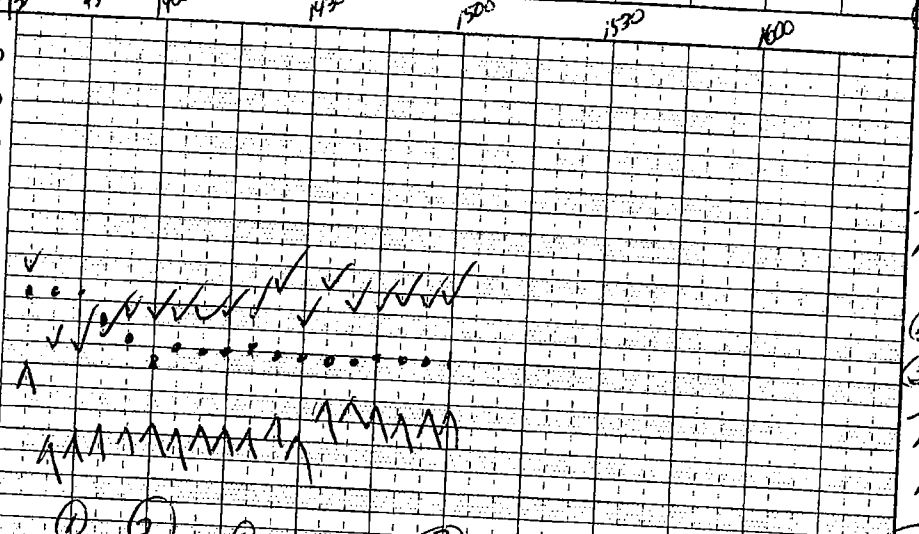
INITIAL DATA: BP- 122/80 HR- 114

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? Y TIME- 1335

TIME 1330 1345 1400 1430 1500 1530 1600

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



VENTIL

VT - ml			(1) 730	(2) 700	(3) 700	710	(3) 700	
f - breaths/min			10	10	9	9	9	16
Peak inf pres / PEEP			18	19	20	20	20	
MODE - S(pon), A(ssist), C(on)		S	C	C	C	C	C	S

MONITORS/ACCESSORIES

X BP/Auto Cuff	X ET CO2 (torr)		32	32	34	34	34	47
BP/oth	X FIO2 (Frac or %)	.67	.67	.67	.67	.67	.67	.68
ART line	X SpO2 (%)	100	98	99	99	99	100	100
X Steth (PC/ES)	ECG	ST	SR	SR	SR	SR	SR	SR
Gas analyzer	X TEMP-site Skin		36.7	36.8	36.8	36.8	37	
	N-M Block (T/4)							
Warming blkt								
Conv warmer								

Mark with letters & symbols, explain under REMARKS — EVENTS / Position → ok! ok! bony prominences padded + arms at <90° angles.

TOTALS: 250 mg, 10 mg, 150 mg, 80 mg, 100 mg, 0.625

TOTAL EBL: 100 cc

TOTAL URINE:

FLUIDS - SUMMARY: CRYSTALLOID- 600 cc; COLLOID-; BLOOD- ø

REMARKS

Code drugs with numbers, events with letters

Pt ID'd & interviewed ok

(1) positioned (R) lateral c bean bag & axillary roll, pillow btw arms + pulse ox on lower +/= radial pulse, blanket btw legs - lower vent feet off bed

(2) Ancef 1 gm IV

(3) TO ADU 2 P extubation - no problems Pt opens eyes spontaneously

Report to Pat [redacted]

RECOVERY AT: PACU ICU 2 (Specify) OTHER

CONDITION: RESP- 18 SpO2- 96 RA BP- 117/[illegible] 96

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1308	1335	1570
	Ready	Begin	End
PROC	1343	1419	1453

PROCEDURES and CPT Codes: Removal Foreign bodies (L) buttock + (L) shoulder + washout

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA 8.0 +/= BBS @ 24 (+) ETCO2

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: DLX1 Atraumatic, MPI airway MAC 3

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

[redacted] EPW

(b)(6)-7 (b)(6)-2

SU[redacted]

ANESTH[redacted] CRNA

PROCEDURE LOCATION: 2 OR

DATE: 17 July 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998

MEDCOM - 14750

COPY 1 - PATIENT'S MEDICAL RECORD

USAPA V1.00

ASA-1

32/M NKDA

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)												
MIDAZ	(mg)	1	3										
FENT	(mcg)	50	100				100		200			50	
PROPOFOL	(mg)		150										
	( )												
	( )												
SUCC ROC	(mg)		100				20						
VOLAT AGENT SEVO	% del		3	1	1	1	1.5	1.5	1.5	0.6/0.4			
SEVO	% e.t.		1.5	1									
AIR	L/Min												
N2O	L/Min												
O2	L/Min		4	2	2	2	2	2	2	6	6	6	

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

FLUIDS — LINE site (R) A 20G ☐ Warmed; LR, ☐ Warmed; ☐ Warmed; ☐ Warmed

LOSSES — EST BLOOD LOSS; URINE -

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: 85 KG

HEMATOCRIT:

INITIAL DATA: BP- 128/82; HR- 120

EQUIP CHECK OK? Y N

PATIENT RECHECK OK for PROCEDURE? TIME- 1015

TIME 1015 30 45 1100 15 30 45 1200 Noon 15 30 45 1300 15

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

250/250 200/200 50/300 200/200 50/300

VENTIL

VT - ml			610	610	900	880	880	900	910	540	
f - breaths/min	16	12	10	10	6	8	8	8	8	16	16
Peak inf pres / PEEP			18	18	22	22	22	22	22	17	
MODE - S(pon), A(ssist), C(on)	S	S	C	C	C	C	C	C	C	C	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)			37	36	36	44	33	32	32	30	54
BP/oth	FIO2 (Frac or %)	RA	RA	.86	.85	.85	.84	.83	.83	.83	.83	.84
ART line	SpO2 (%)	97	97	98	100	100	99	98	99	100	100	100
Steth- PC/ES	ECG	ST	ST	ST	ST	ST	ST	ST	ST	ST	ST	ST
Gas analyzer	TEMP-site											
	N-M Block (T/4)											
Warming blkt												
Conv warmer												

(L) INTERSCALENE BLOCK: BETADINE PREP TO (L) NECK. 2 IN, 22G, INSULATED, B-BEVEL NEEDLE → PNS @ 1.7mA & 1 SEC TWITCH → 0.2mA ABLATED ē 1cc OF MIXTURE: 1:1 MIX OF (1% LIDO + 0.5% BUPIV) @ 5cc/ASPIRATION FOR A TOTAL OF 40cc. (ē 1:200K EPI)

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

TOTALS 5mg, 500mcg — **TOTAL EBL** 300 — **TOTAL URINE** 300

FLUIDS SUMMARY — CRYSTALLOID 800 LR; COLLOID-; BLOOD-

REMARKS

Code drugs with numbers, events with letters

10⁰⁰ PRE OP EVAL REVIEW — NO Δ. 20G IV → (R) A WACKED TO OR.

10¹⁵ OR #2 MONITORS ↑

(L) INTERSCALENE BLOCK (SEE BELOW)

10¹⁶ PRE O2 IND — INT

12⁴⁶ Suction Agreed to EXTUB

Report to [redacted] (b)(6)-2

RECOVERY AT — PACU ICU 2 (Specify); OTHER; CONDITION: STABLE Room Air; RESP 16 SpO2 94; BP 138/102 HR 137

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1000	1015	1305
	Ready	Begin	End
PROC	1045	1121	1250

PROCEDURES and CPT Codes: (L) Shoulder ORIF

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

[redacted] (b)(6)-7

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

(L) ISB + GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

DL x1 / [redacted] 8.0 ETT → VC ē BBS (=), ETCO2 (+) SECURED 22cm/LIPS EYES TAPED 38 CSM

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

ANES [redacted]

PROCEDURE LOCATION: OR 2

DATE: 19 JULY 03

PAGE 1 OF

DA FORM 7389, FEB 1998

MEDCOM - 14751

COPY 1 - PATIENT'S MEDICAL RECORD

USAPA V1.00

7540-01-165-7294

519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

AMINATION(S) REQUESTED

CXR PA/LAT

AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
32	M		EMT	

FILM NO.

PREGNANT ☐ YES ☐ NO

REQ[redacted]

TELEPHONE/PAGE NO.

SI[redacted]

ECIFIC REASON(S) FOR REQUEST (Complaints and findings)

DATE REQUESTED 17 July 03

(b)(6)-2

TE OF EXAMINATION (Month, day, year)	DATE OF REPORT (Month, day, year)	DATE OF TRANSCRIPTION (Month, day, year)

DIOLOGIC REPORT

TIENTS IDENTIFICATION (For typed or written entries give: me — last, first, middle, Medical Facility)

[redacted]

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

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

#1 [redacted]

(b)(6)-2

NURSING UNIT | ROOM | [redacted]

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

17 Nov | 0700

✓ Admit CMO EPW ward | ICW 42

✓ Dx: Multiple GSW

Diet NPO

Plan for OR today

Inf WILL RO WOCeh

: TLC x 2U PRBC

Activity: Bed Rest

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

EPW

[redacted]

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

DATE OF ORDER | TIME OF ORDER | HOURS

17 Nov | 1500

Trach PA ward ICW2

MP Rad Room / MP OSW

Stable

NPO Resume (b)(6)-2 [redacted]

Acute A do Ad w

DVT in Sling

Rx Direct

PATIENT IDENTIFICATION

EPW

[redacted]

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

DATE OF ORDER | TIME OF ORDER | HOURS

IVs LRO 200cc/h

HLW Nun Tr Pr

Mellaril 50mg IM WOQ

MSO4 2-10mg IVP Q2h

Gentamycin 50mg IV Tid

Phenergan 25mg WOQ

Blood 6Unit PRN Q4h

CBC in AM

[redacted] (b)(6)-2

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

U.S. GOVERNME

MEDCOM - 14753

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

PATIENT IDENTIFICATION

EPW

[redacted] (b)(6)-4

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

DATE OF ORDER: 17 JULY 03 | TIME OF ORDER: 2010 HOURS

① PERCOCET, 1-2 P.O. Q 4-6 HRS PRN [redacted]

(b)(6)-2 [redacted]

2100

PATIENT IDENTIFICATION

24' chart [redacted] 2LT/AW 18 July 0100

DATE OF ORDER | TIME OF ORDER

Lasix 2030 HOURS

NPO p MN

for OR 19 JUL

(b)(6)-2 [redacted]

noted 18 July 0100 [redacted]

NURSING UNIT: ICW2 | ROOM NO. | BED NO. 17

PATIENT IDENTIFICATION

24' chart [redacted] 2LT/AW 18 July [redacted]

DATE OF ORDER | TIME OF ORDER [redacted] HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER HOURS

NURSING UNIT | ROOM NO. | BED NO.

DD FORM 4259 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED

U.S. GOVERNMENT PRINTING OFFICE

MEDCOM - 14754

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	HOURS	LIST TIME ORDER NOTED AND SIGN
ACA EPW [redacted]	ICW2		17	19 May 03	1300		
EPW [redacted]	ICW2		17				
EPW [redacted]	ICW2		17				
EPW [redacted]	ICW2		17				
EPW [redacted]	ICW2		17				

Transfer PAW to PCW
MD order (W) Shand
stmt
Vs per ward
ACA, Bedrest
HOB 30-45
Shoulder immob

JP to bulb suct
Reinforce DSG on
TES 10x Col LA
Adv Reg Diet
W2 LR @ 100 cc/hr
Hep lock IV when TOL PO
Meper Accept in W08

08 1604 now

Gentamicin 5 mg/kg W 8 hr
MSO4 2-10 mg IV Q3h
Percocet 1-2 PO Q4h
Phenergan 25 mg IV Q4h
Tylenol 650 mg PO Q4h
Mom 900 PCTRD
CBC in AM

1500 [redacted]

24 chart v [redacted] DLT/AN 20 May 03 0100

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
			26 JUL 03	1300 HOURS	
			(1) X Ray - (L) Shoulder AP + Y lateral		
			(2) D/L Ancef		
			[redacted]		
NURSING UNIT	ROOM NO.	BED NO.	(b)(6)-2		
	24 V/S	[redacted]	[redacted] 7-26-03 2130		

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
			22 July 03	HOURS	
			MOM 30 cc q 8 hrs prn		
[redacted]			V.O. Dr [redacted]	[redacted]	(b)(6)-2
	24 V/S	[redacted]	[redacted] 7-27-03 2136		
			(b)(6)-2 [redacted]		
NURSING UNIT	ROOM NO.	BED NO.			
ZW #2					

(b)(6)-2

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
			7/28/03	0630 HOURS	
[redacted]			D/C to ESW camp (b)(6)-2		[redacted]
			[redacted]		9 Lump Sacks 0645
NURSING UNIT	ROOM NO.	BED NO.			
ICW2					

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.

the proponent agency is the Office of The Surgeon General. MO. 7 YR 2003

RIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 17	18	19	20	21	22	23	24	25	26	27	28	29
7-17	[redacted]	Diet: NPO	7	[redacted]												
			11													
			17													
7-17	[redacted]	Act: Bedrest	5	[redacted]												
			13													
			21													
17	[redacted]	VS: routine	05	[redacted]												
			13													
			21													
17	[redacted]	(L) UE in sling	05	[redacted]												
			13													
			21													
17	[redacted]	regular diet	07	[redacted]												
			12													
			17													
17 daily	[redacted]	Act: Ad Lib	07	[redacted]												
			14													
			22													
17 daily	[redacted]	Reg diet	07	[redacted]												
			11													
			17													

DC'd 17 Jul 03

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P I&D (L) arm/thigh GSW
Multiple GSW

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIME

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. USA

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)					Mo 7 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
7-17	[redacted]	Admit ortho, EPW ward.	7-17	0715	0715	[redacted]	
7-17	[redacted]	For OR today	7-17				
7-17	[redacted]	T & C X2U PRBC	7-17	0715	0730	[redacted]	(5)(6)-2
17	[redacted]	Transfer PACU → ICW2	17	—		[redacted]	
17	[redacted]	Condition: stable	noted		B	[redacted]	
17	[redacted]	CBC in AM	18	04	0400	[redacted]	
18	[redacted]	NPO ā MN for OR on 19 July	19	0000			
	(5)(6)-2						

Order/ Expir Date		PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
-----	-----															
-----	-----															
-----	-----															
-----	-----															
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the proponent agency is the Office of The Surgeon General. MO. YR 2003

RIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 19	20	21	22	23	24	25	26	27	28	29	30	1
19July	[redacted]	Vital signs Per Ratio	05	[redacted]												
			13													
			21													
19July	[redacted]	Activity bed Rest HOB 74°	05													
			13													
			21													
19July	[redacted]	Shoulder Immobilizer	05													
			13													
			21													
19July	[redacted]	JP to Bulb suction	05													
			13													
~~19July~~	[redacted]	~~IS 10X Q1hr while awake~~	21													
19July	[redacted]	IS 10x Q1hr while Awake	05													
			13													
			21													
19July	[redacted]	Reg Diet	05													
			13													
			21													

(b)(6)-2

D/C 28July [redacted]

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: SIB ORIF @ Shoulder

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

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

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIME

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. USA

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 7 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
19July	[redacted]	Transfer to ICW2 From PACU	19July		1500	
19	[redacted]	Stable	noted			[redacted]
20	[redacted]	Xray (L) Shoulder AP & Y lateral	20Jul	ASAP		(b)(6)-2
28		DC to TPW Camp	28July	Upon arrival	1600	[redacted]
	(b)(6)-2					

Order/ Expir Date		PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
19July	[redacted]	Reinforce Drsg PrN	0900													
	(b)(6)-2		2244													

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. 7 Yr. 03

ERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATIO

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 17	18	19	20	21	22	23	24
17	[redacted]	LRC100cc/hr - S2	05	/	[redacted]						
		when tol. PO	13	[redacted]		/					
	(b)(6)-2		21	[redacted]							
			/								
17	[redacted]	ancef 1 gm IVPB	06	/	[redacted]						
		90°	14	/	[redacted]	/					
			22	[redacted]							

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P I&D (L) arm/thigh GSW washout

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

(b)(6)-2

EPW [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

Date	Nurse (b)(6)-2		be Given	be Given		(b)(6)-2
17	[redacted]	gentamycin 500mg IV x1	17	now	2100	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
17/20	[redacted]	MSO4 2-10mg IVP q2° prn-pain														
17/20	[redacted]	phenergan 25mg IVPB q4° - nausea														
17	[redacted]	tylenol 650mg PO q4° prn - fever	0745 18 July	18 July 0330 tr po 100.3												
17	[redacted]	Percocet 1-II tabs q4-6° prn	17 July 2015 II	18 July 0300 II po		18 July 1500 II	18 July 2130 II po									

(b)(6)-2

USAPA V1.00

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

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

Mo. 7 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 19	20	21	22	23	24	25	26	27	28	29	30	1	2
19 July	[redacted]	IV LR @ 100 cc/hr	05	/	[redacted]												
		(HL) when tol. PO	13	/													
			21														
19	[redacted]	Ancef 1 gm IVPD	08	/	[redacted]												
		q8°	16														
			24														
20 July	[redacted]	Motrin 800 mg po TID	06	/	[redacted]												
			14	/													
			22	/													

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: ORIF (L) shoulder.

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

USAPA V1.00

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. 7 Yr. 03

Verify by Initialing: Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
19	[redacted]	Gentamycin 500mg IVPB x 1 now	19	now	1520	[redacted]
19	[redacted]	CBC in AM	20th	0400	0350	[redacted]
	(b)(6)-2					(b)(6)-2

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	TIME/DATE DISPENSED											
[redacted]	[redacted]	MS04 2mg IV Q2	19 July 03 2200 4mg II											
		pr pain	[redacted]											
19	[redacted]	Rescolet II tabs	19 July II 1540	20 July II 0200	20 July 0600 II PO	20 July 2350 II PO	21 July 1520 II	22 July 0100 II PO	22 July 1230	22 July 2040 II	23 July 1955 II	24 July In 0100	27 July II 0328	
		PO q4° prn	[redacted]											
19	[redacted]	Phenergan 25mg IV												
		Q4 prn.												
19	[redacted]	Tylenol 650 PO	19 July 2100 II PO	25 July 0130 II PO		27 July 1350 II	27 July 2140 II	27 July 0530 II						
		Q4 prn.	[redacted]											
19	[redacted]	MOM 800mg TID												
		prn.												
27	[redacted]	MOM 30cc PO q 8hrs	27 July 1000 PO 1150											
		prn												

D/C [redacted]

D/C [redacted]

D/C [redacted]

D/C [redacted]

(b)(6)-2

USAPA V1.00

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 17 JUL 03
Time In: 1505 hrs
Allergies: MEDA
Pre-op V/S: 124/80 – 114
Procedures: Urethral Follicle biopsy, Washout

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 600 Colloid —
OR Output: UOP 350 EBL 100
Meds/Times: 250 mg Fentanyl, 1gm Ancef

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds

History ASA I

Time	1500	1510	1515	1530	1545	1600
SaO2	94	95	94	96	96	96
FiO2	RA	RA	RA	RA	RA	RA
Methods						
240						
220						
200						
180						
160						
140					^	
120				^		^
100	^	^	^			
80	•	•	•	•	•	•
60	^	^	^	^	^	^
40						
20						
RR	16	21	21	22	21	23
T	99		98		99	100
Time	1505		1535		1600	
Pain (0-10)	Ø		Ø		Ø	
LOS						

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1605	LR	50	(R) AC	Epm	

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	1	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	1
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			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	8/10	9/10	9/10

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)

(b)(6)-2 PREP[redacted] CR/AN

DEPARTMENT/SERVICE/CLINIC: ICU #2

DATE: 17 JUL 03

PATIENT SU[redacted] or written entries give: first, middle; grade; date; hospital or medical facility)

Name – last,

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

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(D) Arm	mvt	+	P	B	W	Pk
15'	↓	↓	↓	↓	↓	↓	↓
30'							
45'							
60'							
90'							
D/C	"	"	"	"	"	"	"

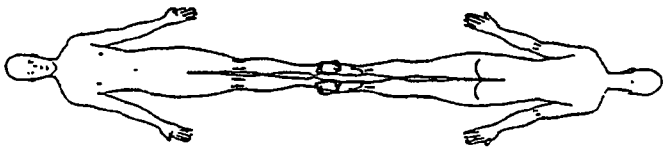
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 1505	(D) shoulder (D) outer buttocks	Pressure dress Gyn dress	Moderate blood Dry/intact
30'	(D) wrist	Gyn/Kerlix	" "
60'	(D) Back region	Bulky pressure	Sm → mod
D/C	" " "	" "	" "



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1605	Urine	yellow/cloudy	200cc

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

(1510hrs) Arrived to PACU via litter & two person assist. Drowsy but awakens upon verbal questioning. Responds to all commands. (+) movement all four extremities c̄ (+) palpable pulses & brisk capillary refill (<3 secs all digits). (D) shoulder dressing c̄ moderately bloody drainage noted & marked (pressure drain to extremity given by CRNA in initial report. Lungs CTA. ARR & (n) (HR 80-90's), BP 117/72. (+) hyperactive to hyperactive bowel sounds all quads. Abd soft, flat non-distended. Foley Cath collecting yellow urine. IV LA in (D) AC patent c̄ site flow positional. Pressure dressing to upper/mid back c̄ small [redacted] bloody drainage. No c/o pain. (b)(6)-2 [redacted] (1605hrs) Cleared PACU. ↑ mod bloody drainage to (D) shoulder region. Marked from previous check. No Δ in other dressings. No c/o pain or noted distress. IV remains patent, but positional. Will give report & transfer to ICW [redacted] (b)(6)-2

Discharge Criteria:
Date: 17 JUL 03 **Time:** 1605 **PARS:** 9
BP: 124/82 **T:** 100° **HR:** 94 **RR:** 23 **SaO2:** 96% RA
Pain Level at D/C (0-10): 0/10
Intake: ~~IV~~ 50cc **Output:** 200cc
Additional Data: Ø
Transferred To: JCW 2
Report Given To: [redacted]
Transferred Via: W[redacted] Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Recovery Roo[redacted]
Charge Nurse Signature: [redacted]

(b)(6)-2

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: 19-Jul-03
Time In: 1300
Allergies: NKA
Pre-op V/S: 128/82 / 120
Procedures: (L) shoulder DCR
Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 800 LR Colloid
OR Output: UOP 300 EBL 300
Meds/Times: 500 ml LR Fentanyl 5 mg Versed

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds / History

Time	1300	1315	1330	1345	1400	1415	1430
SaO2	94	94	94	96	96	96	97
FiO2	RA	RA	RA	RA	RA	RA	RA
Methods							
240							
220							
200							
180							
160							
140	V	V	V	V	V		
120							
100							
80							
60							
40							
20							
RR	22	21	20	22	24	25	22
T	100°	101	100.7	100.4	100.4	100.1	100°
Time	1300	1345	1400				
Pain (0-10)	0	0	0				
LOS							

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1200	LR	125	(R) hand		125

X-rays:

Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

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

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

(Continue on reverse)

PREPARED BY (Signature & Title): (b)(6)-2 [redacted] 91WM

DEPARTMENT/SERVICE/CLINIC: ICU2

DATE: 19-Jul-03

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

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

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

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

USAPPC V2.00

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

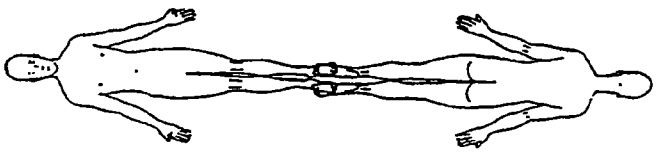
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

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



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1430	Foley	clear yellow	100 cc
1470	JP (L)	Serous	70 cc

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:_____

H [redacted]

H [redacted]

23 0408 7/17/03

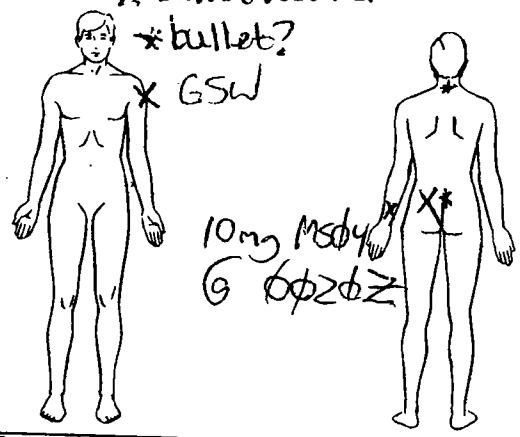
H [redacted]

IRAQ EPW

GSW to (L) shoulder (delt)
GSW To (R) Buttocks/hip
(L) wrist

METTAG © 1983 JOURNAL OF CIVIL DEFENSE
P.O. BOX 910, STARKE, FLORIDA 32091, U.S.A.
1-800-425-5397
All Rights Reserved

X bullet wound
* bullet?
X GSW



10mg MSØ4
G ØØ2ØZ

	23 46Z	ØØ2ØZ	
	135/76	137/82	/
	91	97	
[redacted]	97% RA	100%	

RAC FIG
NS

iv _____ ⊠ _____ im _____

Ancef 1Gm
23 12Z

H [redacted]

REQUEST FOR PRIVATE MEDICAL INFORMATION

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

1. Date. 16 SEPT 2003

2. Patient's Name and SSN [redacted] (b)(6)-4

3. Medical Treatment Facility *(Name and Location)* [redacted] (b)(2)-2

4. Reason for Request.

I MEF INVESTIGATION INTO LOCATION OF Patient.

5. Private Medical Information Sought *(Specify dates of hospitalization or clinic visits and diagnosis, if known)*

Discharge & Location Information.

6. Requestor's Name, Title, Organization and SSN (b)(6)-2 [redacted] / MAG USMC / I MEF

FOR USE OF MEDICAL TREATMENT FACILITY ONLY

7. Check applicable box.

☐ Approved ☐ Disapproved *(State reason for disapproval)*

8. Summary of Private Medical Information Released.

9. Signature of Approving Official.

10. Date.

DA FORM 4254-R, NOV 91 DA FORM 4254-R, Jul 74 IS OBSOLETE USAPPC V1.00

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. 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	(b)(6)-4 [redacted]	UNK - EPW	EPW	M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
UNK	32Y	X	9	muslim.

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—	U	0700	— (b)(6)-4

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
NO	K78	—

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø	ICW2	UNK

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
[redacted] (SOUTH)	UNK

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
UNK

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
Ø5 (b)(2)-2		030728

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
AGAA		030717

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 IED (L) arm/thigh GSW washout

T: 9 Dx: 81210 PR: [illegible]
8771 [illegible]
Inj: 569 88100
E9972

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

DA FORM [illegible] EDITION [illegible]

INPATIENT TREATMENT RECORD COVER S

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

(b)(6)-4

1. REGI[redacted]	2. NAME (Last, First, MI) EPW - #[redacted]					3. GRADE —	ADMISSION REMARKS
4. SEX M	5. AGE 16	6. RACE UNK	7. RELIGION UNK	8. LENGTH OF SVC —	9. ETS —	10. PREVIOUS ADMISSION N	
11. FMP 99	12. SSN [redacted]			13. ORGANIZATION —		14. WARD ICW2	
15. FLYING STATUS —	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 from ER					22. HOURS OF ADMISSION 1830	23. CLINIC SERVICE AEAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK				25. TYPE DISPOSITION 50		26. DATE OF DISPOSITION 21 Jul 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK				27b. TELEPHONE NO. UNK		28. DATE OF THIS ADMISSION 19 JUL 03	ADMITTING OFFICER (b)(6)-2 [redacted]
29. NAME [redacted] Baghdad						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

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
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

(b)(6)-2

SIGNATURE OF ATTENDING MEDICAL OFFICER [redacted]

DA FORM 3647, MAY 79 EDITION OF 1 AUG 78 IS OBSOLETE USAPPC V1.10

I CW 2

ABBREVIATED MEDICAL RECORD

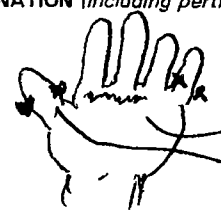
1. ADMISSION DATE *(YYYYMMDD)*
19 Jul 03

2. CHIEF COMPLAINT, PERTINENT HISTORY, AND PERTINENT SYSTEM REVIEW

20 y/o LHD Iraqi ♂ ~ 4 d s/p GSW (L) hand
? altercation c̄ another Iraqi. S̄ C/O.
wound noted @ EPW camp.
ø PM/PS/MED/AM (+) tob.

3. PHYSICAL EXAMINATION *(Including pertinent positives and negatives)*

(L) hand



1-2 mm wounds
* 2
superficial lac
1-2 mm ulcer
3-4 mm redness

2-5 s/s FDS/FDP/EXT
AB/AD
LT2
bright CR
thumb ø IP P/E 2° pc's
↓ LT to tip

4. IMPRESSION *(Enter admission note with plan on progress notes)*

(X-R) comminuted thumb P1 distal 2/3 fx bright CR
(A) 4 d s/p GSW (L) hand c̄ fx as above
(P) OR for I&D & fixation vs casting
Abx, Tetanus

5. ADMITTING OFFICER

a. SIGNATURE
[redacted] MAJ

b. DATE SIGNED *(YYYYMMDD)*
19 Jul 03 1824

6. DISCHARGE NOTE *(Brief hospital course, diagnoses, procedures, condition on discharge, pertinent discharge information (including medications, diet, activity limitations, follow-up instructions).)*

7. DISCHARGE DATE *(YYYYMMDD)*

20 y/o ♂ as above
s/p I&D c̄ casting (L) thumb
plan return to EPW, return 2 wks
for cast Δ & drawing check

(b)(6)-2

8. DISCHARGING OFFICER

a. NAME	b. GRADE	c. TITLE	d. SIGNATURE
[redacted] MAJ	O4	MD	[redacted]

9. PATIENT IDENTIFICATION *(For typed or written entries: Name (last, first, middle), grade, SSN, date of birth, hospital or medical facility, ward number, and register number)*

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

10. OUTPATIENT/HEALTH RECORD MAINTAINED AT:

11. COPY PLACED IN OUTPATIENT RECORD *(X when done)*

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
19 July 03 1850	Rec'd pt from EMT @ 1845, pt ambulatory, dx: GSW (L) hand, condition stable. lungs CTA, (R) hand c̄ drang CDI ⊕ movement, ⊕ sensation to fingers. (B) arm c̄ full ROM ⊕ pulse, SOV (R) hand D5½NS c̄ 20KCL @ 125 cc/hr infusing. ō diff. abd soft nontender BS⊕ x4 quads. B/L ext c̄ full ROM ⊕ pulses. ⊘ c/o pain voiced. pt has NPO p MN orders for OR in am. Will cont to monitor — (b)(6)-2 [redacted] 91WM6
19 Jul 03 22:53	Rec'd c/o pt @ 21:00. ~~A~~ Sleeping in bed. Difficult to awaken. Sclera of eyes ⊕ reddened. PERRLA ⊕ WNL. LCA (B) BS ⊕ x4. ⊕ PPP (B) PIV (R) wrist patent c̄ D5½NS c̄ 20KCL infusing @ 125cc/hr. (L) Hand and FA splint intact. ⊕ sensation ⊕ <3sec. cap refill ⊕ warmth ⊕ ROM to digits. ⊘ c/o pain @ this time. Will cont. to mon. —
(b)(6)-2	[redacted] PLT/AOO —
20 Jul 03	0540: Assumed pt. care @ 0500. Pt. A&Ox3. lungs CTA. ⊕ BS x4. Drang on (R) arm CDI. ⊕ sensation and movement in fingers. IVF D5½NS c̄ 20KCL @ 125 infusing in (R) hand ō difficulty. ⊘ complaints @ this time. Will continue to monitor. [redacted] 91WM6 — (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.

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

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
20 July 03 1610	Assumed pt care @ 1300. 1330 pt off to OR in stable condition. pt returned from surgery @ 1605 via litter from ICU 2. LLE c̄ cast ⊕ movement ⊕ sensation. ⓡ arm c̄ full ROM ⊕ pulse. IV RFA infusing D5 1/2 NS c̄ 20 KCL @ 125 cc/hr. Orders to d/c IVF rec'd will d/c IV p̄ pt eats dinner. lungs CTA, abd soft BS⊕ x4. BLE c̄ full ROM ⊕ pulse. ⓓ No pain voiced @ this time. pt has d/c orders to return to EPW camp when transportation available. Will cont to monitor — [redacted] Gurme
20 July 03 21:30	Assumed c/o pt @ 1900. Pt awake and alert in bed. PERLA ⊕. LCA ⊕. BS ⊕ x4. ⊕ PPⓑ. ⓛ Hand c̄ hard cast c/D/L. ⊕ sensation ⊕ ROM ⊕ <3 sec. cap refill. No c/o pain will cont. to mon [redacted]
21 July 03 0710	Pt alert sitting up in bed. VSS, lungs CTA, HR reg, BS⊕. Cast to ⓛ arm & wrist. Able to wiggle fingers, ⊕ sensation, warm to touch. HL to ⓡ arm. Ready to be D/C to camp. Will cont to monitor — [redacted] Gurme
21 July 03 1420	Assumed care @ 1300 - VSS - meds, x ray ok transfer summary ready - pt. awaiting transport to EPW camp [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
20 Jul	Op Note
1400	Dx Crsw (L) thumb, P. Fx
	Rx I.D. cast
	Surgeon Gruma
	Anes MAC
	EBL ø
	[redacted]
	MAJ
	(b)(6)-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.

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

NSN 7540-01-075-3786

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

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS	CITY	STATE	ZIP CODE
# [redacted] (b)(6)-4			

ARRIVAL

DATE *(Day, Month, Year)*	TIME	TRANSPORTATION TO FACILITY
19 Jul 03	1740	MEDEVAC

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

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

CHIEF COMPLAINT: GSW (L) HAND

CATEGORY OF TREATMENT		VITAL SIGNS					
☐ EMERGENT	TIME 1740	TIME 1740					
☐ URGENT		BP 115/64					
		PULSE 86					
	INITIALS [redacted]	RESP 18					
☒ NON-URGENT		TEMP 99.-					
		WT					

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

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1740	R HAND X-RAY				

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

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

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

[redacted] (b)(6)-4

EPW

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

NSN 7540-01-075-3786

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

TEST RESULTS

CBC		SMAC				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: (L) thumb GSW 4 days ago. ↑ swelling

(+) FOB

O: Proximal phalanx comminuted fx w/ jt involvement.

A: as above

P: Ortho admit for more definite fixation/rest.

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

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

MAJ, MC

DIAGNOSIS

fx (L) proximal phalanx - thumb (4 days old s/p GSW)

CODES

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

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

511-119 NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY							
POST- DAY							
MONTH-YEAR July 19 2003 / DAY	19	20-21	21	22	23		
HOUR	1900	2140 / 960	1138 / 2330				
BLOOD PRESSURE	100/70, 120/74	108/78, 110/68	108/60				
WEIGHT	98%	97%, 97					

PULSE (0) / TEMP. F (•) / TEMP. C

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 16 16 16 16 10 16

Record special data only when so ordered

HEIGHT: WEIGHT →

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. 3W2

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

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 14779

MEDICAL RECORD | **INTRAOPER[illegible]E 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 Amb Staff

2. PATIENT IDENTIFIED, RECORD [redacted]ED AND PROCEDURE VERIFIED BY [redacted] CPT/AN

3. DATE 20 Jul 03 TIME PATIENT ARRIVED IN SUITE OR

4. PATIENT IN RO[redacted] TIME 1340 (b)(6)-2 NUMBER 1-24

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: ALERT. NPO

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC. [redacted] (b)(6)-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:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☑ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☑ CLIP

COMMENTS:

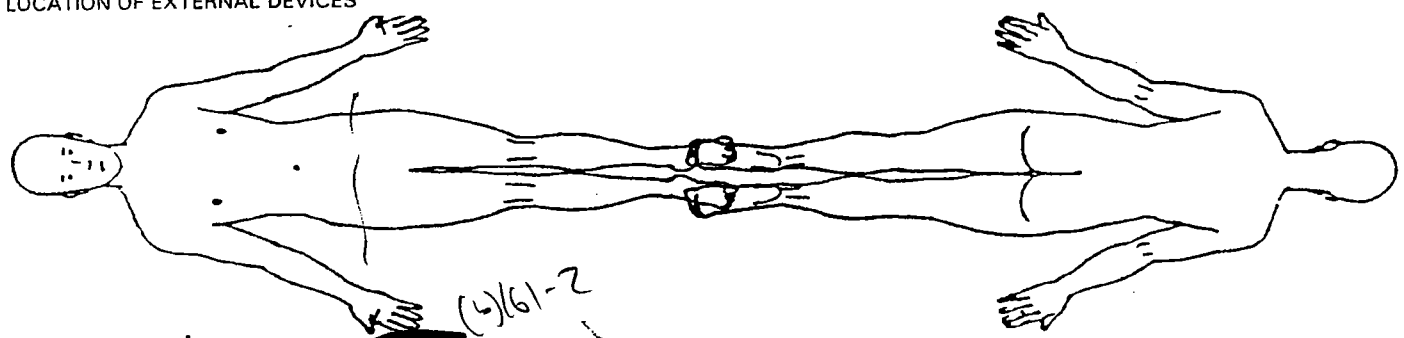
PREP SOLUTION *(Specify)* Hibiclens

SITE: (Rt) hand BY WHOM: (b)(6)-2 [redacted]

SITE: ~ BY WHOM: ~

COMMENTS: & purlzyo

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- S[redacted]p = = Tourniquet

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes ☑ No					
Needle Sharp	☐ Yes ☑ No					
Instrument	☐ Yes ☑ No					
Other	☐ Yes ☑ No					

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

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

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

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

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

☐ BIPOLAR NO: _____

MEDCOM - 14780

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):

0.9%, Nacl

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM 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)*

Kerlix
webril

19. ADDITIONAL INFORMATION

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

20. OPERATION(S) PERFORMED

Rt hand, thumb clean & cast off

21. PATIENT TRANSFERRED TO (b)(6)-2 ICU TIME See Anes. Record METHOD Litter

22. [redacted] SPT/AN

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

MEDICAL RECORD - ANESTHESI

For this form, see AR 40-66; the proponent ager. ne OTSG

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

DRUG	(Units)			
Benadryl	(mg) 50			
morphine	(mg) 5	3/2		
propofol	(mg) 100/100			
	( )			
	( )			
	( )			
VOLAT AGENT: Iso	% del	1.5	2.0	1.5 X
	% e.t.			
AIR	L/Min			
N2O	L/Min			
O2	L/Min	6 —	2 —	2 — 6

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS → (1) (2) (3)

FLUIDS

LINE site 18g RW		
☐ Warmed	RL1000	— 400
☐ Warmed		
☐ Warmed		
☐ Warmed		

LOSSES

EST BLOOD LOSS	Ø
URINE -	

PHYS STATUS 1 (2) 3 4 5 E

BODY WEIGHT: 75 (KG) LB

HEMATOCRIT: N/A

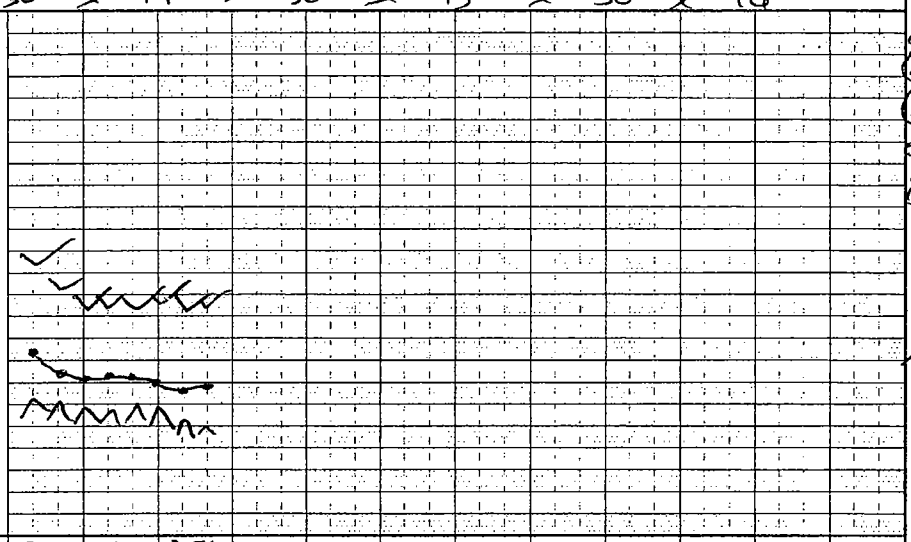
INITIAL DATA: BP- 125/65 HR- 82

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? (Y) TIME- 1320

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

TIME → 30 × 14 × 30 × 15 × 30 × 16



VENTIL

VT - ml		500	310	280
f - breaths/min		18	16	18
Peak inf pres / PEEP		—	—	—
MODE - S(pon), A(ssist), C(on)		S	S	S

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	(+)	(+)	(+)
BP/oth	✓ FIO2 (Frac or %)	0.8	0.8	0.8
ART line	✓ SpO2 (%)	99	99	99
Steth- PC/ES	✓ ECG	SR	SR	SR
Gas analyzer	TEMP-site			
	N-M Block (T/4)			
Warming blkt				
Conv warmer				

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

TOTALS	TOTAL EBL
10	none
	TOTAL URINE
	N/A

FLUIDS - SUMMARY

CRYSTALLOID- 400

COLLOID- Ø

BLOOD- Ø

REMARKS

Code drugs with numbers, events with lettters

Pt & chart ✓. OK to proceed. (1) To room via litter, SOC monitors applied, preO2, (2) Induction (3) To recovery stable. Report given.

RECOVERY AT

PACU ICU (Specify)

OTHER

CONDITION: 96 98

RESP- 15 SpO2-

BP- 102/49 HR- 64

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1325	1335	1420
	Ready	Begin	End
PROC	1340	1350	1410

PROCEDURES and CPT Codes:
(1) EUA lt hand, debridement, casting

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
GM

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
Eyes taped, 30F NA placed, easy mask

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*
#[redacted] (b)(6)-4
20 yo ♂ ICW 2

SURGEONS: [redacted]

ANESTHETIST: [redacted] MAS/CRNA

PROCEDURE LOCATION: 1-1

DATE: 7/20/03

PAGE 1 OF 1

(b)(6)2

ANESTHESIA PLAN OF CARE PRE, EDURAL ASSESSMENT (Sedation/ Anesthesia)

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

PROPOSED PROCEDURE: ORIF w/o pinning 6SW (L) Thumb
SURGICAL SERVICE: ORTHO GYNO ? Altercation c frag
NPO SINCE: PMN

ASA Physical State 1 2 3 4 5 E
WT: 71 KG/LB HT: ____ IN.
ALLERGIES: NKA

HABITS:
TOBACCO: (X)
ETOH: ____
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Ancef c 0400 q6
( ) ____
( ) ____
( ) ____
( ) ____
( ) ____

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

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

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	
Angina	N	Y	
MI	N	Y	
CVA	N	Y	
Other	N	Y	
Pulmonary System:			
Asthma	N	Y	
Bronchitis/URI	N	Y	
COPD	N	Y	
Other	N	Y	
Renal System:			
Acute/Chronic RF	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	
Hiatal Hernia	N	Y	
PUD/GERD	N	Y	
Endocrine System:			
Diabetes	N	Y	
Steriods	N	Y	
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	
Other	N	Y	
Gynecological :			
Pregnancy	N	Y	
Other Significant Hx:			
	N	Y	
	N	Y	
Familial HX	N	Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC

PHYSICAL EXAMINATION
BP 157/78 HR 76 R 16 T 100.2
Pain Scale 0-10 0 SpO2 98%
HEENT - Teeth NL
Trachea
TMJ/Neck MOCI
Oropharnyx 3+ PH
Nares
CHEST: BS CTA
CARDIAC: RRR S M
EXTREMITIES:
IV Access: R PIV
Ulnar Filling:
BACK:
OTHER:

NPO Since PMN

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

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

The patient/legal guardian (b)(6)-2 seems to understand and agrees. Questions answered.
Signed: [redacted] Date: 20 JUN 07 Time: 0730 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

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

SEDATION KEY:

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

EPW

[redacted]

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

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

- Admit ✓
- Dx GSW (C) hand ✓
- vitals routine ✓
- Activity as tolerated
- Diet NPO p MN
- IVF D5 1/2 NS + 20 KCl 125 cc/hr

PATIENT IDENTIFICATION

[redacted]

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

DATE OF ORDER | TIME OF ORDER | HOURS

- Meds Ancef ÷ IV q 6°
- OR in AM

[redacted] MAJ

(b)(6)-2

noted

[redacted] 1845

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

Post-op s/p cast (C)

vitals routine ✓

Activity as tol ✓

Diet regular ✓

meds Tylenol #3 1-2 po q 4 PRN

Ancef ÷ IV q 6° ✓

D/c to EPW camp when available ✓

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

EPW

[redacted]

DATE OF ORDER | TIME OF ORDER | HOURS

D/c instructions

- D/c IV
- D/c Ancef
- Keflex 500 mg po QID * 7 d
- Return for cast Δ 2 wks

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

DA [redacted] MAJ

(b)(6)-2

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL [redacted]

the proponent agency is the Office of The Surgeon General. MO. 7 YR 2003

RIFY BY INITIALING			INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION												
ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED											
				19	20	21	22	23	24						
19 July	[redacted]	vitals routine	6	/	[redacted]										
			13	/											
			21	8m											
19 July	[redacted]	activity as tol	6	/	[redacted]										
			13	/											
			21	8m											
19 July	[redacted]	Diet NPO p MN	6	/	[redacted]										
			11	/											
			17	/											
20 July	[redacted]	Diet Regular	6	/	/	[redacted]									
			11	/											
			17	/	NPO										

(b)(6)-2

(b)(6)-2

Δ'd 20 July 03

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW (L) hand s/p casting (L) hand

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

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

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIME

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*				Mo ____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
19Jul	[redacted]	admit ICW 2	19Jul	NOW		
19Jul	[redacted]	Dx: GSW (L) hand				[redacted]
19July	[redacted]	NPO p MN	20July	2400	Done	[redacted]
19July	[redacted]	OR in am	20July	am		(b)(6)-2
20July	[redacted]	D/C to EPW Camp when available				
	(b)(6)-2					

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

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. 7 Yr 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 19	20											
19 July	[redacted]	IVF D5 1/2 NS c̄ 20 KCL	6	/	[redacted]											
		@ 125 cc/hr	13	/												
			21	EM												
19 July	[redacted]	ancef ÷ gm IV q̄ 6°	4	[redacted]												
			10	[redacted]												
			16	[redacted]												
			22	EM												
20 July	[redacted]	~~am~~ pm Keflex 500mg	4	/	/	[redacted]										
		po QID x 7 days	10	/	/											
			16	/	/											
			22	/	[redacted]											

(b)(6)-2

DC'd 20 July 03

DC 20 July 03

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW (L) hand

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION: EPW H[redacted] (b)(6)-7

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. 7 Yr. 03

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
22 July	[redacted]	Tylenol #3 1-2														
.....	(9/6/-2	PO q 4° prn														
.....	.....															
.....	.....															
.....	.....															
.....	.....															
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.....	.....															
.....	.....															

USAPA V1.00

ASA #2

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: 20 July 03
Time In: 1420
Allergies: NKA
Pre-op V/S: 125/65 82
Procedures: Debridement & Casting of Arm

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 400 Colloid
OR Output: UOP 0 EBL 0
Meds/Times: 0mg MS04

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds

History

Time	1420	1425	1430	1435	1440	1445	1500	1515	1545
SaO2	100	99	99	99	99	98	99		
FiO2	RA	RA	RA	RA	RA	RA	RA		
Methods									
240									
220									
200									
180									
160									
140									
120						V			
	✓	✓	✓	✓			✓		
100									
80									
60									
40									
20									
RR	14	14	12	13	15	17	18		
T	96.4						97.3		
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

Pacu Intake

Time	Solution	Amount	Site	By	Infused
			(b)(6)-2		

X-rays:

Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	1	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	1	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	1	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	✓	✓	✓
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	6	8	10

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): [redacted] LPN

(Continue on reverse)

DEPARTMENT/SERVICE/CLINIC: ICU #2

DATE: 20 July 03

PAT[redacted] entries give: first, [redacted] grade; date; hospital or medical facility)

Name — last,

(b)(6)-2

[redacted] (b)(6)-4

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

20410

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	—	—	Cast	B	W	PK
15'	(L) Arm	+	+	Cast	B	W	PK
30'	(L) Arm	+	+	Cast	B	W	PK
45'	(L) Arm	+	+	Cast	B	W	PK
60'	(L) Arm	+	+	Cast	B	W	PK
90'							
D/C	(L) Arm	+	+	Cast	B	W	PK

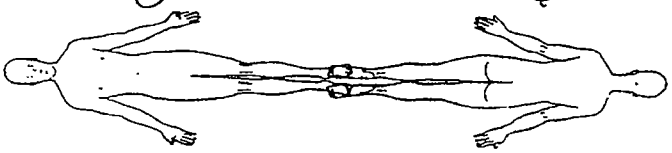
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) Arm	Cast	Ø
30'	(L) Arm	Cast	Ø
60'	(L) Arm	Cast	Ø
D/C	(L) Arm	Cast	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

NURSING NOTES

14:35 - Pt awake only to verbal or painful stimuli. Unable to follow commands. Pt VSS, Sats 99-100% on 8L O_2 NRB. Cast to LUE extending from elbow down, C/D/I, Neurochecks to extremity ~~top~~ WNL. Cap refill < 3 sec. Extremity warm to touch. Pt able to wiggle fingers. Unable to assess pulse due to cast. [redacted] LPN (b)(6)-2

1525:- VSS - Pt awake Sats 98-100 on RA. Pt able to deep breath. Cast to LUE, C/D/I. Neurochecks to extremity WNL. [redacted] LPN

15:30 - Pt urinated 1000 cc clear yellow urine - [redacted] (b)(6)-2

Discharge Criteria:
Date: 17 July 03 **Time:** 1515 **PARS:** 10
BP: 118/67 **T:** 97.3 **HR:** 65 **RR:** 11 **Sa02:** 98
Pain Level at D/C (0-10):
Intake: Ø **Output:** Ø
Additional Data: Ø
Transferred To: ICW #2
Report Given To: [redacted]
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: Spc [redacted] CPT (b)(6)-2

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. [illegible] 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]	(b)(6)-4 EPW # [redacted]	—	M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
Z Z Z Z Z Z Z Z	1 6 Y	X	9	UNK

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—	Z	1830	(b)(6)-4

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø	ICW2	UNK

NAME AND LOCATION OF PRIOR TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
[redacted] Baghdad	UNK

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
UNK

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
(b)(2)-2 5 Ø		Ø 3 Ø 7 2 1

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
A E A A		Ø 3 Ø 7 1 9

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

FOR LOCAL USE

GSW ⓛ hand

Dx: 8822
E9289
Px: 8083

ADMITTING OFFICER (Sig[redacted] PDh [redacted]

SIGN[redacted] CLERK

DA FO[redacted] MAY 80

(b)(6)-2

INPATIENT TREATMENT RECORD COVER SHEET

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

(b)(6)-4

1. REGISTER NUMBER [redacted]			2. NAME (Last, First, MI) EPW [redacted]			3. GRADE EPW	ADMISSION REMARKS
4. SEX M	5. AGE UNKNOWN	6. RACE IRAQI	7. RELIGION UNKNOWN	8. LENGTH OF SVC ~~UNKNOWN~~	9. ETS —	10. PREVIOUS ADMISSION N	
11. FMP 20		12. SSN [redacted]		13. ORGANIZATION		14. WARD ICW 2	
15. FLYING STATUS —	16. RATING/DSG K78	17. DEPT./BEN	18. BRANCH/CORPS —	19. UIC/ZIP		20. TYPE CASE NBI	

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: DIRECT FROM ER	22. HOURS OF ADMISSION: 0750	23. CLINIC SERVICE: ABAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: —	25. TYPE DISPOSITION: TFR CIV HOSPITAL	26. DATE OF DISPOSITION: 28 JUN 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): —	27b. TELEPHONE NO.: —	28. DATE OF THIS ADMISSION: 26 MAY 03	ADMITTING OFFICER (b)(6)-2 DR [redacted]
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] DOGW OOD		30. DATE OF INITIAL 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: SP EXLAP

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	32	32

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
0	[redacted]	0	[redacted]	32	32

SIGNATURE OF [redacted] MAJ, MC

(b)(6)-2

DA FORM 3647, MAY 79 EDITION [redacted] OBSOLETE

USAPPC V1.10

PATIENT TREATMENT RECORD COVER SHEET

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

(b)(6)-2

1. REGISTER NUMBER [redacted]			2. NAME (Last, First, MI) EPW [redacted]			3. GRADE EPW	ADMISSION REMARKS
4. SEX M	5. AGE 40Y	6. RACE IRAQI	7. RELIGION UNKNOWN	8. LENGTH OF SVC —	9. ETS —	10. PREVIOUS ADMISSION NO	
11. FMP 99		12. SSN [redacted]		13. ORGANIZATION —		14. WARD	
15. FLYING STATUS —	16. RATING/DSG K78		17. DEPT./BEN	18. BRANCH/CORPS —	19. UIC/ZIP	20. TYPE CASE BI	

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION DIRECT FROM ER		22. HOURS OF ADMISSION 0815	23. CLINIC SERVICE ABAA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE —		25. TYPE DISPOSITION EPW CAMP	26. DATE OF DISPOSITION 2 JUN03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) —		27b. TELEPHONE NO. —	28. DATE OF THIS ADMISSION 14 MAY 03
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted]			30. DATE OF INITIAL ADMISSION

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

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: GSW ABDOMEN

Dx: 86353
5538
55321
72889
E9912

5462
4576
4603
46643
96659 (X4)
5351
8622
5462

X5

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	2Ø	2Ø

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING [redacted]

DA FORM 3647, MAY [redacted]

(b)(6)-2

USAPPC V1.1

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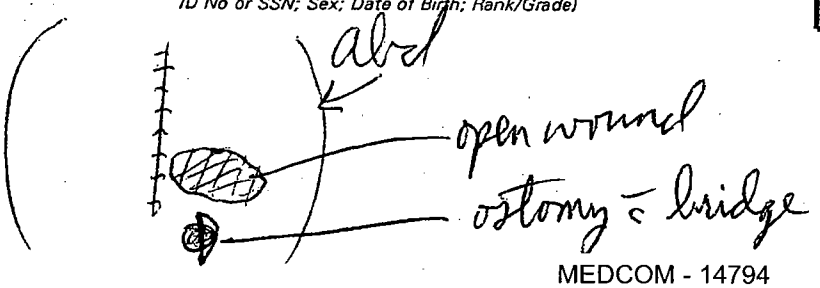
MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	0900
5/14/03	Surgery admit.
	Pt. appears comfortable; 40y/o EPW involved in skirmish, recieved GSW abd 2 days ago. Explore lap by FAST team c colostomy & drain placed. Foley in place. Transfered
(b)(6)-2	to [redacted] today. T: BP 144/79 P.96 RR24
	Pt. in no distress and arrives nontachy and no temp.
	PMH? PSH above Allergy NKMA
	PE HEENT ∅ finding-
	Lungs CTA bilateral Heart RRR
	Abd Flat, pain on palpation.
	Open 10cm wound left abd wall deep to rectus does not appear infected.
	Ostomy LLQ pink - nonfun'l currently.
	Extrems good pulses, warm
	Back - 2 small skin wounds -
	A/P S/P Exploratory lap for GSW. No sign of systemic infection. Given the good appearence of ostomy & no signs of infection believe will cover c IV Abx & observe. Place ostomy bag over ostomy & wet to dry dressings to open wound.
	Keep NPO until gut works.

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 [redacted]

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



[redacted] STAND[redacted] 509 (REV. 5/1999)
[redacted] (10)
[redacted] APA V1.00

MEDCOM - 14794

(b)(6)-2 038

AST NAME | F | MIDI | NUMBER

DATE	NOTES
	Surgery HD #2
5/15/03	8 > 8.5 / 27 (186
0825)	Pt. in no distress, looks good
	A VSS Tm 100
	I/O good U.O. Ostomy bag c̄ ⊕ Flatus
	Abdomen flat, soft.
	Wound – no sign of infection, no granulation.
	Peritoneal drain – no output.
	A/P ① Resp – ambulate, wean off O2
	② CV – Stable, Hct 27
	③ Renal – good U.O. – DC foley.
	④ GI – ⊕ Flatus in bag, advance po.
	if tolerate, Heplock IV
	[redacted] (b)(6)-2
16MAY03 0845	VOP 280cc YELLOW with ORANGE CLEAR FLUID – [redacted]
5/17	Surgery
	Pt doing well, tol diet c̄ BM in bag.
	Tm 101.6 VSS
	Abd Soft, NT
	Wound – obvious bowel evisceration (Hernia)
A/P	Will make NPO, take to O.R. today for
	Hernia reduction & fascia Repair
	Will Consider take down [redacted] bowel –
	[redacted]

DARD FORM 509 (REV. 5/1999) BACK

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MEDCOM - 14795 (b)(6)-2

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
14MAY03 1900	PT vitals T 99.7 P 93 R 18 B/P 150/88 — [redacted]
15May03 0100	Assumed care of PT @ 2100. Pt. quiet, but (b)(6)-2 responsive to verbal stimuli. IV ē LR @150 cc/hr to @EJ. Foley cath to gravity draining amber colored urine, ABD drain to gravity, sealed ē plastic bag intact. ostomy bag intact. ABD drsng Δ'd damp to dry. Peripheral pulses (2+) x4 extremities Bilateral hands ē 2+ edema. Brisk cap refill, ⊕ sensation, ⊕ ROM. HR 93, Reg ē S1 ē S2. Lungs CTA. BS ⊕ ē active x4. Pt. NPO. O2 ē 2L via N.C. to maintain sats > 92%. Will continue to monitor. (b)(6)-2 [redacted]
0400	600cc dark amber urine drained from Foley. Scant drainage from Peritoneal drain ē ostomy. Will continue to monitor. Pt. making efforts to communicate. — [illegible]
15 0630 May 03	Pt is awake, alert, oriz. Breathing is even and unlabored. Breath sounds clear to all fields ⊕. Abd is soft, non distended and tender only near wounds. Peritoneal drain to gravity, ø output at this time. Ostomy site to appliance; large amount of flatus expelled from appliance. M Line insertion and drsg to ⊕ of incision are CDI. Pt has foley to gravity; amber, clear urine. BS ⊕ to ⊕ LLQ (only place able to auscultate 2ª appliances). Pt remains NPO, ⊕ EJ IV flushes well. LR @ 150 cc/hr continues. FROM & neurovascularly intact to ⊕ LE, ⊕ hand remains puffy ē ROM limited by pain; Good cap refill & fingers are warm. ⊕ hand has good ROM, remains somewhat swollen but ø c/o pain; blisters to old [illegible] along wrists and skin discoloration. — (b)(6) [redacted]
15May03 0800	PT vitals T 98.6 P 88 R 16 BP 126/66 SpO2 95 ē [redacted]
15MAY03 1330	PT vitals T 98.4 P 67 R 20 B/P 124/84 SpO2 90 — [redacted]
10May03 1600	Assumed care of Pt @ 1300. VSS. ⊕ LS CTA ⊕ productive cough ē clear sputum. ⊕ S1, S2 ⊕ cap refill > 3 sec. palpable pulses x 4. ⊕ 2 edema ⊕ Hand. Encouraged to move fingers. EJ IV re-dressed. patent HL, ē IV ABX, Pt STV, void 300cc

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STANDARD FORM 600 (REV. 6-97) BACK

NSN 7540-00-634-4176 AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
14MAY03	Pt admitted to ICU 2 via litter from ER.
1000	Pt drowsy but arousable, O2 sat 87-90, O2 ↑
	@ 4L/m O2 sat ↑ 94-96%. ∅ Resp distress noted.
	(L) EJ intact ∅ IV flush as ordered. (R) IV hand
	edematous, not flowing. IV D5W ℄ cath intact.
	T 98.6 P 89 R 12 BP 128/80 O2 sat 94-96% on O2. (L) abd.
	drg D+I. (R) abd. drain ℄ small out of red drainage to DD.
	Foley cath intact draining 500 cc amber urine. BBS CTA
	≈+ bilat., HRR. ∅% Resting quietly @ present. [redacted]
1030	ABS (R) U+L Q. O2 sat 94-96% on 4L/m via NC. [redacted]
1200	T 98.7, P 97, 16 BP 124/81 O2 100% on 4L ↓ to 3L ℄ 99% sat. (b)(6)-2
	[redacted]
14MAY03 1300	Pt vitals taken T 98.1 P 99 R 16 B/P 140/74 [redacted]
14MAY03 1500	Pt vitals taken T 98.1 P 89 R 16 B/P 140/76 (b)(6)-2 [redacted]
14MAY03 1700	Pt vitals taken T 98.3 P 92 R 20 B/P 140/80 [redacted]
14MAY03 1830	Assumed care of Pt @ 1300. VSS. (B) LS CTA, ∅ WOB noted SATS 93-94%
	on 1L via NC, HRR, (+) +1 edema (B) hands d/t handcuffs. Hypo active BS (R) U+L
	Q. Ostomy bag draining scant secretions, site red + bufy, bag secure 360°. Abd
	surgical incision with stitches OPA CDI. Open ABD WOUND WITH W-D drsg. CDI ∅ S/S of
	of infection. Scant amount of drainage to D.D., bag attached for collection. Foley cath
	draining tea colored urine ≈ 500 cc, palpable pulses x 4. Will monitor [redacted] (b)(6)-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.

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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
15 May 03 (cont)	to urinal amber urine. Ostomy draining brown liquid and gas. (+) BS abd incision to stitches CDI, w→d dsgs to abd wound CDI, 4x4 to ⊖ old peritoneal space CDI. Pt ambulated x 1 to BR. Will cont to monitor [redacted]
15 MAY 03 1735	PT vitals taken T 99.2 P 100 R 20 B/P 138/72 SpO2 90 — [redacted] 91WM6 (b)(6)-2
16 May 03 0100	Pt care assumed @ 2100. Pt awake but seems withdrawn. No complaints of pain are noted. Lung sounds are CTA with equal rise and fall of chest. Pulses palpable x4, Bowel sounds present in RLQ, unable to auscultate other quadrants due to dressings and colostomy bag. Colostomy bag ⊘ output during this shift, bag remains intact over LLQ. Abdominal incision c stitches CDI. Wet → Dry done @ 2200, dressing CDI. 4x4 @ LLQ CDI. Pt ambulated and moved beds prior to dressing change. Pt tolerated PO intake. IV ~~to~~ @ ~~[illegible]~~ left external jugular flushes well, no S/S of infiltration or infection noted. Will continue to monitor. SPC [redacted] (b)(6)-2 91WM6
0536	PT Vitals T 99.3 P 91 R 24 BP 118/70 SpO2 96 — SPC [redacted] 91W (b)(6)-2

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

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

REGISTER NO. | WARD NO.

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

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
15 1300 May 03	LATE ENTRY: Pt ambulate 75 feet c̄ moderate standby assist. When sitting up in bed, pt c/o dizziness and mild weakness. Pt exhibited this sx with ambulation as well. Pt was somewhat diaphoretic at beginning of ambulation but condition had improved by end of walk. (b)(6)-2 [redacted] SGAN
16 0550 May 03	Pt is sleepy but arousable. Ø c/o pain. Breathing is even and unlabored. Lung sounds clear c̄ diminished in bases (B). Ab is soft, nontender (c̄ at surgical sites), c̄ distention. BS(+) x4. Less gas out of ostomy this AM than yesterday. BS more active than yesterday however. Abd drains are CDE. EJ flushes well. Pt still c/o and weakness to (B) UE. However previous shift nurse staff reports seeing pt using upper extremities rather frequently. (b)(6)-2 [redacted] SGAN
16 0830 May 03	Drsg to ~~at~~ Abdomen D'd c̄ Betadine solution (3 iodine swabs to 1L NS). Drsg had mod amount of serosang drainage. No stool present in wound (ostomy bag separates wound from ostomy). Wound bed had no purulent drainage and was baby red to pink. [redacted] SGAN
16 1000 May 03	Pt ambulating to Xray and returned. [redacted] SGAN
16 1230 May 03	Ostomy bag loosened. Bag replaced. Tincture of benzoin applied to skin to assist R̄c̄ adhering bag. (b)(6)-2 [redacted] SGAN
~~16 May 1345~~	[redacted]
16 May 03 1445	Pt vitals taken BP 130/70, P. 100, R-20, TEMP 99.6 SPO [redacted] (b)(6)-2
16 May 03 1515	[redacted] pt care @ 1300. VSS. Ostomy site D'd. drsing D'd to wound site in upper abd. lung sounds clear ↑ lobes, diminished ↓ lobes. abd. sq + BS(+)4. pulses (+)x4. EJ HL intact flushed 5 diff. BLE (+) B hands swollen bilat. D'd drsings per pm orders wet to dry. (+) S/S of distress noted @ this time. [redacted] SGAN (b)(6)-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
16May03 2023	Ostomy bag emptied. EJ HL positional, flushed well 3 diff. pt's been sleeping throughout day (b)(6)-2 [redacted] 91WMC
16May03 2230	Pt care assumed @2100. Pt resting, awoken by painful stimuli. Pt had a fever of 101.5° @2130, MO notified. Tylenol 650 mg given rectally @2200. Temperature @2230 100.8. Wet → Dry on abd performed. Wound is moist without S/S of infection. Colostomy site and 2x2 on abdomen CDI. Lung sounds CTA with diminished bases. Pt told to cough, Ø production. IV site @ L external jugular flushes well without signs of infiltration or infection. Pulses ⊕x4, bowel sounds present. Hands swollen w/o signs of improvement since yesterday. Will continue to monitor. SPC [redacted] 91WMC (b)(6)-2
0400	Pt voided 0400 cc clear yellow urine. SPC [redacted] 91WMC
170540 May03	Pt is asleep but arousable. Breathing is even and unlabored. Airway is patent. Lung sounds are congested and diminished in bases. Cough & deep breathing encouraged. B⊕x4. Abd is soft, non-tender (except where surgical sites are), some mild distention. Gas being pat out through ostomy. Midline incision is CDI. Ø signs of leakage from ostomy site. EJ sluggish but flushes. Will inform MD. [redacted]
7MAY03 1310	PT vitals taken T100.0 P97 R24 B/P 140/90 (b)(6)-2 [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)

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

REGISTER NO.

WARD NO. TCW2

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
17May03 1330	pt sleep easily aroused to verbal stimuli. VSS, lung sounds diminished in lower lobes, clear to upper lobes. abd soft midline incision c̄ stitches. Ostomy bag draining s̄ diff, brown loose stool. pulses ⊕. EJ IV infusing LR @ 125 cc/hr s̄ diff. ⊖ s/s of infiltration. Pt is NPO for surgery. will cont to monitor (b)(6)-2 [redacted] 91WM6
17May03 2300	Pt care assumed @ 2100. VSS, pt awake without complaints of pain. Lung sounds CTA with diminished bases, pulses palpable x4, bowel sounds hypoactive. Pt has IV @ L hand infusing LR @ 125cc/hr, IV w/o signs of infiltration or infection. Pt has NG to low intermittent suction draining dark green fluid. Pt has dressing to midline abdominal, CDI. Colostomy bag @ output at this time, site is intact. Foley is draining clear yellow urine 120cc noted at this time. Ubother complaints, will continue to monitor. SPC [redacted] (b)(6)-2 91WM6 (b)(6)-2
18May03 0430	UOP 2000cc DARK AMBER CLEAR FLUID → PFC [redacted] 91W
18May03 0430	NG drain emptied, 50cc of dark green/brown fluid noted. Will continue to monitor. SPC [redacted] 91WM6 (b)(6)-2
18 May 03 0500	Assumed pt care @ 0500. T 99.1 P 92 R 24 B/P 134/78 SaO2 96 Pt. awake. NG tube to low suction c̄ small brownish drainage. Dsg on abd. CDI. Foley to gravity. IV LR infusing in (L) hand s̄ infiltration. Colostomy bag ⊖ output @ this time. Lungs CTA. Hypo active BS in (R) quadrants, none heard in (L) quadrants @ this time. will continue to monitor [redacted] 91WM6
18 MAY 03	1065: UOP 2500cc dark amber urine [redacted] 91WM6

(b)(6)-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

5/17/03 Surgery Op Note:

Prep Dx: Large abdominal wall hernia s/p GSW to abdomen and previous loop colostomy.

Post op Dx: Same

Procedure: Hartman Procedure c̄ Sigmoid end colostomy c̄ Hartman's pouch. Repair of abd wall defect.

Surgeon [redacted] (b)(6)-7

Anesthesia: General

Finding: Intraabdominal contained abscess adjacent to loop colostomy due to leak near ostom. Large fascial defect @ blast site. Small bowel all viable c̄ obvious previous ~~ob~~ resection and anastamosis in 2 regions. No other abnormalities. Hartman's procedure completed c̄ difficulty. Debrided questionable fascia, subcutaneous tiss. and skin. Closure somewhat tight but adequate. Pt. tolerated well

(b)(6)-7 [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)

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

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	Surg POD #1
5/19	Pt no distress
	AVSS E/O u.o. low.
	Clucinin C&P
	Abd Soft. Ostomy pink.
	A/P ① Keep NG until putting air in bag.
	② Bolus IVF & ↑ maintenance rate
	③ Cont. IV Abx Unasyn, Ifen[redacted]
	[redacted] (b)(6)-2
18 MAY 03 1230	NG tube 100 cc dark green/brown fluid/noted [redacted] 91W46
18 May 03 1320	pt resting c̄ eyes closed. NG tube to suction c̄ brownish drainage noted. lung sounds diminished in lower lobes. abd c̄ dressing CDI. Ostomy bag in place ⊘ drainage noted @ this time. foley cath to gravity c̄ amber urine. BS hypoactive ⊕ quad, ⊖ in ⊕ quad. pulses ⊕. IV ⊕ hand infusing LR @ 150 cc/hr ⅁ diff. ⊘ s/s of infiltration noted. Will cont to monitor [redacted] 91WM6
18 MAY 03 1347	PT vitals taken T100.4 P109 R24 B/P 142/64 Sp02 8[redacted] 91W
18 MAY 03 1617	PT vitals taken T99.7 P110 R28 B/P 150/76 Sp02 91 [redacted] W

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO. ICW2

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

PROGRESS NOTES
Medical Record

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

USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
18 may 03 2025	PT vitals taken T100.2 P105 R22 B/P 150/70 SpO2 95 — (b)(6)-2 [redacted] 91W
18 May 03 2030	Total intake 1650cc I + 700cc O's. Emptied 500cc amber urine for the shift & 200cc brown drainage from NG. pt has been resting through out the day. — (b)(6)-2 [redacted] 91WM6
19 May 0120:	Pt. placed on 4L Venturi mask for O_2 sat. <93%. RR 28. Pt. denies pain. Pt. HOB@45°. Temp 100.° Pt. tol. ice chips. HR 112 ≈ S1 & S2 present. Lungs CTA, BS (+) x4 but hypoactive. Will continue to monitor. — (b)(6)-2 [redacted] 47AN
0420	300cc dark yellow urine out by Foley, 600cc dark brown fluid out per N.G. Total Intake IV: 1250 PO: 120cc ice — (b)(6)-2 [redacted]
19 May 03 0750	Assume pt care @ 0500. Pt. awake asking for ice chips. NG tube to suction c brownish drainage. Lung sounds clear diminished in bases. Bowel sounds hypoactive x4. Dsg to ABD CDI. Ostomy bag in place sm. amt of drainage, brown, noted. Foley cath to gravity draining clear amber. LR @ 150cc/hr to (L) hand. no s/s redness/infiltration. Radial and pedal pulses present strong. Swelling to both hands. Will keep elevated. No signs of discomfort @ this time. Will continue to monitor. — (b)(6)-2 [redacted] 91WM6
1000.	N/G D/C'd, 500cc output of dark brown drainage. Foley D/C'd 600cc clear amber UOP. Abd. dsg. D/C'd. stitches intact. no s/s Redness/Infection. Pt sucking on candy. 2mg MSO4 adm. for pain. — [redacted]
1000	pt should void within 6-8 hrs. — [redacted] (b)(6)-2

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
19MAY03 1200	pt sat up in chair for approx. 15 min. VS B/P 148/76 P 114 R 28 T 100.5 SPO2 91 pt resting now. No c/o pain @ this time. pt requesting water. Ice chips were given 30 min ago. (b)(6)-2 [redacted]
19MAY03 1400	Pt. vitals taken BP 160/90, P. 100, R. 22, TEMP. 100.7 SPC [redacted] (b)(6)-2
19MAY03 1800	Pt [redacted] taken BP 109/52, P. 120, R. 22 TEMP 102.0 SPC [redacted]
19MAY03 1930	temp @ t[redacted]me 101.4°F orally - pt. OOB ambulating and to chair x 2 this shift - tolerated CL diet - BS hypoactive - IV patent - pt. not willing to cough only deep breathing - steady on feet only c/c great encouragement and support - colostomy bag in place on stoma, no output this shift - staples intact on abdominal wound - [redacted] CPW (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)

[redacted] (b)(6)-2

EPW

REGISTER NO.

WARD NO. 1902

PROGRESS NOTES
Medical Record

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LAST NAME	AME	MID.	IAL	ID NUMBER

DATE	NOTES
20 May 03	1955 (cont.) LR decreased to 40cc/hr. to (R) Ab. (R) hand swollen, encouraged pt to keep elevated. Incentive Spirometer encouraged. Pt. able to lift two balls. Will encourage q 30 min. [redacted] 9/MMC
1230	INPUT 1790cc — OUTPUT 1750cc (b)(6)-2 this shift [redacted] 9/MMC
20May03 1850	T-101.9, R-24, Sat on RA 88% while resting - pt. ambulated length of ward x2, up in chair @ bedside x 30 min - pt. needs great amount of encouragement & IS use - IV patent - UO adequate - no stool from stoma, colostomy bag intact - Staples open to air, small amt. of drainage noted when ambulating - dsg to wound on back of head intact - pt. doing more for himself & encouragement & regards to moving in bed and ambulating - lungs clear (B) - hypoactive BS (b)(6)-2 [redacted] CBA
1930 20May03	pt. leaking fluid from abdominal wound while in chair @ bedside, staples covered & reinforced dsg & pt. placed in bed — [redacted] CBA
20May03 2215	UOP 120cc clear yellow fluid — [redacted] 9/MMC
20May03 2330	Pt care assumed @ 2000. Pt aware without % pain. (b)(6)-2 VSS, patient in no distress at this time. Lung sounds CTA, pulses palpable x4. Bowel sounds hypoactive but improved over yesterday. Dressing over staples on abd CDI, colostomy bag in place w/ drainage small amount of soft feces. (cont.

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
19 May 03 2300	Pt care assumed @ 2100. Pt is alert and aware, without c/o pain. IV @ L wrist removed, started again @ RAC. Pulses palpable x4, bowel sounds hypoactive, lung sounds CTA with diminished bases. Pt has midline incision stapled, CDI. Colostomy bag is intact, no drainage noted at this time. No other complaints will continue to monitor. SP [redacted] 91WM6 (b)(6)-2
20 May 03 0100	UOP 440cc clear yellow fluid — [redacted] 91W
20 May 03 0400	MSO4 3mg given for pain. SPC [redacted] 91WM6
0800	Assume pt care @ 0500. Pt awake alert follows commands appropriately. No c/o pain @ this time. HR regular. Lungs CTA bilat. Short shallow respirations. Bowel sounds x 4 active colostomy bag in place small amt. of ~~tar~~ drainage to bag. UOP clear yellow 900 cc out this am. Abd. staples intact. No drainage noted. No s/s redness/infection. HL to (R) AC flushes well. No s/s redness/infection. ~~pt temp 100.1F and pt sweating~~. Will ambulate this am. — (b)(6)-2 [redacted] 91WM6
BP 140/80 P 94 R 28 T 100.1	
0955	Pt up to ambulate and to sit in chair. Drainage noted from abd. incision. Abd. dsg applied. Incision to back of head cleaned. Stitches intact, green and white around area, no odor. Non-adhesive bandage applied. (cont)

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)*

[redacted] (b)(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
2330	(cont) . . . pt ~~hepa~~ SS IV site intact without S/S infection
20 May 03	or infiltration. Will continue to monitor. SPC [redacted] 91WM6
21 May 03 0030	UOP 400cc CLEAR yellow fluid — [redacted] 91W
21 May 0230	Pt colostomy bag emptied, unformed light brown stool with gas emptied. SPC [redacted] 91WM6 (b)(6)-2
21 May 0330	UOP 350cc amber urine. SPC [redacted] 91WM6
21 0515 May 03	Pt awake in bed. Voiding spontaneously. Airway is patent. Lungs are clear to upper field but diminished in bases. Abd is soft, nontender & distended. Ostomy to (R) LQ is putting out gas and stool. Drsgs to midline abd are CDI. Pt still c/o mild weakness to (R) LE. FROM to all extremities, and neurovascularly intact to all extremities. IV to (R) arm flushes well. [redacted] (b)(6)-2
21 May 03 1300	pt sleeping easily, aroused to painful stimuli. lung sounds CTA to upper lobes, diminished lower lobes. abd soft, distended, midline incision dressing CDI. Ostomy bag (R) LQ intact (-) drainage noted @ this time. BUE & BLE c FROM c (+) strong pulses. HL to (R) AC (-) S/Sx of infection. Will cont to monitor — [redacted] 91WM6
21 May 03 1628	PT vitals taken T100.5 P102 R 24 B/P 140/72 Sp02 94 — [redacted]
21 May 03 2025	PT vitals taken T100.3 P100 R 24 B/P 140/72 Sp02 94 — [redacted] 91W
21 May 03 2045	pts I 750cc O-900. pt resting, c complaints — [redacted] (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] (b)(6)-4

REGISTER NO.	WARD NO.

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
21May03 2300:	Assumed care of PT @ 2100. Temp 100.3. Dsng to ABD changed packed c̄ iodoform gauze. Brown, foul smelling liquid noted inside wound. PT OOB ⇒ chair x1. Linens Δ'd. Ostomy site c̄ patent stoma. Ostomy Bag intact. HR Reg, Lungs CTA, using IS ✓ extremely well. Bs active x4. Pt tol. cl well. Will continue to monitor — [redacted]
0400:	Sm. soft formed stool approx ½ cup per ostomy — [redacted] (b)(6)-2
22May03 0800 B/P 130/82 P90 R 30 T99.6 Spo2 94%	Assume pt care @ 0500. Temp 99.6. HR regular. Lungs CTA throughout. Abd. dsg intact, brown drainage noted. Will be changed by MD. Ostomy bag in place draining small soft stool and liquid. Wound on back of head cleaned. stitches intact. pt tolerated sips well, adv to reg diet ~~tf~~ ~~prn~~ IV HL'd to (R) AC no s/s redness/infiltration. pt voids per urinal. 100cc but this am clear yellow. No signs of discomfort or pain @ this time. pt sleeping Will continue to monitor. Encourage IS, and will ambulate this am. — [redacted]
0850	Dsg Δ to abd. large amount of drainage noted [redacted] (b)(6)-2 Will go to OR today. — [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
22-MAY-03 0300	PT VS 110/58-12-101.5-100% SpO2. MD [redacted] (b)(6)-2 notified of PT's HOB, ↓ Maintenance fluid to 75 cc/hr CR. PT's lungs CTA(B), ABD dressing C/D/I's. Flanks are soft. Ø edema noted in extremities. PT's Fentanyl increased to 200 mcg/hr. PT was awake and ~~resp~~ nodded yes when asked if he had pain. Will monitor.
22-MAY-03 0400	PT's HR ↓ 110's ↑ fentanyl to 200 mcg/hr. Lungs CTA(B), HOB 40 cc/hr amber and clear. (b)(6)-2 [redacted]
0620 RT	Pt continues on mechanical ventilation size 8 ETT 22cm @ lip [redacted]
23May03	Parameters set SIMV RR12 TV500 PEEP 5 FIO2 50% SaO2 100 HR 108 BP 106/54 BBS coarse pt not breathing over vent [redacted] (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

22 May 03 1542 - Gentamycin 450mg IV given SGT [illegible] 9mm.
22 May 03 - late entry Gent scheduled for 10 today, PT in surgery. SG [redacted] (b)(6)-2
22 May 03 1600 - VSS color good LS CTA ABD drg CDI skin warm to touch, pulses present x 4. Cap refill brisk. Foley to gravity 350cc light amber (-) sediment noted. IV (R) ac 20 g patent, IV (L) ~~FA~~ WRIST INFS 16G patent. PT moving arms, open eyes. ↑ versed to 5mg/hr. Foley cont to monitor SG [redacted] 9/12 mb
22 May 03 1639 PT moving. alert % pain. Fent 50mcg IV push, AND ↑ RATE TO 150MCG/HR TO CONTROL PAIN AND PROTECT AIRWAY FROM SELF EXTUBATION. VS. HR 128 INDICATING NEED FOR ANALGESIA. [redacted] (b)(6)-2
22 May 03 late entry 1615 Unasyn 3.0gm IV given SGT [illegible]
22 May 03 1645 ↑ VERSED FROM 5 TO 7MG TO KEEP PT SEDATED. VSS. WILL CONTINUE TO MONITOR [redacted] (b)(6)-2
1705 PT VSS. SEDATED c̄ VERSED AND FENTANYL. SIMV 12 TV 700 PEEP 5 FiO2 60%. ETT 8 22@ LIP. S1,S2 NSR-ST. GI NGT to LIS GU FTG. DRESSING INTACT ∅ DRAINAGE. REPORT GIVEN TO SG [redacted] (b)(6)

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] (b)(6)-4

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
5/19/03	Surgery POD#2
	Pt. no distress
	AVSS T/o good u.o.
	NG minimal
	Ostomy c̄ stool & air.
	Incisions c̄ D.
	A/P: DC NG, Foley
	Start sips clears.
	Ambulate.
	Cont. Abx for now, ✓ CBC
	[redacted] (b)(6)-2
out of order	
5/20	Surgery POD#3
	Pt c̄ temp WBC 20,000 yest,
	T 100 VSS
	Abd Soft, NT, incisions healing nicely
	Stoma looks good c̄ stool in bag
	A/P: Concern for WBC, cont. current Abx
	↑ pulmonary toilet, ambulate!
	adv. diet
	[redacted] (b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART[redacted]	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. ICW2

[redacted] (b)(6)-7

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)
5/22	Surgery Pt. comfortable, no appetite. T 99.6 VSS WBC ↓19,000 (23 yest) abd incision ~100cc frank pus expressed. A/P/ ~~Infected incisional drainage~~ ① Concern for dehiscence vs. subcut. large pocket infection. — Will take to O.R. today to explore wound/abdominal cavity to I&D, clear.

(b)(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
5/3/03	Op Note Procedure: ① Exp lap ② Hartman's colon LVQ → RUQ c resection T-colon ③ ileostomy ④ placement of tube for chemo Surgeon: Cernosky, Mastro, Lowry Anesthesia: GETA. To ICU, intubated [redacted] (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

[redacted] (b)(6)-4

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LAST NAME	FIRST NAME	MID. INITIAL	ID NUMBER

DATE	NOTES
5/23	1125 Surg Op Note Preop Dx: Large fascia defect s/p GSW Post op Dx: Same Procedure: I&D of fascia / Skin / Subcut. Closure of peritoneal defect c̄ sterile IV bag. approximation of skin c̄ Retention sutures, Maturation of ostomy Surgeon: [redacted] anesthesia: General (b)(6)-2 Finding: Defect too large to approximate the fascia :: IV bag will temporarily be placed until bowel fixed and granulation begins. At that point bag will be removed and skin stapled shut. Pt. tolerated well. [redacted] (b)(6)-2
5/24	Surgery POD #7, 2, 1 Pt. awake on vent. T100 VSS I/O 30 / 7/23 < 78/ Bacteremia Abd. Wound looks good, no sign of infect.
A/P	Resp - ✓ CXR, wean to extubate today CV - transfuse 1 unit pRBC Renal - good d.o., send U.A.

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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

Surgery Cont.

ID - WBC ↑, temp, bacteremia c̄ gram ⊖ on Unasyn and Dent. will add Quinolone (Cipro) to broaden Abx coverage.

GI - stable.

[redacted]

(b)(6)-2

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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
23 MAY 03	DR. [redacted] INSERTED CENTRAL LINE TO RSC. PT TOLERATED WELL.
0830	GIVEN ~~[illegible]~~ FENTANYL 96 MCG, FENT AND 4MG VERSED. CXR ORDERED FOR LINE PLACEMENT VERIFICATION [redacted] (b)(6)-2
0923	PT TAKEN TO OR. MAJ [redacted] PREP PT UP FOR SURGERY [redacted]
1131	PT RETURNED FROM OR C̄ MAJ [redacted] PT SEDATED BUT AROUSABLE. VS 116/60 104 12 100% 96.4 AXILLARY. NEURO 3MM ROUND AND REACTIVE. RESP ETT @ 22@ LIPLINE SIMV 12 PEEP 5 FIO2 50%. TV 700. INLINE SUCTION SCANT AMOUNT OF DRAINAGE RHONCHUSES BILATERALLY. C̄ SYMMETRICAL CHEST MOVEMENT. CV. S1, S2 Ø EC TOPY 109 SINUS TACHYCARDIA. PPP x4 @ 3+. EDEMATOUS ABDOMEN. CAP REFILL <3 SECS. GI NGT (R) NARE TO LIS DRAINING YELLOW BROWN THICK LIQUID. FLUID. JP x2 TO ABD TO LOW CONTINUOUS SUCTION #1 DRAWING SANGUINEOUS FLUID #2 RELEASING AIR NO FLUID NOTED IN TUBE. (R) COLOSTOMY C̄ BAG MEDIUM RED STOOL C̄ SEROSANGUINEOUS DRAINAGE SMALL AMOUNT. BULKY DRESSING CDI WILL MONITOR FOR DRAINAGE. GU FTG VOIDING AMBER URINE Ø SEDIMENT NOTED IN TUBE OR FOLEY BAG. SKIN INTACT. LINES RSC C̄ LR @ 75CC, VERSED AND FENTANYL 20G PAC PATENT INTACT 16G L WRIST PATENT INTACT. PT GIVEN 50 MCG OF FENT AND 5MG OF VERSED TO CALM HIM AND PROTECT AIRWAY. WILL CONTINUE TO MONITOR [redacted]
1150	JP #1 20CC SANGUINEOUS DRAINAGE FROM BULB [redacted] DRAINAGE

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

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	FOUND IN BUMB. JP TUBES 1 & 2 ▲ TO LCS. WILL CONTINUE TO MONITOR OUTPUT [redacted] (b)(6)-2
	27 HR=110 P1=OFF P2=OFF RR=12 SpO2=100% NIBP=OFF T1=OFF T2=OFF ΔT=OFF
	HR 110 PR .14 QRS .08 ST [redacted] (b)(6)-2
23 MAY 03 1728	PT admitted VS 100.8 - 117/61 - 108 - 12 - 100% SpO2 on 50% FIO2 I.V. sites C/D/I, dressings C/D/I. See PA form 4700 dated 23 May 03 for assessment. (b)(6)-2 [redacted]
24 MAY 03	PT RECEIVING PRBC 1 UNIT START 0900 VS 100.2
UNIT #	107 115/54 VS AS FOLLOWS FOR BLOOD TRANSFUSION.
006012	0805 97/48 107 100.1 DR [redacted] FORMED OF BP, CONTINUE TO MONITOR.
B POS	0820 100/52 105 100.2 (b)(6)-2
	0835 101/53 102 100.1
	0905 101/59 101 100.0
	1005 154/67 ABP 111 100.4
	INFUSION OF PRBC UNIT # [redacted] COMPLETE. RECEIVED
	363cc TOTAL VOLUME FOR UNIT OF PRBC. NO REACTION
	OBSERVED. CBC TO BE DRAWN IN
1005	A-LINE STARTED TO (R) RADIAL. PT GIVEN 5 VERSED AND
	50MCG FENT IN PREPARATION FOR PROCEDURE. LIDOCAINE APPLIED
	LOCALLY TO SITE. PT TOLERATED WELL. SITE CDI WILL MONITOR
	FOR CHANGES [redacted] IN /

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(b)(6)-2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
Cont 24MAY03 2100	Sedated, lungs CTA. Will monitor [redacted] (b)(6)-2 SSL 9/12 cm
24MAY03 2300	Pt's JP drains to his ABD dislodged while ~~D~~ing pt's dressing. Dr. Dixon notified. JP drains had ~~at~~ a total of 5cc ~~serous~~ sanguineous fluid in 6 hrs. Pt's VS 137/55 - 103 - 100.5 - 12 - 100% SpO2 on 40% FiO2. Pt's ABD wet to dry dressing A'd. Pt ABD site irrigated and colostomy bag A'd. Serosanguinous fluid noted in colostomy bag. Minimal drainage noted from ABD site.

NOTHING FOLLOWS

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

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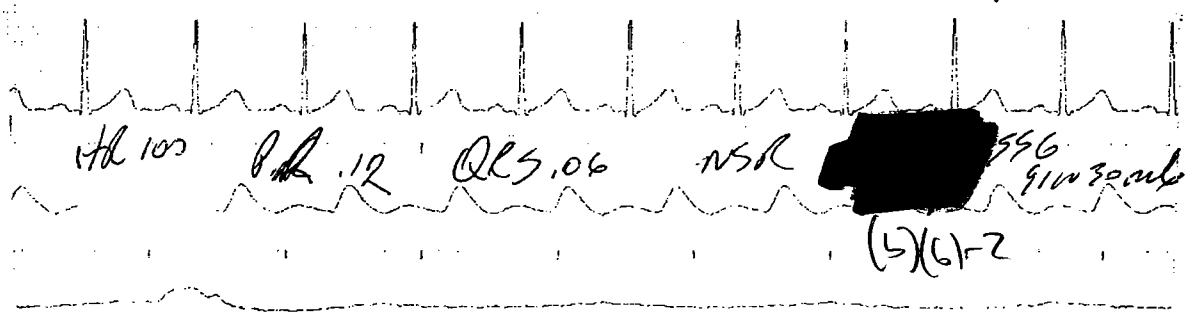
MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
24-MAY-03 1800	PT started 1 unit PRBC's. Unit verified [redacted] by SSG [redacted] (b)(6)-2
	CPO [redacted] (b)(6)-2 Initial VS 100¹ - 102 - 102/52 - 12 - 100% SpO2 on 40% FiO2.
	PT is ventilated. See DA form 4700 dated 24-MAY-03 for PT assessment.
	PT's HCT @ 1530 was 23.5. Will monitor for reactions. [redacted] SSG [illegible]
24-MAY-03 1815	PT's VS 100° - 98 - 112/70 - 100% SpO2 on 40% FiO2 (b)(6)-2 [redacted] SSG [illegible]
24 MAY-03 1830	PT's VS 99° - 103 - 127/61 - 12 - 100% SpO2 on 40% FiO2, O reactions noted. [redacted] SSG [illegible]
	(b)(6)-2
24 MAY-03 1845	PT's VS 99° - 109 - 137/64 - 100% SpO2 on 40% FiO2, O reactions noted. [redacted] SSG [illegible]
24 MAY-03 1900	PT's VS 99° - 101 - 106/50 - 100% SpO2 on 40% FiO2, O reactions noted. [redacted] SSG [illegible]
24 MAY 03 1930	PT's VS 100¹ - 99 - 127/57 - 100% SpO2 on 40% FiO2, O reactions noted. PT's infusion of 1 unit PRBC completed. [redacted] SSG [illegible]

00 HR=100 P1 =122/52(73) P2 =OFF RR=13 SpO2=100% NIBP=116/56(78) T1=OFF T2=OFF ΔT=OFF (b)(6)-2



[redacted] SSG [illegible] (b)(6)-2

24 MAY 03 2100 PT's HCT 27.4, RBC 2.87, increased from 23.5 and 2.41 respectively. VS 100¹ - 97 - 130/60 - 12 - 100% SpO2 on 40% FiO2. PT

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] (b)(6)-4		

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

5/25 Surgery POD# 3, 4, 8

Pt. sedated, vented.

AVSS ABG 7.49/38/97 on 40% FIO2

I/O -2 liter

↓21 8.2/26 639 119/95/5 3.5/26/0.7 95

Lungs

Heart RRate 100

Abd wound clean, no sign of infect.

Extrem +1 edema

(A/P) Resp - Cont vent for now, ABG good on minimal setting, ~~consider weaning~~

Will keep vented for 48 more hours then plan return to O.R. to remove IV bag and close skin. Following this will plan to extubate c̄ knowledge he will have a large abd hernia due to no patch available here.

(2) CV - Transfuse II unit PRBC for Hct 26 and pt. c̄ large healing wound on vent, fighting infection.

(3) Renal - Stable

(4) ID - Improved WBC, T 6, on Day 2 Zosyn/Vent.

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME		SPONSOR'S ID NO.
	LAST	FIRST	[redacted]
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MA[redacted]	

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

REGISTER NO.

(b)(6)-2

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

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
25 May 03	1005 124/61 100 T 100.9 tolerating well SGT [redacted]
	1010 123/61 100 T 100.9 tolerating well SGT [redacted]
	1015 138/70 109 T 100.8 Tolerating well SGT [redacted]
	1030 136/61 110 T 101.4 noted LS rhonchus (b)(6)-2
	~~1045~~ WBS Suctioned lg amt yellow + clear mucus thick. 5cc NSS to trach for suction tolerated fair. PT agitated SaO_2 93-98% bucking vent. PT relaxed after suction SaO_2 98%. LS - ~~Clear~~ amt rhonchi RUQ ō exhalation ~~LUQ, LLQ~~ WBS RL LUL LLL RLL CTA. Will suction again when PT relaxed. SGT. [redacted] (b)(6)-2 91WMC
25 May 03	1045 126/61 104 T 101.4 tolerating well [redacted]
	1100 120/60 101 T 101.3 transfusion PRBC complete tolerating well. SGT [redacted] 91WMC (b)(6)-2
25 MAY 03	MD CARMODY INFORMED OF 3" WOUND C 3 SUTURES HOLDING IT CLOSED. SUTURES REMOVED AND DRY GAUZE APPLIED. WILL MONITOR FOR DRAINAGE. [redacted] (b)(6)-2
25 MAY 03	1400 PT RECEIVED BOMB SQUAD OF FLAT AND RATE ↑ TO 300MCG/HR VERSED ↑ TO 12MG/HR. PT AGITATED PRESSURES ↑ TACHYPNEIC @ 29 SaO_2 100%. PIP ↑ TO 40s-50s PT ETT SUCTIONED C A COPIOUS AMOUNT OF SECRETIONS FOUND YELLOW/WHITE. PT DID NOT TOLERATE WELL ↑ BP 190s/60s PR 30s. SaO_2 91%. PT FiO_2 ↑ TO 50%. PT SATS @ 95-96% C AGGRESSIVE SUCTION VIA ETT AND ↑ IN FiO_2. WILL CONTINUE TO MONITOR. M.D. INFORMED.
(b)(6)-2	[redacted] AN
25 MAY 03	DR. [redacted] STATED TO OBTAIN CXR, START PT ON MUCOMYST Q4°, AND POTENTIALLY PLACE PT ON PROPOFOL TO KEEP SEDATED. WILL OBTAIN CXR

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[redacted] (b)(6)-4

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
0800	DSG ▲ TO ABD DONE C̄ DR. MASIMOTO. MIDLINE WET TO
MAY 25	DRY. LLQ WOUND PACKED DRY DUE TO LIQUID IN WOUND.
	COVERED C̄ 4 COMBINE DSG AND LARGE ABD DRESSING.
	M.D. NOTIFIED OF COLOSTOMY APPEARING PINK AND PALE.
	MONITOR FOR PROGRESSION OF STOOL FROM BAG TO
	INITIATE TUBE FEED WILL CONTINUE TO MONITOR AND REPORT
	▲ TO M.D. [redacted] (b)(6)-2
0805	CENTRAL L[redacted]G ▲'D. SITE NORMAL ∅ SIGNS OF
	REDNESS, EDEMA, DRAINAGE. WILL CONTINUE TO MONITOR SITE.
	[redacted] (b)(6)-2
0900	[redacted] PRBC started per MD order unit # 2452291
	B pos exp date 27May03 VS 123/57 P100 T100.9
	will cont to monitor SGT [redacted] (b)(6)-2 91Wm6
0905	119/57 100 T101.0 tolerating well SGT [redacted] 91Wm6
0910	121/57 100 T101.0 tolerating well SGT [redacted] 91Wm6
0915	114/56 99 T100.9 tolerating well SGT [redacted] 91Wm6
0930	118/59 99 T100.9 tolerating well SGT [redacted] 91Wm6
0945	115/58 99 T101.0 tolerating well SGT [redacted] 91Wm6
1000	112/58 100 T101.0 Tolerating well SGT [redacted]
25May 1000	- PRBC started per MD order unit # [redacted]
	exp 27May03 VS 112/58 100 T101.0 SGT [redacted]

(b)(6)-2

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[redacted] (b)(6)-7

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES (b)(6)-2
	AS SOON AS POSSIBLE, MONITOR VS AND FOLLOW MD ORDERS. [redacted]
1445	PT HAS CALM DOWN C̄ VS 151/50 ABP 152/72 NIBP RR 21 SaO2 94%. HR 118. PIP 23. WILL CONTINUE TO MONITOR FOR CHANGES AND INFORM M.D. [redacted] (b)(6)-2
1500	↑ UO @ 1400 450cc [redacted] 1500 550cc. VS 124/57 119 11BPM 96% SaO2 ON 50% FiO2. PT RESTING COMFORTABLE C̄ ▲ IN RATE OF VERSED @ 12MG/HR AND FENT @ 300MCG/HR. CARDIOMY WILL CONTINUE TO MONITOR [redacted] (b)(6)-2 LT AN
1545	ABG 7.447 PCO2 39.1 PO2 [redacted] HCO3 27 BE 3 SaO2 93%. M.D. NOTIFIED. RT TO GIVE MUCOMYST PER M.D. ORDER. BS B/L SLIGHTLY COARSE RHONCHI, R SIDE DIMINISHED TO LOWER LOBE. VS. 113 113/56 ABP 19 97% @ 50% FiO2. PEEP ↑ TO 8, WILL RECHECK ABG @ 1630. WILL CONTINUE TO MONITOR RESPIRATORY STATUS. [redacted] (b)(6)-2 LT AN
1600	POST MUCOMYST 20% [redacted] ALBUTEROL TX VS 116 ~~+25/60~~ 121/63 99%. RR 16. WILL CONTINUE TO MONITOR. [redacted]
1645	POST MUCOMYST 20% C̄ ALBUTEROL TX ABG 7.4[redacted] (b)(6)-2 PCO2 38.8 PO2 67 HCO3 25 BE 1 SaO2 94%. VS 116 114/54 24 BPM 96%. CONTINUE TO MONITOR. [redacted]
1700	END OF SHIFT PUPILS EQUAL AND REACTIVE RT ETT 8 24@LIP [redacted] SIMV 12 FiO2 50% PEEP 8 TV 700. BS COARSE RHONCHI ↓ C̄

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[redacted] (b)(6)-4		

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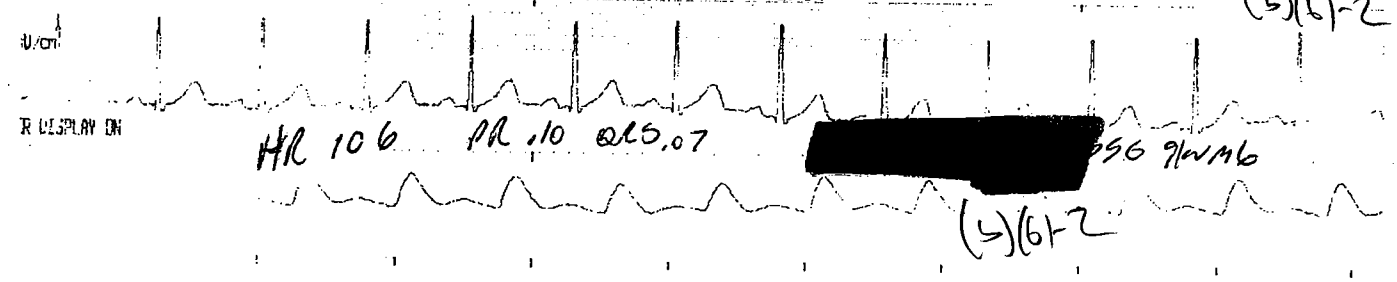
DATE	NOTES
	SUCTION DIMINISHED ON (R) SIDE. ETT WELL SUCTION THICK YELLOW/WHITE SECRETIONS. CV S1,S2 PRESENT ST Ø ECTOPY PULSES STRONG. GI NGT (R) NARE DRAINING YELLOW GREEN SECRETIONS BS NOT APPRECIATED (R) STOMA PACE Ø FLUSH IN BAG. MD INFORMED. GU FTG AMBER URINE >130cc/HR UP TO 550cc/HR. PT C PITTING EDEMA TO ABD AREA 2+ PITTING. DRESSING INTACT WET TO DRY. REPORT GIVEN TO SSG BOYD. [redacted] (b)(6)-2
25-MAY-03 1730	Assumed care [redacted] pt. PT sedated, started Propofol gtt @ 30mcg/hr. Versed gtt d/c'd. VS 113/57-101.3-103-23-98% SpO2 on 50% FiO2. PT trach was suctioned, produced clear frothy sputum in minimal amounts. See DA 4700 dated 25 MAY 03 for assessment. — [redacted] SSG 9/W 30mcg (b)(6)-2
25-MAY-03 1830	PT suctioned, produced minimal amts of clear frothy sputum. VS 101.5-104-20-98% SpO2 on 50% FiO2. PT cleaned & soap & water. (b)(6)-2 [redacted] SSG 9/W 30mcg
25-MAY-03 2130	PT's temp 103.7 (AX). PT given 650mg Tylenol PR, and cold packs placed around patient's. Will monitor for effectiveness. — [redacted] (b)(6)-2

5/03 18:57:48 HR=106 P1 =109/56(72) P2 =OFF RR=24 SpO2=98% NIBP=OFF T1=OFF T2=OFF ΔT=OFF



25-MAY-03 2230	PT's Temp 102.6 (AX). PT's sedated. VS 121-126/49-20-98% SpO2 on 50% FiO2. Will monitor for ↓ temp. — [redacted] SSG

STANDARD FO[redacted] (b)(6)-2 USAPA V1.00

[redacted] (b)(6)-4

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
25MAY 03 2300	PT's ~~given~~ ABD dressing and Head Dressing Δd. PT's dressing to occipital area - site yellow sloughing tissue noted, Ø odor or dlc but area is mushy. Area cleaned c̄ betadine and wet → dry dressing applied. ABD dressing - contains yellow to brown to green colored soaked bandages removed. ABD area yellower than last night's dressing Δ. Suture sites and borders of ~~pu~~ red to pink. Area irrigated c̄ NS and wet sterile dressings applied to area. ~~with~~ ~~sterile~~ Ostomy site has ~~paler~~ more pale areas ~~than~~ compared to yesterday. No gas noted in bag but serosanguinous drainage noted there. (b)(6)-2 [redacted] SG Gwizomb
26MAY 03 0200	PT given Tylenol 650mg PR for Temp 105.5. PT had ice packs placed around him. VS 134/53-10-25-99% SpO2 on 50% F.O2. Will monitor for ↓ Temp. [redacted] SG Gwizomb
26MAY 03 0330	VS 102-115-26-109/54 PT's NGT became dislodged while ~~sitting~~ [redacted] (b)(6)-2 linen, ~~EPT~~ NGT replaced. There was yellowish thick mucous in PT's mouth. ~~Oesophagus~~ Oropharynx suctioned. PT's SpO2 96% on 50% F.O2. [redacted] SG Gwizomb (b)(6)-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

26 May 03 0750 · PT Desat 90% P 120 BP (arterial) 148/88 Suctioned moderate yellow copious mucus - PT sat ↑ 94-95% P 104 BP 120/56 NAD SGT [redacted] (b)(6)-2 91WM6

26 May 03 0930 T-103.2 Tylenol 650mg PR given SGT [redacted] (b)(6)-2 91WM6

26 MAY 03 SPUTUM STAIN SENT TO LAB @ 0935 PER M.D. ORDER. (b)(6)-2 [redacted] SGT

1045 PT BATHED. NEURO SEDATED C PROPOFOL AND VERSED. PEEP ET 8.0 24@ LIPLINE THIN FROTHY SECRETIONS FROM INLINE SUCTION THICK WHITISH/YELLOW SECRETIONS ~~SUCTIONED~~ SUCTIONED GRADY. SIMV 12 PEEP 5 TV 700 FiO2 50% SaO2 100% CV S1,S2 ST PPx4 CAP REFILL ≤3SECS x4. GI NGT PLACE COLOSTOMY Ø FLATUS. ABD DRESSING CDI. GU FOLEY VOIDING APPROXIMATELY AN AVERAGE 100-150cc/HR OF ORANGE URINE. SKIN INTACT JAUNDICED SCLERA LIP SENT TO LAB. WILL CONTINUE TO MONITOR [redacted] (b)(6)-2

26 May 03 BP 89/45 ART 88/50 NIBP M.D. [redacted] NO ACTION TAKEN @ THIS TIME CONTINUE TO MONITOR. [redacted] (b)(6)-2

26 May 03 1325 BP BP cont to be low. propofol stopped to see if BP ↑ arterial - 91/39 87/49 NIBP. NT IN

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DATE	NOTES
26 May 03	cont seeing fowler p 124 SaO2 98% BG [redacted] (b)(6)-2
1345	PT MAPS DROP TO 50s / 40s. MD DIXON INFORMED. PT GIVEN CVP ASSESSED LEVELS 6-7. MD ORDERED 1 LITER NS OVER 30 MINUTES. BP 86/35 ABP 87/49 NIBP. WILL CONTINUE TO MONITOR BP STATUS. [redacted] (b)(6)-2
1357	PT ↑ AGITATION PROPOFOL ↑ [redacted] MCG/KG/MIN AND 50 MCG FENT BOLUS GIVEN. WILL CONTINUE TO MONITOR FOR ↓ AGITATION. VS 136 103/39 16 93%. [redacted]
1411	ABG RESULTS P ↓ SaO2 [redacted] (b)(6)-2 7.437 PCO2 30.5. PO2 46 HCO3 21 BE -4 SaO2 84%. PT SEDATION ↑ SECONDARY TO ↑ AGITATION AND BITING TUBE CONTRIBUTING TO ↓ SaO2. WILL RECHECK ABG @ 1600. [redacted] (b)(6)-2
1415	UO FOR THIS HOUR 30cc DARK AMBER URINE. MD INFORMED. WILL CONTINUE TO MONITOR. [redacted] (b)(6)-2
1430	T 102 given Tylenol [redacted] rectal. VSS SBP [redacted] (b)(6)-2 91 WM6
1500	T 103 ice packs to axilla & groin SBP [redacted] (b)(6)-2
1515	ABG RESULTS pH 7.40 pCO2 26.2 PO2 64 HCO3 16 BE -9 SaO2 93%. M.D. [redacted] INFORMED. VS 125 98/47 ABP 104/60 NIBP 23 BPM 96% SaO2. WILL CONTINUE TO MONITOR. [redacted]
1517	UO FOR THIS HOUR 20cc DARK AMBER URINE. WILL INFORM [redacted] MD. (b)(6)-2 WILL CONTINUE TO MONITOR. [redacted] (b)(6)-2
1520	UA RESULTS GLUCOSE [redacted] BILIRUBIN NEG KETONE NEG SG 1.030 BLOOD 4+ pH 6.0 PROTEIN 1+ UROB 0.2 NITRATE NEG COLOR AMBER CLOUDY. WILL INFORM M.D. [redacted]
1605	ABP 80/38 NIBP 88/51 MAPS 50s-60s. MD [redacted] (b)(6)-2 1 LITER OVER 30 MINUTES. WILL CONTINUE TO MONITOR [redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
26 MAY-03 18	PT Assumed care of pt. VS 105/54 - 98.3 - 122 - 15 - 95% SpO2 on 50% FiO2 See assessment form DA Form 4700 dated 26-MAY-03. Noted Δ's from this a.m. was the yellow sclera in PT's eyes, and pt's MAP's beginning to ↓. PT's CVP [redacted] 2 liter bolus 1st shift. - [redacted] SSG 91W30A6
26-MAY-03 1730	PT suctioned, only small amt light yellow secretions removed. - [redacted] SSG 91W30A6
26 MAY 03 1842	PT's MAP's drop below 60 for 1st time. Informed Dr. [redacted] (b)(6)-2 he ordered for pt. to receive 500cc NS IV Bolus and a CBC. PT's VS 98.5 - 78/47 - 108 - 100% FiO2 on 50%. PT's CBC sent.
26 MAY 03 1930	PT's MAP . Dr. [redacted] (b)(6)-2 orders Dopamine gtt @ 3mcg/kg/min. PT (b)(6)-2 started on gtt VS 100 - 98.5 - 84/51 - 14 - 100% ~~FiO2~~ SpO2 on 50% FiO2. [redacted] SSG 91W30A6
26 MAY 03 2000	PT's Dr [redacted] (b)(6)-2 gave pt. bolus of Dopamine to ↑ pt BP. VS now 128/63 - 106 - 12 - 98% SpO2 on 50% FiO2
26 MAY 03 2020	PT's CBC back. Hgb 9.0 HCT 29.7. Dr [redacted] (b)(6)-2 notified. Ø actions at this time. (b)(6)-2 [redacted] SSG 91W30A6
26 MAY 03 2.00	VS 90/51 - 9[illegible] - 98 - 12 - 99% SpO2 on 50% FiO2. PT's AFD dressing Δ'd. Lighter colored drainage noted from yesterday's dressing Δ. No greenish color just light yellow brown drainage noted in dressings Area irrigated c̄ NS and a moist dressing applied to AFD.
26-MAY-03 2300	Dr. [redacted] Dopamine to 5mcg/kg/min. VS 95 - 119/60 - 12 - 96 - 100% SpO2 on 50% FiO2. (b)(6)-2 (b)(6)-2 [redacted] SSG 91W30A6

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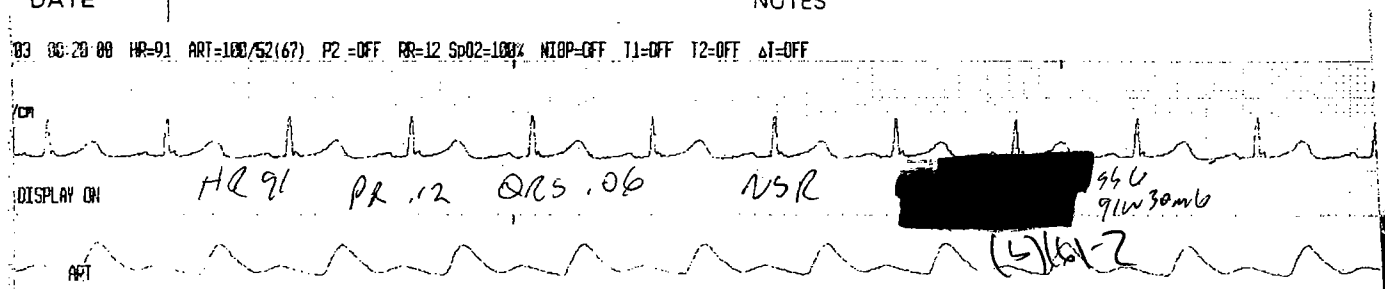
[redacted] (b)(6)-7			

DATE	NOTES

03 06:20:00 HR=91 ART=100/52(67) P2 =OFF RR=12 SpO2=100% NIBP=OFF T1=OFF T2=OFF ΔT=OFF



21 MAY 03 0145	PT's MAP ↓ below 65. Dopamine ↑ to 6.1 mcg/kg/min. VS ↑ Dopamine ↑ 102/55-90-12- -100% SpO2 on FiO2 50%
21 MAY-03 0245	PT's MAP ↓ below 65. Dopamine ↑ to 7 mcg/kg/min. Urinary output 90cc clear amber colored from Q-Ros. VS ↑ 7 mcg 105/59-86-12-96.5(AX)-100% SpO2 on 50% FiO2. Will [illegible] (b)(6)-[redacted] SSG 9/W 30mb
21 MAY 03 0315	PT VS 109/58-12-86-97°(AX)-100% SpO2 on FiO2 50%. PT responsive to pain stimulus. Will ↓ Propofol to 29.0 mcg/kg/min early, Fentanyl to 150 mcg/hr to assess for responsiveness. Urine output 50cc. Lungs ↓ lungs sounds (B). (b)(6)-2 [redacted] SSG 9/W 30mb
21 MAY 03 0330	PT VS 112/60-86-12-97°(AX-100% SpO2 on FiO2 50%. PT suctioned via ventilator cath, Ø secretions produced.
21-MAY 03 0500	PT opened eyes to stimulation. VS 111/54-97°-104/1-100% SpO2 on 50% FiO2. PT's sedative IV meds ↑ to previous settings before assessment. [redacted] SSG 9/W 30mb (b)(6)-2

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
	Late entry:
27 May 03 0600	Eye opening spontaneously. Jaundiced to sclera. Reactive pupils 3mm. Sedated diprivan 30mcg/kg/min. Ventangel infusing @ 25mcg/hr. Equal chest expansion on vent SIMV R12 PIO FIO2 50% TV 700. SaO2 100% Palpable pulses (B). Abd covered c̄ Drsg. CDI. NGT to (R) nare LIS. Placement checked c̄ air bolus. Foley cath intact c̄ amber urine. IVF NS c̄ 20 KCl infusing @ 150cc/hr. Continues c̄ antibiotic therapy. VSS. Will cont. to monitor — [redacted]
1100	Pt to OR. No changes in status — (b)(6)-2 [redacted]
1200	Pt returned from OR. Sedated and paralyzed c̄ TOF 4/4 upon return. IVF cont. to infuse. VSS. Warming measures taken. Will cont. to monitor Drsg to abd CDI. — [redacted]
	VS: 95°, HR 103 SaO2 100% R 12 (b)(6)-2
1215	HR 93 R13 SaO2 100% BP 121/65
1225	HR 92 R12 SaO2 100% BP 122/65
1230	HR 92 R 12 SaO2 100 BP 118/62
1600	Pt resting comfortably. Medications being titrated to effect. Pupils 2mm-3mm reactive. VSS. No changes in status. Will cont. to monitor — [redacted] (TAT)
2015:	(b)(6)-2

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DATE	NOTES
	Surgery
5/27	Pt. sedated, required Dopa for BP in evenning.
	Tm 102 P102 BP 127/66 on 7mg Dopa
	(34) 9.2/29 <449 ~~148~~/106/12 ~~43~~/26 <146
	- Lungs Course sound.
	Heart Rate/02 RR
	Abd Subcutaneous tissue has some purulence and suspect.
	A/P Ongoing infection c̄ WBC remaining ↑ Wound does not appear as clear. Will take back to O.R. to ✓ and washout.
	[redacted] (b)(6)-2
5/27	Op Note
	Procedure: Wound Debridement
	Removal of Bag
	Surg [redacted] (b)(6)-2
	Anes.. Chang
	Findings viable fascia
	viable adipose
	To ICU, critical [redacted] (b)(6)-2
	WASHINGTON,

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
27MAY03 2015	Nursing Note: Pt. opens eyes occasionally. Pupils are reactive to light. Lung sounds clear, unable to ascultate bowel sounds due to ABD ~~dgs~~ dgs since it is DZI, ostomy bag intact, foley to gravity draining amber 100k urine, cap refill <3 sec. Pt. had temp of 102.2 and was given tylenol 650mg PR @ 2000. Vent setting: P=5, SIMV=12; TV=700. FIO2=50%. Dopamin=4mcg/k/min; Fent ↑ to 250mcg/hr due to pt. movement and facial expressions of pain; NS c̄ 20K @ 100cc/hr. (R) subclavian line patent. IV to (L) and (R) AC patent. Cap refill <3sec x4 extremeties. Will continue to monitor. CPT [redacted]
28MAY03 02	Pt. c̄ temp of 103.1 given tylenol PR 650mg. ICE pack applied to axillary blat. —— CPT [redacted] (b)(6)-2
28MAY03 04	Temp now 101.5. —— CPT [redacted]
28May03 0500	Rec'd report from previous shift. Spontaneous eye opening. Reactive pupils. Sedated c̄ fentanyl 200mcg/hr and Pipnivan 40mg/kg/min. Dopamine infusing c̄ 4mcg/kg/min. NS c̄ 20KCl @ 100/hr ventilated c̄ minimal secretions. Abd c̄ bulky dressing. Serosanguinous drainage to LLQ. NGT to LIS and foley to BSD. Colostomy to (R) Qua. —— [redacted]

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DATE	NOTES
28 May 0500 cont'd	(R) Radial A-line intact (R) SC line intact. No changes in status will cont. to monitor — [redacted] AN
5/28	Surgery Pt. looking more lucid. Tm/02.5 now 99 VSS Dopa @ 5 µg (I/O) -1 liter (good u.o.). ↓ 13) 9.6/30 (360 134/3.8 | 107/24 | 8/0.6 (86 abd - wounds clean Heart RPR Lungs - Clear bilateral. A/P (1) Resp - Stable, will start to wean to extubate. (2) CV - Stable on low dose Dopa. (3) Renal - good u.o. BUN/Cr stable. (4) ID - WBC ↓↓; temps ↓ will cont current Abx & watch closely. If respikes a temp, will Δ all lines. (5) GI - Start TF's, will ask Nutrition to see. Start low rate via NG t[redacted] [redacted] (b)(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
28 May 03 1100	Pt resting comfortably, titrating dopamine and diprivan to effect. Explaining to pt plan of care to extubate per interpreter. VSS. Eye opening and nodding head. Follow simple commands. Will cont. to evaluate. Drsg to abd changed and ~~are~~ error pt noted to have a continual bleeding area in lower mid quad (L). Dr [redacted] sutured area and evaluated site. Redressed wet to dry. [redacted]
28 May 03 1300	Diprivan turned off. Slowly weaning fentanyl to awake pt. IVF continue to infuse NS c 20KCl @ 100/hr. TF on hold until extubation per Dr [redacted] Dopamine 4mcg/kg/min. Will cont. to monitor status [redacted] (b)(6)-2
28 May 03 1630	Eye opening, following commands. RR 12. Remains on vent. Fentanyl decreased 75mcg/hr. Diprivan remains off. Calm and cooperative. VS remain stable, afebrile. No distress noted — [redacted]
1910	Nursing Note: Pt. was extubated at 1830 w/ difficulty. Pt. placed on NRB @ 12L. O2 Sat 100. V.S.S. Dopamine ↓ to 3mL/h. Pt. is Alert, Pupils reactive to light, Lung sounds clear; ~~osto~~ colostomy c liquid stool + gas. Drsg to abd intact. (L) AC IV, (R) AC IV, (R) Subclavian patent. Drsg to abd is D+I. CAP refill

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DATE	NOTES
28MAY03	X 4 extremities is Dx. unable to determine Bowel sounds due to drg. Pt. resting & complaint. Will continue to monitor. ——— cpt [redacted]
29MAY03 22W	Pt. had Dsg A'd to abd area, wet to dry. Some bleeding occured while doing drg Δ. V.S.S. Pt. tolerated Δ of drg well. — cpt [redacted]

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MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
30 MAY/03 0920	A-LINE D/C. PT PLACED ON RA TOLERATED FOR 2½ HOURS AND THEN SATS ↓ TO 93-94%. PT PLACED BACK ON [redacted] 2L N.C. SATS ↑ TO 98-99%. WILL CONTINUE TO MONITOR. [redacted] (b)(6)-2
1010	DSG Δ TO ABD WET TO DRY. AREA PINK C SOME PORTIONS OF FIBROUS TISSUE, OTHERWISE NO ~~DRAINAGE~~ [redacted] PURULENT DRAINAGE. PT TOLERATED C 25MCG OF FENTANYL IVP ALONG C MAINTENANCE OF 37.5 MCG/HR. OSTOMY BAG CHANGED. STOMA PINK AND INTACT PERIPHERY C SMALL AMOUNT SEROUS/PURULENT DRAINAGE. WILL MONITOR FOR CHANGES IN STOMA [redacted] (b)(6)-2
1215	PT TOLERATED PO 500 CC TANG, 120CC OF JELLO, TWO SPOONS OF BEEF C NOODLES, TWO SPOONS OF PEAS. PT PREMEDICATED C 12.5MG PHENERGAN. WILL CONTINUE TO ENCOURAGE PO INTAKE
(b)(6)-2	[redacted] TAN
1350	TEMP ⓥ BECAUSE PT ↑ HR 120S AND ↑ RESP RATE 32, ↓ SATS 94% ON 2LNC. PT TEMP 104.1 F. MEDICATED C TYLENOL 650MG, ICE PACKS APPLIED TO ARM PITS AND GROIN, PT SAT C HOB 45°. PT USED IS 10 TIMES. WILL CONTINUE TO MONITOR TEMP. [redacted]
1420	TEMP [redacted] HR 110S RR 20S SATS 98% ON 3LNC. WILL CONTINUE TO MONITOR. [redacted] (b)(6)-2
1423	FENT 50 MCG IVP GIVEN [redacted] C/O PAIN "EUM". CONTINUE DRU[redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME: LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)
				[redacted] (b)(6)-7

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] EPW
(b)(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
1450	TEMP 101.3. PT ENCOURAGE TO DRINK FLUIDS AND USE IJ. WILL CONTINUE TO MONITOR [redacted] (b)(6)-2
1530	PT USED IJS RAISED TWO [redacted] = 900cc PER/SEC x 10 DRANK 60cc H2O. WILL CONTINUE TO MONITOR. [redacted] (b)(6)-2
30MAY03 2230	Nursing Note: Pt. with V.S.S. Dsg A'd to abd, wet to dry. Pt. tolerated dsg Δ' well. Fent. infusing @ 50mg/hr, NSC 20K @ 100cc/hr. Pt. is Alert, tolerating PO's difficulty. Foley to gravity draining amber urine. will continue to monitor. —CPT [redacted] (b)(6)-2
31MAY03 0930	DSG ▲ DONE. DRY DRESSING REMOVED AREA RED/PINK C̄ SOME AREAS SEROUS AND PURULENT DRAINAGE SMALL AMOUNTS. MILD ODOR. COVER SPONGES SOAKED C̄ SALINE AND ABD REDRESSED WET TO DRY. PT TOLERATED WELL. OSTOMY BAG CHANGED. STOMA APPEARS BEEFY RED PT HAVE LOOSE AND FORMED STOOL. BROWN IN COLOR Ø BLOOD NOTED. STOMA CLEANSED AND NEW BAG APPLIED [redacted] (b)(6)-2
1015	PIV IN RAC DC'D SECONDARY TO INFILTRATION. 20G PLACED IN RW. PIV IN LAC DC'D SECONDARY TO INFILTRATION/STREAKING. WILL CONTINUE TO MONITOR AND REPLACE IV [redacted]
1130	FOLEY DC'D PER M.D. ORDER AND PT UP TO [redacted] FOR ONE HOUR. TOLERATED WELL VSS. NAD. [redacted] (b)(6)-2
1200	PT FIRST VOID 625 CLOUT DIFFICULTY [redacted] LUNCH ATE 7-8 SPOONFULLS OF NOODLES C̄ BEEF, 2 BITES OF CAKE, 60cc TANG, 4oz H2O. WILL CONTINUE TO ENCOURAGE PO INTAKE. [redacted] (b)(6)-2
1500	PT [redacted] TO 50cc/HR PT ALTERNATE PO INTAKE AND QS HO. M.D. INFORMED [redacted] (b)(6)-2

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

[redacted] (b)(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD

PROGRESS NOTES

DATE	NOTES
5/31	Surgery POD #4 Pt looks great, alert, tolerating po Tm 104 but ↓ now 100.4 10.7 / 8.6 / 28 < 356 — 1 — 1.8 / 0.9 < 106 albumin 1.4 amylase 172 Abd - Sub Q & tissue clean Ostomy fx'ning nicely c̄ BMs. A/P ① Resp - Stable ② CV - Hct 28, VS stable. ③ ID - WBC ok, Temp concerning, all central lines out, will DC foley. Cont. Abx. Temp could be foley vs. gut intermittent translocation c̄ bacteremia. ④ GI - Advance diet and Enome ⊕ b/w meals. ⑤ Wound - will await dermatome to arrive and plan STSG to cover exposed bowel & Sub-Q. In mean time needs to rehab c̄ nutrition & pulm. toilet. Will start placing binder and out of bed TID to chair

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | [redacted] UMBER (b)(6)-2

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | [redacted]

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

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

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
31 MAY 03 1607	ATTEMPTED TO PUT PT IN CHAIR @ BEDSIDE, PT COULD NOT MAKE IT TO CHAIR. PT PLACED BACK IN BED. ENCOURAGED TO USE IS. PT ELEVATED 2 BALLS = 900cc/SEC. PT TOLERATED WELL. [redacted] / (b)(6)-7
1 JUNE 03 0530	PT HAS MORE PLEASANT ATTITUDE, MORE ALERT TO HIS SURROUNDINGS. RAISED 2 BALLS 900cc/SEC C IS AND MW ENCOURAGEMENT. STRONG PULSES THROUGHOUT. Ø EDEMA TO HANDS & FEET DECREASED FROM 30 MAY 03. GI COLOSTOMY BAG INTACT STOMA BEEFY RED. CAN SPONTANEOUS PLAN: UP OOB AND ENCOURAGE PO INTAKE, USE OF IS.
(b)(6)-2 [redacted] AN /	
6/1/03	Surgery Pt. alert tolerating po AVSS (12.8) 10/28 136/100/19 3.1 I/O good n. o. Abd. - Wound cleaning nicely; granulation beginning over the bowel. Sub Q still requiring wet → dry. Cont. Resp. pulmonary toilet, need ambulation TID, → Place ACE Binder on Abd. (2) CV - Stable (3) ID - WBC ↑ slight, cont IV Abx, dress d's (4) GI - Encourage PO; Start Cal Counts, nutrition to see. (5) Need STSG to abdomen when [redacted] dermatone arrives.

STANDARD FORM 509 (R[redacted]) BA[redacted]

[redacted] (b)(6)-7

[redacted] (b)(6)-7