b(6)-2 All

[redacted] [redacted]

CLINICAL RECORD	~~THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)~~ For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 8 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 5	6	7	8	9	10
5	[redacted]	D5½ NS c 20 meq KCl c 125 cc/hr	05	/	[redacted]				
			13	[redacted]					
			21						
			/						
5	[redacted]	Cipro 400 mg IVPB q8°	06	/	[redacted]				
			14	/					
			22	[redacted]					
			/						
5	[redacted]	Gentamycin 100 mg IVPB q16°	04	/	[redacted]				
			10	/					
			16	[redacted]					
			22						
			/						
5	[redacted]	Pen G 4 million units IVPB q6°	06	/	[redacted]				
			12	/					
			18	[redacted]					
			24						
8 Aug	[redacted]	Saline Lock	5	/	/	/	/	[redacted]	
			13	/	/	/	/		
			21	[redacted]	/	/	[redacted]		
			/						
~~9 Aug~~	[redacted]								

D/C

D/C'd 9 Aug 03 BLS

D/C'd 9 Aug 03 BLS

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P resection of (R) IP

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE 2 OF 2

PATIENT IDENTIFICATION:

EPW [redacted] b(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

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

Transition Sheet

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)					Mo _____ Yr _____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
	.....						
	.....						
	.....						
	.....						
	.....						
	.....						
	.....						
	.....						
	.....						
	.....						
	.....						
	.....						
	.....						
	.....						
	.....						
	.....						
	.....						
	.....	b(4)-2 A11					

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
5	[redacted]	Percocet 1-2 tab q4° pr-pain	5 Aug 1850 BAS †PO	8 Aug 2030 [redacted]	8 Aug 0450 ††PO	6 Aug 1015 ††po	6 Aug [redacted]	6 Aug [redacted]	7 Aug 0952 ††po	7 Aug 1515 [redacted]	7 Aug 2030 [redacted]	8 Aug 0200 [redacted]	8 Aug 1230 [redacted]	8 Aug 2070 [redacted]	9 Aug 1217 †po	12 Aug [redacted]
.....	.....															
.....	.....															
5	[redacted]	MSO4 2-5mg IV q2° pr-pain (breakthrough)														
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															

USAPA V1.00

[redacted] b(6)-2 A11 [redacted]

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. 8 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 9	10	11	12	13
9	[redacted]	Keflex 500mg PO	06	/	[redacted]			
		QID	12	/				
			18	[redacted]				
			24					
9	[redacted]	Cipro 500mg	08	/	[redacted]			
		PO BID	20	[redacted]				

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P resection of (R) index finger I&D of (R) hand

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. 1

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

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

66-4

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

[redacted] T TITLE: Post-Anesthesia Care Unit (PACU) Flow Sheet

OTSG APPROVED (Date)

Date: 7 Aug 03
Time In: 1427
Allergies: NKDA
Pre-op V/S: 132 60
Procedures: R hand, Debrid & Closure

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1000 Colloid
OR Output: UOP 80 EBL Min
Meds/Times:

250 Fent 5 Versed

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds History

Time																		
SaO2	99	99	96	98	99	99	99	99	99	99	99	99	99	99	99	99	99	
FiO2																		
Methods	RA																	
240																		
220																		
200																		
180																		
160									✓	✓								
140	✓	✓	✓	✓	✓	✓	✓	✓				✓	✓	✓	✓			
120																		
100											✓							
80	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•			
60	^	^	^	^	^	^	^	^	^	^	^	^	^	^	^			
40																		
20																		
RR	15	14	15	11	14	15	15	19	20	20	21	20	22	20	11			
T	98A					99A									99A			
Time																		
Pain (0-10)																		
LOS																		

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	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	1	1	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	1	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	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

[redacted] b(c)-2

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 7 Aug 03

[redacted] tries give: Name — last,

[redacted] b(c)-4

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

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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1515	/	Percocet ii	po	/	E	[redacted]

NEUROVASCULAR

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

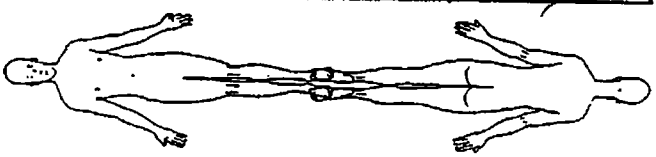
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 1421	(R) hand	Kerlix & Ace	Ø
30' 1457	(R) hand	Kerlix & Ace	Ø
60' 1527	(R) hand	Kerlix & Ace	Ø
D/C 1535	(R) hand	Kerlix & Ace	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

1421 Admitted from OR to PACU. Pt arousable to verbal stimuli. Stable to move all 4 extremities when aroused. IV (D) AC, ≡ s/s of infection noted. Will cont. to monitor. [redacted]
1445 Pt more arousable & trying to stay awake. [redacted]
1500 Pt fully awake. Can move all 4 extremities D5½NS ≡ 20 KCL @ 125 cc/hr via (D) AC. [redacted]
1531 Transferred to FCW2 by litter per Sp[redacted] & CPT [redacted]

Discharge Criteria:
Date: 7 May 03 **Time:** **PARS:** 10
BP: 146 **T:** 99 **HR:** 75 **RR:** 17 **SaO2:** 96
Pain Level at D/C (0-10):
Intake: Ø **Output:** Ø
Additional Data: SMOKER
Transferred To: FCW 2
Report Given To: CPT [redacted]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By:
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 5 AUG 03
Time In: 1500
Allergies: NKMA
Pre-op V/S: 125/67 — 82
Procedures: Removal (R) Finger GSW

Anesthesia Type (Circle): General Spinal Epidural
IV Sedation Nerve Block — 20mg MSO4
OR Intake: Crystalloid 800 cc Colloid
OR Output: UOP EBL 150 — 25mg FENT
Meds/Times: — 5mg VERSED

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

Pre Op Meds

History: ASA II smoker

Time	1500	1505	1510	1515	1520	1525	1530	1535
SaO2	96	97	95	94	89	94	96	94
FIO2	RA	RA	RA	RA	4L	4L	RA	RA
Methods					NC	NC		
240								
220								
200								
180								
160								
140					V			
	V	V	V	V		V	V	
120								V
100								
				•	•	•	•	
80	•	•	•					
	^	^	^					
60				^	^			
						^	^	^
40								
20								
RR	32	21	8	10	28	17	15	17
T	98				99		99	99

Time	1505	1530	1615
Pain (0-10)	0/10	1/10	2/10
LOS			

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1615	D5½ 20K	80 cc	(L) FA	OR	[redacted]

X-rays: N/A Labs: N/A

b6-2

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

[redacted] CPT/AN b(u)-2

DEPARTMENT/SERVICE/CLINIC: ICU #2 (PACU)

DATE: 5 AUG 03

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

[redacted] b(u)-4

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

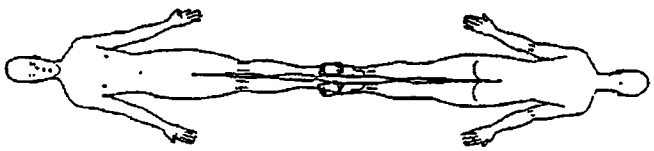
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(R) HAND	BULKY ACE WRAP	(-)
30'	" "	" " / "	(-)
60'	" "	" " "	(-)
D/C	" "	" " "	(-)



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1615	Ø	Ø	Ø

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1500	NSR	—	

WAMC OP 173-E

NURSING NOTES

(1505hrs) Pt arrived to PACU on gurney c̄ 2 person asst. Drowsy, but arousable. Seems to understand a good amount of English. (R) Hand in bulky ace wrap dressing. (R) index finger removed in surgery. Moves all other digits in (R) hand on command & noted limitations. [redacted] to palpate radial pulse just below the ace wrap dressing; brisk capillary refill < 3secs (Neuro, CV, lungs, GU all unremarkable.) – Will continue [redacted] recover for PACU protocol. [redacted] CA/An

(1530hrs) SaO_2 ↓ 87%. Unable to ↑ by cough & deep breath measures. Placed on 4L O_2 via NC. Continue [redacted] & recover [redacted] CA/An

(1615) No Δ in neuro checks to (R) hand. RA SaO_2 94%. (L) FA PIV (#18ga) c̄ D5½c̄ 20KCl @ 125cc/h patent. Ready for transfer to ICW #2. Will give report and transfer now. [redacted] CA/An

b(6)-2 All

Discharge Criteria:
Date: 5 AUG 03 **Time:** 1615 **PARS:** 9
BP: 124/55 **T:** 99 ax **HR:** 110 **RR:** 17 **Sa02:** 94%
Pain Level at D/C (0-10):
Intake: 80cc **Output:** Ø
Additional Data: Ø
Transferred To: ICW
Report Given To: [redacted]
Transferred V [redacted] **Gurney** **Ambulance**
Transferred [redacted]
Cleared IAW Re [redacted]
Charge Nurse Signat [redacted]

DELAY A789849

2nd PRIORITY **MODERATE** A789849

A789849

DECEASED A789849

Mass Casualty Incident Tag
©Eastern PA EMS Council - 1997

(A) (P)

TIME			
AGE		SEX	M
LUNGS			
PULSE	80		
RESP.			
B.P.	120/80		
A	V	P	U

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

Notes/Treatment GSW (R) hand
old Dressing is adhere to infected
dead skin, removing with sterile
water pass cause more injury

To be given to:
TRANSPORTATION OFFICER

TAG# A789849

Priority #		2		D
Primary Injury/Illness				
E.M.S. Unit				
Depart Time				
Hospital				

3rd PRIORITY DELAYED

2nd PRIORITY MODERATE

DECEASED

Minor Injuries/Illness: _____

Moderate Injuries/Illness: _____

2

Life Threatening Injuries/Illness
☐ co-worker injured
☐ uncontrollable emotional disorder

D ☐ OBVIOUSLY DEAD (D.O.A. - D.A.S.)

Mass Casualty Incident Tag

Developed for
Triage and Patient Management

© Eastern PA EMS Council 1997
(610) 820-9212

Additional Information: PT has carefull
a second PT [illegible]
and motion of [illegible]

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 0 1	I Z	0 0 1 4 1 8 0	EPW # [redacted] b(6)-4	EPW	M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
Z Z Z Z Z Z Z Z	2 7 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	1140	b(6)-4

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

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 b(2)-2	ICWZ	UNK

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

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
5 Ø		Ø 3 Ø 8 1 3

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
A E A A		Ø 3 Ø 8 Ø 5

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 & open fx (R) hand

DX	PROC.	Inj.	Trauma
8811	7914	599	9
E[illegible]9	7933		
b(6)-2	8401		
	9357		

b(6)-2

ADMITTIN[redacted] as required) b(6)-2

[redacted] PDR [redacted]

[redacted]

DA FORM 2085, MAR 80

MEDCOM - 15850

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 0014195		2. NAME (Last, First, MI) EPW# [redacted]				3. GRADE EPW	ADMISSION REMARKS
4. SEX M	5. AGE 3	6. RACE —	7. RELIGION —	8. LENGTH OF SVC —	9. [illegible] —	10. PREVIOUS ADMISSION NO	
11. FMP 99		12. SSN [redacted]		13. ORGANIZATION b(6)-4		14. WARD ICU#2	
15. FLYING STATUS NO	16. RATING/DSG —	17. DEPT/BEN K78	18. BRANCH/CORPS —	19. UIC/ZIP —		20. TYPE CASE WIA	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from ER				22. HOURS OF ADMISSION 1730	23. CLINIC SERVICE AEAA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK			25. TYPE DISPOSITION 26		26. DATE OF DISPOSITION 15 Aug 03		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK			27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION 6 Aug 03		ADMITTING OFFICER b(6)-2 DR [redacted]
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b(2)-2					30. DATE OF INITIAL ADMISSION		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA [redacted]

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

GSW

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: GSW to (L) Knee / (L) patellar open fx

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	9	9

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 [redacted] SIGNATURE OF MEDICAL RECORDS OFFICER [redacted]

Dr [redacted]

DA FORM 3647, MAY [redacted] USAPPC V1.10

MEDICAL RECORD

ABBREVIATED MEDICAL RECORD

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

b(6)-4

See [redacted]

PHYSICAL EXAMINATION

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

IGNATURE OF PHYSICIAN

DATE	IDENTIFICATION NO.	ORGANIZATION

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

REGISTER NO.	WARD NO.

[redacted]

b(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL
RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975

539-108

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
8/6/03	ORTHO Staff Triage detained/EPW arrived aeroevac c̄ no hx. Unresponsive initially c̄ elevated temp 103 & tachycardia. Some hx of GSW (L) knee of indeterminate age. Evaluated by Neurology for MS Rs. Hydration & cooling c̄ improving MS. Ext: (R) knee c̄ small effusion, no erythema, painless PROM, palpable patellar defect, entire posterior wound infiltrates medial knee and proximal thigh XR: c̄ stellate patella fx WBC 8.0 IMP: ~~open~~ patellar fx in pt c̄ heat injury Plan: Cont MS Rs, continue hydration when stable → to OR for I&D, IV ABX 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)

8/6/03

REGISTER NO.	WARD NO.

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MEDICAL RECORD	PROGRESS NOTES
DATE	Neurology Consult NOTES
6 Aug 03 1605	HPI Mid 20-ish Iraqi ♂ EPW, brought in by MP's for altered mental status thought to be related to a GSW to this (L) patella. Very little hx is known and only a brief note accompanied the pt. Pt's temp was 103.4 rectally on arrival & he was agitated and intermittently combative. He has been cooled since arrival c̄ water/ice/fan and his MS has progressively improved as his temp has dropped. His core temp was 100.8 rectally by the time I finished my exam, and while he would follow commands & tell his name, he would give no further hx but this may have been intentional.
	PMH Unknown Meds Unknown Allergies Unknown
PE	148/92 103 26 100.8 (R)
	GEN Thin Iraqi ♂ c̄ IV's in either arm, foley cath, wet on a stretch, awake & calm c̄ a (L) knee wounds
	HEENT (L) frontal minor abrasion c̄ min ecchymosis & no swelling. No fx's at the site on palp/inspection of skull ? (R) infraorbital bruise. Canals somewhat occluded by cerumen but no hemotympanum or d/c noted. No raccoon eyes or

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EPW [redacted] b(6)-4

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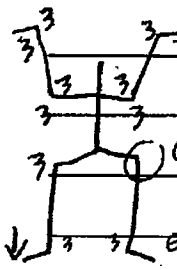
MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	Neuro (2)
6 Aug 03	Battle sign, sinuses NT to palp, oro clear
	Neck full passive ROM, ∅ meningismus
	HT RRR S (m), full pulses
	Skin no rashes noted
	MS Awake + alert S stim. Pt will occasionally attend to me (better to Iraqi translator). He follows verbal commands via translator consistently + quite well but seems a little obstinate at times. He would verbalize his name only, clear enough to anticipate me examining his 2nd ear + rotating his head to allow that S command. Pt is calm + mostly cooperative
	CN VF - Attends to stim in all 4 quads, Fundi - benign sharp disc + no hemo PERRLA 5/5 > 3, ∅ APD, EOMI, ∅ ptosis, intact MM + NFE, hearing grossly intact, intact + sym gag, sym shrug, midline tongue.
	Motor Nl tone + bulk, full strength (5/5 formally in UE & (R) LE but formal testing not done in wounded (L) LE. Sym forearm roll. No abn movements
	Sensory pt would not answer sensory questions but did respond to tactile stim (B)
	Coord Good F→N + RAMs (H→S not tested)
	Gait not tested



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

[redacted]

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[redacted]

6 Aug

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MEDICAL RECORD | **PROGRESS NOTES**

DATE | NOTES

Neuro (3)

6 Aug 03 — Extrem old ecchymosis of (R) posterior shoulder + (R) posterior subAxillary region. Entry + exit GSW of (L) knee of dime/nickle size

drawn @ same time

Piccolo: 133 | 103 | 103 / 4.3 | 25 | 0.9

Isiat: 132 | 19 | 15 / 3.8 | 28 | 101

8.0 | 10.4 | 259 / 34.6 | L 10%

CK - 2449 AST 72

U/A - dark yellow, clear, gluc⊖, bili⊖, Ket 1g >160, 1.020, bld⊖, pH 6.0, pro⊖ uro - 0.2, nit⊖

Assessment

1. Resolving Altered Mental Status - pt seem to be improving in parallel c̄ his drop in core body temp. He is nearly wnl. now (hard to tell b/c it appears he is deliberately not speaking to us. His neuro exam is non focal. I see no evidence of intracranial pathology, meningitis, or a progressive encephalopathy. I suspect heat injury c̄ dehydration.

Recommendations

1. Observation.

b(6)-2 [redacted]

LTC [redacted]

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

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

[redacted]

b(6)-4 [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
7 Aug 03 0800	Neurology PT not very responsive over past 12+ hrs. Pt mainly sleeping + yawning when more awake. PT did awaken this morning to verbal stim. No asymmetrics in motor activity noted, no SZ's, no Δ's/variations in vitals (still AP) PE 129/74, 70, 16, 97% Pt very sleepy. Will open eyes to tactile stim + a little to verbal. Localizes to sternal rub. Verbalizes a few arabic words. Moving all 4 well, no facial asymmetry, yawns frequently. Conjugate versions. Fundi - suboptimal exam ∗ 2° to eye movement but no gross pathology. Medial L'd bracing on (L) more noticable on arm (B) knuckle bracing. Assessment AMS, fluctuating - it is possible pt is developing some cerebral edema from a possible CHI (hx head/orbital abrasions + ecchymosis, pt's mild). Edema may peak 2-5 days out. Pt has (L) knee surg plan for this pm. Exam is non focal. Recommend Would get a CT head if ours were working. Would use short acting agents, mainly benzo's in surgery but do not see specific reason to cancel surgery

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

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

[redacted] b(6)-4

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
06Aug03 1830	NN: Patient arrived from ER on litter @ 1800. Neuro: Patient confused, intermittently agitated and combative. Pupils 2-3mm reactive. Moves all extremities spontantously, occasionally follows commands. Restrained x 3pt, released/checked Q 2°. Resp: lungs clear, resps even and unlabored Sats 100% on RA, Ø cough. CV: HR 60-70's BP stable, pulses palpable, afebrile. GI: BS (+) x4, Ø stool, Ø N/V/D, Ø distention. Will try sips of H_2O advance to regular diet when more awake. GU: foley draining clear yellow urine approx 100cc/°, Ø bladder distention. Lines: 18g (2) AC c̄ NS @ 150cc/°, 18g (R) wrist HL. Meds: Ancef Q 6°, tylenol prn. Plan: monitor neuro status. Skin: Multiple small bruises and scrapes, 15cm to (R) knee c̄ small amount serosang drainage, approx 1-2cm wound, dog bite on arrival. Will go to OR for I+D in AM. Will continue to monitor [redacted] CPT/ AW

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			[redacted] R
	LAST	FIRST	MI	(SSN or Other) b(6)-2

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PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.
EPW # [redacted] b(6)-4		

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b(6)-2 A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
06Aug03 2200	NN: Patient resting, occasionally agitated. Follows commands thru interpreter. Will continue to monitor [redacted] CPT/AN
06Aug03 0200	NN: Ø change to patient status, continues to awaken spont., pupils 2-3mm reactive to light, follows some commands, difficult to determine confusion vs non compliance (willful). Will continue to monitor [redacted] CPT/AN
07Aug03 0430	NN: Labs done, patient bathed, linen changed. Dsg to knee Δ'ed, continues to have serosang drainage. Patient responds to stimuli; loud voice, firm touch, still appears confused, occasionally combative. Pupils unchanged reactive to light [redacted] CPT/AN
07Aug03 0530	Received report from outgoing shift. Pt Resting c eyes closed on backside HOB ↑ 45°. Responsive to loud verbal - opens eyes pupils 2-3mm reactive to light, appears confused then closes eyes again. (+) ecchymosis purple sm ant noted under eyes (−) battle signs noted (+) abrasion (L) frontal head noted (−) drainage (−) edema (−) erythema (−) ecchymosis. LS - 12 S_2O_2 100 RA CTA shallow. even unlabored ABD - flat soft hyperactive x 4 (−) rigidity noted (−) response to palpation. (L) Knee bulky dsg intact mod ant

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
07Aug03 1830	Assumed care of patient @ 1700. Neuro: Patient continues to be confused, slightly combative. Trying to get OOB, follows some commands. Pupils 3-4mm, brisk reaction to light. Moves all extremities well. Resp: lungs clear, breath sounds even and unlabored, sats 99% on RA. Ø cough. CV: Skin warm and dry, afebrile. Pulses palpable. HR 80-100, BP stable. GI: BS ⊕ x4 quads, Ø N/V/D, tolerating sips of clear liquids. GU: foley draining approx 100cc clear yellow urine an hour. Ø bladder distention. Skin: Multiple areas of bruising and scraping. Ace wrap to (L) patella. CDI. Lines: (L) AC 18g ĉ NS @ 125cc/°, (R) wrist 18g HL: patent. Meds: Ancef Q 8°. Plan: Monitor neuro status, N/V status of (L) E. Will continue to monitor [redacted] CPT/TR
07Aug03 2230	NN: Slightly less agitated. Following more commands, seems to speak some english. Continues to restrained, V's Q 2°. Pupils remain 2-4mm brisk reaction to light. Ø other A's. Ancef given. Will continue to monitor [redacted] CPT/RN

(b)(6)-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
08Aug03 0230	NN: Ø Δ in mental status. Pupils 2-3mm brisk reaction, awakens to stimulation. moves all extremities. CMS ✓ to (L) LE intact, pulse +2, Ø drainage on dsg. Will continue to monitor b(4)-2 [redacted] CPT AW
08Aug03 0430	NN: Bath given, linen changed, patient trying to get OOB, follows some commands. Dressing to knee CDI b(4)-2 [redacted] CPT AW
08Aug03 0600 T-97.8	VS 127/64 P 68 R 15 SaO2 100% RA R-lung unlabored shallow LS CTA color good pupils 2cm brisk awakens to verbal c̄ touch opens eyes b(4)-2 talks. Interpreter present "states [redacted] pt mumbling" "makes no sense". holds hand if hand touched. Skin warm to touch cap refil brisk Drg (L) leg bulky c̄ ACE CDI pedal pulse strong able to move extremity. NVI. IV (L) AC patent Running NS @ 150cc/hr (−) S+S infiltrate or infx. foley to gravity draining amber (light) urine sm amt sediment noted. Occasionally sits up in bed seems confused then lies back down ABD soft BS hypoactive x4 (−) facial grimacing

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

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

REGISTER NO. | WARD NO. ICU2

EBW [redacted] b(4)-4

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
08 Aug 03 0600	cont of restlessness during palpation will cont to monitor [redacted] 91WM6
08Aug03 0800	pt breakfast held, pt awakened eyes opened unable to keep pt awake 85T [redacted]
1230	pt lunch held pt awakened eyes opened unable to keep pt awake [redacted] 91WM6
08Aug03 1800	Restless moving about in bed VSS sinus tachy afebrile pt diaphoretic AC ineffective pt hospital cooled c̄ waters + washcloths ice unavailable [redacted] 91WM6
08Aug03 1830	NN: Assumed care of patient. Neuro: Pupils 3mm brisk reaction to light, follows some commands, trying to get out of bed, out of restraints. Moving all extremities well, equally strong. Resp: lungs clear, resp even and unlabored, sats 98-99% on RA. Ø cough. CV: HR in 80-90's, BP stable, skin warm and muddley sweaty, pulses palpable, afebrile. GI: abd soft, flat, N/T. BS ⊕ x4 Ø stool. Tolerating clears, will be NPO p̄ MN for surgery in AM. GU: foley draining clear yellow urine, 50-100cc/h. Skin: multiple contusions and abrasions, dressing to knee CDI, CMVs to distal limb intact. Lines: 18g ⊕AC c̄ D5½NS c̄ 20K @ 175cc/h. Ancef Q 8h. Will continue to monitor.

b(6)-2

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b(6)-2 [redacted]

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PROGRESS NOTES

MEDICAL RECORD

DATE	NOTES
7 Aug 0530	cont serous drg. (+) pedal pulses skin warm to touch noted ecchymosis c̄ edema bilat knuckles. multiple abrasions (L) leg (+) edema noted (small) (L) hip. moves in bed IV 18G (L) AC c̄ NSS 150cc/hr patent SL (R) FA patent Foley to gravity draining 50cc amber urine sm amt sediment will cont to monitor [redacted] 91WM6
07 Aug 0600	noted pt Resting appears to be sleep yawns on occasion NAD [redacted]
07 Aug 0630	pt breakfast held not able to awake [redacted] 91WM6 b(6)-2
8/7/5	Brief Note PreOpDx: Open (L) patellar fx (age unknown) PostOpDx: same Procedure: I&D (L) open patellar fx Surgeon Olivera Anesthesia General LMA EBL: nil Fluids 800cc Findings: Comminuted patella c̄ bone loss Drains: perlove 1" Cx: none Post Op Plan: Repair

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

RELATIONSHIP TO SPONSOR

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b(6)-4

EPW # [redacted]

PROGRESS NOTES
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b(6)-2
A11

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
8Aug03 2100	NN: Patient medicated c̄ 2mg Ativan per Dr [redacted] for restlessness. Minimal improvement. Neuro ✓'s remain the same. Will continue to monitor — [redacted] CPT1 AN
8Aug03 0130	Patient continues to be intermittently agitated. Gave 2mg Ativan IVP. Neuro states unchanged. — [redacted] CPT1AN
9Aug03 0300	Patient bathed, clean gown. Restraints checked. Dressing CDI, distal CMS ✓ intact. Will continue to monitor — [redacted] CPT1 AN
09 Aug-03 0530	Assumed care of Pt. VS 98.4 - 132/90 - 88 - 20 - 99% SpO_2 on RA. Pt has ↓ LOC, responds to tactile stimuli, sits up at times but does not open his eyes, his pupils 3-4mm brisk, PERRLA, Lungs CTA (3), resp even + nonlaborded, CV-S,S2, NSR, 18g Rt forearm AC, GI-BS x4, NO, NT, Foley to gravity draining clear amber urine, Ø BM. Will monitor — [redacted] SSG Gilmore
09 Aug-03 0905	Pt TO OR (neuro) — [redacted] SSG Gilmore
9 AUG 03 (1130hrs)	Returned from OR via litter. Drowsy, but responds to tactile stimuli. Pupils 2-3mm c̄ sluggish response to light. Moves all extremities spontaneously x̄ of on (L) LE Dt ace wrap dressing & Knee brace (lungs): CTA all lobes c̄ SpO_2 @ 98-100% on RA; Ø SOB / difficulty breathing. (CV) +2-2 pulses palpable in all extremities c̄ brisk capillary refill < 3 secs. Color good, skin warm to touch [redacted] CPT

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NO. (SSN or Other)
	LAST	FIRST	MI	[redacted]

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#[redacted]
b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
8/9/03	Preoperative
	PreOpDX: open patella fx
	PostOpDX: same
	Procedure: I&D, ORIF ⊖ Patella
	Surgeon: [redacted] b6-2
	Anesthesia: Gen
	EBL: 4
	Fluids: 1100
	TT: 105 @ 300mg/kg
	Findings: Comminuted patella fx, many medial patella
	CR: P b(6)-2
	Drains: Hemovac. [redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
9 AUG 1130hrs (Cont'd)	S, S, 5 @. B/P stable. ↑ @ systolic of 130's-140's/90's. (GZ/GU): abd soft, flat non-distended c̄ hyperactive bowel sounds in all quads. Foley cath c̄ 125-150cc/h urine output, otherwise unremarkable. (Lines): PIV ↓ (L) FA #18ga c̄ NS @ 150cc → will Δ to D5½c̄ 20K @ 150 per MD's order. JP x1 to (R) Knee draining bloody fluids into collection [redacted] (Blue): Complete recovery and transfer to ICW #2. [redacted]
9 AUG 03 (1325hrs)	PACU post-surgery recovery complete. IV NS Δ to D5½c̄ 20K @ 150cc. Report [redacted] to CA Spears (ICW #2). To transfer to ICW #2 via litter & two [redacted] further hospital care. [redacted]

b(6)-2
A11

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
9Aug03 1530	received pt. from ICU 2 @ ~1400 - VSS - DS½ NS c 20 meq KCl @ 175 cc/hr infusing into (R) AC, site patent - foley to gravity, amber colored urine - (L) leg c̄ ace wrap, knee immobilizer in place, hemavac in place - no drainage, [redacted] (+) 2 pedal pulse in (L) foot - (+) 2 peripheral pulses - pt. does not respond to commands, sits up at random, pulling @ restraints occassionally - PERRLA - pt. will lie back down c̄ a hand lightly placed on chest - responds only to painful stimuli - restraints placed on (B) wrists and (R) ankle - lungs CTA (B) - (+) BS - 2 mg ativan given IVP @ 1400 for agitation, pt. continues to sit up and pull @ restraints [redacted]
9Aug03 2040	labs drawn, Dr. [redacted] aware of results - pt. continues to fight restraints, attempting to pull out foley, open leg brace, sit up, pull IV - IV restarted in (L) FA - Dr [redacted] aware of pt's activity and status - [redacted] b(6)-2

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

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WARD NO. 7CW2

EPW [redacted] b(6)-4

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
10 Aug 03 0250	Pt care assumed @ 2100. VSS, lung sounds clear, bs+x4, pulses ⊕x4. Pt is not orientated or alert, only responds to painful stimuli, has not opened his eyes once this shift. Eyes perrla. Pt on 40 meq KCL in 250cc NS @ 63cc/hr, IV site intact, IV ABX. Dsg on lle cdi, hemovac draining little amount of blood. Pt very combative although not appearing conscious. Has epic restraints on BUE, RLE, and accross chest. Keeps moving all extremeties, and sitting up in bed. Dr [redacted] saw pt, new orders c̄ labs @ 1800. Will continue tomorrow. b(6)-2 [redacted] alumo
0400	Hemovac emptied 60cc blood. [redacted] alumo
0725	Pt. restless in bed c̄ HOB @ 45°, restraints x4. HR Regular, lungsounds clear bilat, bowel sounds (+) x4 quads. Foley draining clear, orange tinged urine, insertion site c̄ white milky fluid draining. IV in (L) FA infusing [redacted] NS c̄ 40meq KCl @ 62cc/hr s̄ s/s of infection or infiltration. Hemovac to (L) LE draining dark blood tinged drainage. Immobilizer to (L) LE intact, pedal pulse palpable, <3sec cap refill. Pt. c̄ decreased LOC, pupils equal & reactive to light, pt. responds to voice & painful stimulation. VSS, slight temp of 100.4, ⊼ tylenol dissolved in H_2O & given to pt. All other assessment findings WNL. Will continue to monitor. [redacted] RT/AA b(6)-2

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

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

#- [redacted]

b(6)-4

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WARD NO. ICU2

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510-112

NSN 7540-00-634-4123

MEDICAL RECORD

progess notes ~~NURSING NOTES~~ (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
17Aug03	0625		Assume pt care @ 0500. Pt sleeping. Responds to touch and verbal stimuli. While awake pt moves back and forth yelling. VSS. D5NS c̄ 20 kcl @ 125cc to central line blue port. Red and white port ⊕ flush ⊕ bld return c̄ white port. Dsg reinforced c̄ tape. CD+I. Jevity plus @ 50cc/hr to G-tube c̄ difficulty. Dsg CD+I. Foley to gravity c̄ dark clear yellow UOP. Pt restrained @ this time to prevent pulling out G-tubes and lines. ⊕ knee dsg and brace CD+I. ⊕ movement ⊕ pulse below splint. Will continue to monitor [redacted]
	1300		Dsg Δ done @ 0845. packed c̄ gauze b/ soaked in Dakins solution. Area pink, foul odor noted pin rose drain intact. MD requested to be @ next dsg Δ. [redacted] SIGNED
17Aug03		1630	assumed care @ 1300 - VSS agitated, yelling, biting anything he can get near his mouth, pulling @ restraints - central line patent - Foley to gravity - Jevity plus purg - tube @ ~60cc/hr - ⊕ knee dsg Δ done, Dr. [redacted] unable to be found for dsg. Δ - pt. scheduled to go to civilian hospital in AM -

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

ICW2

NURSING NOTES

Medical Record

STANDARD FORM 519 (REV. 7-91)
Prescribed by GSA/ICMR, RMM (41 CFR) 201-9.202

CIV

[redacted] b(4)-4

MEDCOM - 15869

b(6)-2 A11

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
17 Aug cont			Dr. [redacted] saw free wound, good granulation tissue noted, some small areas of black tissue, pen rose drain intact, old dsg [redacted] moderate amt. of serosang. drainage [redacted]
17 Aug 03		2200	USS - Remains confused to person, place, time. At time knows who is but is intermittent. Pearl 94% Lungs CTA B/L Resp eun Reg - HR-NSR BS ⊕ x4 quads Abd soft NT. Pedal and Radial pulses +3. dsg to ⓡ knee dry and intact brace is in place. IV off D5NS c̄ 20 mEq KCl @ 125 ml/hr is patent to cent line all 3 ports ACP patent. IV Cleoxan and 2 units gum. Restraints to UE and LE in place and secure [redacted] 8/1/20
18 Aug 03	0430		Dsg to ⓡ Knee Δ'd by MO moderate amt of bloody drng d̄ to dry noted. wound looks clean & Redness drainage noted. Rewrap c̄ Kelix and Ace bandage. brace put back on. MSO4 given for pain control. Resting quietly c̄ pressed. woke up from 10 am was fully out in Arabia. Restraints to UE and LE in place and secure [redacted]
180530 Aug 03	—		Nursing Assessment: Asleep, Arousable c̄ stimulation. AAOx1 c̄ stimulation. Airway intact, breathing even & unlabored, LS CTA(B). Abd soft, nontender, c̄ distention. Gt tube midline abd. Jevity @ 50 ml/hr continuous. Foley to gravity - clear yellow urine. FROM and neurovascularly intact to (B) UE and RLE. Limited ROM and neurovascularly intact to LLE 2° splint/brace. 4-point restraints. C-line dry Δ'd c̄ dressing. C-line not stitched into place at this time [redacted]

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

STANDARD FORM 510 (REV. 7-91) BACK

6 Aug 03

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
320	
110/90	S - detainee brought in - little history
115	reset gunshot wound to (L)
R-18	knee
	↓ mental status
O2-92	Rapid - agitating
	Head - abrasions (L) forehead
	Eyes - ↓ No [illegible]
	Neck - normal - normally no
	pain
	Thorax - No stabilen
	Back - ↓
	Lungs - B.S. all ovr
	Heart - RS -
	Abd - soft - No tender
	(L) knee - [illegible]
	[redacted] DO
	Neuro - responsive & stimulation -
	[illegible]
A -	Gunshot wound (L) knee
	multiple abrasions:
	Chain of Custody
P -	Immediate Transfer [redacted]

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

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

[redacted] b6-4

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

EPW

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10Aug03 1830	assumed care @ 1300 - VSS - D5½NS c 20meq KCl @ 175cc/hr infusing into (L) PA IV - 4 point restraints on pt. for most of shift - pt. reaches for certain things c a purpose, fanning himself, removing clothes - PERRLA - responds only to painful stimuli, does not noticeably respond to commands - Foley draining dk. amber urine, QS - hemovac drain c minimal output, ace wrap and knee immobilizer in place on (L) leg. neuro V's WNL in (L) foot [redacted]
10 Aug 03	HD #5 GSW (L) knee / MSΔ b(4)-2
	- GSW operated / splinted c drain by Ortho. doing well.
Ancef	- MSΔ's. No improvement; still moving all ext. equally c purposely. (pushing away during exam). No PO c tact.
D5NS c 20K @ 125cc/hr	Na initially 141 → 127 → 129 c D5NS c 20K; K+ nl
foley in	BUN/Cre nl; LFT's nl x̄ mild ↑ AST ↑ ALT & Alb ↓ 3.1
	Plan: Zantac ulcer prophylaxis
	Lovenox 30mg SC. q12° DVT prophylaxis.
	500cc boluses; Plan NG + D-feeding tomorrow
	[redacted] / [redacted] b(4)-2

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

EPW b(4)-4

[redacted]

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)*
10 Aug	Pt. care assumed @ 2100. MD informed of labs
2244.	BP 150/100 and temp 100.1. NS bolus 500cc ordered and given. Pt. ~~inf~~ given Tylenol supp. for low grade temp. HR Reg, lungs CTA, BS(+) X4. Foley to gravity draining CYU. Knee brace to (L) UE intact, hemovac intact. (+) ~~ft~~ c̄ Brisk capr refill, pulse 2+. Pt. restrained X4. HOB ^ for comfort. Will cont. to monitor. b(u)-2 [redacted]
0315	10cc bright red bloody drainage out by hemovac [redacted]
110530 Aug 03	NURSING ASSESSMENT: Assumed pt care. Pt appears to be asleep but is not arousable to painful stimuli. Pt has no response to deep painful stimuli or even drop to bacon. Pt does have sporadic, spontaneous verbalizations and movements. The movements typically seem to be the pt's attempt to get up out of bed. Airway intact, breathing is even and unlabored, LS: CTA (B). Some diminished noises to bases of lungs but clears c̄ spontaneous coughing. Abd soft, nontender, c̄ distention. BS(+) x4. Voiding per foley, clear, yellow urine. Pulses to (B) UE, (B) LE, and all extremities are neurovascularly intact. LLE in leg brace c̄ ACE wrap beneath brace, hemovac coming from knee. Dsg is CDI, hemovac has small amount of serosang drng. IV to (R) AC is c̄ s/s of infiltration/infiltration but site is very positional. Pt has not eaten since admission to hospital. Medicine team aware. Will be reminded today. b(u)-2 [redacted]
111200 Aug 03	NURSING NOTE: Dobhoff 12Fr feeding tube placed in (L) nare. Lubricated c̄ water-based jelly prior to insertion. Insertion point marked c̄ black permanent marker, approx 1cm beyond single-lumen ~~[illegible]~~ manufactured mark of tube. Placement verified via auscultation c̄ good gastric bubble. ~~[illegible]~~ fluid returned upon aspiration. Pt didn't cough throughout the procedure. Gastric air bubble auscultated at epigastrium. — Fosinol @ 10cc/hr initiated to tube. [redacted]
111200 Aug 03.	NURSING NOTE: Hemovac DC'd by MD intact. [redacted] b(u)-2

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11Aug03	assumed care @1300 [redacted] - dobhuff tube
1350	in (R) nare c ½ strength ensure infusing ~~into~~
	@10cc/hr, tube taped to nose and forehead -
	IV in (L) FA c D5NS c 20meq KCl @125cc/hr, site
	patent - foley draining dk. amber/orange
	urine QS - (L) leg in ace wrap c Knee immobilizer
	in place, neuro V's WNL in (L) foot/toes -
	pt. c restraints on ankles (B) & upper arms (B)
	& sheet at pt's waist - pt. resting at moment,
	occassionally lifting head, pulling @ wrist
	restraints - PERRLA - pt. does not purposefully
	respond to sternal rub but resisted dsg Δ and
	dobhuff placement b(4)-2 [redacted]
11Aug03	temp @1400 102.7°F, pt. will not take PO
~~1400~~ 1445	tylenol, 650mg tylenol given PR @1445,
	will monitor results - [redacted] CR, AW
2132	Pt. care assumed @ 2100. Pt. febrile @ 101.°A 650
	mg Tylenol given PR. HR Reg, lungs sounds CTA
	bilat. BS (+) but hyperactive. Lower ABD firm. Foley 7
	gravity draining amber/orange color urine. Pt. restrained
	X5 pts. Dobhuff tube in place infusing ½ strength ensure
	@ 10cc/hr. IVF infusing c difficulty. Pulses 2+ x 4 ext

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

EPW b(4)-4

[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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	c̄ brisk capreffill. Knee immobilizer in place. NV checks @ LE WNL. Pt. fighting against restraints, grabbing @ Foley, sheets, people near bed. ~~Pt. movements don't~~ b(6)-2 [redacted] Pt. doesn't respond purposely all the time, but reacted to Lovenox shot. Will cont. to monitor. b(6)-2 [redacted] /LTA
120530 Aug 03	NURSING ASSESSMENT: Assumed pt care. Glasgow coma scale of 7/15 (eyes ① no response to painful stimuli; flexes ④ away from painful stimuli; ② incomprehensible verbal responses - non spontaneous). Airway intact, breathing even and unlabored, LS CTA ⊕. Abd soft, nontender, ↓ distention. BS ⊕ x 4. Voids per foley to gravity (urine clear, ~~yellow~~ orange). Dobhoff tube to ⊕ more. Tube has come out & now a little bit. Advanced to marking on tube & difficulty ~~and repeat~~ retaped. Feeding on hold for OR today. Flow and neurovascularity intact to BUE and RLE. ⊕ LE in knee brace & ACE wrap, RLE. Toes warm, good pulses to LLE. IV to ⊕ FA flushes well & ↓ s/s infection or infiltration. b(6)-2 [redacted] /LTA

NSN 7540-00-634-4176

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11 Aug 03	Neurology The pt has had essentially no clinical change over the past several days. He remains mostly somnolent, unable to follow any commands, briefly agitated when uncomfortable maneuvers are done but verbalizing only a few brief words/sounds. He is unable to feed or toilet himself + has tube feedings. Pt's BP has been a little labile but pt has been AF. [IE] Somnolent but briefly arousable c̄ noxious stimuli. Blinks to threat ? (B). Fundi reveal flat disc. Pt has roving eye movements at times + does not seem to direct gaze ? rarely when agitated. I could not get him to track objects, PERRL, conjugate, no ptosis, no facial asymmetry, sym + ? prom movement of all 4 limbs. Tone is now spastic, ? more so on Rt (L). He is hyperreflexic c̄ extensor toe signs. He responds to noxious stim (B). Assessment 1. Encephalopathy, may be permanent 2° to heat stroke given his lack of improvement + global spasticity. I base

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

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

[redacted] b(6)-4

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
11 Aug 03	Neuro ②
	this mainly on his Temp @ presentation. Less likely but also possible is diffuse axonal injury 2° to CHI. This is possible but his forehead abrasion + cheek ecchymosis WERE quite minor.
	Plan
	1. Continue tube feedings + DVT prophylaxis (Lovenox)
	2. Placement in IRaqi facility
	b(6)-2
	[redacted]
	LTC [redacted]
12AUG03	Brief op note
	Indication ① infected ② knee
	③ Encephalopathy
	Procedure - ① I+D ② knee
	③ open Gastrostomy.
	Anesth - GEM
	Fluids - 1L LR UO 500
	EBL min.
	Findings - G Tube placed on Gast Ant surface of stomach near Greater Curve & complication Necrotic tissue subQ & fascia phlegmonous purulent arthritis
	b(6)-2
	[redacted]

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
12Aug03	CXR done + (R) IJ CVL confirmed correct placement no evidence of pneumothorax (R) + (L). [redacted] CRNA/ME b(4)-2
12Aug03 1500	assumed care of pt. @ 1315 on pt's return from OR S/P knee washout & gastrostomy - VSS BP 150/90 - (+) BS, hypoactive - lungs CTA (B) (R) IJ CVL patent x3 ports c̄ blood return x3 ports - g-tube to gravity drain, minimal reddish/brown output - Foley to gravity draining QS amber urine - IV SD d - dobhoff tube remains in (R) nare, pt. NPO & present - (L) knee c̄ ace wrap and immobilizer in place, neuro V's WNL in (L) foot - pt. b(4)-2 Sleeping calmly & present [redacted] on
12Aug03 1930	pt. became very agitated @ ~1730, pulling at various tubes, restrained @ that point @ (B) wrists and (R) ankle - ensure's strength infusing @ 20cc/hr into dobhoff tube - pt. seemed to be moaning and was grabbing (L) leg, medicated c̄ 2 mg MSO4 for pain [redacted] on b(6)-2

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EPW # [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)*
12Aug03	LSS - Not A Lot to person, place, time. IV of LR @125 to central line is patent o/s/s infiltration saline lock to (R) arm is patent o s/s infiltrat. dobhoff NG patent ~~o/s/s infil~~ ensure @ 20cc/hr ½ strength Rumy. Foley patent draining dark yellow urine. GT drsg dry and intact GT tube to gravity draining dark brown. Acewrap to (L) leg dry and intact splint in place. lungs CTA B/L Resp even Reg. Pearl 3mm BS(+) x 4 quads. Radial and pedal pulses +3 CMS to upper and lower extremities 2-3sec. heart Ausc - S1 S2 o ectopy NSR. Restraints to upper and lower extremities in place and secure. [redacted]
12Aug03	NG feeding stopped @ 2400 per MD order - [redacted] b(6)-2
	[redacted] b(6)-2
8/17/03	Pre OPX - Infected Knee Post OPX. SAW Anesthesia - Regional ITD Surgeon [redacted] Fluid - ~~minimal~~ 300cc LR b6-2 EBL: minimal Post OPNote: Cont ABX [redacted]
8/17/03	PT received from OR for TKO of (L) knee. PT fluids ok in progress ordered. PT mentally debilitated. PT pulled out NG/NG tube, tube reinserted. Xray obtained & follow & determine placement. PT & Gr Knee GT [redacted] DOC of (L) knee intact, GT dressing clean. Contact line dressing as well. [redacted] b(6)-2 in no medical distress [redacted]

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STANDARD FORM 600 (REV. 6-97) B[redacted]

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13Aug03 1300	Pt stable but agitated. Pt making purposeful movements and attempting to speak. Will open eyes partially to verbal and tactile stimuli. Given 4mg MSO4 for post op pain. NG tube to (R) nare intact, (R) nare ⅕ redness or inflammation. CL to (R) IJ CDI. 3 ports functioning properly. IV to (R) arm removed. Lungs CTA bilat, ∅ resp distress. NSR. Abd soft, non-tender, bowel sounds active x4 quads. G-tube placed yesterday, dsg CDI, draining dark green bile. Brace to (L) leg intact. Strong pulses and brisk cap refill to bilat LE. — b(6)-2 [redacted] LV/RN
1330	Pt resting calmly on his side. ∅ agitation noted. Loose kerlix restraints to wrists. Will cont Τ pain management — b(6)-2 [redacted] LV/
1500	Pt alert and awake. Speaking to translator pt able to give name and some info, still confused about details of injury. Dophoff removed. Pt drinking water and juice. MSO4 controlling pain and agitation. Pt loosely restrained. Will monitor — [redacted] LV/RN

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

EPW# [redacted]

b(6)-2

RECORDS MAINTAINED AT: ▶ b(6)-2

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

CHRONOLOGICAL RECORD OF MEDICAL CARE **STANDARD FORM 600** (REV. 5-84) Prescribed by GSA and ICMR FIRMR (41 CFR) 201-45.505

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
0145 14Aug03	Pt care assumed @ 2100. BP slightly elevated, other VSS. Lung sounds CTA, pulses+ x4, BS(+). LLE dsg CDI, pulse and capillary refill(+), (1) foot edematous. G-tube site on abd c̄ dsg CDI, draining bile to gravity. Triple lumen to (R) IJ intact, all 3 ports working. LR Δ'd to D5NS c̄ 20meq KCl @ 125 cc/hr. IV ABX running IVPB. Foley catheter intact, draining CYU. 2mg MSO4 given for pt moaning "claim" @ 0130. Pt slowly being able to verbalize words, occasionally opening eyes and making eye contact. Interpreter spoke c̄ patient, patient not verbalizing anything understandable, pt later tried to speak c̄ nurse. Will continue to monitor [redacted] b(6)-2
14Aug03 0655	Pt care assumed @ 0600. VSS. T̄ temp of 100.2 Pt restless trying to verbalize. Pulses + x4 G Tube draining bile to gravity. Foley draining dark amber urine D5 c̄ 20meq KCl running. Pt sitting up c̄ assistance will continue to monitor [redacted] b(6)-2
0645	Central line to (R) IJ intact (+) flush x3 (+) blood return c̄ distal line. HR reg. Lungs CTA Abd. BS x4 G tube dsg CD+I. Tylenol 650mg given for temp. Pt NPO p̄ breakfast. [redacted] b(6)-2
14Aug03	OP Note Pre op Dx: Septic Arthritis (L) knee Post op Dx: same Procedure: Debrid I+D (L) knee Surgeon: [redacted] b6-2 [redacted] ASL G Fluid: 300cc

*U.S. Government Printing Office: 1996 - 404-763/40001

STANDARD FORM 600 BACK (REV. 5-84)

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)*
14Aug03	1245 Pt returned from ICU3 p̄ recovery from I+D of (L) LE. VSS. G-tube in place. Foley to gravity. Central line c̄ NS c̄ 20KCl @ 125cc/hr. Dsg Δ'd - Cond intact. Dsg and brace to (L) LE, CDI. pt restless. @ this time moving up and down. b(6)-2 [redacted] SIMMS
14Aug03 1445	assumed care @1300 - VSS BP 160/96 - central line patent x 3 ports c̄ blood return - g tube clamped - Foley draining clear urine QS - ace wrap on knee, knee immobilizer in place on (D) leg + pt. sleeping @ present, (B) wrist restraints in place - lungs CTA (B) - (+) BS, hypoactive - pt. making limited eye contact and asking questions in Arabic, still acting confused as he is occassionally pulling @ Foley and central line b(6)-2 [redacted] Ch. A
14Aug03 2100	Osmolite HN tubefeed started @ 10cc/hr via Kangaroo tubing, Dr [redacted] aware of tubefeed type Δ - Jevity plus will be used when rate reaches 30cc/hr [redacted] ecp b(6)-2

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[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)
14Aug03	VSS - is confused as to person, time, place. IV 20mL NS Running to central line is patent @ s/s infiltration. Pearl Lungs CTA BIL Reg even. HR - WSR - BS (+) x 4 quads: Ace wrap and brace to (R) leg leg in place. +1 edema to (L) foot. OS molite HN. Running to at ↑ 10cc to 20cc is patent @ Residuals Restraints to UE and LE in place and secure. Lying quietly unbal ō eyes closed appear. — S at [redacted] 9/ca b(a)-2
15 14Aug03	Assumed pt care at 0545. Pt sleeping has wrist restraints & R leg restraint. central line Patent w/ NS 20 KCL running. Foley draining Amber urine. G-Tube w/ clear osmolite lungs CTA w/ even breathing b(a)-2 LLE in brace pt due to OR this AM — Pt c [redacted] after
15 14Aug03	Pt bathed w/ all lines flushed osmolite stopped at 0700 due to NPO mid. order or notified. — [redacted] 9/ca
15Aug03	Pt awake spoke to staff and transfer.
15Aug03	Opnote Preop Dx: Infected (L) knee Postop Dx: same Procedure: I&D (L) knee Surg: [illegible] Fluids: 150 cc Postop Dx: TID wet to dry Cover A&X [redacted] b(a)-2
15Aug03 1640	assumed care upon pt's return from (L) Knee washout ~1500 - VSS - pt. very agitated/3 c/o pain, restrained (B) wrists & (R) ankle, given 5mg MSO4 for knee pain IVP - pt. slept for ~30 minutes and is now very agitated again [redacted] b(a)-2

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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)*
16Aug03	USS - Becoming more Alert to person, still confused as to place, time. IV of D5NS @ 125ml/hr. to central line is patent @ S/S of infiltration. Brace and Ace wrap to (R) leg in place and dry and intact. GT in place and patent. Pearla 4mm - HR - NSR - Lungs CTA B/L - BS (+) x4 quads, Pedal and Radial Pulses +3. foley to gravity urine clear yellow. Restraints to UE and LE in place and secure. b(6)-2 Sgt [redacted]
16Aug03 0320	PT Agitated and confused most of Pm. Quieted down @ 2Am. has been awake intermittently but falls back Asleep - IV D5NS @ 125ml/hr to central line is patent S S/S infiltration. Tube feeding osmolyte HN @ 20ml/hr @ Residual @ 2900 TOL well. Restraints to UE and LE in place and secure. b(6)-2 Sgt [redacted]
16Aug03 0745	Pt. awake & restless in bed, pulling @ lines & intermittently yelling in Arabic. HR Regular, lungsounds clear bilat, bowel sounds (+) x4 quads. Central line in place (R) EJ, D5½NS c̄ 20kcl meq @ 125cc/hr infusing into proximal port, medial port flushed well c̄ 3cc NS c̄ good bld return, distal port flushed well c̄ 3cc NS c̄ bld return. G tube in place c̄ leakage around insertion site, ~~feeding plus~~ Osmolite HN infusing @ 20cc/hr. Foley draining clear orange tinged urine. (L) LE DSG Δ'd by MD, warm to (L) knee c̄ foul odor & (+) S/S of infection. Wound repacked c̄ ½% Dakins soln. & ABD pads, wrapped c̄ kerlex & ace wrap. All other assessment findings WNL. (L) LE pedal pulse palpable, cap refill < 3sec, (+) sensation, full ROM

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EPW [redacted] b(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
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FIRMR (41 CFR) 201-9.202-1

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
16Aug con't	in digits & ankle. Will continue to monitor. — [redacted] T/AN
16Aug03 1720	assumed care @ 1300 - VSS - very restless & agitated, restrained (B) wrists & (R) ankle - left leg in immobilizer, dsg Δ done, 4x4's & Kerlix c̄ large amount of drainage, wound bed c̄ a red moist appearance, no pus or drainage in wound bed, penrose drain in wound, neuro v's WNL in (L) foot - Jevity plus tube feed begun @ 40cc/hr via g-tube, residuals < 2cc - central line patent x3 ports, blood return x2 ports, D5NS c̄ 20meq KCl @ 125cc/hr - foley draining amber urine QS - pt. continues to be confused and disoriented, follows simple commands infrequently — [redacted] R.AN
16Aug03 2130	VSS - Remains confused as to person & times, place, time. IV to central line D5 NS c̄ 20meq of K @ 125 cc/hr, is patent Ø S/S of infiltration. foley to gravity is patent draining clear straw colored urine. Peripheral 3m - Lungs CTA bilateral resp - even Reg. HR - NSR. BS Ø x4 quads. Radial and pedal pulses +3. Dress to (R) knee dry and intact brace in place. Restraints to UE and LE d/c place and secure. Awake & present yelling out in Arabic. — [redacted]
16Aug03 2330	Dress Δ to (L) knee due mod amt of bldy drainage noted. wound looks clean Ø redness or discharge. penrose drain replaced & dr. Repacked c̄ super sponges and covered c̄ Abd pad. Rapped c̄ Ace wrap. brace in place — [redacted]

FPI: LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

558-104 b(2)-2 7540-01-075-3786

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

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

SEX: M

DUTY/LOCAL PHONE: AREA CODE | NUMBER

AGE: ?

HOME PHONE: AREA CODE | NUMBER

ARRIVAL

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

TRANSPORTATION TO FACILITY: AB

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

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

CURRENT MEDICATIONS: ?

ALLERGIES: ?

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: GPW GSW (L) knee ↓ mental status

CATEGORY OF TREATMENT

☐ EMERGENT
☐ URGENT
☐ NON-URGENT

TIME: 1405

INITIALS:

VITAL SIGNS

TIME	1405		1605		
BP	131/74		148/92		
PULSE	102		103		
RESP	26		20		
TEMP	102.3	103.4 rectal	100.8 rectal		
WT			100% O2 Sat RA		

LAB ORDERS

X	CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT	
	URINE C&S	UA MSCC/CATH		X CHEM: 8, LFTS (1 Stat)	
	BLOOD C&S X				

X-RAY ORDERS

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

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1405	X-RAY (L) KNEE				

DISPOSITION: ☐ HOME ☐ FULL DUTY

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

MODIFIED DUTY UNTIL

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

#[redacted]

b(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

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

TEST RESULTS

CBC		SMAC		ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
WBC 8.0		128 CK 2449 *		SUP O2	PH	PO2	RESULTS (L) patellar Fx Skull series WNL reviewed c Dr. Brennan	
H/H 10.4/31.6		139 / 103 / 15 / 103		PCO2	SAT	OTHER ABG 7.447 39.9 76 28 4		
PLT 259		25 / 0.9						
PT				U/A	DIP		EKG INTERPRETATION UA neg blood (qe Ketones	
APTT	BHCG	ETOH	GLU		MICRO			

PROVIDER HISTORY/PHYSICAL

S: EPW presents c GSW to (L) knee O2 Sat 96% on RA - not responding to verbal commands Axillary temp 102. Wound to (L) knee 1cm around bleeding controlled. Hardened area above knee non-ex tremities

O: VS notes tachycardia B/P WNL febrile Not responding to verbal commands or deep pain stimuli. Spontaneous resp (+) gag, swallow Opens eyes spontaneously GCS -9 Eyes ~~PERRLA acc~~ optic discs WNL Ears TM's gray flat Mouth OP WNL + gag membranes moist Heart RRR tachycardia Lungs CTA Chest even excursion Lower (L) knee traumatic effusion palpable patellar Fx Back Skin intact & negative abrasion wounds Rectal - normal tone prostate WNL ~~(L) knee no pain response to~~ A: (L) Knee trauma altered mental status

CONSULT WITH	TIME	ACTION	RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP
Olivero Ortho	1		
Command Neuro			
			[redacted] STAMP [redacted] Capt MC

DIAGNOSIS A: ① Altered mental status, prob heat injury/stroke D(6)-2

② Fx patella (L) knee c effusion

P: Admit

CODES

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

#[redacted] (6)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

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: 20's

HEIGHT: } unknown
WEIGHT:

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

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

4. PROPOSED SURGICAL PROCEDURE: s/p GSW
open patellar fx (L) knee, MS Δ

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition multiple bruises & scratches
Tobacco ? ppd X___yrs. Body Piercing Ø Diabetes (Y) (N) ROM_____ 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: Ancef

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

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

[redacted]

b(u)-4

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

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

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

[redacted] 17 AN b(6)-2 7 Aug 03 DATE

11. POSTOPERATIVE EVALUATION:
LEVEL OF CONSCIOUSNESS: ☐ A&O ☒ Drowsy ☐ Sleepy ☐ Intubated
LEVEL OF ACTIVITY: ☒ Moves All Extremities ☐ Moves Upper Extremities ☐ Transferred to litter 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)
b(6)-2

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title [redacted] 17 AN
DATE: 7 Aug 03 TIME: 0750

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Tit[redacted] 17 AN
DATE: 7 Aug 03 TIME: 0925

b(6)-2 A11

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

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

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

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY 1LT [redacted] b(6)-2 A11

3. DATE 7 Aug 03 TIME PATIENT ARRIVED IN SUITE 0817

4. PATIENT IN ROOM TIME 0817 NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: S/P GSW (L) knee. MS △. NPO p MN. Patent Foley cath

6. NURSING PERSONNEL

ASSIGNED SCRUB	SGT [redacted] 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	1LT [redacted] 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) Pt. supine on padded OR table. BUE on padded arm boards <90°.

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

COMMENTS: Normal anatomic body alignment maintained

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO Dr. [redacted]

DONE BY: ☒ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP Left Knee

COMMENTS: No nicks or cuts noted

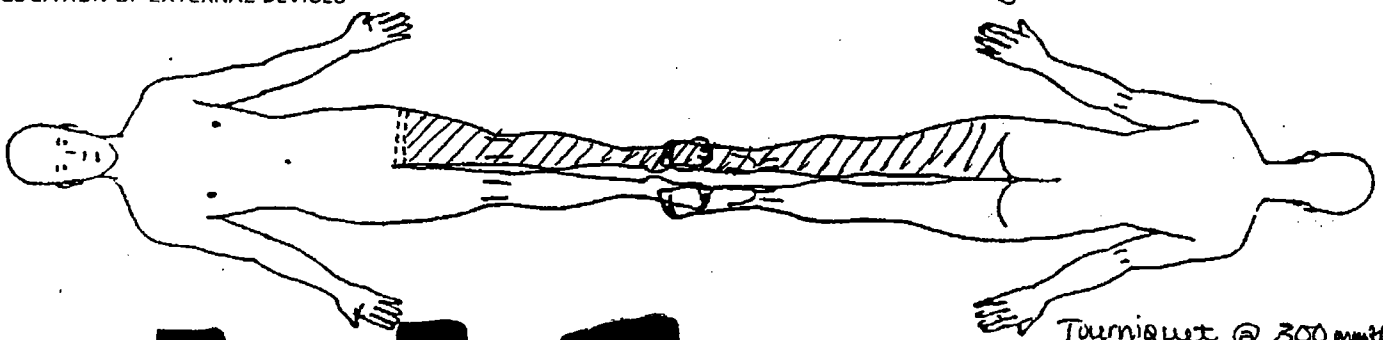
PREP SOLUTION (Specify)

SITE: Left leg BY WHOM: 1LT [redacted]

SITE: BY WHOM:

COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



LEGEND X [redacted] Ground Pad – Safety [redacted] = = = [redacted] Tourniquet ☒ - prep

Tourniquet @ 300 mmHg x 27 min

Initial: SGT 1LT [redacted]

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No		C	C	SGT [redacted]	1LT [redacted]
Needle Sharp	☒ Yes	☐ No					
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

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

[redacted]

P(6)-4

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

☒ ESU NO: #3 Cut 30 Coag 30

GROUND PAD: BRAND VL REM Polyhesive II

LOT NO: 689316 Exp 2005-03

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.01

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

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

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. Penrose Drain 1"	2.	3.
SITE	1. Left Knee	2.	3.

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

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

DA 5179 initiated

20. OPERATION(S) PERFORMED
I&D © knee wound / Left open patella Fracture

21. PATIENT TRANSFERRED TO ICU2 TIME 0925 METHOD Litter

22. REGISTERED NURSE SIGNATU[redacted] b(6)-2 [redacted] IT/N

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

b(4)-2 All

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: Gurney BY Anesthesia/OR nurse

2. PATIENT IDENTIFIED, [redacted] D PROCEDURE VERIFIED BY LT [redacted]

3. DATE 9 Aug 03 TIME PATIENT ARRIVED IN SUITE 0900

4. PATIENT IN ROOM TIME 0900 NUMBER 2-4

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	Sgt [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* SPR #9

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

COMMENTS: proper body alignment maintained, head on foam donut, arms extended less than 90° on padded armboards, position approved by surgeon + anesthesia

8. SKIN PREPARATION

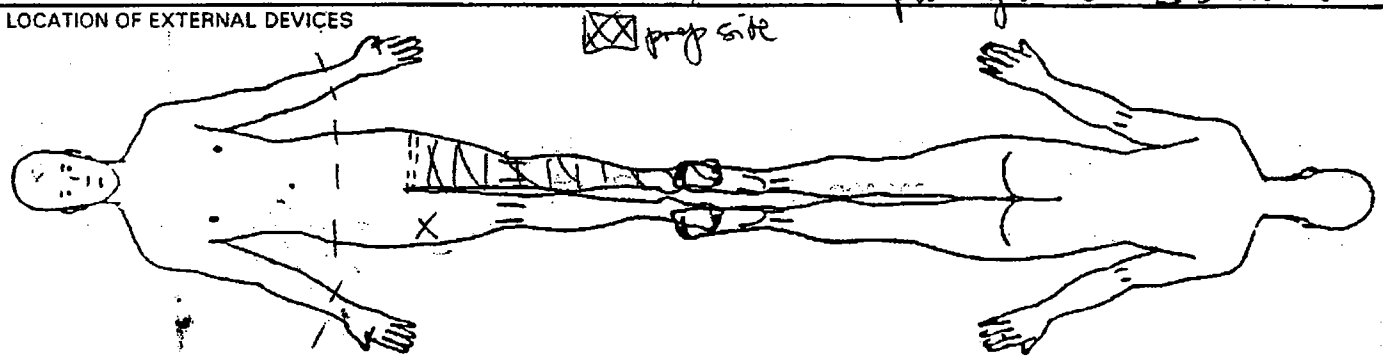
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine/Betadine
SITE: L leg BY WHOM: [redacted]
SITE: BY WHOM: [redacted]

COMMENTS: no pooling or skin Δ's noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad [redacted] -- Safety Str[redacted] = = = Tourniquet (placed by surgeon over webbing)

C = Correct I = Incorrect Initial: [redacted]

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

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

[redacted]

ICU2 b(4)-4

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

☐ ESU NO: VL Force 2 #3 (000417)
GROUND PAD: BRAND VL Rem Polyhesive II
LOT NO: 68936 2005-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

MEDCOM - 15892

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

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

Small Frag Set CMS #0921501
4.0mm Cancellous Screws
~~35x~~ 40x2 35x1
219.98 Washer x3
20g Wire CMS # 0522101
x1

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		
b(6)-2		

PHYSICIAN'S SIGNATURE [redacted]

15. X-RAY IN OPERATING [redacted] IF YES, SITE
YES ☒ NO
(L) knee C-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 ☐

	1.	2.	3.
TYPE/SIZE	400ml Hemovac		
SITE	(L) knee		

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs Xeroform
Kerlix ABD
Acewrap
Immobilizer

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

Tourniquet ↑ 0925
↓ 1[illegible]
Bone not used

- DA 5179 in chart

20. OPERATION(S) PERFORMED
I+D (L) knee
ORIF (L) patella

21. PATIENT TRANSFERRED TO ICU2 b(6)-2 TIME see DA7389 METHOD litter c safety [illegible]

22. REGISTERED NURSE SIGNATURE [redacted] TIAN

REVERSE OF DA FORM [redacted] USA 1.01

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

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

1. PATIENT TRANSPORTED TO OPER[illegible]TING ROOM
VIA Litter BY Anesthesia/OR nurse

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

3. DATE 12 Aug 03 TIME PATIENT ARRIVED IN SUITE 1020

4. PATIENT IN ROOM TIME 1020 NUMBER [redacted]

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: nkda

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: proper body alignment maintained, head on foam donut, arms extended at less than 90° on padded arm boards, position approved by surgeons and anesthesia

8. SKIN PREPARATION

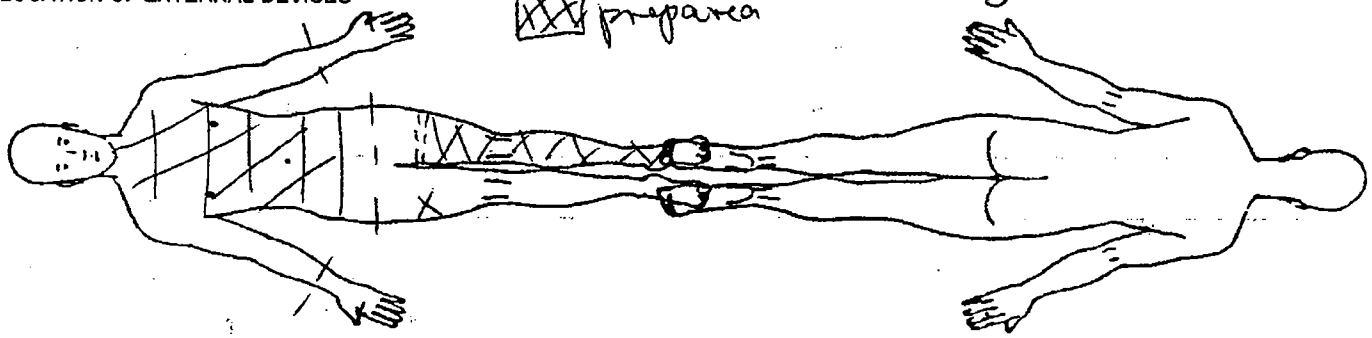
HAIR REMOVAL [X] YES [ ] NO Dr. [redacted]
DONE BY: [X] OR [ ] NURSING UNIT
METHOD: [ ] DEPILATORY [X] RAZOR [ ] CLIP

COMMENTS: no nicks or cuts noted

PREP SOLUTION *(Specify)* Betal Betal #19
SITE: L leg BY WHOM [redacted]
SITE: clavicle to symphysis pubis BY WHOM [redacted]

COMMENTS: no pooling or skin Δ's noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad SM – Safety Strap SM === Tourniquet placed by Dr. [redacted]

C = Correct I = Incorrect

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

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

#[redacted]
ICW2 b(6)-4

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

[X] ESU NO: VL Force 2 # 4
GROUND PAD: BRAND VL Rem Polyhesive II
30130 LOT NO: 68936 2005-03
[ ] ESU NO:
GROUND PAD: BRAND
LOT NO:
[ ] BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY
none		

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 ☐

	1.	2.	3.
TYPE/SIZE	24 F Malecot	1 in Penrose	
SITE	1. G-tube Abdomen	2. (L) knee	3.

18. DRESSING/IMMOBILIZATION (Specify)
4x8 + Tape (Abdomen)
Fluffs ABD pads
Kerlix
~~Aurocap~~ Acewrap
Knee Immobilizer

19. ADDITIONAL INFORMATION
WC ~~III~~ IV
Surgeons: [redacted]
Anesthesia: [redacted]
Anesthesia Type: General
66-2
30/30
Bovie Pad site intact pre-op ✓; post-op ____ Bovie Settings: Coag/Cut
Tourniquet Site intact pre-op ✓; post-op ✓
Tourniquet Time: Up 1056 Down 1144

20. OPERATION(S) PERFORMED
CL insertion, G tube placement, arthrotomy left knee

21. PATIENT TRANSFERRED TO Recovery TIME Sel DA7389 METHOD Litter c̄ safety strap on

22. REGISTERED NURSE SIGNATURE
Stan [redacted] AN

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

b(4)-2

b(6)-2

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

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA gurney BY anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED B[redacted] CPT AN

3. DATE 13AUG03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 0617 NUMBER 2-1 (2)

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA

6. NURSING PERSONNEL

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

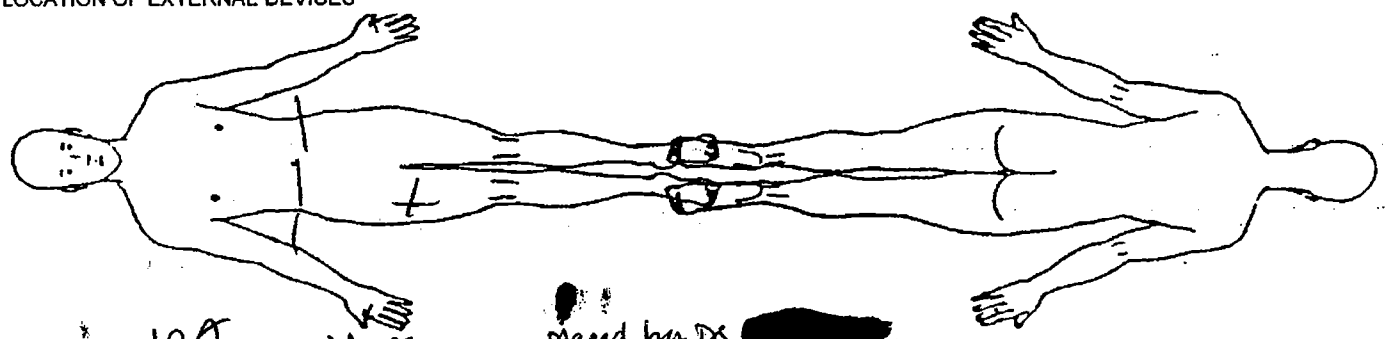
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine/Betadine
SITE (L) leg BY WHOM: CPT Leeder/CPT Holmes
SITE: BY WHOM:

COMMENTS: no pooling of prep noted.

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad (YES) ⊢ Safety Strap (YES) === Tourniquet Placed by Dr. [redacted] TTT – 14Mins @ 300mmHg

10. COUNTS

C = Correct I = Incorrect

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

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

CIV [redacted] b(6)-4

[redacted] b(2)-2

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

☒ ESU NO: CUT 30 COAG 30 Valleylab #2-1
GROUND PAD: BRAND Valleylab E7507
LOT NO: 68936 2005-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NACL

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE [redacted]

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

YES ☐ NO ☑

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

TYPE/SIZE	1. 1" Penrose	2.	3.
SITE	1 (C) Knee	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

- fluffs
- Kerlix
- ABD pads

19. ADDITIONAL INFORMATION

WC

Surgeons: DR [redacted] Anesthesia: MAJ [redacted] Anesthesia Type: Gen b(c)-2 All

Bovie Pad site intact pre-op CI ; post-op CI Bovie Settings: Coag/Cut 30-40/30-40

20. OPERATION(S) PERFORMED

I & D left Knee

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU2	0710	gurney

22. REGIST[redacted] [redacted]

REVER[redacted]

USAPA V1.01

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

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA gurney BY anesthesia

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

3. DATE 14AU603 TIME PATIENT ARRIVED IN SUITE —

4. PATIENT IN R[illegible] [redacted] TIME 0933 NUMBER 2-1 (1)

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA

b(6)-2

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] 91D b(6)-2	RELIEF SCRUB	b(6)-2
ASSIGNED CIRCULATOR	CPT [redacted] AN	RELIEF CIRCULATOR	CPT [redacted] (0945-1000)

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

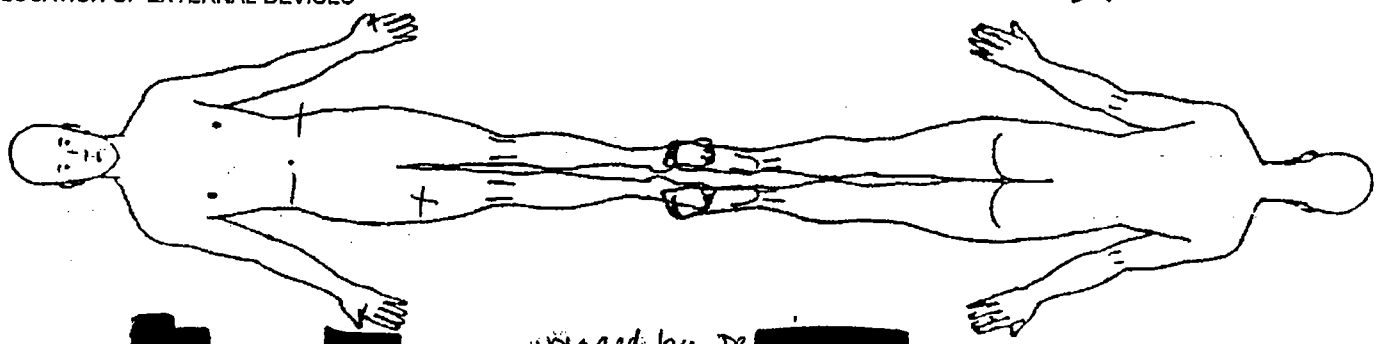
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine/Betadine
SITE: (L) Leg BY WHOM: CPT [redacted]
SITE: BY WHOM:

COMMENTS: No pooling of prep noted.

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad [redacted] Safety Strap ═══ Tourniquet

[redacted] placed by Dr. [redacted] b(6)-2 ϕ used.

C = Correct I = Incorrect

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

CIV [redacted] b(6)-4

[redacted] b(2)-2

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

☒ ESU NO: Valleylab E7507 CUT — COAG #2-1
GROUND PAD: BRAND Valleylab
LOT NO: 68938 2005-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NACL

OTHER ORDERS	TIME	CARRIED OUT BY

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

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

YES ☐ NO ☒

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☐

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

18. DRESSING/IMMOBILIZATION *(Specify)*

- fluffs
- Kerlix
- ABD pads

19. ADDITIONAL INFORMATION

WC

Surgeons: DR [redacted] b(6)-2 Anesthesia: CPT [redacted] b(6)-2 Anesthesia Type:

Bovie Pad site intact pre-op [redacted]; post-op [redacted] Bovie Settings: Coag/Cut 30/30

20. OPERATION(S) PERFORMED

I & D (L) [redacted] Knee

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU 3 b(6)-2	1045	gurney

22. REGISTERED N[redacted]IRE

[redacted] CPT N GGE

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

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT** b(6)-2

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Gurney BY Anesthesia

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

3. DATE 15 Aug 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN R[redacted] TIME 1318 NUMBER 1-1 (2)

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted] 91D b(6)-2	RELIEF SCRUB	b(6)-2
ASSIGNED CIRCULATOR	CPT [redacted] 66E	RELIEF CIRCULATOR	CPT [redacted] (1300-1330

7. POSITION AND POSITIONAL AIDS (Specify) Bilateral arms on padded arm board <90

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

COMMENTS: b(6)-2

8. SKIN PREPARATION

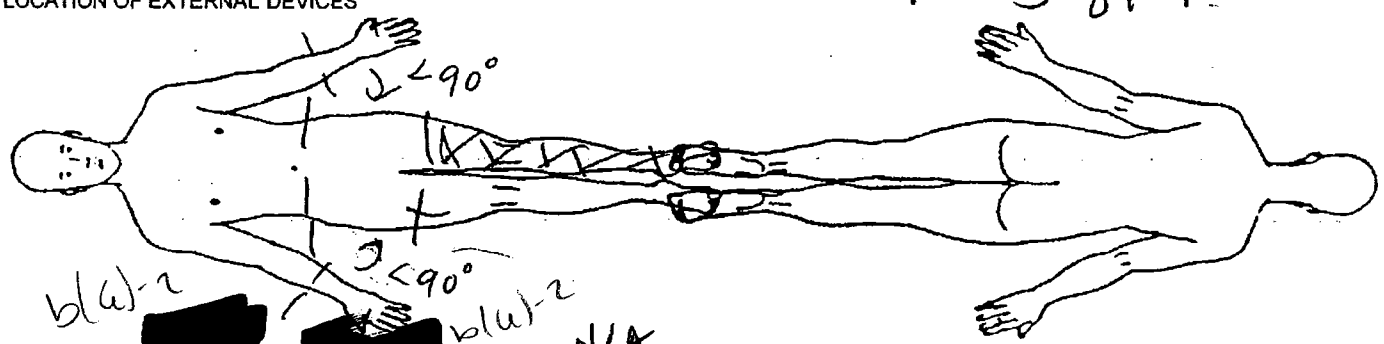
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION (Specify) Betadine/Betadine [redacted]
SITE: (L) Knee BY WHOM: CPT [redacted]
SITE: BY WHOM: CPT [redacted]

COMMENTS: no pooling of prep noted.

9. LOCATION OF EXTERNAL DEVICES



b(6)-2 [redacted] b(6)-2 N/A

LEGEND: X [redacted] d [redacted] ap === Tourniquet ~~XXX~~ prep b(6)-2

C = Correct I = Incorrect

10. COUNTS			Initial Other	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes	☐ No	C		C	SSG [redacted]	CPT [redacted]
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)-4

[redacted] b(2)-2

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

☐ ESU NO:
GROUND PAD: BRAND Valleylab E7507
LOT NO: 68936 2005-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Dakins Sol. 1/4	QS	Intraop	Soak	Pharm.	Dr. [redacted]

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S): b(6)-2

0.9% NACL

OTHER ORDERS	TIME	CARRIED OUT BY

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

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

YES ☐ NO ☒

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	1/8 Penrose		
SITE	(L) Knee		

18. DRESSING/IMMOBILIZATION *(Specify)*

- fluffs
- kerlix
- ace wrap

19. ADDITIONAL INFORMATION

WC b(6)-2

Surgeons: Dr. [redacted] Anesthesia: CPT [redacted] esthesia Type: gen.

Bovie Pad site intact pre-op [redacted]; post-op [redacted] Bovie Settings: Coag/Cut 30/30

20. OPERATION(S) PERFORMED

I & D Left Knee

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU b(6)-2	1415	gurney

22. REGISTERED NURSE SIGN[redacted] PT AN

[redacted] OF DA FORM 5179-1, [redacted]

USAPA V1.01

7 Aug 03

Date: 06 Aug 03 Bed#: 7

Patients Name: U EPW #[redacted]

Time	01	02	03	04	05					14	15	16	17	18	19	20	21	22	23	24
BP	113/61	121/72	112/67	118/66										Admit 130/73	111/68	120/62	115/63	130/68	119/66	111/61
TEMP		97.9												99.1				98.0		
HR	61	80	66	68										72	66	69	63	69	63	60
RR	15	19	13	15										12	10	17	10	12	17	15
SAO2	100	100	100	100										100	100	100	100	100	100	100
FIO2	RA	RA	RA	RA										RA	RA	RA	RA	RA	RA	RA
INPUT																				
PO																				
IV NS	150	150	150	150										150	150	150	150	150	150	150
NGT																				
IVPB														50						50
TOTAL	150	150	150	150										200	150	150	150	150	150	150
Balance	(1300)	(1450)	(1600)	(1750)										(200)	(350)	(500)	(650)	(800)	(950)	(1150)
OUTPUT																				
URINE		250*												400				500*		
NGT																				
STOOL																				
TOTAL		250		250										400				500		
BALANCE		(1150)		(1400)										(400)				(900)		
Restraint ✓																				
~~TURN~~ Q 2		✓		✓										✓		✓		✓		✓

MEDCOM - 15902

[redacted] b(3)-4 [redacted]

Date: 07 Aug 03 Bed#: 7
Patients Name: ERW # [redacted] b(3)-4

Time	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
BP	116/63	118/71	129/74	O	O	124/85	118/83	141/81	131/76	122/72	132/70	125/80	127/57	126/69	135/62	144/73	153/73	150/74	142/75	142/78
TEMP	97.3		97.8			97.6			97.6		100.8					98.8				97.9
HR	60	64	70	R	R	48	62	55	59	66	91	116	117	100	118	86	70	68	69	78
RR	12	10	16			13	14	14	14	16	24	18	24	26	27	22	19	19	16	15
SAO2	100	100	100			100	100	98	98	98	97	95	95	96	99	98	99	99	100	100
FIO2	RA	RA	RA			RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
INPUT																				
PO	Ø	Ø	Ø	800																
IV	150	150	150			125	125	125	125	125	125	125	125	125	125	125	125	125	125	125
NGT	N/A	N/A	N/A	O	O	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A							
IVPB		50								50								50		
				R	R															
TOTAL																				
OUTPUT																				
URINE	50	45	50	300			300	150	225	125			550			400				450
NGT	N/A	N/A	N/A			N/A	N/A	N/A	N/A	N/A										
STOOL	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø										
TOTAL	50	45	50		300															
BALANCE	(50)	(95)	(145)		(445)		(745)	(895)	(1120)	(1245)			(1795)			(2195)				(2645)
TURN Q 2																				

MEDCOM - 15903

511–119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY — 08 Aug 03

MONTH-YEAR DAY

19 HOUR: 01 02 03 04 05 06 07 08 09 10 11 12 13 14

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: 17 15 18 17 14 15 15 15 16 18 18 15

BLOOD PRESSURE: 144/75 134/73 140/74 137/72 125/68 127/64 129/74 125/67 122/71 133/74 126/66 126/78 136/70 129/60

O2 Sats: 100 100 100 99 100 100 100 100 100 100 100 100 100 100

HEIGHT: WEIGHT →

Input total: 125 125 125 125 125 125 125 125 125 125 125 125 125 125

Output total: 320 430 610

total IN — total out

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.

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY		NI[redacted]			DAY			NIGHT			[redacted]					
POST- DAY		08Aug			08Aug			09Aug			10					
MONTH-YEAR	DAY												N		12	
19	HOUR	18	22	02	06	10	14	18	22	02						

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

105° / 40.6°
180 / 104° / 40.0°
170 / 103° / 39.4°
160 / 102° / 38.9°
150 / 101° / 38.3°
140 / 100° / 37.8°
130 / 99° / 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

OR / RECOVERY

RESPIRATION RECORD

BLOOD PRESSURE	120/67	126/83	130/63	132/80		134/78		140/70		138/90	138/92	130/90		124/82	130/90
Sats	99	99	100	88	96%			96%		93	98%	98	98	96	
HEIGHT: WEIGHT →															
Input IV	300	700	700	0	150										
PO		50		400	—										
output - foley	240	520	500		950										

Record special data only when so ordered

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

REGISTER NO.

~~WARD NO.~~ TCW2

STANDARD FORM 511 (REV. 7-95) BACK

#[redacted]

b(4)-1

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY 17

POST-OP DAY DOS

MONTH-YEAR Aug 2003 DAY 12 13 14 15 16 17

HOUR 21 03 09 15 21 03 09 15 21 03 09 15 21 03 09 15

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

105° 40.6°
180 104° 40.0°
170 103° 39.4°
160 102° 38.9°
150 101° 38.3°
140 100° 37.8°
130 99° 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

RESPIRATION RECORD

BLOOD PRESSURE

SpO2

HEIGHT: WEIGHT →

Record special data only when so ordered

IV LR 125/hr 125

ensure dob Hs 20/hr 20

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

EPW [redacted]

REGISTER NO.

WARD NO. ICW2

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY															
POST- DAY															
MONTH-YEAR Aug	DAY	15		18											
18 03	HOUR	0530													
PULSE (0)	TEMP. F (°)														TEMP. C
	105°														40.6°
180	104°														40.0°
170	103°														39.4°
160	102°														38.9°
150	101°			V											38.3°
140	100°	V													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		16		16											
BLOOD PRESSURE		130/88		150/88											
		100		97											
HEIGHT:	WEIGHT →														

(Centigrade Equivalents, for Reference only)

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

b(6)-4 b(6)-2 b(6)-4

Ward/Section:	REQUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI:	DATE: 11AUG TIME: 0400	SSN:

b(6)-2

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M 30-190 u/l (F)
NA^+		128-145 mmo
K^+		3.3-4.7 mmol/l
CL-		98-108 mmol/
tCO_2		18-33 mmol/l

(Piccolo) Metabolic Panel

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

======= PICCOLO =======
11/08/03 03:47
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3152AA4
OPER #: 013 DR #: 000
SERIAL #: 0000100676

GLU	103	73-118	MG/DL
BUN	5*	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	314	39-380	U/L
NA+	♦♦♦	128-145	MMOL/L
K+	4.0	3.3-4.7	MMOL/L
CL-	96*	98-108	MMOL/L
tCO2	24	18-33	MMOL/L

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

Na -134

REMARKS:

b(6)-2

REPORTED BY:	DATE:	LAB ID NO.:
[redacted]	11Aug03	

b(6)-4

Ward/Section: 10W2	REQUESTING PHYSICIAN: [redacted] b(6)-4	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted]	DATE: 11AUG	TIME: 0900	SSN/PSEUDO SSN: [redacted] b(6)-4

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

Coagulation Studies			Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)		
TEST	RESULT	REF. RANGE	UNIT	TYPE	CROSSMATCH
PT	17.2	9.8-13.6 secs			
APTT	32.1	21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS: [redacted] b(6)-4

REPORTED BY: [redacted]	DATE: 11Aug03	LAB ID NO.:

b(4)-2

Ward/Section: Eleventh	REQUESTING PHYSICIAN: Dr [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. b(4)-4 [redacted]	DATE 8/11 TIME 2328	SSN/PSEUDO SSN: [redacted] b(4)-4

(Hematology) CBC

ID: 000538
WB

Patient Limits

WBC	8.5 *	x10^3/uL	4.5	10.5
RBC	4.03	x10^6/uL	4.00	6.00
Hgb	12.3	g/dL	11.0	18.0
Hct	38.2	%	35.0	60.0
MCV	94.7	fL	80.0	99.9
MCH	30.5	pg	27.0	31.0
MCHC	32.2 L	g/dL	33.0	37.0
Plt	420.	x10^3/uL	150.	450.
LYM	7.6 *	%	20.5	51.1
LYM	0.6 *	x10^3/uL	1.2	3.4

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

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: b(4)-2

REPORTED BY: [redacted]	DATE: 11 Aug 03	LAB ID NO.:

b(4)-2

REQUESTING PHYSICIAN: [redacted]			LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
[redacted]	DATE: 9 Aug	TIME: 1515	SSN/PSEUDO SSN:

b(4)-2

ID: 000538 09-08-03
UB 15:57

				Patient Limits	
WBC	12.3	H	x10^3/uL	4.5	10.5
RBC	4.36		x10^6/uL	4.00	6.00
Hgb	12.4		g/dL	11.0	18.0
Hct	41.2		%	35.0	60.0
MCV	94.5		fL	80.0	99.9
MCH	28.4		pg	27.0	31.0
MCHC	30.0	L	g/dL	33.0	37.0
Plt	175.	*	x10^3/uL	150.	450.
LYM%	27.1	*	%	20.5	51.1
LYM	3.3	*	x10^3/uL	1.2	3.4

CBC

REF. RANGE
4.8-10.8 x 10^3
4.7-6.1 x 10^3
14-18 g/dl (M) 12-16 g/dl (F)
42-52% (M) 37-47% (F)
80-94 fl (M) 81-99 fl (F)
130-500 x 10^3 verified
20.5-51.1%

Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

TEST	RESULT	REF. RANGE
Color	yel	N/A
App	clr	N/A
Glu	N	Negative
Bili	N	Negative
Ket	Lge	Negative
SG	1.015	N/A
Bld	Neg	Negative
pH	7.0	N/A
Prot	Neg	Negative
Urob	8	0.2-1.0
Nit	N	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

Acid Test: Lge
Bact: Hvy
Mucus: Hvy
WBC: 5-10

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

b(4)-2

REMARKS:		
REPORTED BY: [redacted]	DATE: 9Aug03	LAB ID NO.:

b(6)-2

b(6)-2

Ward/Section: CCW2

REQUESTING PHYSICIAN: [redacted]

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

LAST FIRST MI: [redacted]

DATE: 9Aug03 TIME: 15

SSN/PSEUDO SSN:

(STAT)			(Piccolo) Chemistry 12			(Piccolo) Metabolic Panel		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
		mmol/L	ALB		3.5-5.5 g/dl	GLU		73-118 mg/dl
		mol/L				BUN		7-22 mg/dl
		bol/L				CA++		8.0-10.3 mg/dl
						CRE		0.6-1.2 mg/dl
		Hg (art)				NA+		128-145 mmol/l
		g (ven)				K+		3.3-4.7 mmol/l
		Hg (art)				CL-		98-108 mmol/l
		/L (art)				CO2		18-33 mmol/l
		/L (ven)						
		/L (art)						
		/L (ven)						

i-STAT 6+

Pt: [redacted] 66-4

Pt Name:_____

Glu_____126 mg/dL

BUN_____5 mg/dL

Na_____127 mmol/L

K_____3.0 mmol/L

Cl_____106 mmol/L

Hct_____30 %PCV

Hb*_____10 g/dL

*via Hct

Sample Type_:

09AUG03 16:01

Oper: 7702

Physician:_____

Ser# 40763

Ver: JAM5046A
CLEW A93

PICCOLO

09/08/03 15:34

REFERENCE RANGE: MALE

PATIENT #: [redacted]

METHYLE 8

DISC LOT #: 3141AA4

OPER #: 702 DR #: 000

SERIAL #: 0000100084

GLU	132*	73-118	MG/DL
BUN	5*	7-22	MG/DL
CRE	0.7	0.6-1.2	MG/DL
CK	554*	39-330	U/L
~~NA+~~	~~+++~~	~~128-145~~	~~MMOL~~
~~K+~~	~~4.1~~	~~3.3-4.7~~	~~MMOL~~
~~CL-~~	~~99~~	~~98-108~~	~~MMOL~~
tCO2	24	18-33	MMOL

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 0

(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
CO2		18-33 mmol/l

Abuse		

REMARKS:

b(6)-2

REPORTED BY: [redacted]

DATE: 9Aug03

LAB ID NO.:

b(6)-2

Ward/Section: ICU2	REQUESTING PHYS: Dr [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: PW [redacted]	DATE: b(6)-4 7AUG03	TIME: 0400	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
V		
P		
L		
S		
B		
Lymph		
Atyp		
RBC Morph		

66-4

ID [redacted] 07-08-03
WB 04:35

			Patient Limits	
WBC	8.7	x10^3/uL	4.5	10.5
RBC	4.23	x10^6/uL	4.00	6.00
* Hgb	12.7	g/dL	11.0	18.0
Hct	39.7	%	35.0	60.0
MCV	93.9	fL	80.0	99.9
MCH	30.1	pg	27.0	31.0
MCHC	32.1 L	g/dL	33.0	37.0
Plt	294.	x10^3/uL	150.	450.
LY%	18.3 *L	%	20.5	51.1
LY#	1.6 *	x10^3/uL	1.2	3.4

Baso	
Imm	

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: b(6)-2

REPORTED BY: [redacted] **DATE:** 7 Aug 03 **LAB ID NO.:**

b(6)-2

Ward/Section:	REQUESTING PHYSICIAN:		CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: b(6)-4	[redacted]	DATE: 7Aug03	TIME: 0400	SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (a 41-51 mmHg (ve
PO2		80-105 mmHg (a N/A (ven)
TCO2		23-27 mmol/L (a 24-29 mmol/L (v
HCO3		22-26 mmol/L (a 23-28 mmol/L (v
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol
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

======= PICCOLO =======
07/08/03 04:37
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: 678 DR #: 000
SERIAL #: 0000100494

ALB	3.1*	3.3-5.5	G/DL
ALP	59	26-84	U/L
ALT	54*	10-47	U/L
AMY	34	14-97	U/L
AST	58*	11-38	U/L
TBIL	1.4	0.2-1.6	MG/DL
BUN	♦♦♦	7-22	MG/DL
CA++	9.2	8.0-10.3	MG/DL
CHOL	140	100-200	MG/DL
CRE	0.9	0.6-1.2	MG/DL
GLU	97	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

Bun 11

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GL		
BU		
CA		
CR		
NA		
K+		
CL		
tCl		
Al		
Al		
Al		
A		
A		
T		
G		
T		
N		

i-STAT EC8+

Pt: [redacted]
Pt Name:_____

Glu_____93 mg/dL
BUN_____11 mg/dL
Na_____141 mmol/L
K_____3.6 mmol/L
Cl_____106 mmol/L
TCO2_____29 mmol/L
AnGap_____10 mmol/L
Hct_____37 %PCV
Hb*_____13 g/dL
*via Hct
PH_____7.419
PCO2_____43.3 mmHg
HCO3_____28 mmol/L
BEecf_____4 mmol/L

Sample Type_:

07AUG03 04:33

Oper: [redacted] 66-2

Physician:_____

Ser# 40763
Ver: JAM5046A
CLEW A93

REMARKS: b(6)-2

REPORTED BY: [redacted] **DATE:** 7Aug03 **LAB ID NO.:**

b(6)-2

Ward/Section: ICU #2	REQUESTING PHYSICIAN: [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: # [redacted] b(6)-4	DATE 8/6/03	TIME 1830	SSN/PSEUDO SSN: # [redacted]

b(6)-4

(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 urine	NEG	

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus 11

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

REMARKS: b(6)-2

REPORTED BY: [redacted]	DATE: 6 Aug 03	LAB ID NO.:

EMT

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI	STATUS	RANK	SSN
[redacted] EPW			

Time called	Called to	Physician	Date

b(6)-4

i-STAT EC8

Pt: [redacted]

Pt Name:_____

Glu_____101 mg/dL
BUN_____15 mg/dL
Na_____139 mmol/L
K_____3.8 mmol/L
Cl_____109 mmol/L
TCO2_____28 mmol/L
AnGap_____8 mmol/L
Hct_____37 %PCV
Hb*_____13 g/dL
*via Hct
pH_____7.515
PCO2_____32.9 mmHg
HCO3_____27 mmol/L
BEecf_____4 mmol/L

Sample Type:

06AUG03 14:37

Oper:

Physician:

Ser# 40763
Ver: JAM5046A
CLEW A93

Chemistry (Piccolo Analyzer)

TEST	RESULT	REF. RANGE
ALT		10-47 U/L
AST		11-38 U/L
GGT		5-56 U/L
ALB		3.3-5.5 g/dl
ALP		26-84 U/L
Amylase		14-97 U/L
Ca		8-10.3 mg/dl
Chol		<200 mg/dl
Creat		0.6-1.2 mg/dl
BUN		7-22 mg/dl
GLU		73-118 mg/dl
Tbili		0.2-1.6 mg/dl
TP		6.4-8.1 g/dl
UA		2.2-6.6 mg/dl (F) 3.6-8.0 mg/dl (M)

Urinalysis

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

Hematology

TEST	RESULT	REF. RANGE

66-4

ID: [redacted]
WB 06-08-03
14:29

			Patient Limits	
WBC	8.0 *	x10^3/uL	4.5	10.5
RBC	3.66 L	x10^6/uL	4.00	6.00
Hgb	10.4 L	g/dL	11.0	18.0
Hct	34.6 L	%	35.0	60.0
MCV	94.6	fL	80.0	99.9
MCH	28.4	pg	27.0	31.0
MCHC	30.0 L	g/dL	33.0	37.0
Plt	259.	x10^3/uL	150.	450.
LY%	10.1 *L	%	20.5	51.1
LY#	0.8 *L	x10^3/uL	1.2	3.4

Other		
Spun Crit		42-52% (M) 37-47% (F)
~~Man WBC~~		4.8-10.8x10³
~~Manual Plt~~		130-500x10³ verified

Microbiology

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

~~CKMB~~		
~~Troponin~~		
DOA		
~~Alcohol~~		

OTHER:

Ward/Section:

LAST, FIRST, MI.

REQUESTING PHYSICIAN:

DATE

TIME

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

SSN/PSEUDO SSN:

(Hematology) CBC

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

Coagulation Studies

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

Urinalysis

TEST	RESULT	REF. RANGE
Color	Dark Yellow	N/A
App	Clear	N/A
Glu	Yes	Negative
Bili	Yes	Negative
Ket	>160 Large	Negative
SG	1.020	N/A
Bld	Yes	Negative
pH	6.0	N/A
Prot	Yes	Negative
Urob	0.2	0.2-1.0
Nit	Yes	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

Acetest (ketones) - Large

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:

DATE: 6 Aug 03

LAB ID NO.:

b(6)-2

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

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted]	DATE 6AUG	TIME 1550	SSN/PSEUDO SSN:
LAST, FIRST, MI. [redacted]				

(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 (ar 41-51 mmHg (ven 80-105 mmHg (ar N/A (ven)
PO2		23-27 mmol/L (ar 24-29 mmol/L (ve
TCO2		22-26 mmol/L (ar 23-28 mmol/L (ve
HCO3		95-98%
sO2		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
		-2) – (+3) nmol/L
		0-20 mmol/L
		.12-1.32 mmo
		-26 mg/dl
		0-105 mg/dl
		.7-1.5 mg/dl
		8-51% PCV
		2-17 g/dl
		try
		EF. RANG

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^{+}		128-145 mmol/l
K^{+}		3.3-4.7 mmol/l

b(6)-4

```
======= PICCOLO =======
06/08/03                14:35
REFERENCE RANGE:        MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #:             3141AA4
OPER #: 269             DR #: 000
SERIAL #:               0000100676
.......................
GLU   103    73-118   MG/DL
BUN   ♦♦♦    7-22     MG/DL
CRE   0.9    0.6-1.2  MG/DL
CK    2449*  39-380   U/L
NA+   122*   128-145  MMOL/L
K+    4.3    3.3-4.7  MMOL/L
CL-   103    98-108   MMOL/L
tCO2  25     18-33    MMOL/L

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

```
======= PICCOLO =======
06/08/03                14:50
REFERENCE RANGE:        MALE
PATIENT #: [redacted]
LIVER PANEL PLUS
DISC LOT #:             3135BA4
OPER #: 269             DR #: 000
SERIAL #:               0000100684
.......................
ALB   3.4    3.3-5.5  G/DL
ALP   60     26-84    U/L
ALT   ♦♦♦    10-47    U/L
AMY   28     14-97    U/L
AST   72*    11-38    U/L
TBIL  1.8*   0.2-1.6  MG/DL
GGT   13     5-65     U/L
TP    6.9    6.4-8.1  G/DL

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

Repeated

```
i-STAT G3+
Pt: [redacted]
Pt Name:_____

TCO2_________29 mmol/L

At 37C
PH_______7.447
PCO2______39.9 mmHg
PO2_________76 mmHg
HCO3________28 mmol/L
BEecf________4 mmol/L
sO2*________96 %
  *calculated

Sample Type_:
  06AUG03      14:40

Oper: 0

Physician:_____

Ser# 42011
Ver: JAMS046A
     CLEW A93
```

	DATE:	LAB ID NO.:

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)																		
Robinul	(mg)	.2																	
Fentanyl	(mcg)	100	50	50	50														
propofol	(mg)	100																	
	( )																		
MSO4	(mg)			10															
Labetalol	(mg)	15		10															
VOLAT AGENT 1.50	% del	1.5	1.5	.01	.6														
	% e.t.																		
AIR	L/Min																		
N2O	L/Min																		
O2	L/Min	6	3	3	3	3	4												

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

FLUIDS

LINE site																		
	☐ Warmed		14 — 500															
18g (2) ac	☐ Warmed	NS — 500																
	☐ Warmed																	
	☐ Warmed																	

LOSSES

EST BLOOD LOSS																		
URINE -			200															

TOTALS	TOTAL EBL
12	100
250	
100	
	TOTAL URINE
10	200
25	

FLUIDS - SUMMARY

CRYSTALLOID- 800

COLLOID- Ø

BLOOD- Ø

PHYS STATUS 1 (2) 3 4 5 E

BODY WEIGHT: 65 (KG) LB

HEMATOCRIT: ✓

INITIAL DATA: BP- 137/84 HR- 83

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? Y TIME- 0822

TIME 0830 0900

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

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

VENTIL.

VT - ml	330	250	370	420
f - breaths/min	12	15	18	15
Peak inf pres / PEEP	/	/	/	/
MODE - S(pon), A(ssist), C(on)	S	S	S	S

MONITORS/ACCESSORIES

BP/Auto Cuff	✓ ET CO2 (torr)	43	41	42	41
BP/oth	✓ PIO2 (Frac or %)	.89	.89	.89	.89
ART line	✓ SpO2 (%)	100	100	100	100
Steth- PC/ES	✓ ECG	SR	SR	SR	SR
Gas analyzer	✓ TEMP-site	Avail			
	✓ N-M Block (T/4)				
Warming blkt					
Conv warmer					

Mark with letters & symbols, explain under REMARKS. EVENTS Position → (O)

REMARKS — Code drugs with numbers, events with letters

0800 pt ID. Form 2400 complete.
0820 RM. O2, monitors
0827 LMA insert x1 atraumatically
0833 (T) ↑ 300 mmHg
0906 (T) ↓ 27 min
0927 pt RTC — LMA removed
0936 RPT TO SGT GRAVES

RECOVERY AT 0933

PACU ICU Z (Specify)

OTHER

CONDITION:

RESP- 15 SpO2- 100 (O2)

BP- 137/84 HR- 88 60

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0800	0820	0940
	Ready	Begin	End
PROC	0827	0834	0927

66-2

PROCEDURES and CPT Codes: I & D (L) LEG

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GAT LMA

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

[redacted] b(6)-4

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: LMA #4 insert x1 atraumatically. soft bite in place, cuff + 25cc air, eyes taped, LMA secured + tape

SURGEONS: [redacted] b(6)-2

PROCEDURE LOCATION: Z

DATE: 7 AUG 03

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)	07	30	10	30	11	30
Fentanyl	mcg ( )	100	50 50 50				
Versed	(mcg)	150					
Ecotrin	(mcg)	100					
	( )			450 cc		2 L/A	
	( )						
VOLAT AGENT	Forane % del	2			1.5		
	% e.t.						
AIR	L/Min						
N2O	L/Min						
O2	L/Min	2					

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

FLUIDS

LINE site		07	30	10	30	11	30
#18 - IV	☐ Warmed			1000			
	☐ Warmed						
	☐ Warmed						
	☐ Warmed						

LOSSES

EST BLOOD LOSS							
URINE -							

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: 90 KG LB

HEMATOCRIT: 39

INITIAL DATA: BP- 118/60 HR- 90

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? ✓ TIME- 0800

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

TIME → 07 30 10 30 11 30

VENTIL / MONITORS/ACCESSORIES

	07	30	10	30	11	30
VT - ml	900	900	800	830	740	750
f - breaths/min	10	10	9	8	8	8
Peak inf pres / PEEP	20	21	20	21	21	21
MODE - S(pon), A(ssist), C(on)	CV	CV	CV	CV	CV	CV
BP/Auto Cuff / ET-CO2 (torr)	28	25	26	25	25	26
BP/oth / FIO2 (Frac or %)	.7	.7	.7	.7	.7	.7
ART line / SpO2 (%)	100	100	100	100	100	100
Steth- PC/ES / ECG	SR	SR	SR	SR	SR	SR
Gas analyzer / TEMP-site	95	95	95	95	95	95
N-M Block (T/4)						
Warming blkt						
Conv warmer						

Mark with letters & symbols, explain under REMARKS — EVENTS Position → 02 b(6)-2

TOTALS — TOTAL EBL: 250 ABL 20

TOTAL URINE: 150 100 600 800

FLUIDS - SUMMARY

CRYSTALLOID- 1100

COLLOID- 0

BLOOD- 0

REMARKS — Code drugs with numbers, events with letters

Urine - monitor on (2) Sa Before (3) Induced & Extubated (4) To ICU 2→ OR Wing

Tourniquet Time 1106

RECOVERY AT

PACU ICU 2 (Specify)

OTHER

CONDITION:

RESP- 22 SpO2- 96%

BP- 166/82 HR- 116

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	08	08	11
PROC	Ready 0700	Begin 0700	End 1110

PROCEDURES and CPT Codes: ORIF Ft (c) [redacted] b(6)-2

ANESTHETIC TECHNIQUES: Describe block technique under Remarks GETA, b(6)-2

PATIENT IDENTIFICATION: Typed or written entries: Name, Grade/Rank [redacted]

MANAGEMENT: Intubation route, blade, technique, comments #8.0 ETT NDVAI BL=DS

[redacted]

b(6)-4

PROCEDURE LOCATION: OR 2

DATE: 1 Aug 07

MEDCOM - 15920

→ LOC on Ward responsibility of Anesthesia

Static encephalopathy 2° to Heat Stroke

MEDICAL RECORD - ANESTHESIA

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

NYCPA

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

DRUG	(Units)								
Versed	(mg)	Ø							
fentanyl	(ug)	250							
propofol	(mg)	170							
SCh	(mg)	100							
Vecuronium	(mg)		3	3	/ Neostigmine/ Glycopyrrolate 5/0.8				
MSO4	(mg)	4	2			3	2		
VOLAT AGENT	% del								
ISO	% e.t.	1.5	2	2	2	2	1	X	
AIR	L/Min								
N2O	L/Min								
O2	L/Min	6	2	2	2	2	2	10	

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

FLUIDS

LINE site		
LR 20ii (R)	☒ Warmed	700
(R) IJ triple lumen	☐ Warmed	[Flushed 50ii Heparin x3 lumens + asp blood x3]
	☐ Warmed	

LOSSES: EST BLOOD LOSS; URINE - 300

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 70 (KG) LB

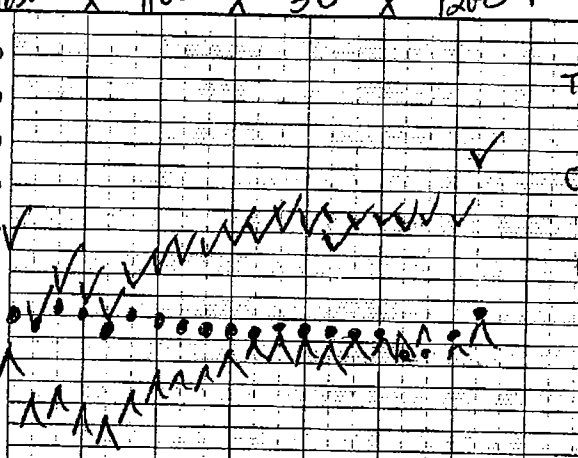
HEMATOCRIT: 38.2

INITIAL DATA: BP- 124/87; HR- 98

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? Y; TIME- 1025

TIME → 1030 X 1100 X 30 X 1200



TO PACU Report Anesthesia recovered pt x15min BP@1220 148/99

VENTIL / MONITORS/ACCESSORIES

VT - ml		5/800	830	870	860	890	540	250-510	
f - breaths/min		10	10	10	10	6	6	15-20	
Peak inf pres / PEEP			19	20	20	20-17	17	—	
MODE - S(pon), A(ssist), C(on)		S/C	C	C	C	C	C	S	S
BP/Auto Cuff	ET CO2 (torr)	4	25	24	25	26	40	35-40	
BP/oth	FIO2 (Frac or %)	.8	.6	.8	.8	0.87	0.85	0.85	
ART line	SpO2 (%)	99	99	99	99	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	SR	
Gas analyzer	TEMP-site	Avail	Avail						
	N-M Block (T/4)						4/4	4/4 Sust Tet 15sec	
Warming blkt									
Conv warmer									

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

TOTALS: 250; 170; 100; 10

TOTAL EBL: <100

TOTAL URINE: 500

FLUIDS SUMMARY: CRYSTALLOID- 1000; COLLOID- Ø; BLOOD- Ø

REMARKS (Code drugs with numbers, events with letters)

Pt ID'd, chart reviewed. Pre-anesthetic assessment done. To OR, monitors, smooth induction & intubation. (L) subclavian CVL attempted by [redacted] & [redacted] success. (R) IJ 3 Lumen placed 5 difficult by [redacted] All 3 lumens aspirated venous appearing blood & flushed easily. Sebetalol 10mg IV @1200. OP suctioned; extubated & comfortable after

RECOVERY AT: 1210 — PACU / ICU ____ (Specify) / OTHER ____

CONDITION: Stable

RESP- 21; SpO2- 98; BP- 162/97; HR- 91

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1015	1020	
	Ready	Begin	End
PROC	1038	1050	1201

PROCEDURES and CPT Codes: (L) Knee arthroscopy / G-tube / CVL placement

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — GETA — Eyes Taped — Arms secured & padded

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments — DL x1 c̄ Mac 3 — 8.0 ETT in — (+) ETCO2; equal BS

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

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

SURGEONS: [redacted] / [redacted] b(6)-2

PROCEDURE LOCATION: 1

DATE: 12 AUG 03

ASA 3
20/m NKDA

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)					TOTALS
MIDAZ	(mg)	3	2			5 mg
FENT	(mcg)	50	50			100 mcg
PROPOFOL	(mg)	100				
	( )					
	( )					
Succ	(mg)	60				
VOLAT AGENT FORANE	% del	1	1	1X		
	% e.t.					
AIR	L/Min					
N2O	L/Min					
O2	L/Min	8	2	2	2 8	

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

TOTAL EBL: 100
TOTAL URINE: NA

FLUIDS
LINE site (R) IJ 3L ☐ Warmed — LR →
☐ Warmed
☐ Warmed
☐ Warmed

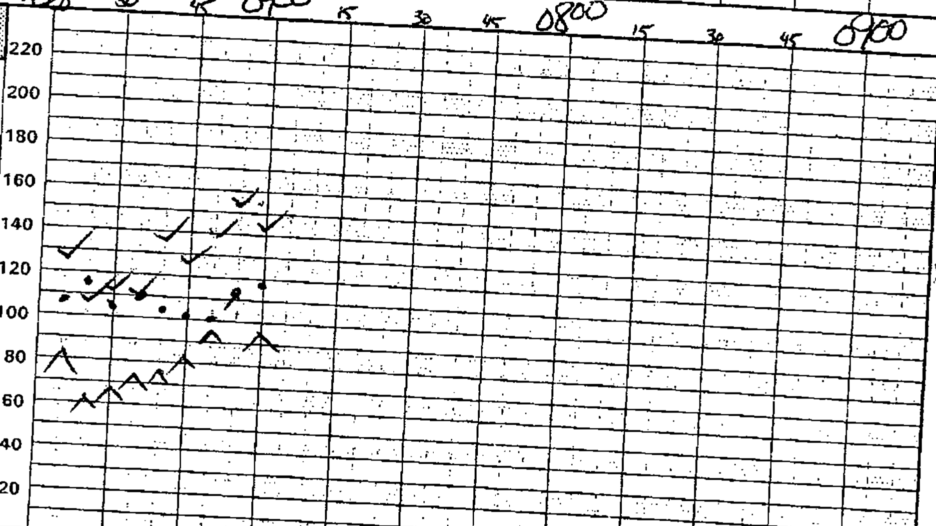
FLUIDS - SUMMARY
CRYSTALLOID- 100 LR
COLLOID-
BLOOD-

LOSSES
EST BLOOD LOSS
URINE -

PHYS STATUS: 1 2 (3) 4 5 E
BODY WEIGHT: 70 KG
HEMATOCRIT:
INITIAL DATA: BP- 128/82 HR- 107
EQUIP CHECK: (OK?-) Y N
PATIENT RECHECK: (OK for PROCEDURE?) TIME- 06[19]

TIME → 0600 15 30 45 0700 15 30 45 0800 15 30 45 0900

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



REMARKS
Code drugs with numbers, events with lettters

06[05] PreOp Eval (R) IJ 3L
06[18] OR #2 monitors Pre O2 ind/int
07[00] Suction Agreed to Ext

VENTIL

VT - ml	800	780			
f - breaths/min	12	10	6	34	28
Peak inf pres / PEEP	18	19			
MODE - S(pon), A(ssist), C(on)	S	C	C	S	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	29	34	36	37
BP/oth	FIO2 (Frac or %)	.81	.81	.81	.81
ART line	SpO2 (%)	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR
Gas analyzer	TEMP-site	AXILL →			
	N-M Block (T/4)				
Warming blkt					
Conv warmer					

Mark with letters & symbols, explain under REMARKS EVENTS Position → 0—/

RECOVERY AT: PACU (ICU 2) (Specify)
OTHER
CONDITION: STABLE Room Air
RESP- 12 SpO2- 97
BP- HR- 118

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	06[05]	06[18]	
	Ready	**Begin**	**End**
PROC	06[25]	06[37]	0700

PROCEDURES and CPT Codes: I&D (L) Knee GSW

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GETA

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*
ICU 3/ICU-3
[redacted]
b(6)-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
DLX1/MAC 3 8.0 ETT → VC ē BBS ⊖, ETCO2 ⊕ Secured EYES TAPED

SURGEONS: [redacted] b6-2

ANESTHETIST: [illegible]

PROCEDURE LOCATION: OR #2 28CSH
DATE: 13 Aug 03

DA FORM 7389, FEB 1998 MEDCOM - 15922

NKA ASA II

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)	0945	10		30		1100
Versed	(mg)	3					
Fent	(cc)	2	1		5.5		
Lido/Propofol	(mg)	20/120					
Succ	(mg)	70					
	( )						
	( )						
VOLAT AGENT	Forane % del	X1.5	1.5	1.5	2.0X		
	% e.t.						
AIR	L/Min						
N2O	L/Min						
O2	L/Min	X4	2	2	2	10	

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

FLUIDS

LINE site							
Tibial	☐ Warmed	LR 100					
" D5-1/2	☐ Warmed	(250)	100				400
	☐ Warmed						
	☐ Warmed						

LOSSES

EST BLOOD LOSS							
URINE - Foley					110		

TOTALS	
3	TOTAL EBL
250mg	MIN
	TOTAL URINE
	Ø 110

FLUIDS SUMMARY

CRYSTALLOID- LR 400

COLLOID- Ø

BLOOD- Ø

REMARKS

Code drugs with numbers, events with letters

Prep, NPO, Id Bond Placed IV patent on O2 monitors Stable IV induction post. prep. drugs 0955 CPT [redacted] to relieve - report received. 1005 Zofran 4mg IV 1038 PO SIW x2. Pt extubated 5 difficulty TO ICU 3 on stable condition. Report to [redacted]

b(6)-2

BP 170/116 hx ICD3 - Given Fent 1 20mg Esmolol total

PHYS STATUS 2845 E

BODY WEIGHT 70 KG LB

HEMATOCRIT

INITIAL DATA BP- 115/60 HR- 111

EQUIP CHECK OK?- Y N

PATIENT RECHECK OK for PROCEDURE? Yes TIME- 0935

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

TIME → 0945 1000 X 20 X 1100

VENTIL

VT - ml	800	680	690	300	600
f - breaths/min	8	8	8	24	15
Peak inf pres / PEEP	18	17	17	-	-
MODE - S(pon), A(ssist), C(on)	C	C	C	A S	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	33	32	31	45	41
BP/oth	FIO2 (Frac or %)	.76	.77	.78	.78	.78
ART line	SpO2 (%)	100	100	100	100	100
Steth- PC/ES	ECG	ST	ST	SR	SR	SR
Gas analyzer	TEMP-site					
	N-M Block (T/4)	4 0 4				
Warming blkt						
Conv warmer						

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

RECOVERY AT 1043

PACU ICU 3 (Specify)

OTHER

CONDITION: Stable

RESP- 16 SpO2- 98 RA

BP- HR- 107

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0920	0935	1045
	Ready	Begin	End
PROC	0942	0957	1030

PROCEDURES and CPT Codes: I & D Lt Knee

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

[redacted] b(6)-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

GA RSI & opioid eyes taped Hypnotic Dx x1

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

Grd I view 8.0 ETT @ 2 Y BS = B + ETCO2

SURGEON: [redacted] b(6)-2

PROCEDURE LOCATION: OR 2

DATE: 12/04/03

MEDCOM - 15923 [redacted]

DA FORM 7389, FEB 1998

ASA II ♂ NKDA

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)	
Versed	(mg)	2.5
Fentanyl	(mcg)	150
Propofol	(mg)	140
Lidocaine	(mg)	50
Sch	(mg)	100
	( )	

VOLAT AGENT: Iso % del 2.0 - 1.5 X; % e.t.

AIR L/Min; N2O L/Min; O2 L/Min: 10 - 2 - 2 - 10

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

FLUIDS — LINE site: (R) 15 x 3 ☐ Warmed; ☐ Warmed; ☐ Warmed; ☐ Warmed; D5W (500) → 150

LOSSES — EST BLOOD LOSS; URINE - Foley (150 cc/hr)

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 70 KG LB

HEMATOCRIT:

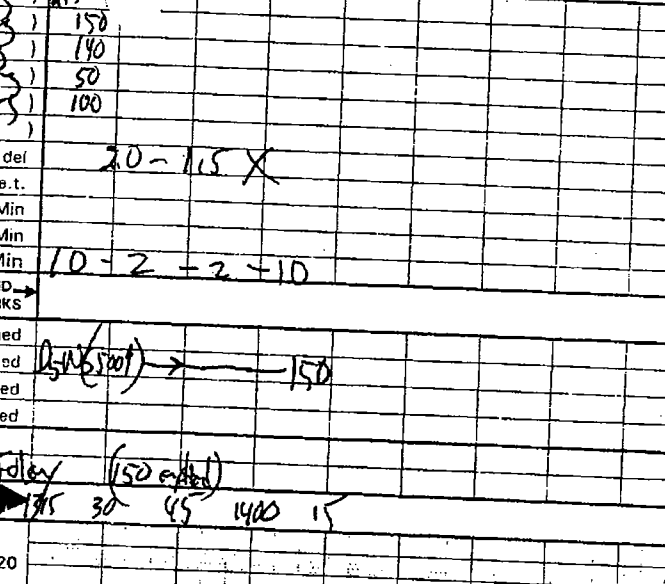
INITIAL DATA: BP- 156, 90; HR- 105

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE Okay; TIME- 1250

TIME → 1305 30 45 1400 15

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



VENTIL

VT - ml	–	740	800	800
f - breaths/min	20	7	7	15
Peak inf pres / PEEP	–	20	20	–
MODE - S(pon), A(ssist), C(on)	S	C	C	S

MONITORS/ACCESSORIES

BP/Auto Cuff	X	ET CO2 (torr)	(+)	32	31	37
BP/oth	X	FIO2 (Frac or %)	.65	.65	.66	.66
ART line	X	SpO2 (%)	100	100	100	100
Steth- PC/ES	X	ECG	ST	ST	ST	ST
Gas analyzer	X	TEMP-site dch	97	97	97	97
	X	N-M Block (T/4)				
Warming blkt						
Conv warmer						

Mark with letters & symbols, explain under REMARKS — EVENTS Position → 0-1 → → →

TOTALS — TOTAL EBL: n/a; TOTAL URINE: 150

FLUIDS SUMMARY — CRYSTALLOID- 200cc; COLLOID- Ø; BLOOD- Ø

REMARKS — Code drugs with numbers, events with letters

1310 Pt'd on ICU
2. Chart reviewed
To OR via litter.
1320 In room. (+) mask
(+) O2, Sux with IV. Under
easy mask ventilation
Propped, eyes taped,
arms < 90°
1337 Procedure started.
1410 Pt sxw XZ. Pt
extubated awake,
To ICU 3 in stable
condition, Report
to RN

RECOVERY AT 1415; PACU ICU 3 (Specify); OTHER; CONDITION: Stable; RESP- 20; SpO2- 98 RA; BP- 140/91; HR- 10

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1305	1320	1420
	Ready	Begin	End
PROC	1330	1337	1410

PROCEDURES and CPT Codes: I&D (L) Knee

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

#[redacted] b(6)-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: DNL x 1 attempt c MAC 4, #8 ETT, Grade I view; (+) BBS (+) ETCO2, Secured @ 2

SURGEONS: [redacted] b(6)-2

PROCEDURE LOCATION: OR 1

DATE: 15 Aug 02

No Δ in Anesthesia q5-90 Sun 14 Aug 03, date of last Sx

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 20 DAYS MOS (YRS)

Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE:
SURGICAL SERVICE: ORTHO
NPO SINCE: MN

ASA Physical State 1 (2) 3 4 5 E
WT: 65 (KG)/LB HT: 70 IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: Ø
ETOH:
DRUGS:

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) Ancef
( )
( )
( )
( )
( )

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

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

10.4
4.0 259
34.6

139 / 109
3.8 / 28 / 101

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 cleared by neuro for Sx
- Other N Y (2° to infect)

Gynecological :
- Pregnancy N Y

Other Significant Hx: N Y

Familial HX N Y / N Y

ASSESSMENT
PAST SURGICAL/ANESTHETIC

Ø

PHYSICAL EXAMINATION
BP ___ HR 81 R 16 T ___ SpO2 100%
Pain Scale 0-10 ___
HEENT - Teeth intact
Trachea midline
TMJ/Neck 3 FB
Oropharnyx MP II
Nares patent
CHEST: CTA
CARDIAC: S1S2
EXTREMITIES:
IV Access: 18g (U) Ac
Ulnar Filling:
BACK:
OTHER:

NPO Since MN

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

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

The patien[redacted] b(4)-2 to understand and agrees. Questions answered.

Signed: [redacted] CPT CRNA Date: 7 AUG 03 Time: 0800 Hrs

POST-ANESTHESIA EVALU[redacted]AND NOTE (NON ASU)
{ } NO APPARENT ANESTHE[redacted]OMPLICATIONS { } OTHER

Signed: _____ Date: _____ Time: _____ Hrs

Patient Identification: (Ward) ICU 2

[redacted] b(4)-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.

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

PATI[redacted] MEDCOM 15925

Previous edition is obsolete

ANESTHESIA PLAN OF PROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 20's DAYS MOS (YRS)

Sex (✓) MALE ( ) FEMALE

PROPOSED PROCEDURE: arthrotomy (L) knee; G-tube; CVL placement

SURGICAL SERVICE: [redacted] bbz

NPO SINCE: MN

ASA Physical State 1 2 (3) 4 5 E

WT: 70 KG/LB HT: ___ IN.

ALLERGIES: NKDA

HABITS:

TOBACCO:

ETOH: Ø

DRUGS:

CURRENT MEDICATIONS:

( ) = ordered as premed

(✓) Cefoxitin 1gm IVPB 06-14
(✓) D5 1/2NS c 20meq KCl @ 125 ml/hr
(✓) Zantac 50mg IVPB 08-06-24 06
(✓) Lovenox 20mg SC q 12
( )
( )

PREMEDICATIONS:

None Yes (@ ___ Hrs) /CC

___ . ___ mg IV IM PO

___ . ___ mg IV IM PO

___ . ___ mg IV IM PO

LABORATORY STUDIES:

HB/HCT: ___/___

U/A:

OTHER: PT-17.2 / PTT 42.1 8-11-03

8.5 | 12.3 / 38.2 | 420

8-10-03

	98	5
4.0	21	0.8

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

Familial HX N Y

ASSESSMENT

PAST SURGICAL/ANESTHETIC

PHYSICAL EXAMINATION

BP 124/82 HR 98 R 16 T 38.6 / T-37.0 O2 P Tylenol

Pain Scale 0-10 SaO2 96%

HEENT - Teeth intact

Trachea midline

Beard TMJ/Neck 3FB's

Oropharynx

Nares Patent

CHEST: CTA (B)

CARDIAC: S1 S2

EXTREMITIES:

IV Access: EJ (R) FA 18G

Ulnar Filling:

BACK:

OTHER: Unresponsive during assessment

Foley

NG-Tube

feeds

Unresponsive upon admission 7 day 03

Pt. [redacted] lids closed

No. CHI; pt in and out of consciousness

STATIC Encephalopathy 2° to Heat Stroke

NPO Since MN

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

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

Unable to obtain informed consent c̄ interpreter. Pt. unresponsive.

The patient/legal [redacted] understand and agrees. Questions answered.

Signed: [redacted] RNA/MA Date: 8-12-03 Time: 0937 Hrs

POST-[redacted]

{ } NO [redacted] ANESTHETIC COMPLICATIONS { } OTHER

b(6)-2

Signed: ___ Date: ___ Time: ___ Hrs

Patient Identification: (Ward) ___

[redacted] b(6)-1

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.

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

PATIE

Previous edition is obsolete

ANESTHESIA PLAN OF C **PROCEDURAL ASSESSMENT (Sedation/Anesthesia)**

Age 20's DAYS MOS (YRS) Sex (✓) MALE ( ) FEMALE

ASA Physical State 1 2 (3) 4 5 E
WT: 70 (KG)/LB HT: ____ IN.
ALLERGIES: NKDA

PROPOSED PROCEDURE: arthrotomy (L) knee; G-tube; CVL placement
SURGICAL SERVICE: [redacted] 06-2
NPO SINCE: MN

HABITS:
TOBACCO: ____
ETOH: Ø
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed

(✓) Ancef 1gm IVPB 06-
(✓) D5 1/2NS c 40meq KCl @ 125
(✓) Zantac 50m IVPB 08
(✓) Lovenox 30mg SC q12 6-24 06
( ) ____
( ) ____

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

LABORATORY STUDIES:

HB/HCT: ____ / ____
U/A: ____
OTHER: PT-17.2 / PTT 42.1 8-11-03

8.5 | 12.3 / 38.2 | 420

8-10-03 — | 98 | 5
4.6 | 21 | 0.8 | 120

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	foley
Gastrointestinal:			
Hepatitis	N	Y	? NG-tube
Hiatal Hernia	N	Y	feeds
PUD/GERD	N	Y	
Endocrine System:			
Diabetes	N	Y	
Steriods	N	Y	
Thyroid	N	Y	
Neurological:			Unresponsive upon
Seizures	N	Y	admission 7 May 03
Neuropathy	N	Y	[redacted] labs assessed
Other	N	Y	Pt. Possible Post Stroke
Gynecological:			Sx. CHI; Pt in and out
Pregnancy	N	Y	of consciousness
Other Significant Hx:			STATUS Encephalopathy
	N	Y	2° to Heat Stroke
	N	Y	?
Familial HX	N	Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC

?

PHYSICAL EXAMINATION
BP 124/82 HR 98 R 16 T 38.6 / T-37.0 (O) (P) Tyle
Pain Scale 0-10 SaO2 96%
HEENT - Teeth intact
Trachea midline
Beard TMJ/Neck 3FB's
Oropharynx
Nares Patent
CHEST: CTA (B) =
CARDIAC: S1 S2
EXTREMITIES:
IV Access: IV (R) FA 18G
Ulnar Filling:
BACK:
OTHER: Unresponsive during assessment

NPO Since MN

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ (✓) General: Mask/Intubation

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian.
Unable to obtain informed consent c̄ interpreter. Pt. unresponsive.
The patient/legal guardian [redacted] understand and agrees. Questions answered.
b(6)-2 Signed: [redacted] RNA/MA Date: 8-12-03 Time: 0937 Hrs

POST[redacted]SIA EVALUATION AND NOTE (NON ASU)
{ } NO[redacted]PARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

#[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.

ANESTHESIA PLAN OF C **PROCEDURAL ASSESSMENT (Sedation/Anesthesia)**

Age 20's DAYS MOS YRS Sex (✓) MALE ( ) FEMALE

PROPOSED PROCEDURE: arthrotomy (C) knee; G-tube; CVL placement
SURGICAL SERVICE: [redacted] p6-2
NPO SINCE: MN

ASA Physical State 1 2 3 4 5 E
WT: 70 KG/LB HT: ____ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: ____
ETOH: Ø
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed

(✓) Ancef 1 gm IVPB 06-24-06
(✓) D5 1/2 NS c 40 meq KCl @ 125 cc/hr
(✓) Zantac 50 mg IVPB 08-06-24-06
(✓) Lovenox 30 mg SC q 12
( ) ____
( ) ____

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

LABORATORY STUDIES:
HB/HCT: ____ / ____
U/A: ____
OTHER: PT - 17.2 / PTT 42.1 8-11-03

8.5 > 12.3 / 38.2 (420

8-10-03 — 98 | 5
4.6 | 21 | 0.8 (120

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	foley
Gastrointestinal:			
Hepatitis	N	Y	? NG-tube
Hiatal Hernia	N	Y	feeds
PUD/GERD	N	Y	
Endocrine System:			
Diabetes	N	Y	
Steriods	N	Y	
Thyroid	N	Y	
Neurological:			Unresponsive upon admission 7-11-03
Seizures	N	Y	
Neuropathy	N	Y	[redacted] lids assessed
Other	N	Y	Pt. [redacted] Heat Stroke
Gynecological :			Na. CHI; Pt in and out
Pregnancy	N	Y	of consciousness
Other Significant Hx:			STATIC Encephalopathy
	N	Y	2° to Heat Stroke
	N	Y	
Familial HX	N	Y	?

ASSESSMENT
PAST SURGICAL/ANESTHETIC
?

PHYSICAL EXAMINATION
BP 124/82 HR 98 R 16 T 38.6 / T-37 @ 0720 P Tyle
Pain Scale 0-10 SaO2 96%
HEENT - Teeth intact
Trachea midline
Beard TMJ/Neck 3 FB's
Oropharnyx
Nares patent
CHEST: CTA (B) =
CARDIAC: S1 S2
EXTREMITIES:
IV Access: IV (R) FA 18G
Ulnar Filling:
BACK:
OTHER: Unresponsive during assessment

NPO Since MN

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ (✓) General Mask/intubation

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian.
Unable to obtain informed consent c̄ interpreter. Pt. unresponsive.
The patient/legal guardian [redacted] understand and agrees. Questions answered.
Signed: [redacted] RNA/MA Date: 8-12-03 Time: 0937 Hrs

b(6)-2

POS[redacted]E (NON ASU)
{ } N[redacted]RENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

#[redacted]
b(6)-2

SEDATION KEY:

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 6 Aug 03 TIME OF ORDER: 1730 HOURS

LIST TIME ORDER NOTED AND SIGN

Admit = ICU 2
Dx = 1. MS Δ 2. (L) patellar open Fx
Cond = Guarded
VS = per protocol
AU =
Act = Bedrest ĩ restraints
Nursing = Drsg. Δ's (L) knee

PATIENT IDENTIFICATION

[redacted]

b(6)-9

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

Diet = Reg
Labs = Chem 12, metabolic, CBC in am
IV = Saline Lock (R); NS @ 150 cc/hr (L)
Special = Urine Drug Screen now
Meds = Ancef ĩ gm IV q 6°
Tylenol 325 mg ii po q 4° PRN

NOTED 6 Aug 03 1750

[redacted] 6-6-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

[redacted]

PATIENT IDENTIFICATION

[redacted]

b(6)-2

DATE OF ORDER HOURS

038

NURSING UNIT	ROOM NO.	BED NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 8/7/03 TIME OF ORDER 0930 HOURS

LIST TIME ORDER NOTED AND SIGN

- Post IVD Clonee
- Stable
- Routine vitals
- Bed rest treatments
- Reinforce Dressing PRN
- NS @ 125 cc/hr

DOC 1000
07 Aug 03
SUTWA
[redacted]
9NMB

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

- Foley to gravity
- Amp 1gm IVPB q8°
- Percocet 1 po q4° PRN pain
- Tylenol 1 po q4° PRN T > 100.5
- Demerol 50mg IV PRN breakthrough pain
- Phenergan 25mg IVP q6° PRN nausea
- Colace 100mg po BID
- Regular Diet

[redacted] UMT

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER

[redacted]

b(6)-2

PATIENT IDENTIFICATION

[redacted] b(6)-4

DATE OF ORDER Aug 7 TIME OF ORDER 0945 HOURS

D/C Percocet/Tylenol/Demerol
Phenergan/Colace.

Doc

24V [redacted] CPT/AN

NURSING [redacted] BED NO.

2255 / 07 Aug 03 [redacted]

[redacted]

07 Aug 03

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 YSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

ATIENT IDENTIFICATION

EPW # [redacted] b(4)-4

URSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS | LIST TI ORDE NOTED SIGN

8 Aug

D5 1/2 NS c 20 K meq Done

@ 175 cc /hr

Bolus [redacted] Done

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

[redacted]

ATIENT [redacted] b(4)-4

URSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

08Aug03 2030

Ativan 2mg IVP Q4° prn agitation

VO: Dr [redacted] / [redacted] b(4)-2

noted b(4)-2 [redacted] 2100 8Aug03

ATIENT IDENTIFICATION

URSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

ATIENT IDENTIFICATION

URSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

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]

NURSING UNIT: ICU #2 | ROOM NO. | BED NO.

b(6)-4

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

8/9/03

- Bedrest
- Routine v/t's
- Stable
- Advance Reg diet as tol
- D5 1/2 NS c 20meq KCL @ 150cc/hr
- Ancef 1gm IVPB q8°
- Tylenol 650mg po q4°
- Recordaquat ophthalmic q shift

Noted @ 1210hrs [redacted]

b(6)-2

PATIENT IDENTIFICATION

#[redacted]

NURSING UNIT: ICU #2 | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

[redacted]

b(6)-2

PATIENT IDENTIFICATION

#[redacted]

NURSING UNIT: ICU #2 | ROOM NO. | BED NO.

b(6)-4

DATE OF ORDER | TIME OF ORDER | HOURS

PATIENT IDENTIFICATION

#[redacted]

NURSING UNIT: ICU #2 | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT: ICU #2 | ROOM NO. | BED NO.

DATE OF ORDER: 9 Aug 03 | TIME OF ORDER: 1210 HOURS | LIST TIME ORDER NOTED AND SIGN

1. Transfer to ICU 2
2. CBC / chem 12 / metabolic panel / H/H today.

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

Noted @ 1220 hrs 9 Aug 03 [redacted]

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT: ICU #2 | ROOM NO. | BED NO.

DATE OF ORDER: 10 Aug 03 | TIME OF ORDER: 0200 HOURS

1. A IVF to D5 NS c 20 kcl @ 125 cc/hr
2. 40 mEq KCl in 250 cc NS over 4 hrs.
3. Metabolic panel 10 Aug @ ≈ 1800.

[redacted] b(6)-2

Noted [redacted] 0230

PATIENT IDENTIFICATION [redacted]

[redacted]

b(6)-4

NURSING UNIT: ICU #2 | ROOM NO. | BED NO.

DATE OF ORDER: 10 Aug 03 | TIME OF ORDER: HOURS

1. 500 cc NS bolus IV
2. Zantac 50mg IVPB q 8° (1st) 8-16-24
3. Lovenox 30mg SC. q 12° 1st p AM lab
4. Met panel ~~q 8°~~ q PT/PTT in AM

[redacted] b(6)-2

Noted/sent [redacted] 1417 8/10/03

PATIENT IDENTIFICATION

b(6)-4 [redacted]

NURSING UNIT: ICU #2 | ROOM NO. | BED NO.

DATE OF ORDER: 11 Aug 03 | TIME OF ORDER: 1030 HOURS

1. Place DHT
2. start enoxa @ 10cc/hr

[redacted]

b(6)-2

NURSING UNIT: ICU #2 | ROOM NO. | BED NO.

[redacted]

DA FORM 1 APR 79 4256 REPLACES [redacted] WHICH [redacted]

b(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

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

NURSING UNIT	ROOM NO.	BED NO.
ICW#2		

DATE OF ORDER 8/11/03 TIME OF ORDER 2300 HOURS — LIST TIME ORDER NOTED AND SIGN

- CBC now
- Hold tube feeds ~~p~~ MN

ILTAN 8/11/03 2300

[redacted]

b(4)-2

PATIENT IDENTIFICATION

EPW [redacted] b(4)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW2		7

DATE OF ORDER 8/12/03 TIME OF ORDER 1200 HOURS

Admit to ICW2
S/p knee w/ shoulder ½
Gastrostomy
Cond stable
Vitals Routine
All - NKDA
Act Bedrest

b(4)-2

[redacted] 1240

PATIENT IDENTIFICATION

EPW [redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW2		7

DATE OF ORDER TIME OF ORDER HOURS

Nurse - Foley to Gravity
G-Tube to Gravity Drain
Central line care
Diet - NPO
IVF - LR @ 125 cc/hr
meds
Clindamycin 900 mg IV TID 06-14-22

PATIENT IDENTIFICATION

EPW [redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW2		7

DATE OF ORDER TIME OF ORDER HOURS

Gent 450 mg IV QD 2000
Tylenol 650 mg Per DNT/PR Q6° PRN Fever
MSO4 2-4 mg IV Q1° PRN Pain
CXR on Admit to ward
ZANTAC 50 mg [redacted] -24

Ø38 b(4)-4

b(4)-2

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

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: EPW [redacted]

NURSING UNIT: ICW2 | ROOM NO. | BED NO. 7

DATE OF ORDER: 8/13/03 | TIME OF ORDER: 0700 HOURS | LIST TIME ORDER NOTED AND SIGN

① Resume PreOp orders, - meds, diet, fluids, - activity
② D/C Lovenox
[redacted]

PATIENT IDENTIFICATION: EPW [redacted]

b(4)-4

NURSING UNIT: ICW2 | ROOM NO. | BED NO. 7

DATE OF ORDER: 13 Aug | TIME OF ORDER: 2200 HOURS

1. D/C LR
2. D5 NS ~ 20 kmcg @ 125 cc/hr
[redacted] / [redacted] b(4)-2
V.O. Dr. [redacted] / LT [redacted]
① Diet AAT, NPO ~ Bkfst.

PATIENT IDENTIFICATION: EPW [redacted]

NURSING UNIT: ICW2 | ROOM NO. | BED NO. 7

DATE OF ORDER: 14/AM | TIME OF ORDER: 8/14/03 0150 HOURS

14 Aug 03 1030
- Resume PreOp orders, meds, activity, diet
- NPO ~ MN
[redacted] V
[redacted] 14 Aug 03

PATIENT IDENTIFICATION: EPW [redacted]

NURSING UNIT: ICW2 | ROOM NO. | BED NO. 7

DATE OF ORDER: 14 Aug '03 | TIME OF ORDER: 1600 HOURS

1. Jevity plus G tube feeding. (1.2 cal/cc
2. Start @ 10 cc/hr
3. Check residuales q 4°
4. Increase by 10 cc/hr up to 100 cc/hr if residuals are less than the last 2 hrs of tube feedings
[redacted]

0038

NURSING UNIT: ICW2 | ROOM NO. | BED NO. 7

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

[redacted] b(4)-2

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994 – 362-710

MEDCOM - 15935

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

CIV

[redacted]

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

DATE OF ORDER: 14 AUG 03 | TIME OF ORDER: 1920 HOURS | LIST TIME ORDER NOTED AND SIGN

(1) Benadryl 50 mg IV Q6° PRN itching

b(6)-2

[redacted]

[redacted] 14 Aug 03

PATIENT IDENTIFICATION

CIV [redacted]

b(6)-4

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

DATE OF ORDER: 15 Aug | TIME OF ORDER: HOURS

1. Restart tube feedings as previously ordered PO OR

[redacted]

b(6)-2

[redacted] 1630

PATIENT IDENTIFICATION

CIV

[redacted]

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

DATE OF ORDER: 8-15-03 | TIME OF ORDER: 1520 HOURS

- Resume preop orders, meds, fluids, activity
- Begin wet to dry dressing changes TID (0900-1500-2300)
- Dakins solution begins 8/16/03.

[redacted]

PATIENT IDENTIFICATION

DATE OF OR[redacted] Y-18 033806

Transfer to Iraq Hospital

[redacted]

b(6)-2

038

NURSING UNIT | ROOM NO. | BED NO.

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994—383-710

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

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

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 6	7	8	9	10	11	12	13
6 Aug	[redacted]	VS: per protocol	05	/	[redacted]						
			17								
6 Aug	[redacted]	Activity: Bedrest c̄	05								
		restraints	17								
[redacted]											
6 Aug	[redacted]	Diet: regular	06								
			12								
			18								
7 Aug	[redacted]	Nursing: reinforce	05								
		Drg PRN	17								
7 Aug	[redacted]	Foley to gravity	05								
			17								
11	[redacted]	Ambulate Feeding tube c̄	06								
		Ensure 10 oz/hr	14								
			22								
11	[redacted]	NTD: Δ Ensure tubing &	12	/	/	/	/	/	[redacted]		
		bag q 24 hrs									

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS:

MS Δ ↑ (L) patellar open fx
S/P I+D (L) knee

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

EPW # [redacted]

b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

b(6)-2 All

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo Aug Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
6Aug	[redacted]	Admit ICU 2 - condition guarded	6Aug	NOW	1730	[redacted]
6Aug	[redacted]	labs: chem 12, metabolic, CBC in AM	7Aug	D4	done	[redacted]
6Aug	[redacted]	Urine drug Screen now	6Aug	now	done	[redacted]
7Aug	[redacted]	Diet regular 0600	7Aug	06	held	PT not able to awa
7Aug	[redacted]	Admit ICU 2 - stable post IV DOKUE	7Aug	0930	0930	[redacted]
10Aug	[redacted]	Metabolic Panel @ 1800, 10Aug	10Aug	1800	1830	[redacted]
10Aug	[redacted]	Metpanel & PT/PTT in AM	11Aug	0400		[redacted]
10	[redacted]	Place DHT	11	Now	DONE	[redacted]
11	[redacted]	CBC now	11	2300	2328	[redacted]
11	[redacted]	Hold Dobhoff feed p MN	12	0001	0001	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
7Aug	[redacted]	Reinforce Dressing prn														
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
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USAPA V1.00

b(6)-2 A11

CLINI RECORD

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

Mo. 8 Yr. 03

VERIFY G

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 12	13	14	15	16	17	18
12	[redacted]	Vitals: routine	05	/	[redacted]					
13/8			13							
			21							
			/							
12	[redacted]	activity-bedrest	05	/	[redacted]					
13/8			13							
			21							
			/							
12	[redacted]	Foley to gravity	05	/	[redacted]					
13/8			13							
			21							
12	[redacted]	g-tube to gravity drain	05							
13/8			13							
			21							
			/							
12	[redacted]	Diet ~~NPO~~	07	/	[redacted]					
13/8		Clears	11	/						
	[redacted]	AAT	17							
			/							
15	[redacted]	wa D dsg Δ TID	07	/	/	/	/	[redacted]		
		c dakin's sol'n 1/2%	15	/	/	/	/			
		(Start 16Aug03)	23	/	/	/	/			

Δ'd 13Aug03

ALLERGIES YES [X] NO

PRIMARY DIAGNOSIS: S/P Knee washout & gastrostomy

ADDITIONAL PAGES IN USE: [ ] YES [ ] NO

PAGE NO:

PATIENT ATION:

EPW [redacted]

b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED.

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b(6)-2 All (NON-MEDICATION) Mo 8 Yr 00

	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
12	[redacted] admit to ICWZ	8/12		1315	[redacted]
12	[redacted] Condition stable	8/12		[illegible]	[redacted]
12	[redacted] CXR on arrival toward	12		1430	[redacted]
14	[redacted] NPO p̄ Brkfst	14	AM	—	[redacted]
14	[redacted] NPO p̄ MN	14	MN		
14	[redacted] Resume preop orders, meds, activity level.	14	1030	1830	[redacted]
15	[redacted] resume previous orders, etc	15	1530		[redacted]

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

USAPA V1.00

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 6	7	8	9	
6 Aug	[redacted]	IV: Saline lock (R)	05	[redacted]				Δ 0930 07 Aug 03
		NS @ 150cc/hr (L)	17	[redacted]				SGT [redacted] 77 MMC
6 Aug	[redacted]	Ancef 1gm IV Q6°	04	[redacted]				
			12					
		b(4)-2	18	[redacted]				Δ 0930 07 Aug 03
			24	[redacted]				SGT [redacted] 91 MMC
07 Aug	[redacted]	IV: NS @ 125cc/hr	09	[redacted]				Δ 0945 07 Aug 09 45
			17					[redacted]
07 Aug	[redacted]	Ancef 1gm IVPB	06					
		q 8°	14					Δ 0945 07 Aug 09
			22					[redacted]
07 Aug	[redacted]	Colace 100mg PO	08					D/Ced 07 Aug 03
		BID	20					0945 [redacted]

ALLERGIES: ☐ YES ☐ NO	PRIMARY DIAGNOSIS: MS Δ 4 (L) patellar open Fx S/P I+D (L) Knee	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO PAGE NO.

PATIENT IDENTIFICATION:

EPW # [redacted]

b(4)-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. Aug 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
01 Aug	[redacted]	Tylenol 325mg	
		II po Q 4° prn	
		T > 100.5	
01 Aug	[redacted]	Percocet II po	
		q 4° PRN PN	
01 Aug	[redacted]	Demerol 50mg	
		IV PRN q break through pain	
01 Aug	[redacted]	Phenergan 25mg	
		IVP q 6° PRN	
		Nausea	
		b(6)-2	

① Cel 01 Aug 03 [redacted]

AP

USAPA V1.00

b(6)-2A11

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. Aug Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 6	8	9	10	11	12	13
7 Aug	[redacted]	Ancef 1gm IVPB q 8°	06	[redacted]						
			14							
			22							
7 Aug	[redacted]	IV NS @ 125cc/hr	05							
			13							
[redacted]										
08 Aug 03	[redacted]	IV D5 1/2 NS c̄ 20K @ 175cc/° Δ to D5NS c̄ 20meq KCL @ 125cc/hr	05	[redacted]						
			17							
10 Aug	[redacted]	Zantac 50mg IVPB Q8°	08							
			16							
			24							
10 Aug	[redacted]	Lovenox 30mg SC Q12°. 1st dose ā AM lab.	06							
			18							
11 Aug	[redacted]	Ensure 10cc/hr through DHT.	05							
			13							
			21							
10	[redacted]	D5NS c̄ 20meq KCl @ 125cc/hr	05							
			13							
			21							

See below Δd 10 Aug 03

DC 08 Aug 03 1600

DC 8/8/03

ALLERGIES: ☐ YES ☒ NO — NKDA

PRIMARY DIAGNOSIS: (L) patellar open FX s/p I+D (L) knee

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. Aug Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
08 Aug	[redacted]	Bolus last of NS bag	08 Aug	1600	1615	[redacted]
10Aug	[redacted]	40 meq KCL in 250cc NS over 4Hrs	10Aug	0300	0300	[redacted]
10Aug	[redacted]	500cc NS Bolus x 1 now	10Aug	2200	2200	[redacted]
		b(6)-2				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
8 Aug	[redacted]	Ativan 2mg IVP Q4°	8/8 2100	8/9 0130	9Aug 1400	9Aug 1900	10Aug 1200									
		pm agsitation	2mg IVP	2mg IVP	[redacted]											
10Aug	[redacted]	Tylenol 650mg po q4° PRN	10Aug 0720	10Aug 2000	11Aug 1445	8-11 2125	8-12 0430									
		b(6)-2	[redacted]													

USAPA V1.00

b(6)-7 All medication

CLINICAL RECORD

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

Mo. 8 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 12	13	14	15	16	17	18
12	[redacted]	Central line care	05	[redacted]						
13/8		flush QS, Ads g	13	[redacted]						
		q72°(□) - flush 5cc	21	[redacted]						
		saline q shift on open ports	/							
12	[redacted]	LR @ 125cc/hr	05	/ [redacted]						
13/8			13	[redacted]						
			21							
			/							
12	[redacted]	Clindamycin 900mg	06	/ [redacted]						
13/8		TID IV	14	[redacted]						
			22	[redacted]						
			/							
12	[redacted]	gentamycin 450mg	20	[redacted]						
13/8		IVPBQD	/							
			/							
12	[redacted]	Zantac 50mg IVPB	08	/ [redacted]						
13/8		q8°	16	[redacted]						
			24	[redacted]						
		~~Ancef 1gm IVPB q8°~~	~~06~~							
			~~16~~							
			~~24~~							
8/14	[redacted]	D5 NS c̄ 20meq KCl @	05	X X [redacted]						
		125cc/hr.	13	X X [redacted]						
			21	X [redacted]						

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/P Kreewash out b/b gastrostomy

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

EPW [redacted] b(4)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

med MEDCOM - 15945

b(6)-2A17

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN ~~[illegible]~~-MEDICATION)				Mo 8 Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
14	[redacted]	~~NPO~~ p				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
12	[redacted]	tylenol 650mg per	13Aug 1440 1000 [illegible]													
		DUT/PR q6° prn	[redacted]													
		fever														
12	[redacted]	MSO4 2-4mg IVP	12Aug 1450 2mg	13Aug 1320 4mg	13Aug 1530 [redacted]	13Aug 2045 [redacted]	14Aug 0149 [redacted]	15Aug [redacted]	15 1515 [redacted]	[redacted] 2109 2mg IV	15 2210 [redacted]	16Aug 0910 4mg IV	16Aug 4mg IV 2215	17Aug 0916 4mg IVP	17Aug 0951 4mg IVP	
		q1° prn-pain	[redacted]	[redacted]	[redacted]		[redacted]			[redacted]			[redacted]	[redacted]		
14	[redacted]	Benadryl 50mg IVP	14Aug 03 50mg 2050													
		q6° PRN-itching	[redacted]													

USAPA V1.00

b(6)-2 A11

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. 8 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
14	[redacted]	OSmolite HN tube	04	/	[redacted]			
	------	feeding @ 10cc/hr	RA Ile		[redacted]			
	------	-check residuals	residual	/	0	0	0	Ø
	------	q4°, increase by	08	/	[redacted]			
	------	10cc/hr up to 100cc/hr	rate	/	/	30cc	50cc	
	------	if residuals less	residual	/	/	2cc	5cc	
	------	than the last 2hrs	12	/	[redacted]			
	------	of tube feeding	rate	/	/	30cc	50cc	
	------		residual	/	/	[redacted]		
	------		16	/	[redacted]			
	------	-once rate reaches	rate	/	10	20cc	30cc	
	------	30cc/hr tube	residual	/	5cc	1cc	1cc	
	------	feed can be	20	[redacted]				
	------	Δ'd to Jevity plus	rate	10	20	30cc		
	------	(1.2cal/cc)	residual	/	3cc	5cc		
	------		24	(RA)	[redacted]			
	------		rate	(30)	20	50	50	
	------		residual	(0)	10	Ø	Ø	

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/P knee washout & gastrostomy

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION:

CIV [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

137/84 p60
15

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: 07 Aug 03
Time In: 0935
Allergies: NKDA
Pre-op V/S: 10/24/83
Procedures: I+D (R) patella

Anesthesia Type (Circle): General, Spinal, Epidural, IV Sedation, Nerve Block, LMA
OR Intake: Crystalloid 500 Colloid 300
OR Output: UOP 200 EBL 100
Meds/Times: MS04 10 Fent. 250

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds / History

Time	0935	0940	0945	0950	0955	1000	1005	1010	1015	1020	1025	1030
SaO2	100	100	100	100	100	100	100	100	100	100	98	95
FiO2	60	60	60	60	60	60	60	60	60	60	60	60
Methods												
240												
220												
200												
180												
160												
140												
120												
100												
80												
60												
40												
20												
RR	15	16	17	18	18	15	12	15	18	14	15	
T	96.6				97.4				97.6			
Time												
Pain (0-10)	0	0	0	0	0							
LOS												

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1115	NSS	3750	LAC	—	300

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	1	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	8	9

Codes
AIRWAY: A = Ambu, BB = Blow-by, M = Mask, FT = Face Tent, RA = RoomAir, NC = Nasal Cannula
V/S: X = A-line BP, " = Cuff BP, = Pulse
TEMP: S = Skin, O = Oral, A = Axillary, T = Tympanic, R = Rectal
LOS: C = Cervical, T = Thoracic, L = Lumbar, S = Sacral

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

PREPARED BY (Signature & Title): SGT [redacted] 91WM6
DEPARTMENT/SERVICE/CLINIC: ICU 2
DATE: 07 Aug 03

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

EPW # [redacted]

b(6)-4

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

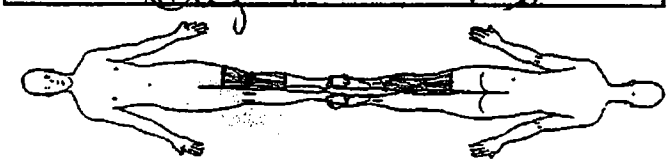
MEDICATIONS						
Allergies:						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR							
Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	L leg	+	+	P	BK	W	PK
15'	L leg	+	+	P	BK	W	PK
30'	L leg	+	+	P	BK	W	PK
45'	L leg	+	+	P	BK	W	PK
60'	L leg	+	+	P	BK	W	PK
90'	L leg	+	+	P	BK	W	PK
D/C	L leg	+	+	P	BK	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		N/A					
Lochia							
Peripad#							
Fund. Cond.							

DRESSINGS			
Time	Location	Type	Drainage
Adm	(L) leg	bulky/ACE	Ø
30'	(L) leg	" "	Ø
60'	(L) leg	" "	Ø
D/C	(L) leg	" "	Ø



PACU OUTPUT			
Time	Source	Color/Appearance	Amount
1115	Urine/foley	Amber sediment	350

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?
		N/A	

WAMC OP 173-E

NURSING NOTES

0935 - 20+ y.o. EPW ♂ transferred via litter to bed from OR to ICU2. tolerated well. Resting c̄ eyes closed responsive to painful stimuli color good VS - 137/84 P. 105 R. 15 even unlabored shallow SaO2 100% ℓ O2 via face mask. LS CTA. ABD soft ⊖ DTN ⊖ rigidity. pupils EOMI skin warm to touch T 96.6 pulses present x 4 cap Refill brisk x4. Dressing bulky c̄ Ace wrap CDI. NVI to painful stimuli. IV 18 G (L) AC Running LR @ 125cc/hr patent. heplock RFA sluggish to flush ⊖ infiltrate will cont to monitor SGT [redacted] MM

1115 - ADMIT ICU2. PACU D/C VSS SaO2 98% RA. PT sat up spontaneously confused not able to track c̄ eyes. spoke in Arabic. undiscernable - went back to sleep NAD SGT [redacted]

Discharge Criteria:
Date: 7 Aug Time: 1115 PARS: 9
BP: 143/88 T: 97.6 HR: 78 RR: 16 SaO2: 98
Pain Level at D/C (0-10): unable to evaluate
Intake: 300 Output: 350
Additional Data: NPO
Transferred To: N/A
Report Given To: N/A
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: N/A
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 9-Aug-03
Time In: 1130
Allergies: NKDA
Pre-op V/S:
Procedures:

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

OR Intake: Crystalloid 1100 Colloid
OR Output: UOP 200 EBL 90
Meds/Times: 250 mg Ref 0940, 6mg MS04 1105

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

Pre Op Meds

History

Time	11 30	11 35	11 40	11 55	12 00	12 25	12 30
SaO2	99	100	100	100	100	98	96
FiO2	RA	RA	RA	RA	RA	RA	RA
Methods	SR	OF	SS				
240							
220							
200							
180							
160	V	V	V				
140				V	V	V	V
120							
100	A	A	A				
80	O	O	O	A	A	A	A
60							
40							
20							
RR	24	20	22	22	19	18	18
T	96.0	96.2	96			98.3	98.3
Time	1130						
Pain (0-10)							
LOS							

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1230	NS	150	(L) FA	O.R.	150cc

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	9	9

Codes

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

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

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

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

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): [redacted] b(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU #2

DATE: 9 AUG 03

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

#[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	(B) LE	BRACE	N/A	P	B	W	PK
15'	"	"	"	"	"	"	"
30'	"	"	"	"	"	"	"
45'	"	"	"	"	"	"	"
60'	"	"	"	"	"	"	"
90'	"	"	"	"	"	"	"
D/C	"	"	"	"	"	"	"

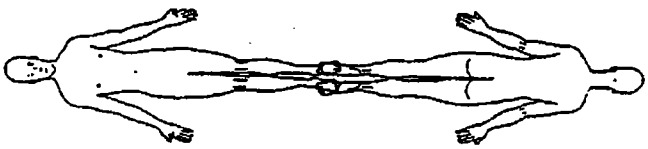
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 1130	(B) LE	ACE WRAP	(-)
30' 1200	" "	" "	"
60' —			
D/C 1230hrs	" "	" "	"



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1230	Urine	yellow/cloudy	150cc

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
		N/A	

WAMC OP 172-E

NURSING NOTES

See progress note [redacted]

b(6)-2

Discharge Criteria:
Date: 9 Aug 03 **Time:** 1230hrs **PARS:** 9
BP: 148/92 **T:** 98.3 **HR:** 80 **RR:** 18 **SaO2:** 99%
Pain Level at D/C (0-10): Ø
Intake: 150cc **Output:** 150cc
Additional Data: —
Transferred To: ICU #2
Report Given To: [redacted]
Transferred Via: [redacted] Gurney Ambulance
Transferred By: [redacted] SA/A
Cleared IAW Recover[redacted]
Charge Nurse Signat[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 — Static encephalitis 2° heat stroke Condition

OTSG APPROVED (Date)

Date: 12 Aug 03
Time In: 1720
Allergies:
Pre-op V/S:
Procedures: ① Knee arthroscopy G-tube, CVL in (R) IJ

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

OR Intake: Crystalloid 1,000 Colloid
OR Output: UOP 500cc EBL <100
Meds/Times: 10mg labetalol

250 Neat
10mg Nay

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

Needs CXR to verify line placement

Pre Op Meds

History

Time	1200	1225	1250	1245	1310
SaO2	100	98	97	98	97
FIO2	28	28	28	28	28
Methods					
240					
220					
200					
180					
160					
	✓	✓	✓		✓
140				✓	
120					
100					
	^	^	^	^	^
80	•	•			
60			•	•	•
40					
20					
RR	17	19	20	19	19
T					
Time					
Pain (0-10)					
LOS					

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	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	9	9

Codes

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

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

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

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

PREPARED BY (Signature & Title): [redacted] PT/AN

DEPARTMENT/SERVICE/CLINIC: ICU 2

DATE: 12 Aug 03

b(6)-2

PATIENT'S IDENTIFICATION (Name — last, first, middle; grade; date; hospital): [redacted]

[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
1225		MSO4 2mg	IVP			[redacted]

NEUROVASCULAR

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

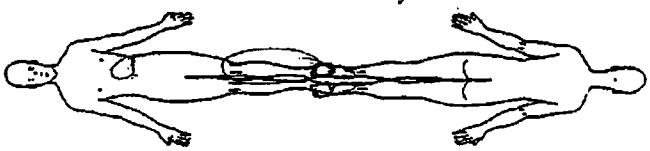
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) knee	ace wrap	none
30'	(L) knee	ace wrap	none
60'			
D/C	(L) knee	ace wrap	none



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
		N/A	

WAMC OP 173-E

NURSING NOTES

Pt received in PACU area very drowsy and slightly agitated. Drsg around G-tube and on (L) knee clean, dry + intact. Jehoff in (R) nare removed in place. Pt currently calm + VS stable. Will continue to monitor [redacted] RN

Discharge Criteria:
Date: 17 Aug 03 **Time:** **PARS:** 9
BP: 144/98 **T:** **HR:** 56 **RR:** 13 **Sa02:** 99%
Pain Level at D/C (0-10):
Intake: _____ **Output:** _____
Additional Data: _____
Transferred To: ICW 2
Report Given To: _____
Transferred Via: W/C [redacted] Gurney [redacted] Ambulance
Transferred By [redacted]
Cleared IAW Recovery [redacted]
Charge Nurse Signatur [redacted]

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
A	Ⓛ foot	+	+	P	B	W	PK
1	Ⓛ foot	+	+	P	B	W	PK
3							
4							
6							
9							
D	Ⓛ foot	+	+	P	B	W	PK

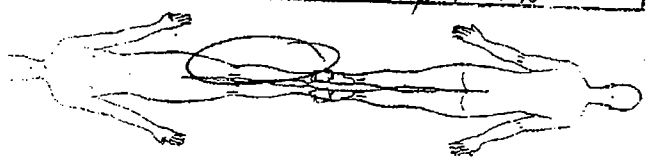
Movement/Sensation: + = present, - = absent Temp: C = Cool
W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
A	Ⓛ knee	ace wrap	none
3			
6			
D	Ⓛ knee	ace wrap	none



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

VAMC OP 173-E

Pt received on unit S/A 1+0 of Ⓛ knee. Alert but not coherent. Ortho to check chart, dry + intact c̄ brace in place. Lobbolt remains in Ⓡ hand [redacted] Will continue to monitor [redacted] Pt more agitated, v/s stable [redacted] c̄ 1 bp noted. Will be [redacted] to ICW & [redacted] Pt transferred to Tew 2. Pt [redacted] responsive & worked and [redacted] phenil. Pt very combative, restraints applied. V/S stable. Pt still able & work his way [redacted] Ⓛ hand and pulled out IV [redacted]

Discharge Criteria:
Date: 13 Aug 03 Time: 0745 PARS: 9
BP: 156/100 T: HR: 102 RR: 12 SaO2: 100%
Pain Level at D/C (0-10):
Intake: Output:
Additional Data:
Transferred To: ICW 2
Report Given To: Sgt [redacted]
Transferred Via: W/C [redacted] Gurney Ambulan
Transferred By: Cpt [redacted]
Cleared IAW Recov [redacted]
Charge Nurse Signatur [redacted]

2040

Post-Anesthesia Care Unit (PACU) Flow Sheet

ASA 3

Date: 13 Aug 03
Time In: 0710
Allergies: NKDA
Pre-op V/S:
Procedures: I+D Olecrane

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 100 Colloid
OR Output: UOP 0 EBL 100
Meds/Times:

100 mcg Fent

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds

History

Time	0710	0715	0730	0745
SaO2	99	97	99	99
FiO2	RA	RA	RA	RA
Methods				
240				
220				
200				
180				
160				
140	134 ✓	134 ✓	✓	✓
120	•			
100			100	
80	92	93		
60				
40				
20				
RR	14	18	18	18
T	97.3			
Time				
Pain (0-10)				
LOS				

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2		2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1		2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2		2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1		1
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2		2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	8		9

Codes
AIRWAY
A = Ambu
BB = Blow
M = Mask
FT = Face Tent
RA = Room
NC = Nasal Cannula
V/S
X = A-line
" = Cuff BP
= Pulse
TEMP
S = Skin
O = Oral
A = Axillary
T = Tympan
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

b(6)-2

PREPARED BY (Signature): [redacted] 101/ANC

(Continue on reverse)

DEPARTMENT/SERVICE/CLINIC: ICU2

DATE: 13 Aug 03

[redacted] IDENTIFICATION [redacted] written [redacted] (Print, middle; grade; date; hospital facility) [redacted]

Name – last,

#[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

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 Aug 03
Time In: 1047
Allergies:
Pre-op V/S: 113/60, 111
Procedures: I&D ⊕ LE

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

OR Intake: Crystalloid 400 Colloid
OR Output: UOP 100 EBL Minimal
Meds/Times: Fentanyl, Versed, Esmolol 30 mg

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

Airway: Nasal, Oral, ETT, Trach, Other: Natural

Pre Op Meds / History

Time	1047	1053	1058	1103	1108	1113	1120	1140	1160	1255
SaO2	97	98	97	100	98	97	95	96	96	98
FiO2	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
Methods										
RR	16	19	15	19	21	20	16	21	17	16
T	96.8				96			97		
Time										
Pain (0-10)										
LOS										

Scale: 240, 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1047	LR	450	RLJ TLC		100

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	1	1	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	8	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)

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

DEPARTMENT/SERVICE/CLINIC: ICU3

DATE: 14 Aug 03

PATIENT'S IDENTIFICATION (Name - last, first, middle; grade; date; hospital or [redacted]) [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
1115	/	MSO4 3mg	IV	/		[redacted]

NEUROVASCULAR

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

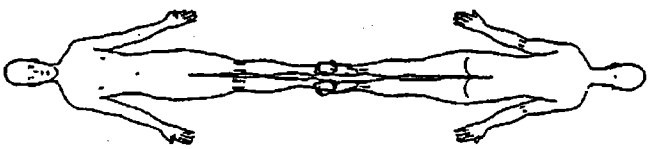
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	LLE, Abd	Ace Wrap	None
30'	LLE	Ace Wrap	None
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1158	Foley	Dark Yellow	300

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

1050 - Pt arrived from OR via litter. Airway natural. Receiving UR @ TKO. Dressings to PEG tube & LLE c/D/I [redacted] /AW

1110 - Pt removed PEG tube dressing. 4x4 dressing reapplied [redacted] /AW

b(6)-2

Discharge Criteria:
Date: 14Aug03 **Time:** 1154 **PARS:** 9
BP: 148/93 **T:** 96° **HR:** 102 **RR:** 17 **Sa02:** 98
Pain Level at D/C (0-10): —
Intake: 100 **Output:** 300
Additional Data:
Transferred To: ICW 2
Report Given To: CT [redacted]
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: Cpt [redacted]
Cleared IAW Recovery Ro[redacted] B-3 [redacted]
Charge Nurse Signature: [redacted] /AW

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: 15 Aug 03
Time In: 1419
Allergies: ——
Pre-op V/S: 156/90, 105
Procedures: I+D (L) Knee

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

OR Intake: Crystalloid 200 Colloid ——
OR Output: UOP 150 EBL ——
Meds/Times: Fent, Versed 150mcg 2.5mg

Drains
Hemovac
NG
JP
T-tube
(Foley)
TLS

Airway
Nasal
Oral
ETT
Trach
Other Natural

Pre Op Meds History

Time	1419	1420	1430	1440	1450
SaO2	98	99	99	99	98
FIO2	RA	RA	RA	RA	RA
Methods					
240					
220					
200					
180					
160					
140					
120					
100					
80					
60					
40					
20					
RR	18	20	21	19	21
T	97.4				

Time	
Pain (0-10)	
LOS	

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1419	NS w 20K	200	TLC	——	50

X-rays: Labs:

Post-Anesthesia Recovery score

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

b(6)-2 [redacted] /AN

DEPARTMENT/SERVICE/CLINIC: ICU 3

DATE: 15 Aug 03

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

Name – last,

[redacted]

b(6)-4

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

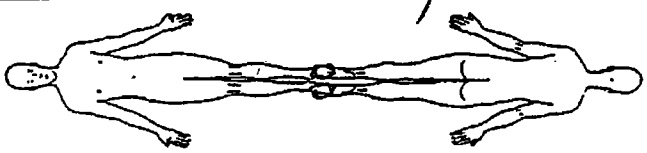
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	LLE	Ace Wrap	None
30'	LLE	Ace Wrap	None
60'			
D/C	LLE	Ace Wrap	None



PACU OUTPUT

Time	Source	Color/Appearance	Amount
	Foley		

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

NURSING NOTES

1419: Pt arrived from OR via litter. Pt moving arms and legs, attempting to pull at lines. Pt uncooperative + does not follow commands. Pt very restless [redacted] and agitated. Requiring 3 staff members to keep pt calm [redacted] CS/RN

b(6)-2

Discharge Criteria:
Date: 15 Aug **Time:** 1457 **PARS:** 10
BP: 150/90 **T:** 97.4 **HR:** 145 **RR:** 22 **SaO2:** 98%
Pain Level at D/C (0-10): —
Intake: 50 **Output:** —
Additional Data:
Transferred To: ICW 2
Report Given To: Cpt [redacted]
Transferred Via: W/C Gurney Ambulance
Transferred By: Cpt [redacted]
Cleared IAW Recovery [redacted] B-2
Charge Nurse Signature [redacted] RN/LPN

b(6)-2

WAMC OP 173-E

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A 1 1 D 1	I Z	0 0 1 4 1 9 5	EPW# [redacted] b(6)-4	EPW	M

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

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	Z	1730	b(6)-4

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

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
I Z		9	YEAR / [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø b(2)-2	ICU#2	UNK

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
[redacted]	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)
2 6		0 3 0 8 1 3

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
A E A A		0 3 Ø 3 Ø 6

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: GSW to (D) Knee / L Patellar open fx

Dx: 8221, 34839, 9920, 71100, E9000

Dx: 7966 (7), 7936, 4319

992.0, 348.3, 822.1, 920, 910.0, E991.2, E900.9

79.69, 79.39, 86.28x4, 43.19

ADMITTING OFFICER (Signature as required) Dr [redacted]

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

DA FORM [redacted] COM - 1596[redacted]

b(6)-2

INPATIENT TREATMENT RECORD COVER EFT

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

1. REGISTER NUMBER: 00 14200	2. NA[redacted]			3. GRADE: EAW	ADMISSION REMARKS
4. SEX: M	5. AGE: 24y	6. RACE: X	7. RELIGION: MUSLIM	8. [redacted] b(6)	9. ETS: -2	10. PREVIOUS ADMISSION: NO
11. FMP: 99	12. SSN: [redacted]		13. ORGANIZATION: TAG# D15631		14. WARD: ICW1
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	23. CLINIC SERVICE	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: —			25. TYPE DISPOSITION: XFER TO 21st CSH	26. DATE OF DISPOSITION: 26 AUG 2003	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): —			27b. TELEPHONE NO.: —	28. DATE OF THIS ADMISSION: 06 AUG 2003	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] b(2)-2				30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: S/P GSW TO ABD

DX
86350
8760
8748
99859
99931

V443
569.61
E9912

PROC
8609

863.50
876.0
874.8
998.59
998.31
569.61
E991.2

8/12 93.57
97.83
97.84
8/18 93.57

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	14	14

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	14	14

SIGNATURE OF ATTENDING MEDICAL OFFICER: DR. [redacted] SIGNATURE: [redacted]

[redacted] b(6)-2

DA FORM 3647, MAY 75 EDITION [redacted] USAPPC V1.10

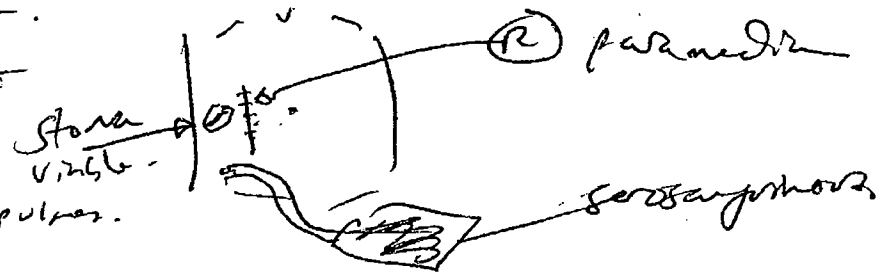
MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

24 yo. ♂ s/p GSW (L) neck and GSW abdomen/Back yesterday ⇒ Temp: Hospital Neck not treated (and looks ok) and got laparotomy for abdomen. T-Colon injury ⇒ colostomy done, Drain placed Back wound closed.

PHYSICAL EXAMINATION

11/5/78 (L) neck @ post scar tiny little wound
lungs clear.
Abd soft



Ext: normal pulses.

PROGRESS (Enter date of discharge and final diagnosis)

Plan NPO / Levine / AGIR / [redacted]

b(6)-2

b(6)-2

[redacted]	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted] MAT [redacted]	06 AUG 03		

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

REGISTER NO.	WARD NO.

[redacted]

b(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975

539-106

117

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6 Aug 03	24 y/o Iraqi National c̄ 1d hx of RUQ abdominal wound
1530 hrs.	2° to GSW. Pt was shot by Iraqi National while
T: 98.8	works for American (U.S. Army) Reg. Fellow. Pt.
P: 100	was subsequently transported to Al Kasch Hospital Lab pr
R: 16	was capacity & vital signs performed.
B/P: 130/90	
PO2: 99%	a.) Stable, Unrelated c̄ NAD, WD, Affect
A: NKDA	HEENT: WNL c̄ except of JPG tube placed in @ Midline
M: Ø	Pul: CTAB s W, RR
P: Ø	CV: CTAB s M, R
L: Last Meal 1800	Abd: Soft NT, @ BS, @ TTP to @ Quadrants,
L: Ju Juice	Has Foley bag & drainage bag in place.
O/I: 625 ml	Ext: Foley Cath in place
GOP: 50 ml	
Urine: 200 ml	A/P.) 1d hx of GSW to RUQ - Stable Moderate to
Vitals @ 1600	28th GSW per LTC Moore, 9/28th FST for
T: 99	Continue Care. Pt is considered EPW.
P: 110	• MEDEVAC to [redacted] b2-2
R: 20	• 9-Line MEDEVAC Called @ 1645 [redacted] b(2)-2
B/P: 112/72	• Δ IV to LA, DC @ [redacted]
PO2: 94%	
	* Ø IV ABX's given, Ø Narcotics [redacted]

PITAL OR MEDICAL FACILITY	STATUS	DEPART./S[redacted]	RECORDS MAINTAINED AT
ISOR'S NAME b(2)-2	SSN/ID NO.	RELATIONSHIP TO SPONSOR	TLT SP PMC

[redacted] ON: [redacted] (Written entries, give: Name - last, first, middle; ID No or SSN; Sex; Rank/Grade.)

REGISTER NO.	WARD NO.

[redacted]

2/5/79 M Iraqi National
EPW

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
06 Aug 03 2015	Received pt. from EMT about 1930. Pt. transfered from litter to bed. VSS. Pt. alert & oriented. Pupils equal @ 4mm & reactive. Resp. even, unlabored. Lungs CTA throughout c̄ slight exp. wheeze noted (R) UL, anterior. SpO_2 98-100% RA. HR regular c̄ ∅ murmur S̄T c̄ ectopy. HR 110's. 2+ pulses x 4. Abd. soft, flat, non distended. Hyperactive BS (R) UQ, otherwise absent. Colostomy c̄ bag intact. Min. amt. watery stool draining - located (R) UQ. NG tube (R) nare c̄ green drainage. 50cc emptied upon arrival. NGT to LCS. Foley to gravity drainage c̄ dark amber urine. Vertical abd. incision on (R) side of abd. about 12 inches in length c̄ sutures intact. ∅ s/s. of infection. Drain located (R) LQ c̄ bloody drainage. 225cc drained/emptied upon arrival. 18g PIV (R) AC c̄ LR @ 150cc/hr infusing S̄ difficulty. Pt. denies pain @ this time. Will cont. to monitor. [redacted]
06 Aug 03 2100	UOP last hour 20cc concentrated, amber color. Will monitor next hour to see if output ↑. [redacted]
06 Aug 03 2200	UOP to 30cc/hr. Pt. cont. to deny pain at this time. Sleeping S̄ c/o. Will cont. to monitor. [redacted]
06 Aug 03 2300	Colostomy bag emptied. Colostomy site pink & beefy c̄ fatty tissue & fascia visible around stoma. Surgeons aware & plan to re-do stoma within next few days. Pt. c/o pain around incision/drain site. Medicated c̄ 4mg MSO4 IVP. - giving adequate pain control. [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

b(6) - 2 All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
07 Aug 03 0015	<15cc drainage from NG noted. Ø fluid replacement given. Pt. sleeping. IV Abx treatment going. VOP cont. @ 30cc/hr. Dressing Δ'd around drain site. Old dressing saturated c̄ serosanguinous drainage. Drain kept in place c̄ sutures. Site looks good Ø S/S infection. New dressing placed. — b(6)-2 [redacted] Δ'd
07 Aug 03 0230	Drainage bag Δ'd from Iraqi bag to Foley bag because tubing in original bag clotted & is unable to be stripped. 200cc bloody drainage emptied from bag. Serosanguinous drainage cont. to leak from site. b(6)-2 [redacted] Δ'd
07 Aug 03 0440	Pt. able to sleep through the night c̄ c/o. Ath care done. Exit wound to (R) back closed c̄ sutures intact. New dressing applied to site. Ø drainage on old dressing. Dressing @ drain site saturated c̄ serosanguinous fluid. Dressing Δ'd. Very little bloody drainage noted in tubing. Grimacing noted on pt's face c̄ turning. Pt. medicated c̄ MSO4 4mg IVP. Small wound to (L) neck. Ø drainage through the night. b(6)-2 [redacted] Δ'd
07 Aug 03 0445	Pt. guarding (R) LE. States that he is unable to move leg on his own. (+) sensation to leg. Will monitor. b(6)-2 [redacted] Δ'd
0530	Assumed care of pt resting in bed. Pupils 3mm & brisk. Grips strong equal bilaterally. HR in high 90's T̄ tachy. Palpable pulses in all extremities. IL currently infusing @ 150cc/hr via 18ga @ forearm. Lungs T̄ inspiratory wheezing noted bilaterally. O2 sats 97-99% on room air. Color normal for race. Abdomen c̄ incision noted, sutures intact. Colostomy to RLQ c̄ small amt of liquid drainage noted. Absent bowel sounds in 3 quads c̄ hyperactive bowel sounds noted in

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
7 Aug 03 cont	RLQ. Drain also noted in R lower quad c̄ small amt of sanguinous drainage noted. Drsg around site c̄ serous sanguinous drainage noted. Drsg R'd, new one applied. NGT to LCS c̄ minimal amt of green drainage to replace c̄ 1/2 cc/cc of ice. Foley to gravity draining adequate amt of yellow urine. No problems noted c̄ present time, will continue to monitor [redacted] app/m b(6)-2
07 AUG 03 0723	Surgery POD # 2 Doing well. Vone 60/60/100 = 7 ml 3h. minimal stoma output (6 ml, some 17-0) NGT 1 pint Sitting - 600cc Drain in pelvis - Ø → will remove today wound c̄ 10 I. Clear D/C Drain Also IVF, NGT. [redacted] b(6)-2 [redacted] 0723
0815	Drain in R lower quad D/C'd by Dr. [redacted] 4mg Nebs given prior. Pt. tolerated c̄ difficulty, will continue to monitor b(6)-2 [redacted] app/m
0930	Drsg to R lower quad checked, small amt drainage noted — [redacted] app/m

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMB (SSN or Other)
	LAST	FIRST	MI	[redacted]

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.
# [redacted] b(6)-4		

PROGRESS NOTES
Medical Record

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

bled - 2 All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
7Aug03 1400	Pt up to stand, Afternoon care performed. Stoma c̄ brown edges noted. Small amt of liquid stool noted. 4mg MSO4 given for c/o pain. Weakness noted in (R) lower extremity. Pt unable to stand and place pressure on that side. Will continue to monitor [redacted] CPT/[illegible]
1700	Pt continues to rest in bed. Denies any pain @ present. States he has tingling in (R) leg. Will continue to monitor [redacted] CPT/[illegible]
7Aug03 1738	Received pt @ 1700. Pt. Sitting ↑ in bed. A+O×3. Weakness to (R) LE. Dr. [redacted] notified. Resp. even unlabored. Lungs CTA throughout. SpO2 96-98% RA. ST c̄ ∅ ectopy. HR 100-110s. 2+ pulses x4 extremeties. NGT to LCS c̄ min. amt. green drainage. Colostomy to (R) UQ c̄ dark brown liquid stool. (+) BS (R) LQ. Hyperactive to (L) quadrants. Foley to gravity c̄ clear amber urine. Abd. incision c̄ sutures intact. ∅ signs of infection. Pt. denies pain @ this time. Will cont. to monitor. [redacted] KEAN
7Aug03 2000	Axillary Temp of 102.° 650mg Tylenol PR given. Pt. c/o being cold. Will monitor [redacted] KEAN
7Aug03 2100	Temp ↓ to 101.8 Ax. Pt. also c/o dry mouth. Assisted pt. in brushing his teeth. ∅ other c/o [redacted] KEAN
8Aug03 0200	NGT drained total 10cc green fluid over 8°. Replaced c̄ 10cc maintenance fluid from IV @ 0100. VSS. ∅ other Δ's. Pt. able to sleep c̄ difficulty. [redacted] KEAN
8Aug03 0410	Pt. washed up this Am. Dressing to (R) LQ Δ'd. Old dressing saturated c̄ serosanguinous drainage. Site looks good ∅ redness. Still bleeding from hole. New dressing applied to site. Colostomy emptied. Green/brown stool. T 100.4. [redacted] KEAN

ST[redacted] REV. 5/1999) BACK

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
08 AUG 03 0720	Surgery POD#3
	Drain Removed yesterday Tm 102, & after WBC 6.2 NGT 10/12h
	Wound clean & gas in stoma
	Plan D/C suction on NGT probable D/C NGT today A/G/P: day #2 ⇒ full 7 days. b(6)-2 will cover everything for now [redacted]
10 AUG 03 0545	Surgery POD#5 Tm 101, [illegible] now
	Wound clean everything a&d soft
	Stoma functioning b(6)-2
	Plan Continue ab [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)
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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
8Aug03 0900	Pt alert, VSS. T 99.4. Heart sounds S1 S2 present. Lung sounds CTA bilaterally. + BS x 4 quadrants. Colostomy site draining dark brown liquid stool. UOP sufficient, Foley d/c'd this am @ 0745. Will Monitor urine output. Sutures to (R) side of Abdomen C/D/I ∃ s/s of infection. NG tube to (R) nare taken off suction @0730 this am. Will Dc if out put < ~~300~~ 100cc/hr. by order of Dr. [redacted] b(6)-2 IV D5½NS + 20K infusing @ 125cc/hr (R) wrist. Site ∃ s/s of infection. ∄ c/o Pain this am. Will continue to monitor pt. [redacted]
08Aug03 1617	Pt urinating spontaneously in sufficient amounts. NG tube Dc'd. To be advanced to Clear liq diet. Using incentive b(6)-2 spirometer. T 100.5 → 99.5 @ 1620 ∄ 650mg of Tylenol. c/o [redacted] numbness/tingling in RLE. Will continue to monitor [redacted]
8AUG03 1800	Received pt resting in bed w/o c/o @ this time. (Neuro) AOx3, PE, MAE ∃ ↓ ROM ∃ RLE. PT c/o tingling (Per interpreted to RLE. (D) sensation, slightly ↓ed. PERRLA. (Resp) RR 20's, SpO2-95%. RA, even, unlabored, CTA ∃ ↓ @ bases. (CV) S1S2 NSR (AP) 70's 3+ pulses ∃ CRC 3sec throughout. All extremities warm (GI) SNTND ∃ inc. to RLQ-stitches CDI, OTA. Colostomy to RLQ/RUQ - liquid brown stool in pouch. BSx4 quads. (Integ) cont

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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H [redacted] b(6)-4

EPW

b(6)-2 A11

LAST NAME	FIRST NAME	MIC	INITIAL	ID NUMBER

DATE	NOTES
cont	(R) Flank c̄ GSW. 2X2 over site - CDI. Warm - dry intact brown in color. (Lines) 22g PW (R) RA/AC area. LR @ 125cc/hr. HL when fol. PO well c̄ U/O ↑. POC: IV ABX, drsng Δ as, monitoring — CPT [redacted]
8AUG03 2050	Pt given 4 mg MSO4 IVP. ~~Ad~~ c/o pn to Abd by pointing and stating "Allum". Awaiting effects — CPT [redacted]
8AUG03 2100	(+) results. Pt's no longer showing visual S/S of pain i.e. facial grimaces — CPT [redacted]
9AUG03 0100	4mg MSO4 IVP given for Abd pn — CPT [redacted]
9AUG03 0100	(+) results. Ved physical S/S. of pn. Pt sleeping at this time. — CPT [redacted]
9AUG03 0330	2mg MSO4 IVP for abd pn — CPT [redacted]
9AUG03 0430	Pt resting comfortable in bed @ this time — asleep. No events throughout pm. IV ABX per schedule c̄ pn management prn. VSS. Tylenol 650mg PO given for low grade temp. Cont to monitor c̄ LR @ 125cc. Pt tolerated H2O x3 cups w/o N/V/d - CPT [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
09 AUG 03 0750	Surgery POD # 4
	T 100.5, Abds now
	Drinking well. Stoma - + Sto. / ⊘ gas.
	Incision c/D/I
	Pt - A/O/F Day # 4 today
	- + Diet -
	↓ IVF.
	[redacted] MAJ [redacted]
	b(6) - 2 All
9Aug 03 0900	Pt a+o*3, VSS, Afebrile this am. Pupils PERRLA. Heart Sounds S1, S2 present ∅ murmur. Lung sounds CTA bilaterally + BS x 4 quadrants. Stoma to RUQ Draining Brown, liquid Stool. Sutures to (R) side C/D/I ∅ S/S of infection. Drsg to Drain site RLQ Δ'd this am. UOP sufficient. Voiding spontaneously. Tolerating Clr Liq ∅ complaint. Will HL IV ~~per MD~~ [redacted] & advance to Reg diet per MD [redacted] orders. Abx Given as ordered. Will continue to Monitor - [redacted] LPN

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MI	INITIAL	ID NUMBER

DATE	NOTES
9Aug03 11:30	Pt OOBTC for 45min. Tolerated well. c/o pain in back & RLE. Using Incentive spirometer frequently. T @ 10:00 98.6. Tolerating Clr. Liquids ~~S~~ Complaint b(6)-2 vop sufficient. Will Continue to Monitor [redacted] LPN—
9Aug03 15:00	Pt tolerated small amount of reg diet [redacted] without Complaint Disg to back Aid. Afebrile. Will Continue to monitor. [redacted]
9Aug03 16:00	~~Disg to~~ IV Aid from (R) Forearm to (L) Bicept: T@ 15:12 100.9 Tylenol given. T° Now 99.4. Pt c/o pain 4mg MSO4 given per Dr Rosen's orders. Pain controll sufficient. Order to transfer to ICW held due to bed space. Will continue to Monitor. [redacted] b(6)-2
1745	Nursing Notes Pt is A&O; lungs clear; sutures to Ex lap open to air and D&I; colostomy intact. Hyperactive BS; c/o c/o pain. IV to (L) Bicep is patent. Pt. on antibiotics. urinating ~~S~~ difficulty. ——— CPT [redacted] b(6)-2
2400:	Nursing notes Pharmacy was out of Ampicillin which was due at this time. Dr. [redacted] notified and give a verbal order for Unasyn 3gm x 1. He stated to let ~~the doctor know during~~ his doctor know of the lack of Ampicillin. ——— CPT [redacted] b(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
10 Aug 03	Nursing: Pt Alo * 3, VSS. T° @ 11:00 99.8. Heart Sounds
12:45	S1, S2 Present ∅ Murmur. Lung Sounds CTA bilaterally.
	+ BS * 4 quadrants. Colostomy in place draining brown
	liquid stool, passing flatus. Colostomy Care done this
	am. Stoma necrotic looking @ upper & lower edges. Will
	Notify MD. Sutures to abdomen C/D/I. Drsg to drainage
	site Δ'd. Bleeding spontaneously, Vap sufficient. Drsg to
	Lumbar region Δ'd. Sutures intact, site ∅ s/s of infection.
	IV ② bicept patent & ∅ s/s of infection. IV ampicillian
	2gm q6 Δ'd to Ancef 1 gm IV [redacted] per MD orders. Will
	Continue to Monitor. — [redacted] LPN
10 Aug 03	Pt T 100.1 @ 1439. Tylenol given. [redacted] Incentive Spirometer Encouraged.
15:30	OOBTC @ 11:00 * 1 hour. Tolerated well. 15:00 C/O pain
	4mg MSO4 given ∅ adequate relief. Will continue to
	Monitor. — [redacted] LPN
10 Aug	Dr. [redacted] looked @ stoma. Stated it looks good.
1600	T° 100° — [redacted] LPN
1745	VS 117/56 78 18 @ 98% RA 37.1 ©= 99.8 [redacted] LPN
	ALERT AND ORIENTED. NEURO PUPILS 3MM BRISK BILATERALLY [redacted] CTA
	BILATERALLY EVEN UNLABORED BREATHING. IS TON REPETITIONS Q 1° PT
	ABLE TO ELEVATE SU 3 BALLS ON IS ∅ GOOD EXCHANGE AND NO FATIGUE.

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]

PROGRESS NOTES
Medical Record

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b(6)-2 A11

LAST NAME	FIRST NAME	MIDDLE INIT.	ID NUMBER

DATE	NOTES
	CV NSR ∅ ECTOPY S1,S2 (+) RADIAL 3+ DP 3+ BILATERALLY CAP REFILL BRISK. GI COLOSTOMY PINK/BEEFY C̄ SOME AREAS PURPLISH HUE (+) CAP REFILL BRISK. SOFT AND FORMED STOOL IN BAG, BROWN IN COLOR. GU VOIDING TO URINAL W̄ DIFFICULTY. CLEAR YELLOW URINE. SKIN TO (P) OF MIDLINE SUTURES INTACT INCISION WELL APPROXIMATED ∅ S/S OF INFECTION. BRUISING TO RETROPERITONEAL (L) SIDE BLUISH/REDDISH HUE. TENDER TO TOUCH AND PALPATION. ~~WILL CONTINUE~~ 20G IV HEPLOC TO (L) BRACHIAL. CONTINUE TO MONITOR. [redacted]
1800	VOID 375cc TO ~~FOLEY~~ URINAL CLEAR YELLOW. [redacted]
1920	PT REQUED 2 TABS PERCOCET FOR PAIN TO ABD. WILL [redacted]
1940	VOID 200cc TO URINAL CLEAR YELLOW. [redacted]
2115	VOID 400cc TO URINAL CLEAR YELLOW [redacted]
2130	ANCEF 1GM HANG AND INFUSING TO (L) BRACHIAL PIV [redacted]
2310	GENTAMICIN HANG AND INFUSING TO (L) BRACHIAL PIV [redacted]
2310	VOID 375cc TO URINAL. [redacted]
2355	FLAGYL HANG AND INFUSING TO (L) BRACHIAL PIV [redacted]
0305	VOID 400cc TO URINAL [redacted]
0310	MEDICATED C̄ 2 TABS PERCOCET FOR PAIN TO ABD. WILL [redacted]
0330	TMAX 98.5. VSS 118/57 81 20 @ 99% RA [redacted]
0415	OSTOMY CARE DONE BAG CHANGED C̄ MOD AMOUNT OF SUR AN FORMED STOOL FROM STOMA. STOMA IS BEEFY RED C̄ SOME ADIPOSE TISSUE TO PERIPHERY BLUISH/NECROTIC AREAS TO EXCESS TISSUE. STOMA C̄ (+) CAP REFILL. NEW OSTOMY BAG APPLIED ~~DSL TO SHAVE~~ [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

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[redacted] b(6)-4

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
11 Aug 03 0600	received report from outgoing shift pt resting c̄ eyes closed easily roused A+O x 3 NAD VSS color good cap refill brisk. NVI. LS CTA even unlabored ABD soft (-) DTN (-) rigidity BS active x 4 sutures intact (-) drainage colostomy site pink some granulation noted dry brown stool formed soft stool. IV (L) upper arm patent flushed c̄ 10cc NSS Ancef 1gm given per schedule (-) infiltrate (-) S+S infx. will cont to monitor SGT [redacted] 91WM6 b(6)-2
11 Aug 03 1000	OOB in chair (+) L leg weakness drag leg denies pain in leg. tolerated well. SGT [redacted] 91WM6
11 Aug 1200	Back in bed tolerated well. NAD c/o ABD pain given percocet II tabs PO c̄ 180cc H2O. Rest c̄ eyes closed NAD SGT [redacted] 91WM6 b(6)-2
11 Aug 03 1500	Surgery PO date. Doing well Abd. Wound c I D / I Stoma functioning [redacted] b(6)-2 Abx Day # 6

RELATIONSHIP TO SPONSOR	SPONSOR'S N[redacted]	SPONSOR'S ID NUMBER (SSN or Other)
	LAST / FIRS[redacted]	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY [redacted]	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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b(e)-2-All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
11 Aug 03 1530	C/o abd pain, reassessed colostomy removed noted sm amt diffuse non bleedy superficial ulceration on stoma. @ 11:00 (+) erythema noted. liquid stool draining from 11:00. MD notified - (L) + (R) of outside stoma noted necrotic. stoma itself Deep Red - MD aware came to bedside. Stoma assessed by Dr [redacted] states surround stoma is mucus skin and will fall off. BS active (+) RUQ RLQ. Sm amt BRN noted (R) side of abd. KUB ordered; MOM QHS. pt NAD fluids encouraged SGT [redacted] MMM
1630	KUB completed @ bedside Dr [redacted] aware stated KUB is fine. no further intervention necessary SGT [redacted] MMM
	1745 11 Aug 03 - Pt resting comfortably in bed assessment as follows (A) FC, purposeful movements (O) for pain; (B) CL4 (P) 75 use sats 92% (M) cough (E) NSL; +3 pitting edema (E) 2+; S1/S2 (G) 75 colostomy in (R) abd. side; necrotic area to ostomy; Mucus at this time; Abd soft tender; no smell of necrotic ostomy; (O) tenderness; slight distention to (R) side; (B) ; encouraged po intake; (G) pt advised sport. (G) 75 on to (L) LE. [redacted] 1127 MMM

STANDARD FORM 509 (REV. 5/1999) BACK

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
12 Aug 03	0730 Pt resting c̄ eyes closed, A+O x 3, V/S HR 76 RR 16 Sats 96% BP 136/78 Temp 95.6, Good skin color, cap refill brisk, ∅ BS X 3 quadrants, LS CTA, Abd soft ∅ DTN ∅ Rigidity, Sutures intact ∅ Drainage, Colostomy site pink drainage brown slightly formed stool, IV (L) Upper Arm ∅ Signs of infection. Continueing to monitor. SPC [redacted] 91WM6 b(6)-2
0730	Pt Complained of pain, gave 2 Percocets per doctors orders. SPC [redacted] 91WM6
	b(6)-2
12 AUG 03 1850	Surgery
	Eating, Stooling (mom 30 - pos HS)
	Abd:
	wound c ID I
	still slightly tender between stoma and wound but no fluctuance, ∅ erythema
	every other suture removed on abd.
	+ all sutures on back.
	plan - Local wound care
	- ∅ OOB + ambulation b(6)-2
	[redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME	
	LAST	FIRST

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

b(6)-2 A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
b(6)-4	# [redacted]		

DATE	NOTES
12Aug03	1600 Dr. [redacted] removed the back sutures and everyother suture on the ABD, Then covered c̄ steri strips. SPC [redacted] 91WM6
1830	Pt A+O, gestures c̄ hands. LSCTA RR unlabored, reg. S.S. ∅murmur, 2+ pulses all extrem. Abd soft, tender, steri strips intact. ⊗ colostomy drng liquid brown stool. Voiding sufficient amts to void. Ate ¼ dinner, drinking sufficient amts. Pl to monitor stoma + VS b4°. Will monitor [redacted]
2030	Resting comfortably. Denies any pain discomfort unable to speak English but able to communicate using body language. HOB 30°, able to self position. VS stable. Temp 99.7. Will continue monitor pain discomfort. [redacted] MAY AN
13AUG03 0830	Pt sleeping, VSS. Will monitor. [redacted] LTAN
0400	Pt colostomy bag Δ'd, stoma cleaned. VSS, will monitor. [redacted] LTAN
0800	Pt resting awakes upon external stimuli. A+Ox3. Pt's colostomy draining soft brown stool. Colostomy bag C/D/I and free of sts of infection. ⊕ Pulse's all extremities +2. SPC [redacted] 91WM6
0810	Pt complained of pain. Gave 2 percocet tabs. SPC [redacted]
13 AUG 03 (1015hrs)	Pt continues to do well this a.m. No % discomfort p̄ receiving percocet tabs. Colostomy bag Δ'd @ 0830hrs. Report given to SPC [redacted] Transfer [redacted] ICW 2 VIA W/C. [redacted] CRTAN

STA[redacted] (REV. 5/1999) BACK

USAPA V1.00

b(a)-2 A11

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13Aug03	1100 pt transferred from ICU2 via W/C @ 1030. Alert and Oriented. No c/o pain. VSS. HR reg. Lungs CTA Abd ML incision c̄ sutures intact and steri strips. Colostomy to RUQ intact c̄ soft brown stool. BS×4. Wound to lower back c̄ steri strips and 4×4 dsg CD+I. pt has limited ROM to RLE. pt resting @ this time. Will continue to monitor [redacted] 9/WM6
	1115 HL to (L) brachial + flush c̄ redness/infiltration Waiting for MD for new orders [redacted] 9/WM6
13Aug03 1330	Assumed pt care @ 1300. VSS pt awake et alert. lungs CTA, abd c̄ midline incision c̄ sutures et steri strips intact (-) s/sx of infection noted. colostomy bag to RUQ intact, BS(+). drains to ↓ back area CDI. RLE c̄ limited ROM, LLE c̄ full ROM (+) pulses to both. BUE c̄ full ROM (+) pulses, HL to LUE, (-) s/sx of redness/swelling noted. (-) c/o pain/discomfort voiced @ this time. Will cont to monitor [redacted] 9/WM6
13Aug03 21:57	Rec'd c/o pt @ 21:00. Restraints x2 (L) wrist/Ankle. VS WNL × temp ↑ 100.2. Awake and alert in bed. Skin W/D PERRLA(+) WNL. LCA(+). APPS. S2. BS(+)×4. ABD soft + non-tender. Colostomy intact. stoma beefy red in color. (+) flatus (+) stool

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

RECORDS MAINTAINED AT: ICW2

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

[redacted]

EPW

CHRONOLOGICAL RECORD OF MEDICAL CARE **STANDARD FORM 600** (REV. 5-84) Prescribed by GSA and ICMR FIRMR (41 CFR) 201-45.505

b(6)-2 A11

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	(R) PPB. HL (L) arm a patent. leaking @ insertion site, will replace. c/o pain @ this time. ML ABD incision c sutures OTA CDI. will mon temp throughout shift [redacted] BRT/AN
14 Aug 03 0530	NURSING NOTE: Assumed pt care. AAOx3. Airway intact, breath even and unlabored, LS CTA (B). Abd soft, nontender to rec surgical site, ~ distention. (+) BS(+) x4 but quiet. Midline incision c steri strips & sutures, open to air, well approximated, ~ drng, some redness noted. Colostomy to (R) UQ pouching out light brown, soft stools flatus. FROM and neurovascularly intact to (B) UE and (B) LE. IV HL to (R) FA ~ s/s infection/infiltration. — [redacted] b(6)-2 A11
14 Aug 03	SURGERY POD #9
0800	T ~ 100.2, Doing well but c/o peristomal pain. VSS. Stool in bag peristomal / incisional — no fluctuance No erythema
	plan: CBC. continue physical therapy. W/C abd sutures [redacted]
14 Aug 03 1445	pt care assumed @ 1300. pt awake et alert. VSS. lungs CTA, abd c midline incision OTA, steri strips intact, (D) S/Sx of infection noted. Colostomy bag to RUQ intact, draining loose brown stool. RLE c limited ROM (+) pulse. LLE c full ROM (+) pulse. BUE c full ROM (+) pulses. (D) IV access noted. (D) c/o pain/discomfort voiced @ this time. Will cont to monitor, drsing to ↓ back area CDI. — [redacted] 9 WMC

b(a)-2 A-4

NSN 7540-00-634-4176

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
14 Aug 03 22:19	Rec'd c/o pt @ 21:00. VS WNL x temp ↑ 100.8. Awake and alert in bed. Restraints x2 (L) wrist/ankle. Skin w/D&I PEPPLADWNL. LCA (B). HRRS, S2. BS (+) x4. ABD soft + non-tender. Colostomy RUQ intact c̄ (+) flatus (+) liquid brown stool. Stoma beefy red in color and firm. ML ABD incision well approx c̄ steri-strips intact. ∅ c/o pain @ this time (+) PP (B). Will cont to mon. ii Tylenol given for ↑ temp. [redacted] RT/AN
14 Aug 03 2230	Pt temp 100.5 @ 2230 — Sgt [redacted]
14 Aug 03	1210 - pt alert & oriented lying in bed VSS, lungs CTA, HR reg, BS (+), pulses (+) x4. Colostomy bag s/d. Stoma beefy red. Midline incision c̄ steri strips intact — ∅ S/S of infx. ∅ complaints of pain at this time. Will cont to monitor [redacted]
15 Aug 03 1330	Pt awake & alert, VSS. lungs CTA, abd soft, colostomy bag RUQ intact draining brown semi-formed stool @ this time, midline incision c̄ steri strips (+) S/S of infection noted, BS (+) x4. RLE BLE c̄ (+) pulses. BUE c̄ (+) pulses. (+) complaints voiced. Will cont to monitor - [redacted] 9/wm4

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. ICWZ

EPW [redacted] b(a)-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

b(6)-2 A11

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
15 Aug 03 21:50	Rec'd c/o pt @ 21:00. Pt. motioning for me and holding gauze to ABD. ML ABD incision c̄ pinhole dehiscence noted. Beige, milky opaque, watery drainage pouring from wound. Dr. [redacted] notified, and ~~assessest~~ assessed. Packed c̄ iodoform gauze and applied DSD. ∅ new orders written. per Dr [redacted] will notify surg. MD. ↑ temp 100.6 ÷ Tylenol given. Restraints x1 (D) ankle. PERLA ⊕ wnl. LCA ⊕ HRR S1S2. BS ⊕ x4. ML ABD inc. see above statement. Colostomy bag intact draining liquid brown stool. Stoma beefy red in color RUQ ⊕ PP ⊕. ∅ further c/o's. will cont to mon. [redacted] DLT/AN
20:00	Held mom d/t colostomy draining very soft stool. Moderate amt [redacted] DLT/AN
00:38	Pt. taught via demonstration to empty colostomy bag. Pt performed emptying bag c̄ some assistance ō difficulty. [redacted] DLT/AN
0248.	Pt ↓ temp 97.8. DSG to ML ABD incision saturated c̄ serosang. drainage ~~& color~~ error [redacted] Odor noted. Reinforced c̄ DSD. will mon. [redacted] DLT/AN
16 Aug 03	1000 - Pt Alert & oriented lying in bed. Colostomy intact. Dsg applied to abd wound. VSS, lungs CTA, HR reg, BS ⊕ x4, pulses ⊕ x4. Voiding ∅ complaints. Will cont to monitor - [redacted]
16 Aug 03 1500	Assumed pt care @ 1300. Pt awake & alert. VSS. lungs CTA, abd c̄ midline incision covered by 4x4 gauzes, drang CDI. colostomy bag to RUQ intact, leaking around edges, taped sides until another colostomy bag can be located. ↓ & ↑ ext c̄ ⊕ pulses. 1430: PT c̄ pt. pt ↑ ambulating in the aisle. pt tol well. drang to abd A'd, site c̄ ⊕ active drainage noted. BS ⊕ x4 quads.

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STANDARD FORM 600 (REV. 6-97) BACK

NSN 7540-00-634-4176

b(6)-2 All

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
cont'd 16 Aug 1500	⊖ complaints voiced Will cont to monitor [redacted] 91WM6
2040	abd dressing c̄ mod amt of reddish ~~&~~ brown ~~draining~~ drainage. dressing Δ'd. Iodoform to 1st pin hole site Δ'd, site oozing reddish brown drainage hole approx 1" in depth, 2nd pin hole site ⊖ drainage noted. covered sites c̄ 4x4 gauzes et secured c̄ silk tape. pt tol well. [redacted] 91WM6
16 Aug 03 21:49	Rec'd c/o pt @ 21:00. Restraints x 2 (B) wrist/Ankle. VS WNL per flowsheet x̄ ↑ temp 100.5. ii̇ Tylenol given. Skin ↑ warm to touch. PERRLA WNL LCA (B). BS (+) x 4. ML ABD dsg C/D/I Colostomy RUQ intact. Stoma beefy red in color. ~~a steel~~ Error [redacted] scant amt brown stool noted in colostomy bag. (+) PP (B). ⊖ c/o pain @ this time. Will cont. to mon. [redacted] 2T/AN
0335	Pt c/o pain in (B) leg ii̇ Tylenol given. Colostomy Duoderm adhesive ~~a~~ adhering to pt. skin. Stool noted under adhesive and in wound. Bag removed. Stoma care performed. ~~to (B) of~~ Error [redacted] (2) side of stoma necrotic tissue noted. Tissue beneath necrotic tissue, pale pink in color. Several ulcerated spots noted p̄ cleaning. Stool adhered to stoma. scant amt. bleeding noted. ML ABD dsg removed. Wound packing removed. Iodoform packing replaced. Medial and distal incision pinhole dehiscence noted.

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. ICW2

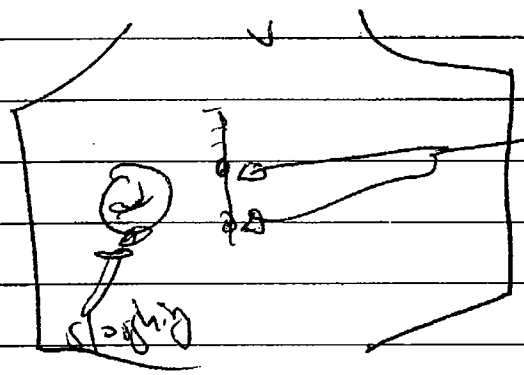
[redacted] EPW

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)
	DSD applied to ML ABD incision C/D/I. Dr [redacted] aware of stoma status and ML ABD incision status. Will mon [redacted] b(6)-2
17Aug03 0630	Pt. awake & alert in bed & complaints @ this time. HR Regular, Lung sounds clear bilat, bowel sounds (+) x 4 quads. Colostomy draining soft brown stool, colostomy bag intact, stoma moist & pink. DSG to mid abdominal vertical incision & to mid lower back CDI. All other assesme findings WNL. Will continue to monitor. [redacted] DLT/A b(6)-2
17AUG03 @ 1122	Surgery p.o. #2 eating well, stoma functioning But wound & drainage Ably,



Draining area purulent fusch disch (looks okay)

Plan/ OR for Small wound washout / packing. [redacted] b(6)-2

b(a)-2 A11

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)*
17Aug03 1337	Pt resting, quietly aroused to verbal stimuli. VSS temp 99.7. pt is NPO. lungs CTA, abd c̄ midline incision, dressing CDI. colostomy bag to RUQ intact draining brown semi formed stool. ↓ ext ↑ ext c̄ full ROM ⊕ pulses. abd c̄ BS⊕x4 quads. Dressing to back CDI. ⊖ complaints voiced. will cont to monitor. pt is O/C for surgery. — [redacted] RN/WMC
17 Aug03 21:53	Rec'd c/opt @ 21:00. Restraints x2 ⊕ ankle/wrist. Awake and alert in bed. VS w/r. per flow sheet ↑ temp ↑ 100.5. ⅡTylenol given. Will retake temp. in 1°. PERRLA⊕ w/r. Skin W/D/I. LCA⊕ HRRS,S2. BS⊕ x4. Colostomy RUQ intact. Stoma beefy red in color. Pale pink tissue to right and left of stoma noted. @ the distal ⊕ edge of stoma necrotic tissue remains. Superior ⊕ of stoma pea-sized ulcer noted and ⊕ to the ulcer sm. blister noted. c/o pain. M2 ABD dsg c/D/I. Will cont. to mon. [redacted] SCT/AND
0100 0200	Temp 99.2° ⊕ Results from Tylenol [redacted] SCT/AND per pt. request colostomy emptied by pt ⊖ difficulty some assistance required. Soft & formed lt. brown stool moderate amt noted. Bag cleaned. Will cont. to mon. [redacted] SCT/AND
Addendum	MOM 30cc PO held d/t status of stool [redacted] SCT/AND

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. BCWR

b(a)-4 [redacted] EPW

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

b(6)-2

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
18AUG03 0740	OP Note
	Wound I&D
	Surgeon: [redacted]
	MAC / local anesthesia
	EBL: Ø
	Findings: Wound opened. Tiny facial dehiscence @ center of wound but everything else felt solid. Despite the small dehiscence, that he is 13 days out from his surgery, everything is tightly sealed in. He is at slight risk for evisceration but more harm than good would be done to try to fix the facial defect now.
	[redacted]
18Aug03	1230- Pt received from FST via stretcher. Dsg applied to abd incision, Ø drainage noted. Colostomy intact. NS @ KVO into (D) arm. On regular diet now. Voiding Ø complaints, VSS lungs CTA, HR reg, BS⊕, pulses ⊕ x4. While cart to monitor [redacted]

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STANDARD FORM 600 (REV. 6-97) BACK

1st FST

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

18 Nov 03 0740

OP Note b(6)-2 All

Ward 710

EPW s/p GSW to scalp/ASD, treated at Iraqi Hospital = (A) Paramedian incision + colostomy, wound infection on Day #11 - → ICU

Surgeon: [redacted]

MAC: [redacted]

OSL: Ø

Findings: Small fascial dehiscence but margins are well together otherwise wound clean + packed

Plan
- Return to 28th CSH
- Dressing Δ's.

[redacted] MAJ [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO. ICW2

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1989)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

[redacted] b(6)-4

b(6)-2 A11

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)*
18Aug03	assumed care @1300 - VSS - SL in (L)
2040	AC removed as pt. tol. regular diet -
	lungs CTA (B) - BS x2 quads, minimal output
	in colostomy bag - abd dsg Δ w→D, small
	amount of bleeding in wound bed, old dsg c
	moderate amount of serosang drainage -
	NO GS - percocet II q4° x 24°, no c/o pain @
	this time — [redacted]
8-19-03	Pt. care assumed @ 2100. VSS. HR Reg
0033	lungs CTA, BS(+) x4. NL ABD Dsng CDI.
	Colostomy c̄ min output of soft semi-formed
	brown stool. Pt c/o ∅ pain. ∅ IV access.
	Will cont. to monitor. — [redacted]
19 Aug 03	0630 - pt alert + oriented lying in bed. VSS,
	lungs CTA, HR reg, BS (+), pulses (+) x4. Dsg to
	midline incision to abd. Colostomy intact.
	Voicing ∅ complaints at this time. Will
	cont to monitor — [redacted]
	0900 - Dsg Δd to abd wound, wet → dry
	applied, loosely packed. Crew II percocet for
	pain — [redacted]

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. ECW

EPW [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)*
19 Aug 03 1345	Pt care assumed @ 1300. VSS. pt awake & alert. lungs CTA, abd c̄ midline incision draing c̄ mod amt of serosang drainage noted. colostomy bag to RUQ intact draining brown semi-formed stool. BS⊕. pulses ⊕x4/⊕ IV access noted. ⊖ c/o pain voiced @ this time. Will cont to monitor — [redacted] Allwine
19 Aug	Progress notes D(6)-2 A11 VSS/AFOB Tolerating PO Ostomy Functioning well Cont hd Dressings Δ [redacted]
19 Aug 03 1930	Drsing to abd Δ'd. Site ⊕ beefy red, sm amount of oozing red blood noted. ⊖ s/s of infection noted. wound gently packed c̄ gauze wet to dry covered by abd pad. pt tol drsing Δ well — [redacted] Allwine
19 Aug 03 2345	Rec'd c/o pt. ~~care~~ error @ 21:00. Restraints x2 ⊕ wrist/ankle. Awake and alert in bed. Skin WD/I. LCA⊕ HPPSS2 BS⊕x4 ABD soft to palpation. M/L ABD dsg intact c̄ serosang and greenish colored drainage noted. ABD pad removed and new ABD applied. Colostomy RUQ intact edges loose & not adhering to ABD skin, reinforced c̄ tape. Stoma beefy red in color. Inferior ~~to~~ error section of stoma pale in color. MDs aware. Colostomy draining liquid brown stool. MOM held. ⊕ Pedal pulse. ⊖ pain x1 ⊕ Percocet given. VS WNL

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STANDARD FORM 600 (REV. 6-97) BACK

b(6)-2 A11

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)*
	x̄ temp↑100.8 ii Tylenol given. Retook temp @ approx. 00:00 temp remained @ 100.8. Will cont. to mon [redacted] [redacted] 91W/AN
20 Aug	0900 - Pt alert & oriented lying in bed. VSS, lungs CTA, HR reg, BS⊕, pulses⊕ x4. Colostomy bag Δd, Stoma beefy red. Dsg Δd to midline abd incision. Voiding ∅ complaints. Will cont to monitor [redacted]
20 Aug 03 1415	pt awake & alert awaiting transportation to be EVAC. lungs CTA, abd c̄ midline drsing CDI. colostomy bag to RUQ intact, ⊖ drainage noted @ this time. ↓ & ↑ ext c̄ / from ⊕ pulses. ⊖ IV access noted. ⊖ c/o pain voiced. Will cont to monitor [redacted] 91Wmb
20 Aug 03 21:59	Rec'd c/o pt @ 21:00. Restraints x2 ⊕ wrist/ankle. VS WNL x̄ ↑ temp 101.5°. ii Tylenol given. Will retake temp. throughout shift. Awake and alert in bed. Skin W/D/I. x̄ ML ABD inc. DSG C/D/I. ⊕ ↓ Back. old dsg removed. Green-yellow drainage noted. Ward pink around edges and white in center. cleansed c̄ NS and new DSD applied and secured c̄ silk tape. RPLHRWR, LCA⊕ HRR SS2. ABD⊕ BS x4. Colostomy

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. ICU

EPW [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

b(6)-2 A11

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	intact. Stoma unchanged. Beefy red in color. (+) PP (B). Will
	cont. to mon. [redacted]
0005	temp 99. [redacted]
21 Aug 03 1330	assumed care @ 0500 - VSS - no c/o pain @ this time - pt. emptied colostomy bag, liquid dk. brown stool - ambulated x 10 minutes - abd. dsg Δ'd, w→D, wound bed c̄ some granulation tissue, some yellow/green drainage on old dressing none noted in wound bed - NO QS - (+) BS, hypoactive - pt. awaiting transport to 21st CSH — [redacted]

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STANDARD FORM 600 (REV. 6-97) BACK

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

AUG 2 6 2003 25 y/o male PJ arrived to Cropper w/ colostomy bag ripped out and wound exposed.

Above note

Laparotomy wound heading ~~bag~~ with healthy granulation

Colostomy - suture site in place.

Approximately

Sent to CSH for Surgery evaluation

(A) Infected colostomy site

(P) Refer to CSH Surgery for evaluation

- Routine

Ambulatory

Dr. [redacted] Maj b(6)-2
CoB 109th ASMB

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

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

[redacted] b(6)-4

EPW

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

CoB 109th ASMB
BIAP IRAQ

AUTHORIZED FOR LOCAL REPRODUCTION

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

Chief Complaint:

BP: 103/58 LHP: PMH: PSH:

P: 85 Allergies: Meds: Tob:

R: 15 S: 25yo EPW here for referral "infected

T: 98.2 Colostomy.

3PO2

O. 25yo Iraqi, male Colostomy RQ - Stoma intact, ϕ signs of infection, patent - ϕ stool formed, brown. Skin around stoma intact. Abd incision open, about ½" deep approx 3" long - minimal amount of thick beige drainage.

A. Open abd wound
Colostomy

P① New colostomy bag
② Wet to dry dressing to abd wound.
③. Colostomy cleansed with soap + warm water b(6)-2 [redacted]
④ RC EPW camp
⑤ RTC PRN

[redacted]
FAMILY NURSE PRACTITIONER
~~426-98-7439~~

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.

Name: EPW, Age: 25 Rank: EPW

SSN: [redacted] b(6)-2

Init:

DOB:

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

USAPA V2.00

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*	
	0400	0700
Output	400	
HR	88	76
RR	24	16
Sats	100	96%
BP	131/72	136/88
Temp	99.7	95.6

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

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

REGISTER NO.	WARD NO.

[redacted] b(6)-4

[redacted] b(6)-2

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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

NSN 7540-01-075-3786

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

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

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

TRANSPORTATION TO FACILITY

SEX: M

DUTY/LOCAL PHONE: AREA CODE | NUMBER

AGE: 25

HOME PHONE: AREA CODE | NUMBER

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			

MEDICAL HISTORY OBTAINED FROM

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS: Ø

ALLERGIES: NKDA

INJURY OR OCCUPATIONAL ILLNESS

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

HOW

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: Abd pain / wound (Colostomy)

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☒ NON-URGENT

TIME: 1240

INITIALS: [redacted] 662

VITAL SIGNS

TIME 1240					
BP 110/70					
PULSE 88					
RESP 18					
TEMP 98.4					
WT					

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE

DISPOSITION: ☐ HOME ☐ FULL DUTY

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

MODIFIED DUTY UNTIL | RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE | TIME OF RELEASE

REFERRED ▶ | TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

#[redacted]

b(4)-4 b(2)-2

#[redacted] — [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

558-104

b(2)-2

7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER TR[redacted]

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS Fragi-

CITY

STATE

ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)* 06/08/03 TIME 1740

TRANSPORTATION TO FACILITY Medevac

SEX M

AGE 24

DUTY/LOCAL PHONE

AREA CODE

NUMBER

HOME PHONE

AREA CODE

NUMBER

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			

MEDICAL HISTORY OBTAINED FROM

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS ~~Aled~~ denies

ALLERGIES NKDA

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT

24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT

COMPLETED INITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT GSW

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☒ NON-URGENT

TIME 1740

b(2)-2

INITIALS [redacted]

VITAL SIGNS

TIME	1740	1800	1825		
BP	113/69	116/71	115/78		
PULSE	122	111 ST	105 ST		
RESP	97.7	18	16		
TEMP	↓				
WT	98.7		96.7		

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE

DISPOSITION ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

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

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED TO WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

[redacted]

b(a)-4

EMERGENCY CARE AND TREATMENT *(Patient)*

Medical Record

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

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

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							EKG INTERPRETATION	
PT				U/A	DIP			
APTT	BHCG	ETOH	GLU		MICRO			

PROVIDER HISTORY/PHYSICAL Iraqi shot yesterday - GSW to abd treated in Iraqi hospital Foley changed UOP 500cc - cystostomy performed. NG tube in place - IV infiltrated [redacted] AFOF3. HRRR. Lungs CTA (B). Abd soft + tender hypoactive BS

b(a)-2

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

DIAGNOSIS

CODES

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

[redacted] b(a)-2

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

b(2)-2

ES8-104 7540-01-075-3

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT (Patient)

LOG NUMBER T[redacted]

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS [redacted] b(6)-4

CITY | STATE | ZIP CODE

SEX: M

AGE: 21

DUTY/LOCAL PHONE: AREA CODE | NUMBER

HOME PHONE: AREA CODE | NUMBER

ARRIVAL

DATE (Day, Month, Year): 18 AUG 03 | TIME: 0658

TRANSPORTATION TO FACILITY: LITER CARRY

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			

MEDICAL HISTORY OBTAINED FROM

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS: NONE

ALLERGIES: NONE

INJURY OR OCCUPATIONAL ILLNESS

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

HOW

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: I&D ABDOMINAL WOUND

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☑ NON-URGENT

TIME: 0658

INITIALS: b(6) Z[redacted]

VITAL SIGNS

TIME	0658				
BP	108/65				
PULSE	89				
RESP	16				
TEMP					
WT					

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

☑ PULSE OX 100% ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE

DISPOSITION: ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

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

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

[redacted] b(6)-4

EMERGENCY CARE AND TREATMENT (Patient)
Medical Record

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

MEDICAL RECORD

CONSULTATION SHEET

REQUEST

TO:	FROM: (Requesting physician or activity)	DATE OF REQUEST
Surgery - CSA	Dr. [redacted] Dr. [redacted] CoB 109th ASMB BIAP.	20 Aug 03

REASON FOR REQUEST (Complaints and findings)

Infected colostomy site

PROVISIONAL DIAGNOSIS

As above

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	
[redacted] b(6)-2		☐ BEDSIDE ☐ ON CALL	☐ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO PATIENT EXAMINED ☐ YES ☐ NO TELEMEDICINE ☐ YES ☐ NO

(Continue on reverse side)

SIGNATURE AND TITLE	DATE

HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	DEPARTMENT/SERVICE OF PATIENT

RELATION TO SPONSOR	SPONSOR'S NAME (Last, first, middle)	SPONSOR'S ID NUMBER (SSN or Other)

PATIENT'S IDENTIFICATION (For typed or written entries, give: Name -- last, first, middle; ID no. (SSN or other); Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.
b(2)-2 EPW - [redacted]		

b(6)-4

[redacted]

CONSULTATION SHEET
Medical Record

STANDARD FORM 513 (REV. 4-98)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

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

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: litter BY anesthesia

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

3. DATE 18 AUG 03 TIME PATIENT ARRIVED IN SUITE 0655

4. PATIENT [redacted] TIME 0711 NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

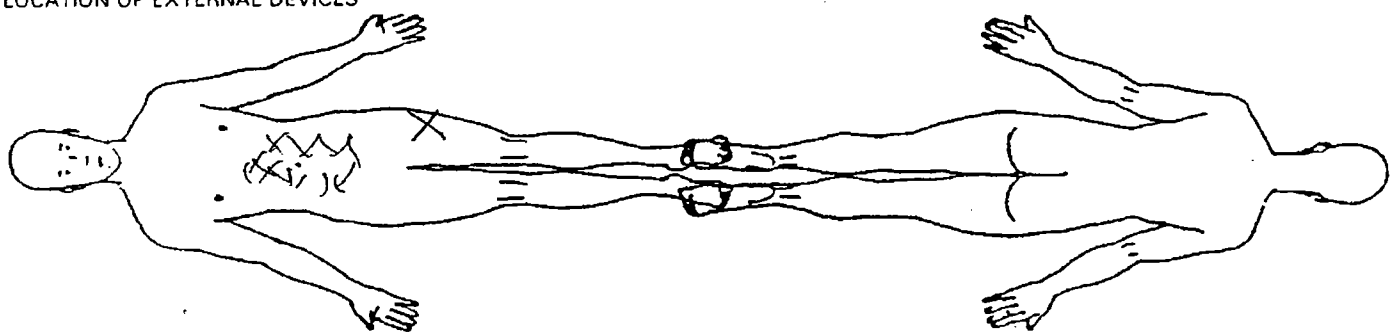
COMMENTS: Proper body alignment maintained, padded arm boards

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine Sol'n
SITE: Abd. BY WHOM: [redacted]
SITE: BY WHOM: b(6)-2
COMMENTS: No pooling of fluids

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

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

☒ ESU NO: #2 30/30
GROUND PAD: BRAND Conmed
LOT NO: 0109221

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION 50/50	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
1% Xylocaine / .5% Marcaine	6cc				[redacted]
					b(6)-2

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*

4X4's
4X8's
Tape

19. ADDITIONAL INFORMATION

Surgeon: [redacted]
Anesth: [redacted] b6-2

Colostomy on arrival

Sedation/local

20. OPERATION(S) PERFORMED

I & D abd. wound

21. PATIENT TRANSFERRED TO [redacted] b(2)-2 TIME 0740 METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] CPT/N-1 b(6)-2

REVERSE OF DA FORM 51[illegible] OCT 87 USAPA V1.01

MEDCOM - 16001

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY 8 Aug

19 HOUR 01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 01 02 03 04

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

RESPIRATION RECORD

BLOOD PRESSURE: 18 20 20 19 14 18 24 23 13

99.4 100.3

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 | DAY | 19 | 20 | 21 | 22 | 23 | 24 | 25

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° | 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. ICW 2

STANDARD FORM 511 (REV. 7-95) BACK

ICW [redacted] b(4)-4

511-119 NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR Aug 07 DAY 13 14 15 16 17 18 19

2007 10 HOUR

PULSE (0) TEMP. F (°) TEMP. C

105° 40.6°

180 104° 40.0°

170 103° 39.4°

160 102° 38.9°

150 101° 38.3°

140 100° 37.8°

130 99° 37.2°

98.6° 37.0°

120 98° 36.7°

110 97° 36.1°

100 96° 35.6°

90 95° 35.0°

80

70

60

50

40

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

124/78 130/88 96 [redacted] 120/56 152/68 96 98 122/78 112/60 100 97 98 98 118/60 98 97 124/66 124/62 97 98 122/66 118/66 98 98

HEIGHT: WEIGHT → 98 97

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

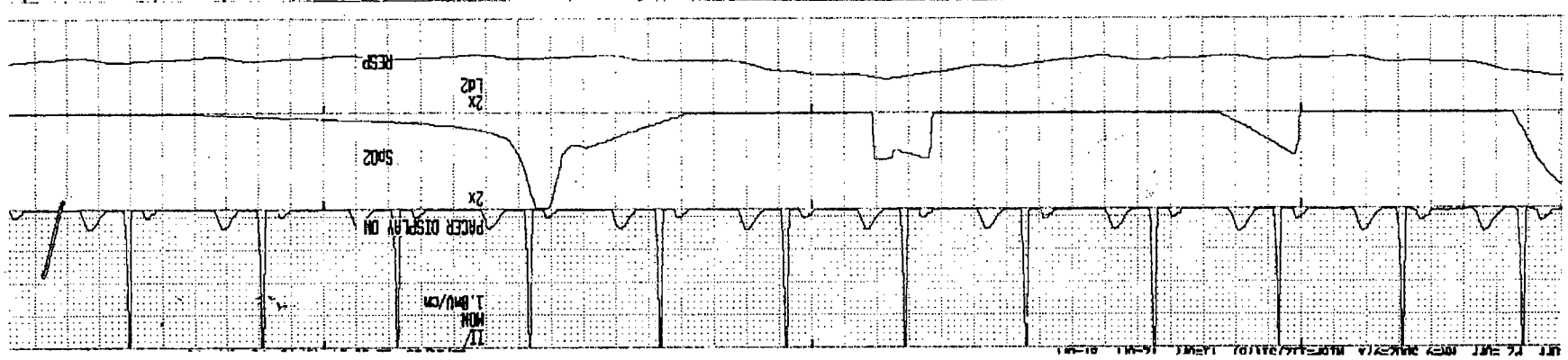
Medical Record

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

3^2/4

Date: 12Aug03 Bed#: 1
Patients Name: [redacted] b(a)-4

Time	05	06	07	08	09	10 4Ø	11	12	13	14	15	16	17 3Ø	18	19	20	21	22	23	24	04
BP			136/78				140/80				144/82					132/70				125/68	128/66
TEMP			95.6				97.2				97.8					99.7				99.2	99.4
HR			76				77				78					72				70	75
RR			16				16				16					12				14	14
SAO2			96%				97				99									96	96
FIO2			RA				RA				RA					RA				RA	RA
INPUT																					
PO																					
IV																					
NGT																					
TOTAL																					
OUTPUT																					
URINE		350			175	300		100			200		75	250					250	200	325
NGT																					
STOOL																					



MEDCOM - 16005

Date: 11 Aug Bed#: 1

Patients Name: [redacted] b(6)-4

Time	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
		118				122				12				138				122		
BP		56				70				68				86				58		
TEMP		99.6				99				99.4								99.5		
HR		90				88				90				79				92		
RR		16				20				22				20				20		
SAO2		100				100				100				99				99		
FIO2		RA				RA				RA				RA				RA		
INPUT																				
PO			240	240				180	240			240				240		240		
IV		50		50						50										
NGT	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A							
TOTAL																				
OUTPUT																				
URINE				625				250								450		250	550	
NGT																				
STOOL				x1																
TOTAL																				
BALANCE																				
TURN Q 2																				

MEDCOM - 16006

Time																						
BP	142/70					140/78																
TEMP	100.5			100.2		99.4						99.8		100.4								
HR	88					90																
RR	20					18																
SAO2	98%					97																
FIO2	RA					RA																
INPUT	180																					
PO						0	0	100	240	0	240	0	0	0	240							
IV	100					0	0	100	0	0	0	0	0	0	100							
NGT						0	0	0	0	0	0	0	0	0	0							
TURN Q 2						self					cook	self										
TOTAL	280					0	0	+200	+240	+240	+680	+680	+680	+680	1020							
OUTPUT																						
URINE	200			175		0	0	100	350	0	100	0	0	400	200							
NGT						0	0	0	0	0	0	0	0	[illegible]	0							
STOOL						0	0	0	0	0	0	100	0	0	0							
Subtotal	200			175		0	0	[illegible]														
TOTAL	200			375		0	0	-100	-450	-550	-550	-650	-650	-1050	-1250							
BALANCE						0	0	+100	-10	-10	+130	+30	+30	-370	-230							

[redacted]

b(6)-2

MEDCOM - 16007

Time	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
BP		113/59										115/62					138/58			
TEMP		97.4				98.6					100.9	99.1			101		101			
HR		87										90					84			
RR		23										18					20			
SAO2		97										97					94			
FIO2		RA										RA					RA			
INPUT																				
PO	Ø	Ø	240	Ø	240	300	Ø	Ø	240	Ø	Ø	240		220						
IV	75	100	Ø	100	Ø	Ø	Ø	100	Ø	Ø	Ø	100		100					100	100
NGT	—	—	—	—	—	→	—	—	—	—	—	—								
TURN Q 2	Self	—	—	—	—	OOBTC	Self	Self	Self	Self	—	—								
Hourly	75	100	240	100	240	300	Ø	Ø	240	Ø	Ø	340		320					100	
TOTAL	75	175	415	515	755	1055	1055	1055	1295	1295	1295	1635		2100					2200	2300
OUTPUT																				
URINE	Ø	Ø	300	Ø	100	300	Ø	Ø	100	300	Ø	150		200	200		200		200	
NGT	—	—	—	—	—	—	—	—	—	—	—	→								
STOOL	Ø	Ø	Ø	Ø	100	Ø	Ø	Ø	Ø	Ø	Ø	100								
Hourly	0	0	300	0	200	300	Ø	0	100	300	0	250		200	200		200		200	
TOTAL	0	0	300	300	500	800	800	800	900	1200	1200	1450		1650	1850		2050		2250	
Hourly ±	+75	+100	-60	+100	+40	0	0	+100	+140	-300	0	+90								
BALANCE	+75	+175	+115	+215	+255	+255	+255	+355	+495	+195	+195	+285								

[redacted] b(6)-4

MEDCOM - 16008

Time	03	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
BP																				
TEMP																				
HR																				
RR																				
SAO2																				
FIO2																				
PN level			(+)																	
MED			morphy																	
effects				(+-+)																
INPUT																				
PO	Φ	Φ	240	Φ																
IV	125	125	125	125																
NGT																				
TURN Q 2																				
TOTAL	—	—	—	740																
OUTPUT																				
URINE	Φ	Φ	Φ	200																
NGT																				
STOOL	X1																			
TOTAL				200																
BALANCE																				

MEDCOM - 16009

Date: 8 Aug 03 Bed#: 1

Patients Name: [redacted] b(6)-4

Time	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
BP																				
TEMP																				
HR																				
RR																				
SAO2																				
FIO2																				
INPUT																				
PO	NPO																			
IV	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125
NGT	Ø	Ø	Ø	Ø	Ø	Ø	Ø	>Dc'd												
														100				100		200
Hourly	125	125	125	125	125	125	125	125	125	125	125	125								
TOTAL	125	250	375	500	625	750	875	1000	1125	1250	1375	1500				2340				3380
OUTPUT																				
URINE						280			150	0		100			200			200		100
NGT	Ø	Ø	Ø	Ø	Ø	Ø	Ø	>Dc'd												
STOOL	Ø	Ø	120	Ø	Ø	Ø	Ø	Ø	150	0	0	25								
Foley			300	Dc'd																
Hourly	Ø	Ø	480	0	0	280	0	Ø	300	0	0	125								
TOTAL	Ø	Ø	420	480	420	700	Ø	Ø	1000	1000	1000	1125			1325			1325		1625
BALANCE	125	+250	-375	+50	+250	+95	220	+345	+160	+850	+375	+375								
hourly	+125	+125	-275	+125	+125	-155	+125	+125	-185	0	+125	±0								+1755
TURN Q 2	Sp/R	"	"	"	"	"	"	"	"	"	"	"								

SEE SF 511 [redacted]

b6-2

7
3380
1625
1755

MEDCOM - 16010

Date: 6AUG03 Bed#: 1

Patients Name: EPW [redacted] b(6)-4

Time	1930 05	2000 06	2100 07	2200 08	2300 09	2400 10	01 11	02 12	03 13	04 14	05 15	16	17	18	19	20	21	22	23	24
BP	128/78	122/74	119/70	120/78	120/80	118/76	115/75	115/74	120/72	110/71										
TEMP	99.4									98.8										
HR	110	100	98	101	103	102	99	104	97	101										
RR	21	19	18	18	18	17	17	16	16	17										
SAO2	98	98	99	98	99	99	98	98	98	98										
FIO2	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA										
INPUT																				
PO	NPO	—	—	—	—	—	—	—	—	—										
IV	150	150	150		150	150		150	150	150										
NGT																				
IVPB				100		100	100													
TOTAL	150	300	450	550	700	850	900	1050	1200	1350										
OUTPUT																				
URINE		100	20	30	30	30	40	40	40	30										
NGT	50																			
STOOL	0																			
JP	225	—	—	—	—	—	—	20												
TOTAL	275	375	395	425	455	485	525	585	625	655										
BALANCE																				
TURN Q 2																				

MEDCOM - 16011

Date: 07 Aug 03 Bed#: 1
Patients Name: EPW # [redacted]

Time	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02
BP	111/68	112/65	108/63	118/61	110/60	107/61	103/59	111/59	109/59	119/64	116/62	122/69	114/57	109/55	107/80	122/67	117/60	111/56	115/51	112/55	117/55	122/60
TEMP		98.6														102.°	101.8	101.4				101.
HR	99	98	96	95	92	91	93	92	101	118	116	119	119	104	113	117	115	95	95	94	93	102
RR	15	15	14	19	14	16	15	15	17	24	23	26	23	19	23	24	21	20	17	18	18	20
SAO2	97	98	98	98	98	98	98	98	97	95	96	96	97	96	98	97	95	96	95	95	96	98
FIO2	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
INPUT																						
PO																						
IV	150	150	150	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125
NGT																						
NPO		100		100				100				100		100				100		100	100	
Ice/ice			3	100																		
Subtotal	150	250	150	285	125	125	125	225	125	125	125	225	125	225	125	125	125	225	125	225	225	125
TOTAL	150	400	550	835	960	1085	1210	1435	1560	1685	1810	2035	2160	2385	2510	2635	2760	2985	3110	3345	3570	3695
OUTPUT																						
URINE	60	60	100	90	90	90	90	70	70	50	50	90	70	100	100	100	75	75	75	100	50	50
NGT			60									<50cc								10		
STOOL																						
Subtotal	60	60	160	90	90	90	90	70	70	50	50	90	70	100	100	100	75	75	75	110	50	50
TOTAL	60	120	280	370	460	550	640	710	780	830	880	950	1020	1080	1180	1280	1355	1430	1505	1615	1665	1715
BALANCE																						
TURN Q 2																						

output 0400 – 100 cc – 1915 out
intake 125 cc – 3945 in

MEDCOM - 16012

13AUG03 [redacted] bed 1

	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05
BP INV																								
BP NIBP			113/66																					
TEMP			99																					
HR			76																					
RR			13																					
SP02			97																					
FIO2			RA																					
INPUT																								
PO																								
IV																								
NGT																								
SUB TOTAL																								
TOTAL																								
OUTPUT																								
URINE		350																						
NGT																								
STOOL																								
SUBTOTAL																								
TOTAL																								
BALANCE																								

MEDCOM - 16013

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

LAST, FIRST, MI. [redacted] b(6)-4	DATE 7 Aug 03	TIME 1330	SSN/PSEUDO SSN: [redacted] b(6)-2

(Hematology) CBC

b6-4

ID: [redacted]

07-08-03
13:46

			Patient Limits	
WBC	6.2	x10^3/uL	4.5	10.5
RBC	3.28 L	x10^6/uL	4.00	6.00
Hgb	8.5 L	g/dL	11.0	18.0
Hct	25.6 L	%	35.0	60.0
MCV	87.2	fL	80.0	99.9
MCH	25.8 L	pg	27.0	31.0
MCHC	29.6 L	g/dL	33.0	37.0
Plt	132. L	x10^3/uL	150.	450.
LY%	12.3 *L	%	20.5	51.1
LY#	0.8 *L	x10^3/uL	1.2	3.4

REF. RANGE
10^3
10^9
(M) (F)
M) F)
M) F)
10^3
1%
rential

Lymph			
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: [redacted]	**DATE:** 7 Aug 03	**LAB ID NO.:**

b(6)-2

b(6)-2

Ward/Section: EMT	REQUEST [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. b(6)-4 [redacted]	DATE 6 Aug	TIME 1750	SSN/P[redacted]N: [redacted]

(Hematology) CBC

b6-2

ID: [redacted] 06-08-03
OB 18:09

			Patient Limits	
WBC	12.0 *H	x10^3/uL	4.5	10.5
RBC	4.64	x10^6/uL	4.00	6.00
Hgb	11.9	g/dL	11.0	18.0
Hct	40.6	%	35.0	60.0
MCV	87.6	fL	80.0	99.9
MCH	25.7 L	pg	27.0	31.0
MCHC	29.3 L	g/dL	33.0	37.0
Plt	176.	x10^3/uL	150.	450.
LY%	10.2 *L	%	20.5	51.1
LYM	1.2 *	x10^3/uL	1.2	3.4

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

Urinalysis

TEST	RESULT	REF. RANGE
Color	Amber	N/A
App	Hazy	N/A
Glu	1+	Negative
Bili	neg	Negative
Ket	neg	Negative
SG	1.025	N/A
Bld	large	Negative
pH	6.0	N/A
Prot	1+	Negative
Urob	0.2	0.2-1.0
Nit	neg	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

SSA - 14 1-5 EPI
clinitest - 1%
40-50 RBC

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: 6 Aug 03	LAB ID NO.:

b(6)-2

b(6)-2

Ward/Section: EMT	REQU[redacted]AN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted]	DATE: 6 Aug	TIME	SSN/P[redacted]DO SSN: [redacted]

(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		3.5-5.5 g/dl

b(6)-4

```
======= PICCOLO =======
06/08/03              17:54
REFERENCE RANGE:          MALE
PATIENT #:
GENERAL CHEMISTRY 12
DISC LOT #:          3142AA4
OPER #: 678        DR #: 000
SERIAL #:        0000100684
.......................
ALB    2.9*   3.3 5.5    G/DL
ALP    41     26-84      U/L
ALT    89*    10-47      U/L
AMY    13*    14-97      U/L
AST    141*   11-38      U/L
TBIL   0.9    0.2-1.6    MG/DL
BUN    13     7-22       MG/DL
CA++   8.4    8.0-10.3   MG/DL
CHOL   109    100-200    MG/DL
CRE    1.3*   0.6-1.2    MG/DL
GLU    117    73-118     MG/DL
TP     5.6*   6.4-8.1    G/DL

INST QC: OK      CHEM QC: OK
HEM 2+,  LIP 0 ,  ICT 0
```

(Piccolo) Metabolic Panel

TE
GLU
BUN
CA+
CRE
NA+
K+
CL-
CO2
TES
ALB
ALP
ALT
AMY
AST
TBIL
GGT
TP
TES
NA+
K+
CL-
CO2

```
i-STAT EC8+
Pt [redacted]                66-4
Pt Name:_____________

Glu_________117 mg/dL
BUN__________19 mg/dL
Na__________137 mmol/L
K___________4.4 mmol/L
Cl__________108 mmol/L
TCO2________27 mmol/L
AnGap________7 mmol/L
Hct__________39 %PCV
Hb*__________13 g/dL
  *via Hct
pH________7.418
PCO2______40.6 mmHg
HCO3________26 mmol/L
BEecf________2 mmol/L

Sample Type_:

  06AUG03      17:52
Oper: [redacted]          66-2
Physician:_______________

Ser# 40763
Ver: JAMS046A
     CLEW A93
```

REMARKS:

REPORTED BY: [redacted]	DATE: 6 Aug 03	LAB ID NO.:

b(6)-2

b(6)-2

Ward/Section: ICU 2	REQUES[redacted]CIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. b(6)-4 [redacted]	DATE 7Aug03 / TIME 1330	SSN/PSEUDO SSN: [redacted]

(Hematology) CBC

b6-4

ID: [redacted]
NB 07-08-03 13:46

			Patient Limits	
WBC	6.2	x10^3/uL	4.5	10.5
RBC	3.28 L	x10^6/uL	4.00	6.00
Hgb	8.5 L	g/dL	11.0	18.0
Hct	28.6 L	%	35.0	60.0
MCV	87.2	fL	80.0	99.9
MCH	25.9 L	pg	27.0	31.0
MCHC	29.7 L	g/dL	33.0	37.0
Plt	138. L	x10^3/uL	150.	450.
LYM	12.3 L	%	20.5	51.1
ALYM	0.8 L	x10^3/uL	1.2	3.4

			REF. RANGE
			0^3
			0^9
			(M) (F)
			M) F)
			M) F)
			10^3
			1%
			rential
Lymph			
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

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: 7Aug03	LAB ID NO.:

b(6)-2

66-2

MEDICAL RECORD — ANESTHESIA

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

Vecuronium	[redacted]
Fentanyl	[redacted]
	( )
	( )
	( )
VOLATILE AGENTS	% (de)
	% e.t.
AIR	L/Min
N2O	L/Min
O2	L/Min

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

LINE site	☐ Warmed
	☐ Warmed
	☐ Warmed
	☐ Warmed
LOSSES	EST BLOOD LOSS
	URINE –

PHYS. STATUS: 1 2 3 4 5 E

BODY WEIGHT: 65 KG LB

HEIGHT/WEIGHT:

INITIAL DATA: BP 110/72 HR– 81

SKIN CHECK: OK? – Y N

PATIENT READINESS: OK for PROCEDURE ✓ TIME– 0630

TIME → 0530 0800

SYMBOLS: BP by cuff V ^ ; Heart rate ● ; Resp rate ; BP (transduced) ⊥ T ; TOURNIQUET T – ✗ ; ANES– X-X ; PROC ⊙–Ø

220 200 180 160 140 120 100 80 60 40 20

VT – ml	
f – breaths/min	
Peak inf pres / PEEP	
MODE– S(pon), A(assist), C(on)	SV SV SV SV
✓ BP/Auto Cuff	ET-CO2 (torr)
BP / oth	✓ FIO2 (Frac or %) 1.0
ART line	SpO2 (%)
Steth- PC/ES	ECG SR SR SR SR
Gas analyzer	TEMP- site
	N-M Block (T/4)
Warming blkt	
Conv warmer	

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

TOTALS	
5 40	
250 420	TOTAL URINE
1	1011

FLUIDS & BLOOD REMARKS
CRYSTALLOID– 2000
COLLOID– 0
BLOOD– 0

REMARKS – Code drugs with numbers, events with letters
(1) Time on – Monitors on
(2) To ICU

RECOVERY AT: PACU ICU ✓ (Specify) OTHER

CONDITION: RESP– 10 SpO2– 97 BP– 108/57 HR– 76

	Start	Room	End
ANES	0630	0650	0740
	Ready	Begin	End
PROC	0655	0700	0725

PROCEDURES and CPT Codes: I & D Abd Incision

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: MAC

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: 100% NRB MASK

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

[redacted] b(6)-4

[redacted] b(6)-2

[redacted]

PROCEDURE LOCATION: FST

DATE: 18 AUG 03

PAGE 1 OF 1

WRAMC OVERPRINT 558
1 OCT 99

MEDICAL RECORD – ANESTHESIA

MEDCOM - 16018
PATIENT RECORD

b(6)-4

b(6)-2

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]

NURSING UNIT | ROOM NO. | BED NO.

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

06 AUG 03

✓ Admit to ICU 12

✓ NPO

NGT to LCS.

Strict I&O.

LR @ 150 cc/h

Foley to BSD.

Drain in RLQ to BSD

Noted [redacted]

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

✓ - empty q 1 hour

✓ Then empty sterile Technique q 6h.

Ampicillin 2g IV q 6h

Gentamicin 240mg IV q D

Flagyl 500mg IV q 8h

Morphine 4mg IV q 2h PRN

Tylenol 650mg PR q 4h PRN

1935

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

Replace NGT losses

½ cc:cc c LR

q 8h.

[redacted]

[redacted]

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

07 AUG 03 0723

IVF ⇒ D5½NS + 20mg KCl/L @ 125 cc/h

Replace NGT cc:cc q 8h c̄ Base IVF (D5½ + 20).

Drain to be D/c'd by me today.

[redacted]

Noted 7 Aug 03 [redacted]

038

NURSING UNIT | ROOM NO. | BED NO.

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

b(6)-4

b(6)-2

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]

NURSING UNIT | ROOM NO. | BED NO.

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

07 AUG 03 0841 HOURS

CBC @ Noon.

PSD to drain site PRN

Aug 03 0850 [redacted]

[redacted]

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF O[redacted]

28 AUG 03 0720 HOURS

(1) D/C Suction and leave NGT to open drainage.

(2) If drainage <100 cc/4h ⇒ Remove NGT +

(3) 00B

(4) Incentive Spirometer. Keep NPO

[redacted]

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

(5) D/C Foley. HOURS [redacted]

NAT DOSEN

28 AUG 03 1800

Clear liquids

Urine tolerating well

+voiding, ⇒ IVF @ 75 cc/hr [redacted]

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

Chart 0400 9/8/03 HOURS [redacted]

09 AUG 03

Regular diet

W Heplock. [redacted]

b(6)-2
A11

CLINICAL RECORD - DOCTOR'S ORDERS
For use of this form, see AR 40-66, the proponent agency is OTSG

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

PATIENT IDENTIFICATION

#[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
09 AUG 03	1250 HOURS	
Transfer to ICW		Noted [redacted]
		[redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
10 AUG	0115 HOURS	
V.O.		
Give Unasyn 3gm IV X1 now		Noted [redacted]
Dr [redacted] /CP [redacted]		
[redacted]		AUG 6

PATIENT IDENTIFICATION

b(6)-2 [redacted]

10 AUG 1730 NOTED

NURSING UNIT	ROOM NO.	[redacted]

DATE OF ORDER	TIME OF ORDER	
B/. 10 AUG 03	0900 HOURS	
① D/C Amp. with		
② Start Ancef 1gm IV q8h and continue Gent / Flagyl.		[redacted]

PATIENT IDENTIFICATION

10 AUG 1920 NOTED

NURSING UNIT	ROOM NO.	[redacted]

DATE OF ORDER	TIME OF ORDER	
10 Aug 03	1900 HOURS	[redacted]
① D/C Ofloxy		
② Percocet ~~II~~ PO q 4° PRN pain		
		[redacted]

b(6)-4 b(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

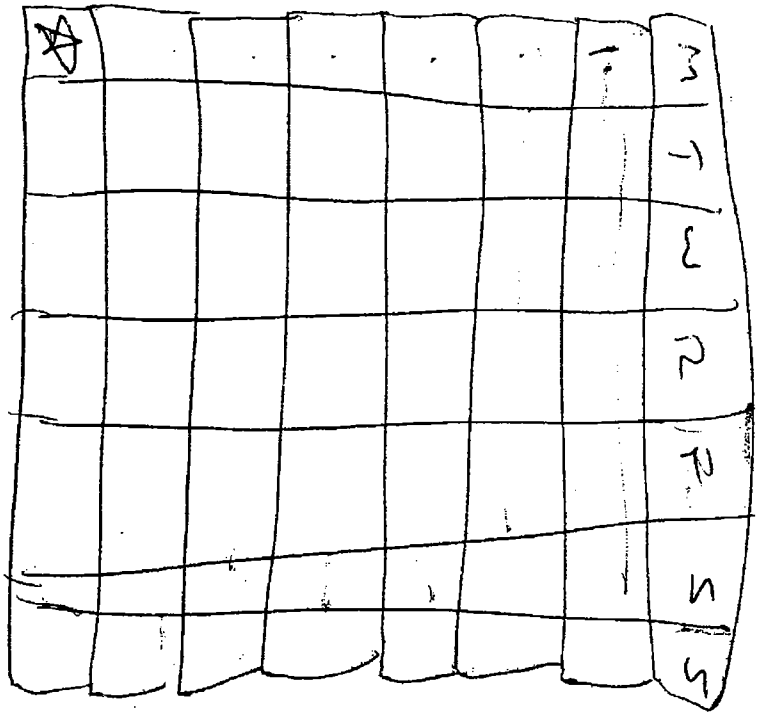
PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
# [redacted]	11 AUG 03	1500 HOURS	
	D/C Abx tomorrow. Am.		
NURSING UNIT / ROOM NO. / BED NO.	[redacted]		

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
# [redacted]	11 AUG 03	16:15 HOURS	
	① AXR - 1 View AP. ✓ Done 1630		
	② MOM 30 cc q 6 HS 11 Aug 03 [redacted]		
NURSING UNIT / ROOM NO. / BED NO.	[redacted]		

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
# [redacted]	12 Aug 03	1500 HOURS	
	Consult Physical Therapy for ambulation (R) Leg weakness		
NURSING UNIT / ROOM NO. / BED NO.	[redacted]		
	24° chart ✓ 12 Aug [redacted]		

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
# [redacted]		HOURS	
038			
NURSING UNIT / ROOM NO. / BED NO.			

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


3
1
2
2
1
5
4

b(6)-2 All

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]

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

DATE OF ORDER: 13 Aug 03 | TIME OF ORDER: 1600 HOURS | LIST TIME ORDER NOTED AND SIGN

V.O. from Dr [redacted]
to LT [redacted]

resume all pre-op orders.

[redacted] LT/MN

PATIENT IDENTIFICATION: [redacted]

b(6)-4

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

DATE OF ORDER | TIME O[redacted] HOURS

ICW orders.
1) VS Routine ✓
2) please D/c all abdominal wound sutures
Stoma care PRN ✓
Regular diet ✓
ESC today please ✓

PATIENT IDENTIFICATION: [redacted]

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

DATE OF ORDER | TIME OF ORDER | HOURS

Tylenol 650 mg po q4h PRN
percocet II tab po q4h PRN [redacted]
MOM 30 cc po q48h. ✓
Physical Therapy for (R) leg ROM / Ambulation
D/c Heplock

14 Aug 03 0900

NURSING UNIT: ICW2 | ROOM NO. | BED NO.: 24 [redacted]

PATIENT IDENTIFICATION: [redacted]

DATE OF ORDER | TIME OF ORDER

17 AUG 03 1122 HOURS

NPO, To OR [redacted]

noted [redacted] 17 AUG 03 @ 164[redacted]
1130 Regular diet
NPO after midnite
To OR tomorrow [redacted]
@ 1st FST. [redacted]

0038

NURSING UNIT: ICW2 | ROOM NO. | BED NO.: 84 [redacted]

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

b(6)-2

☆ U.S. GOV

MEDCOM - 16024

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 ORDERS NOTED AND SIGN
[redacted] EPW b(6)-4	18 AUG 03 @ 0740 HOURS Postop VS q 4h strict I+O Reg Diet IV: continue present IVF @ 150 u/h and heplock once tol. po.	
NURSING UNIT: TCW2 / ROOM NO. / BED NO.		
PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER	
	Morphine 4mg IV q4h PRN Percocet II tab po q4h strict 0-24h then PRN. [redacted]	
NURSING UNIT / ROOM NO. / BED NO.	b(6)-2 [redacted]	
PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER HOURS	
NURSING UNIT / ROOM NO. / BED NO.		
PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER HOURS	
NURSING UNIT / ROOM NO. / BED NO.		

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

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-68; the proponent agency is OTSG

b(6)-2

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]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 18 AUG 03 TIME OF ORDER: 0740 HOURS | LIST TIME ORDER NOTED AND SIGN

Postop
✓ VS q-tive
✓ Regular diet
✓ T Qual 650 mg po q 4h PRN
Abdominal Wound Dressing changes BID

18 Aug 03 [redacted]

PATIENT IDENTIFICATION: [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

✓ Use saline moistened gauze + gently pack open wound, cover c̄ DSD + change BID.

b(6)-4

✓ Morphine 4mg IV q 4h PRN
✓ Stoma care PRN
✓ IV continue present fluid @ 150 cc/h

PATIENT IDENTIFICATION: [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF [redacted]

⇒ D/C once taken [redacted]

✓ Percocet II tab po [redacted] q 4h strict x 24h [redacted] then go PRN. [redacted]

PATIENT IDENTIFICATION: [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF [redacted] | TIME OF ORDER | HOURS

24hr VS [redacted] TIAN 8-29-03 0037

28 Aug-03

Transfer [redacted] b(2)-2

[redacted] noted [redacted] 9/Wm 28 Aug 03

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1996—403-924

"USE BALL POINT PEN. PRESS FIRMLY. [illegible] PAPER REQUIRED"

b(6)-2 +1

CLINICAL RECORD — THERAPEUTIC DOCUMENTATION — CARE PLAN (NON-MEDICATION) (AR 40-407) — Mo ___ Yr ___

PERFORMANCE — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK NURSE	RECURRING ACTIONS FREQUENCY TIME	HR	DATE COMPLETED
GAUG	[redacted]	Diet: NPO	05	[redacted] DC'd 8 Aug 03
			17	
GAUG	[redacted]	NGT to LCS	05	[redacted] A'd 8 Aug 03
			17	
GAUG	[redacted]	Strict I&O's	05	[redacted] Copy Forward 9 Aug
			17	
GAUG	[redacted]	Foley to BSD	05	[redacted] A'd 8 Aug 03
			17	
GAUG	[redacted]	Empty drain in	06	rewritten below
		RLQ to BSN	12	
		sterile technique	18	
		q 6hr	24	
8Aug	[redacted]	empty drain in RLQ	02	
		to BSD sterile	08	[redacted] A'd 7 Aug 03
		technique QL°	14	
			20	
8Aug	[redacted]	D/C suction and leave	05	[redacted] DC'd 8 Aug 03
		NGT to open drainage	17	
8Aug	[redacted]	If NGT drainage ≥100cc/4hr	05	[redacted] DC'd 8 Aug 03
		Remove NGT & keep NPO	17	
8Aug	[redacted]	OOB	05	[redacted] copy forward 9 Aug
			17	
8Aug	[redacted]	Ambulate ad lib	05	[redacted] Copy 9 Aug
			17	forward
8Aug	[redacted]	Diet [illegible] (when	05	[redacted]
8Aug	[redacted]	tolerating liquids, advance to IV	17	[redacted] DC'd
		[illegible]		

ALLERGIES: ___ YES ___ NO PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: X YES ___ NO

PAGE NO: ___

[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 76 — EDITION OF 1 OCT 75 IS OBSOLETE — USAPA V1.00

b(6)-2 A11

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)			Mo Aug Yr 2003	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
6Aug	[redacted]	Admit to ICU#2			DONE	[redacted]
6Aug	[redacted]	Drain in RLQ to BSD	6Aug		1930	[redacted]
		empty NOW				[redacted]
7Aug	[redacted]	Drain to be D'c'd by me today	7Aug		0830	[redacted]
7Aug	[redacted]	CBC @ Noon	7Aug	1200	1500	[redacted]
8Aug	[redacted]	D/C Foley	8Aug		0745	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED														
7Aug	[redacted]	Drsg A to Drain site PRN	1500 8/7	0600 8Aug													

Copied Forward

USAPA V1.00

b(6)-2 #11

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

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 09	10	11	12	13	14
6 Aug	[redacted]	Strict I&O's	05	[redacted]					
			17						
8 Aug	[redacted]	OOB	05	[redacted]					
			17						
8 Aug	[redacted]	Incentive spirometer	05	[redacted]					
			17						
9 Aug	[redacted]	Regular diet	07	[redacted]					
			12						
			18						

ALLERGIES: ☐ YES ☐ NO
NKA

PRIMARY DIAGNOSIS:
S/P GSW to Abd

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO
PAGE NO: 02

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

b (6) - 2 A 11

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
6Aug	[redacted]	Admit to ICU #2				
9Aug	[redacted]	Transfer to ICW				
12Aug	[redacted]	Consult PT for ambulation (B) leg weakness				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
7Aug 03	[redacted]	Drsg A to drain site PRN														

USAPA V1.00

b(6)-2 A11

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

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

WRITE BY DATE AND TIME — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK NURSE	RECURRING MEDICATIONS DOSE FREQUENCY	HR	DATE DISPENSED
6AUG	[redacted]	LR @ 150cc/hr	05	[redacted] Hd 7Aug03 [illegible]
			12	[redacted]
6AUG	[redacted]	Ampicillin 2gm IV	06	[redacted]
		q 6h	12	[redacted]
			18	[redacted] DC'd 8Aug03
			24	[redacted]
	[redacted]			[redacted] DC'd 12Aug03
	[redacted]			[redacted] DC'd 12Aug03
6AUG	[redacted]	Replace NGT losses	08	[redacted]
		1/2cc: cc c̄ LR	16	Hd 7Aug03 [illegible]
		q 8hr.	24	[redacted]
7Aug03	[redacted]	D5 1/2 NS c̄ 20KCL @ 125cc/hr	05	[redacted] DC
			17	[redacted]
7Aug	[redacted]	Replace NGT loss,	08	[redacted]
		cc:cc c̄ base IVF	16	[redacted] DC'd 8Aug03
			24	[redacted]
8Aug	[redacted]	IVF ↓ to 75cc/hr when	05	[redacted]
		tolerate PO & + BOP	17	[redacted] DC'd 9Aug03
				[redacted]
				[redacted] DC'd 12Aug03

ADDITIONAL PAGES IN USE ___ YES ___ NO

PAGE NO. ___

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIME

D	7	8	9	10	11	12	13	14
E	15	16	17	18	19	20	21	2
N	23	24	01	02	03	04	05	0

[redacted] b(6)-4

DA FORM 4078, 1 FEB 79 — EDITION OF 1 OCT 64 IS OBSOLETE UNTIL EXHAUSTED

b(4)-2 A11

THERAPEUTIC DOCUMENTATION - CARE PLAN

Order Date	Clerk Nurse	SINGLE ORDER PRE OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
[redacted]						[redacted]
[redacted]		[redacted]				[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED													
6Feb	[redacted]	Morphine 4mg	0230	0430	0830	1130	1430	1730	2030	2330	0130	0330	0530	0730	0930	[redacted]
		IV q 2hrs PRN	4mg	4mg	4mg	[redacted]			M2	4mg	4mg	3mg			DC'D	192
	[redacted]	[redacted]														
	[redacted]	[redacted]														
	[redacted]	[redacted]														
	[redacted]	[redacted]														

JBRPA V1.0

CL ECORD | THERA EUTIC DOCUMENTATION CARE PLAN (M ATIONS) | Mo Aug Yr. 03

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

VERIF | INITIAL PROPER COLU | LOWING EACH ADMINISTRATION

ORD DA	RK/ SE	RECURRING ...EDICATIONS, DOSE, FREQUENCY	HR	...E DISPENSED 13	14	15	16	17	18	19	20	21	22	23
13 Aug	[redacted]	IV HL	06	/	[redacted]									
			13	/										
			21	[redacted]										
11	[redacted]	MoM 30 cc PO, HS	21	/	[redacted]	Hold	Hold	Hold	Hold	Hold	Hold	Hold	Hold	[redacted]
18	[redacted]	IV NS @ 150 cc/hr	05						/	[redacted]				
		then HL	17						[redacted]	X	[redacted]			
TO Aug	[redacted]	Percocet ±TQ4° x 24°	12 am						[redacted]	X				
		then PRN	16						[redacted]	X				
			20						[redacted]	X				
			24						[redacted]	X				
			04						X	[redacted]	X			
			08						X	[redacted]	X			
		b(6)-2 A11												

ALLE | ☐ NO | PRIMARY DIAGNOSIS: S/P GSW to Abd | ADDITIONAL PAGES IN USE: ☐ YES ☐ NO | PAGE NO. _____

PAGE | N:

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

DA F | FEB 79 | EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. | USAPA V1.00

Ve
Ini

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. _____ Yr. _____

Order Date	SINGLE ... ER, PRE-OPERATIVES	... en	Time to be Given	Time Given	Initials
	b(a)-2 A1				

Order/ Expir Date	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
13 Aug [redacted]	Tylenol 650mg q4° PRN	15 Aug 2150 [redacted]	0100 15 Aug [redacted]	0124 16 Aug [redacted]	0835 17 Aug [redacted]	17 Aug 21:59 [redacted]	20 Aug 00:20 [redacted]	0145 20 Aug [redacted]							
13 Aug [redacted]	Percocet ½ tabs q4° PRN pain	20 Aug 0000 [redacted] (H)	21 Aug 1430 [redacted]												
13 Aug [redacted]	MSO4 4mg IV Q4° PRN														

USAPA V1.00

[redacted] b(a)-4

b(4)-2

ECORD | THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATION)

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

Mo. 8 Yr 03

INITIAL PROPE... MN FOLLOWING EACH COMPLETION

RK/ SE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 13	14	15	16	17	18	19	20	21	22
copied												
BAug [redacted]	Regular Diet	6	/	[redacted]								
		12	/									
		17										
12 [redacted]	Consult PT for ambulation @ leg weakness	08	/	[redacted]								
14 [redacted]	Vitals Routine	06	/	[redacted]								
		14										
		22	/									
18 Aug Dr [redacted]	Abd. Wound Dsg Δ's BID wet → Dry gently packed	08	/	/	/	/	/	/	[redacted]			
		20	/	/	/	/	[redacted]					

ES ☐ NO

PRIMARY DIAGNOSIS: S/P GSW to abd

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

ON:

EPW # [redacted] b(4)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00

b(6)-2-A11

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 08 Yr 03

	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
14	[redacted] DC all abl wound sutures	14	Today	0930	[redacted]
14	CBC today	14	AM	093	[redacted]
17 Aug	NPO to OR	17 Aug	NOW	CX	
17	[redacted] NPO p MN - to OR & FST in AM	18 Aug	0000	0000	[redacted]
20	Transfer to [redacted]				
	b(2)-2				

	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
14	cf Stoma Care pra	17 Aug 0230 [redacted] See note													

USAPA V1.00

. RECORD—SUPPLEMENTAL MEI ... A

For use of ... AR 40-68; the proponent agency is the Offic... ...geon General.

REPORT TITLE

POST-ANESTHESIA CARE UNIT (PACU) FLOW SHEET

OTSG APPROVED (Date) 8/18/03 Aug 18 03

DATE: 08/18/03

TIME IN: 7:40

PROCEDURE: I & D ORB Incision.

TYPE ANESTHESIA: GEN SAB EPIDURI NERVE BLOCK IV SED MAC.

OR INTAKE: Crystalloid: 250 Colloid

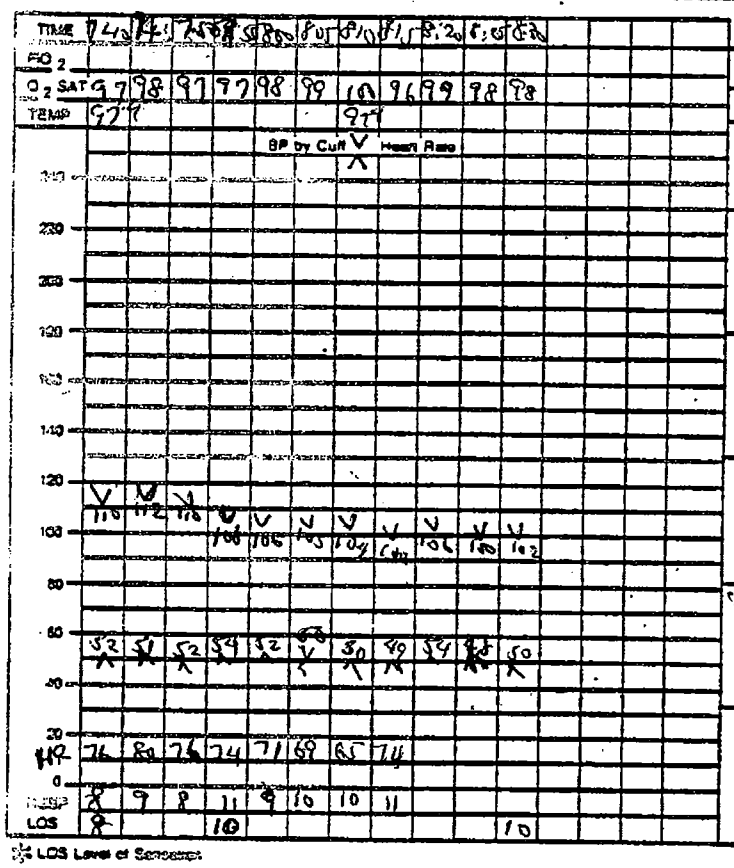
OR OUTPUT: Urine Output EBL

b(6)-2

INTAKE					OUTPUT			
TIME	SOLUTION	Amt Hung	SITE	BY	Amt. Infused	TIME	SOURCE	COLOR	AMT
ADM.	RL	800	LA	[redacted]					

X-RAYS DONE:

LABS DRAWN:



REACT SCORE — ACTIVITY SCORE		IN	30 Min	OUT
(R)espirations:	0 Ventilator essential 1 Spont. resp.: <10/min: airway essential 2 Spont. resp.: no support: >10/min	2	2	2
(E)nergy	0 Does not move legs 1 Moves legs, cannot sustain head lift 2 Sustains head lift, moves legs	2	2	2
(A)lertness	0 Awakens only with vigorous stimulation 1 Awakes only when stimulated gently 2 Awake, seldom dozes	1	2	2
(C)irculation Adults	0 BP 20% pre-anesthesia level 1 BP 20-50% pre-anesthesia level 2 BP 50% pre-anesthesia level	2	2	2
~~Infants~~	~~0 Carotid only reliable pulse palpable~~ ~~1 Axillary pulse felt feast but not wrist~~ ~~2 Pulse can be felt easily at wrist~~			
(T)emperature	0 Axillary temp. <95 F 1 Temp. 95-98 F 2 Temp >98 F	1	2	2

* LOS Level of Sensorium

(Continue on reverse)

PREPARED BY (Signature & Title) RPT [redacted] 8/18/03 b(6)-2

DEPARTMENT/SERVICE/CLINIC ~~WARD 2-D~~ 1ST FST

DATE 18 Aug

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

[redacted] CPW.

b(6)-4

DA FORM 1 MAY 78 4700

MEDDAC FBg OP 173 (Revised) 1 Nov 89 (HSXC-NU)

INITIAL ASSESSMENT:

LEVEL OF CONSCIOUSNESS:
- Alert
- (Responsive)
- Unresponsive

AIRWAY:
- Nasal
- (Oral)
- Endotracheal
- Tracheostomy

OXYGEN
- Hudson Mask 40%
- Oxygen Mist
- Nasal Cannula
- (Room Air)

DRAINS
- Hemovac
- Jackson-Pratt
- N/G
- Foley

SIGNATURE [redacted] b(6)-2

MEDICATIONS

ALLERGIES:

Time	Medication/A&T	Route/Site	BY

DRESSINGS

	SITE	TYPE	DRAINAGE
	MIDLINE ON (D) SIDE OF ABD	STERILE GAUZE.	NO

CBI INFORMATION

TIME	CBI IN	URINE OUT	COLOR	URINE BAL

PACU FLUID TOTALS

CRYSTALLOID IN	RL 100 cc	URINE OUTPUT	
COLLOID IN		EMESIS	
P.O		NG TUBE	
		JP DRAIN/HEMOVAC	
TOTAL INTAKE	100	TOTAL OUTPUT	

TO ICW2

DISCHARGE CRITERIA Time: 8 20 Date: 8 10 8/18/03

REACT Score:

VS: BP 102/50 R 11 HR 72 T 97.4

Cleared according to WARD 2-D SOP C-2

Charge Nurse Signature: b(6)-2 [redacted]

NURSES NOTES:

7:40 Pt easily arousable & verbal and textbook stimuli. Pt received 5 mg of IV morphine and 250 mcg of fentanyl, also 200 mL of crystalloid in OR. Pt has DSD to mid abdominal post incision on (D) side of abdomen. Pt has colostomy bag. Pt sat at RAM air 99%. 800 Pt allowed to rest for recuperation. Bowel sounds present and flatulence in colostomy bag. Pt has bounding radial and pedal pulses bilaterally. Pt opens eyes spontaneously and understands verbal commands. Pt to be discharged to ICW 2. S_1, S_2 present, urinary bladder not distended. Received 100 cc of RL. Pt remains alert and oriented x3. Sat 99% Pt ambulated with assist x2 to Day Room. No SOB or distress. [redacted]

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. LOCATION (State or Country Code.)
A I I D I	I Z

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
	[redacted] b(6)-4 UNK IRAQI	1 EPW	M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
B N K	24 y	X	9	MUSLIM

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
— TAGIT [redacted] b(6)-4	U	1330	—

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
—	—	1	☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø	ICW1	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

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

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
2 1		03 08 20

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
		03 08 06

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

FOR LOCAL USE

DX: S/P GSW TO ABD

ADMITTING OFFICER (Signature as required) [redacted] b(6)-2

SIG [redacted]

DR [redacted]

DA [redacted]

b(6)-4

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER: 0014205	2. NAME (Last, First, M): EPW# [redacted]			3. GRADE: EPW	ADMISSION REMARKS
4. SEX: M	5. AGE: 26	6. RACE: —	7. RELIGION: —	8. LENGTH OF SVC: —	9. ETS: —
10. PREVIOUS ADMISSION: NO	11. EMP: 99	12. SSN: [redacted]	13. ORGANIZATION: —	14. WARD: ICW#2	
15. FLYING STATUS: —	16. 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: 1240	23. CLINIC SERVICE: AEAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: —			25. TYPE DISPOSITION: 50	26. DATE OF DISPOSITION: 18Aug03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): —			27b. TELEPHONE NO.: —	28. DATE OF THIS ADMISSION: 7aug03	ADMITTING OFFICER: DR [redacted]
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted]				30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
31. [redacted]					

b(6)-2

b(2)-2

33. CAUSE OF INJURY

☐ Check if Continued on Reverse

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW to (L) Leg & Elbow S/P I&D (L) Leg.

825.31
881.01
875.0
873.8
E991.2

79.67

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	11	11

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING [redacted] RECORDS OFFICER

DR [redacted]

FORM 3647, MAY 75 EDITION OF 1 AUG 75 IS OBSOLETE USAPPC V1.10

b(6)-2