CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-68; the proponent agency is OTSG

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

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

DATE OF ORDER: 20 Aug 03 TIME OF ORDER: 0829 HOURS

LIST TIME ORDER NOTED AND SIGN: b(6)-2 [redacted]

1. Heplock IV ✓
2. Advance to regular diet
3. Colace 100 mg PO BID ✓
4. Percocet 1-2 PO q4° PRN pain ✓
5. [redacted]

NURSING UNIT | ROOM NO. | BED NO.

b(6)-2 [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER: 20 Aug 03 TIME OF ORDER: 1355 HOURS

OK to transfer to 21 CSCT

[redacted]

b(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 21 Aug 03 TIME OF ORDER: 0909 HOURS

DC oxygen
V O2 sat on 1 hr
Transfer meds on chart
Transfer with IV heplocked

b(6)-2 [redacted] noted 21 Aug 03 0945

NURSING UNIT | ROOM NO. | BED NO.

b(6)-2 [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER: 21 AUG 03 [redacted] HOURS

1. Tx to ICU
dx - (R) LL pneumonia
cond Guarded
Vitals Q1° & SAT & I/O
All - NKDA
Act - OOB TID
Nurse - Foley to Gravity

1850 KI

NB over

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: 1986—409-824

"USE BALL POINT PEN. PRESS FIRMLY. NO CARBON PAPER REQUIRED"

Diet - NPO [redacted]

IVF - D5 1/2 NS @ 125cc/hr

Meds - Morphine 3.375 mg IV Q8° 1st Dose Now ✓

Lovenox 80 mg SQ BID ✓

Albuterol 0.5 cc in 2.5 cc NS Q6°

Atenolol 50 mg PO QD

LABS CBC, Chem 8, Chem 12 QAM.

185° [redacted]

b(6)-2

[redacted]

21 AUG 03 2020 — Chem 12 AUG 03 2000

LR 500 cc IV Bolus Now [redacted]

b(6)-2.

---

b(6)-2 [redacted]

8/22/03

KCl 40 meq in 500 cc NS. Run over 4 hrs

Hold medication during Run

Hx D drop to D5 1/2 NS + 20 KCl @ 125 [redacted]

Mike 23 Aug 03

8/22/03 0940

[redacted] b(6)-2

CXR Hx Arm and in Arm

24° chart ✓ [redacted] ILTIAN 22 Aug 03 @ 2145

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]

DATE OF ORDER: 23 Aug 03 TIME OF ORDER: 0657 HOURS

Advance to Regular Diet
Repeat CBC ~~tomorrow~~ 1400

[redacted] b(4)-2

LIST TIME ORDER NOTED AND SIGN

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 22 Aug 03 TIME OF ORDER: 1911 HOURS

Please give 250 cc bolus NS

[redacted] b(4)-2

noted [redacted] 08/23/03 2325

24 ✓ [redacted] T/AN 08/23/03 2325

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 24 AUG 03 TIME OF ORDER: 1015 HOURS

1-IV to 75cc/hr

b(4)-2 [redacted]

stop Mr 1005

NURSING UNIT | ROOM NO. | BED NO.

Vehicle checks done [redacted] 25 Aug 03 0330

PATIENT IDENTIFICATION

DATE OF ORDER: 24 AUG 03 TIME OF ORDER: 0530 HOURS

① morphine 2mg IV Prn

b(4)-2 [redacted] PT/AN

~~0338~~

NURSING UNIT | ROOM NO. | BED NO.

24 ✓ done [redacted] 26 Aug 0200

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, T ND SIGN EACH SET OF ORDERS. IF PRO ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NU IN COLUMN INDICATED BY ARROW BELO

PATIENT IDENTIFICATION

[redacted]

b(6)-4

DATE OF ORDER: 25 Aug 03 TIME OF ORDER: 0706 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) CXR, Pelvic Xray today

(2) Heplock IV

[redacted] b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 25 AUG 2003 TIME OF ORDER: 1240 HOURS

(1) Digoxin .25mg po QD 1300

(2) DC IV fluids

~~(3) Nubain 2mg/kg 10mg/min cmy~~

(3) Lasix 20mg IVP 1300

(4) Pulmonary suppression

[redacted]

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 25 Aug 03 TIME OF ORDER: 2000 HOURS

(1) Ambien 5mg PO @ HS

Noted [redacted]

NURSING UNIT: 24° Nurse [redacted] ROOM NO. | BED NO.

26 Aug 0200 [redacted]

b(6)-2

PATIENT IDENTIFICATION

b(6)-4

[redacted]

DATE OF ORDER: 26 Aug 03 [redacted] HOURS

Start Dobutamine Drip @ 5mcg/kg/min

V.O. per Dr. [redacted] 1734 [redacted]

b(6)-2

NURSING UNIT: 24° Chart [redacted] ROOM | BED NO.

[redacted] 1221 27 Aug 03

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

THE DOCTOR SHALL RECORD DATE AND SIGN EACH SET OF ORDERS. IF P[illegible]M ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM N[illegible]ER IN COLUMN INDICATED BY ARROW BE[illegible]

PATIENT IDENTIFICATION

DATE OF ORDER: 26 Aug 03 TIME OF ORDER: 1600 ~~26 Aug 03~~ [redacted] HOURS

LIST TIME ORDER NOTED AND SIGN

X (1) PCXR
X (2) ABG + VBG to determine baseline
X (3) Place on 100% NRB
X (4) ABG + VBG c̄ NRB
X (5) ABG + VBG 30 mins p̄ Dobutamine started

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER _____ HOURS

X (6) Hold today's Dose of Atenolol
X (7) D/C Dobutamine,
X (8) Switch pt back to NC
X (9) 1L NS Bolus
X (10) ABG + VBG p̄ NS bolus
X (11) V.O. per DR [redacted] 1[redacted] [redacted] /on

b(6)-2 All

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 26 AUG 03 TIME: 1700 [redacted] HRS

(1) transfuse 2 units of PRBCs each over 1 hour

[redacted] 26 Aug 03 1736

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

EPW
[redacted]
b(6)-4

DATE OF ORDER: 26 AUG 03 TIME OF ORDER: 2240 HOURS

(1) MSM 30cc po x1

Noted 26 Aug 03 @ 2245 via [redacted]

[redacted]

NURSING UNIT: ICU1 | ROOM NO.: 240 Chart | BED NO.: [redacted] /on 26 Aug 03 1551

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
EPW [redacted] b(6)-4			27 AUG 2003	0830 HOURS	
			① CBC & 8		
			b(6)-2 [redacted]		[redacted] 27 Aug 03
NURSING UNIT	ROOM NO.	BED NO.			
ICU 1					

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
			27 Aug 03	1300 HOURS	[redacted]
			NPO except for sips of H2O v.o. per Dr. [redacted]		[redacted]
NURSING UNIT	ROOM NO.	BED NO.			

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
			27 Aug 03	1456 HOURS	b(6)-2
			EKG Now v.o. per Dr.		[redacted]
NURSING UNIT	ROOM NO.	BED NO.	[redacted]		

PATIENT IDENTIFICATION			DATE OF ORDER	[redacted]	
			27 Aug 03	1500 HOURS	27 Aug 03 1545
			① Infuse 2cc/hr IV GA		
			b(6)-2		
[redacted]					
NURSING UNIT	ROOM NO.	BED NO.	27 Aug 03 155[redacted]		
	24 Chart		[redacted]		

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

DATE OF ORDER: 27 AUG 2003 TIME OF ORDER: 1600 HOURS

(1) NPO
(2) DC lovenox
(3) [redacted] NG tube → drainage 1000cc
(4) NG to CIS b(6)-2 [redacted]

LIST TIME ORDER NOTED AND SIGN: [redacted] 1616 27 Aug 03

NURSING UNIT: ICU1 ROOM NO.: 240 BED NO.:

Chart Check 0015 28 Aug [redacted] LT/AN

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

DATE OF ORDER: 28 AUG 03 TIME OF ORDER: 0830 HOURS

0900 (1) NS wash 20 kcal at 75cc/hr
(2) Δ CBC to am draw and PRN
(3) Vit K 10mg SQ QD x 3 days
0850 (4) Transfuse 1 unit prbcs over 1 hr [redacted] LT/AN

Noted 28 AUG 03 0855 [redacted] LT/AN

NURSING UNIT: ROOM NO.: BED NO.:

b(6)-2 [redacted]

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

DATE OF ORDER: 28 AUG 2003 TIME OF ORDER: 1600 HOURS

(1) DC NPO
1755 (2) Declamp NG b(6)-2 [redacted]

Noted 28 AUG 03 1755 [redacted] LT/AN

NURSING UNIT: ROOM NO.: BED NO.:

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

DATE OF ORDER: 28 Aug TIME OF ORDER: 2110 HOURS

(1) Remove NG tube
V.O. Dr [redacted] LT/AN

b(6)-2

[redacted] 28 August 03 0623 LT/AN

NURSING UNIT: ICU1 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 AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
#[redacted] b(6)-4	ICU-1			29 AUG 2003	0900 HOURS	
				① DX Sun		
				② Advance diet as tolerated		
				③ OB & Chem		[redacted] 29 Aug 03 0951
				④ KCl 40mg po x1		
				[redacted]		b(6)-2
PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	
#[redacted] b(6)-4	ICU1			29 AUG 03	1600 HOURS	
				① physical therapy consult		[redacted] 30 Aug 03 0934
				[redacted]		
						b(6)-2
PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	
[redacted] b(6)-4	ICU1			29 Aug 03	2015 HOURS	Noted 0020 on 30 Aug 03 [redacted]
				① Tylenol 1 gm PO q6° PRN		
				[redacted]		b(6)-2
PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	
b(6)-4 #[redacted]	ICU1	24° Chart		30 AUG 03	0830 HOURS	
				① Wean O2 as tolerated		
				② OB & Chem, PT & wound check		[redacted] 30 Aug 03 0934
				[redacted]		
				[redacted] 30 Aug 03	0934	

b(6)-2

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

DATE OF ORDER: 3 AUG 2003 TIME OF ORDER: 0832 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Dl'ds to CBC, not 8 QD
(2) DC A-line
(3) DC Foley
(4) Ambulate with PT [redacted]

Noted 0840

NURSING UNIT | ROOM NO. | BED NO.

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

DATE OF ORDER: 23 Sep 03 TIME OF ORDER: 0800 HOURS b(6)-2

(1) Transfer to ICW DR [redacted]
(2) Diagnosis: sepsis, pulmonary embolism
(3) Condition: stable
(4) Vitals q shift with pulse ox
(5) NPO 4
(6) Activity: ward privileges
OOB to chair daily

NURSING UNIT: ICW#1 | ROOM NO. | BED NO.

PATIENT IDENTIFICATION | DATE OF ORDER | TIME OF ORDER | HOURS

(7) physical therapy consult daily
(8) Nursing: IV to saline lock
(9) Diet: regular
(10) meds @ Pulse 20mg po QD
(2) O_2 2 L NC
(3) Atenolol 50mg po QD
(4) Digoxin .125mg po QD

b(6)-4 Noted [redacted] QD 08SEP03

NURSING UNIT [redacted]

PATIENT IDENTIFICATION 1235 | DATE OF ORDER | TIME OF ORDER | HOURS

(5) Colace 100mg po BID
(6) Maalox 2 tablespoons every 6 prn
(7) Lab: CBC, met 8, M, W, F

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

JP/5300 28SEP03 [redacted]

DA FORM 1 APR 79 4255 PREVIOUS EDITION OF 1 JUL 79, WHICH MAY BE USED.

U.S. GOVERNMENT PRINTING OFFICE: 1985—505-924

"USE BALL POINT PEN. PRESS FIRMLY. NO CARBON PAPER REQUIRED"

b(6)-2
A1

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW		

DATE OF ORDER: 9/4 TIME OF ORDER: 1030 HOURS

(1) Ambulate daily
(2) Physical Therapy - daily
(3) Wound (abdominal) care:
Do not pack wound deep - gauze to keep skin from closing only
(4) Heparin 5000 u sq bid
[redacted]

LIST TIME ORDER NOTED AND SIGN

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.
3AP	2030	5 Sep 03

DATE OF ORDER: 5 Sep 03 TIME OF ORDER: 0900 HOURS

(1) Warm Or to off

5 Sep 03 1800 RD

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.
3AP	2030	7 Sep 03

DATE OF ORDER: 7 Sep 03 TIME OF ORDER: 0315 HOURS

(1) Tylenol 325 mg tabs po + # q4 aspirin
V.O. Dr [redacted]

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

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

CLINICAL RECORD - 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

Noted [redacted] 10 Sep 03

NURSING UNIT: ICW #1 | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	9/10	0800 HOURS	
1	NS c 75/hr		
2	Blood Cx		
3	Urine Cx		
4	UA		
5	CXR [redacted] b(6)-2		
	24: Chest [redacted] 0800		

PATIENT IDENTIFICATION

b(6)-2

Noted [redacted] 10 Sep 03

NURSING UNIT | ROOM NO. | BED NO. 1800

	DATE OF ORDER	TIME OF ORDER	
	9/12	HOURS	
1	D/ hip wound Change dressing qday		
	b(6)-2 [redacted]		
	~~24: Chest [redacted] 1800 10 Sep 03 1930~~		

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
	9/15	HOURS	
1	D/C Digoxin		
2	D/C Heparin		
3	D/C Coban		[redacted] 9/15/03
4	D/C to prison / custody		1400
5	D/C IVF		

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
	[redacted]	b(6)-2 HOURS	

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

b(6)-2 All

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. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 17	18	19	20
17/8	[redacted]	VS Q1°	06	[redacted]			
			18				
17/8	[redacted]	ACT: Bed Rest	06	[redacted]			
			18				
17/8	[redacted]	DIET: NPO	06	D/C 17/8/03 0300			
			18				
17/8	[redacted]	CALL MD T>101.5, SBP>180, U/O <30cc°	06	[redacted]			
			18				
17/8	[redacted]	ICS Q8	06	[redacted]			
			18				
17/8	[redacted]	DIET: Clears	06	[redacted]			
			18				
17/8	[redacted]	Foley to GRAVITY	06	[redacted]			
			18				

ALLERGIES: ☐ YES ☐ NO
RNDA

PRIMARY DIAGNOSIS:
s/p SHRAPNEL WOUNDS: (L) Iliac CREST fx, ENTAP.

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

PATIENT IDENTIFICATION:
[redacted] EPW
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/w-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	
17/8	[redacted]	ADMIT ICU2	17/8	ASAP	0130	[redacted]	
17/8	[redacted]	COND: STABLE	17/8	ASAP	0130	[redacted]	
17/8	[redacted]	~~MD~~ ONCALL OR TONIGHT	17/8	ASAP	0130	[redacted]	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
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b(4)-2 A H

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. 09 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 02	03	04	05	06	07	08	09	10	11	12	13	14	15
02 SEP 03	[redacted]	Vitals q shift c̄ pulse	06	[redacted]													
		ox	18														
02	[redacted]	Act.: ward	06														
		privledges	18														
02	[redacted]	OOB to chair daily	06														
			18														
02/04	[redacted]	Physical therapy	10														
		consult daily															
02	[redacted]	Diet: Regular	06	[redacted]													
			18														
02	[redacted]	CBC, met 8, M,W,F	05														
04	[redacted]	Ambulate daily	Dk 18														
			18														
			Dk														
9/4	[redacted]	Wound (abdominal) care:	Dk 18														
		Do not pack wound deep	18 06														
		gauze to keep skin from															
		closing only.															
9/4																	
12 SEP 03	[redacted]	Ship wound - △	06														
		drsg q day	18														

D/C 12 SEP 03

ALLERGIES: ☐ YES ☒ NO — NKDA

PRIMARY DIAGNOSIS: Ex Lap, Pulmonary Embolism

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

PATIENT IDENTIFICATION: # [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

D(e) - 2 A11

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 09 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
02 SEP03	[redacted]	Tx to ICW, condition - stable	02 SEP03	—	—	[redacted]
10 SEP03	[redacted]	Blood cx	10 SEP03	—	—	[redacted]
10	[redacted]	Urine cx	10	—	—	[redacted]
10	[redacted]	UA	10	—	—	[redacted]
10	[redacted]	CXR	10	—	—	[redacted]
9/15	[redacted]	D/C to prison custody	9/15			

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
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b(6)-2 A11

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

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 16	17												
2	[redacted]	VS QS & pulse ox	6	[redacted]													
			18														
2	[redacted]	ACT: ward privileges	6	[redacted]													
			18														
2	[redacted]	OOBTC daily.	6	[redacted]													
		Ambulate daily	18														
2	[redacted]	Physical therapy	8	[redacted]													
		consult daily	18														
2	[redacted]	Diet, Regular	6	[redacted]													
			18														
2	[redacted]	CBC, METS MWF	05	/	/	/	/	/	/	/	/	/	/	/	/	/	/
12	[redacted]	Drip wound - Δ	08	[redacted]													
		drsg qday	X														

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
EPIDAP, PE

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*				Mo _____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
15 Sept	[redacted]	D/C to prison custody				
	-----	blcd-2				

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

(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. Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 28	29	30	31	1	2	3	4	5	6
28Aug03	[redacted]	Δ CBC to Qam draw +	04	/	[redacted]								
		18 QD	18	/									
29 Aug 03	[redacted]	Advance diet as	07	/	[redacted]								
		tolerated (Regular)	11	/									
			17	/									
29 Aug 03	[redacted]	OOB to Chair	06	/									
			18	/									
30 Aug 03	[redacted]	OOB to chair, PT to	06	/	/	[redacted]							
		work with	18	/	/								
	[redacted]		X										
31 Aug 03	[redacted]	Ambulate with PT	06	/	/	/	[redacted]						
			18										
31 Aug 03	[redacted]	Δ lab to CBC Not 8 QD	04	/	/	/	/	[redacted]					

(b(6)-2)

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P Ex Lap (Aug) @ Ileac Fy

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted] b(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

b(6)-2 A11

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
29 Aug 03	[redacted]	DIC Swan	29 Aug 03		0900	[redacted]
30 Aug 03	[redacted]	Physical Therapy Consult	30 Aug		done	[redacted]
31 Aug	[redacted]	DC A. lee	31 Aug 03			[redacted]
31 Aug	[redacted]	DC pleg	31 Aug 03			[redacted]

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

b(6)-2 A11

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. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 18/19/20/21
18 Aug	[redacted]	VS q 4° x 48°, then Q 8°	05	[redacted]
			13	
			21	
18 Aug	[redacted]	NPO / clears in AM	06	
			11	
			17	
18 Aug	[redacted]	Foley to gravity drainage	05	[redacted]
			13	
			21	
18 Aug	[redacted]	Incentive spirometer Q1° WA.	05	[redacted]
			13	
			21	
18 Aug	[redacted]	OOB TID	05	[redacted]
			13	
			21	
20 Aug	[redacted]	Reg Diet	05	[redacted]
			13	
			17	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P Ex Lap

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

EPW H[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(W)-2 A11

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
18Aug	[redacted]	Transfer to ICW				
818	[redacted]	CXR, PA/LAT tonight ~~p~~ t-y			DONE	
818	[redacted]	Please get Rythm strip for eval			DONE	
818	[redacted]	Send CBC, chem 8			DONE	
818	[redacted]	ABG tonight			DONE	
818	[redacted]	Lopressor 5mg IVP now	8/18	8t	2245	[redacted]
818	[redacted]	Lasix 20mg IVP now	8/18		2200	[redacted]
818	[redacted]	1L NS c 40mg KCl X1 now @ 125c/hr	8/18	2345	2345	[redacted]
21Aug	[redacted]	D/C O2 ✓ O2 Sat in 1 hr.	21Aug	1000	1000	[redacted]
21Aug	[redacted]	Transfer c meds on chart	21Aug			
21Aug	[redacted]	Transfer c IV heplocked	21Aug		1000	[redacted]

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

USAPA V1.00

b(4)-2 A 11

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 26	27	28	29	30	31	1	2
26 Aug 03	[redacted]	Start Dobutamine	06	[redacted]							
		Drip @ 5mcg/kg/min	18			DC'd [redacted] 26 Aug 03 1550					
27 Aug 03	[redacted]	Prilosec 20 mg	10	[redacted]							
		PO QD		[redacted]							
28 AUG 03	[redacted]	NS c 20 KCl @ 75 cc/h	06	[redacted]							
			18								
28 AUG 03	[redacted]	Vit K+ 10 mEq SQ QD	10	[redacted]							
		x 3 days									
30 Aug 03	[redacted]	Wean O2 as tolerated	06	[redacted]							
			18								

ALLERGIES: ☐ YES ☐ NO

NKDA.

PRIMARY DIAGNOSIS: s/p Ex Lap, (R) Iliac Fx

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO. 2

PATIENT IDENTIFICATION:

[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

b (ce) - 2 All

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
26 Aug	[redacted]	Transfuse 2 units of PRBCs	26 Aug 03	#1	2018	[redacted]
	-----	each over 1 hour	26 Aug 03	#2	2114	[redacted]
26 Aug 03	[redacted]	MOM 30cc X1	26 Aug 03	Stat	2242	[redacted]
28 Aug 03	[redacted]	Transfuse 1 unit PRBC over 1°	28 Aug 03		0958	[redacted]
29 Aug	[redacted]	KCl 40 meq PO x 1	29 Aug 03		1015	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED													
29 Aug 03	[redacted]	Tylenol / TGM PO Q6°	2024 1109	30 Aug 03 0800												
-----	-----	PRN		[redacted]												
-----	-----													L		
-----	-----															
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USAPA V1.00

b(4)-2 All WHITE

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. 08 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 21	22	23	24	25	26	27	28	29	30	31	1	2	3
21 Aug	[redacted]	~~AR @ 125 cc~~	07	/	[redacted]												
22 Aug	[redacted]	D5½NS+20KCL 125	19	M	[redacted]										DC 8/24/03		
21 Aug	[redacted]	Lovenox 80mg SQ	20	/	[redacted]												
2	------	bid	22	M	[redacted]												
21 Aug	[redacted]	Zosyn 3.375 gm IV	14	/	[redacted]												
	------	q 8°	22	M	[redacted]												
	------		06	/	[redacted]												
21 aug	[redacted]	Albuterol 0.5 cc	06	/	[redacted]												
	------	in 2.5 cc NS q 6°	12	/	[redacted]												
	------		18	M	[redacted]										D/C'd 28 AUG 03		
	------		24	M	[redacted]												
21 aug	[redacted]	Atenol 50mg po q day	10	/	[redacted]												
	------		X														
24 Aug	[redacted]	D5½NS + 20 kcl @	06			A											
	------	75 cc/hr	14		[redacted]										DC — AC		
	------		22			A	[redacted]										
	------		X														
25 Aug	[redacted]	H.L. IV	06	/	/	/	/	[redacted]									
	------	(flush q 8)	18	/	/	/	/	[redacted]							D/C		
	------		X														
25 Aug	[redacted]	Zosyn 3.375 gm IV	06				/	[redacted]									
	------	q 8°	14					[redacted]									
	------		22					[redacted]									
25 Aug	[redacted]	Aspirin 0.25 mg qd	10					[redacted]									
	------	(P.O.)	X														
~~24~~ Aug	[redacted]	Lovenox 80 mg SQ	10					[redacted]							DC'd 27 Aug 03		
	copied 25 Aug	bid	22														

ALLERGIES: ☐ YES ☐ NO — NKDA

PRIMARY DIAGNOSIS: S/p Exp. Lap (Neg.), (R) iliac Fx, (R) LL Pneumonia

ADDITIONAL PAGES IN USE? ☒ YES ☐ NO — PAGE NO. 1

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

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

b(6) · 2
All

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)			Mo. Aug Yr. 2003	
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
6/21/	[redacted]	LR 500cc Bolus x1 now		RIAH	2020	[redacted]
22Aug	[redacted]	40mg KCl IVP Bam 4°-	done		[redacted]	
		hold W Maint drug rm.				
23Aug	[redacted]	Please give 250cc NS bolus	23Aug03	1411	done	
25Aug	[redacted]	MS24 mg IVP now	25Aug	0536	0536	[redacted]
25 Aug	[redacted]	Lasix IVP	25 Aug	1300	done	[redacted]
25 Aug	[redacted]	Dulcolax suppository	25 Aug	26Aug03	0710	[redacted]
25 Aug	[redacted]	DC IV Fluids	25 Aug	0710	done	[redacted]
25 Aug	[redacted]	5mg PO @ HS Ambien	25 Aug	2200	2200	[redacted]
26Aug	[redacted]	Place on 100% NRB	26Aug03		1400	[redacted]
26Aug	[redacted]	Hold today's dose of Atenolol	26Aug03		1400	[redacted]
26Aug	[redacted]	Switch pt back to NC	26Aug03		1400	[redacted]
26Aug	[redacted]	1L NS Bolus	26Aug03		1605	[redacted]

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

USAPA V1.00

b(4)-2
All GREEN

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. 08 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 21	22	23	24	25	26	27	28	29	30	31	1	2	3
21 aug	[redacted]	Condition guarded	07	[redacted]													
			19														
21 aug	[redacted]	Vitals q 1° c̄ sat	07														
			19														
21 aug	[redacted]	I + O q hr.	07														
			17														
21 aug	[redacted]	OOB T.10	07														
			19														
21 aug	[redacted]	Foley to gravity	07														
			19														
21 aug	[redacted]	~~NPO~~ ~~CLD~~ Reg	07														
			19														
21 aug	[redacted]	CBC, Chem 8, Chem 12 q am	04														
23Aug03	[redacted]	Regular Diet	07														
			11														
			17														
25Aug03	[redacted]	~~Digoxin .25 mg po QD~~	~~10~~														
27Aug03	[redacted]	CBC Q8°	04														
			12														
			20														
27Aug03	[redacted]	NPO except for sips of H_2O	06														
			18														
27Aug03	[redacted]	NG to LIS	06														
			18														

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
S/P Exp. Lap (neg.), (R) iliac Fx
(R) LL Pneumonia

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

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

4 26 P7 / 182

4 17 P7 / 11a

b(6)-2 A11

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. Aug Yr. 2003
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
21 Aug	[redacted]	Transfer to ICU	21 Aug	-	Done	[redacted]
22 Aug	[redacted]	CXR in AM 0400	23 Aug	0400	0500	[redacted]
23 Aug	[redacted]	CBC 1400	23 Aug	1400	1420	[redacted]
25 Aug	[redacted]	CXR + pelvic X ray	25 Aug	0830	0830	[redacted]
26 Aug 03	[redacted]	PCXR	26 Aug 03		1230	[redacted]
26 Aug 03	[redacted]	ABG + VBG to determine baseline	26 Aug 03		1335	[redacted]
26 Aug 03	[redacted]	ABG + VBG $\bar{c}$ NRB	26 Aug 03		1442	[redacted]
26 Aug 03	[redacted]	ABG + VBG 30 mins $\bar{p}$ Dobutamine	26 Aug 03		1544	[redacted]
26 Aug 03	[redacted]	ABG + VBG $\bar{p}$ NS Bolus	26 Aug 03		1644	[redacted]
27 Aug 03	[redacted]	EKG Now	27 Aug 03		1510	[redacted]
27 Aug	[redacted]	NG Tube → Lavage 1000cc	27 Aug 03		1645	[redacted]
28 Aug	[redacted]	Clamp NGT	28 Aug 03		1555	[redacted]
28 Aug	[redacted]	D/C NG Tube	28 Aug 03		2110	[redacted]

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

USAPA V1.00

b(6)-2 All

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. 09 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	02	03	4	5	6	7	8	9	10	11	12	13	14	15
02 Sep 03	[redacted]	N to SL (flush q	06	[redacted]													
		shift)	18														
02	[redacted]	Prilosec 20mg po QD	10	[redacted]													
02	[redacted]	D2 2L NC	06	[redacted]													
~~02~~	[redacted]	~~Atenolol 50mg p.r.n.~~	18	[redacted]													
02	[redacted]	Atenolol 50mg po QD	10	[redacted]													
02	[redacted]	Digoxin .125mg po QD	10	[redacted]													
02	[redacted]	Coreg 100mg po BID	10	[redacted]													
			22	[redacted]													
04	[redacted]	Heparin 5000U SQ	10	[redacted]													
	[redacted]	BID	22	[redacted]													
[redacted]			06	[redacted]													
			18	[redacted]													
			HR	16	17	18											
28 Sep	[redacted]	Prilosec 20mg po	10	[redacted]													
		QD	X														
28 Sep	[redacted]	~~Digoxin~~ Atenolol	10	[redacted]													
		50mg po QD	X														

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: Ex GAP, Pulmonary Embolism

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

PATIENT IDENTIFICATION:
#[redacted]

b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	Mo. 09 Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
5sep03	[redacted]	Wean O2 to off	5sep03			[redacted]
5sep	[redacted]	D/C IVF				
		b(6)-2				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
05sep03		maalox 2tbsp q6° prn														
7	[redacted]	Tylenol 325mg + tylox q4 prn	7sep 0800	6sep 1900	9sep 1545	10sep 0610										
		b(6)-2	[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. 05

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 18/19 2021
18 Aug	[redacted]	LR @125cc/hr.	05	✓ [redacted]
20 Aug		HL IV	13	[redacted]
			21	
18 Aug	[redacted]	Ancef 1gm q8°	08	✓ [redacted]
			16	✓
			24	
8-18	[redacted]	Albuterol tx Q4° overnight, then PRN -	00	X [redacted] ✓
			04	X ✓
			08	X ✓
			12	X ✓ ✓
			16	X ✓ ✓
			20	[redacted] ✓ ✓
18 Aug	[redacted]	Wean O_2 to keep sat. 92%	5	X [redacted]
			15	X
			21	[redacted]
		~~Lopressor 5mg IVP~~		
8-18	[redacted]	Lovenox 40mg SQ QD → 1st dose tonight	21	[redacted]
19 Aug	[redacted]	Atenolol 50mg PO QD	17	✓ [redacted]
19 Aug	[redacted]	Colace 100mg PO QD	10	✓ ✓ [redacted]
			22	✓ [redacted]

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P Ex Lap

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

PRN Meds

18 Aug AVM	MSO4 2-6mg q2° PRN Give MSO4 for Breakthrough pain. 19 Aug 1400 4mg IVP AVM
18 Aug AVM ~~20 Aug.~~	Phenergan 12.5mg IVP q6° PRN 20 Aug. 12.5mg IVP ~~at~~ 0012 AOS
20 Aug KL	Albuterol tx PRN
19 Aug 03 AVM	Percocet 1-2 PO q4° PRN pain

ONE TIME ORDERS

8·20· 0000. Mylanta 30cc PO x Now [redacted] AOS

b(6)-2 All

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 17	18	19	20
17/8	[redacted]	Ancef 1gm Q8	08	[redacted]			
			16				
			24				
			/				
17/8	[redacted]	LR @ 150cc/HR	04	[redacted]			
			18				
			/				

ALLERGIES: ☐ YES ☒ NO
KNDA

PRIMARY DIAGNOSIS: S/P shrapnel wound (L) iliac crest washout/3x c̄ an ex lap

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

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				Mo._____ Yr._____
Order Date	**Clerk/ Nurse**	**SINGLE ORDER, PRE-OPERATIVES**	**Date to be Given**	**Time to be Given**	**Time Given**	**Initials**
		b(6)-2 All				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED													
1-19/8	[redacted]	MSO4 2-6 mg	0130 18 Aug 03	18 Aug												
		IVP Q1-2hr pen	5mg IV	3mg AW	2018 1430											
1-17/8	[redacted]	Zofran 4mg IVP	18 Aug													
		Q6hr prn	1600 [redacted]													

USAPA V1.00

EPW [redacted] b(6)-4

25AUG03

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

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89 b(6)-2

INITIAL SHIFT ASSESSMENT

	TIME	0800	INITIALS		INITIALS	1800	INITIALS [redacted]
NEURO	PUPILS	PERRLA			-	PERRLA	
	SENSORIUM	Alert, verbalizes			-	A+O x3, expresses	
		needs				needs appropriately	
					-	MAE	
RESPIRATORY	RESPIRATORY PATTERN	Regular labored E			-	deep, rapid, labored	
	BREATH SOUNDS	increased activity			-	CTA bilaterally E	
	SECRETIONS	FIO2 3LN sat 98%				diminished bases	
					-	Ø cough	
					-	4LNC 97%	
SKIN	COLOR	pink/tired			-	normal for race	
	INTEGRITY	abdominal incision DxI			-	ab incision, staple intact	
		(L) iliac dressing DxI				min redness & swelling	
IV SITE	LOCATION	(R) forearm AC - A.L.				good approximation, Ø drainage	
	CONDITION	intact, Ø S+S of				or odor	
		infection					
					-	(R) AC patent Ø S/S of	
						infexn	
GASTRO	ABDOMEN	Hyperactive BS all			-	BS present x 4 quad	
	BOWEL SOUNDS	quadrants			-	round, large	
		& BM					
GU	URINE:	foley clear yellow			-	foley dark yellow	
	COLOR/CLARITY	urine q S					
CARDIOVASCULAR	CARDIAC RHYTHM	NSR E PVC / ST 1/100			-	NSR/ST E occ PVC	
		rate 98-100.			-	S1S2	
		JVD (R). Upper			-	+1 pulses x 4 ext	
		LE edema. Abd			-	Upper & lower Ext edema	
		distended.				+2	

LEGEND: Cr - Creatinine; F_IO_2 - Fraction of inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; SA - Fractional; SAT - Saturation; TRACH - Tracheostomy

b(6)-2

(Continue on reverse)

[redacted] (Signature & Title) CPT [redacted]

DEPARTMENT/SERVICE/CLINIC: ICU I

DATE: 25AUG03

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

EPW [redacted]

b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

EPW [redacted] b(6)-4 25 Aug 03

DATE 25 AUG 03 | BY SIP EXP. (AP L NEG) @ ILIAC FK @ LL PNEUMONIA | HOSPITAL DAY

VITAL SIGNS																	
TIME	06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21
BP Arterial Line		116	120	114	186	119	118	112	113	113	107	120	105	110	110	109	105
BP Cuff	117/76	71	82	68	70	76	81	79	80	80	79	75	72	68	74	69	75
Temperature	97.7			98.2			97.9				97.5				98.0		
Pulse	103	98	102	102	99	99	100	104	106	106	102	95	96	96	98	102	103
Respiratory Rate	26	27	28	10	29	26	25	31	21	21	29	25	32	34	36	34	26
SpO2	94	94	94	94	95	94	95	93	93	93	94	94	93	97	98	96	96
FIO2	3L	3L	3L	3L	3L	3L	3L	3L	3L	2L	2L	2L	2L	4L	4L	4L	4L
														POGS	POGS	POGS	POGS

INTAKE																		
TIME	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21	8°T
IVF:	75	off																
P.O.			150			150			300		150		100					350
														off				
TOTALS										1430	1500	1515	1600	1700				

OUTPUT																			
URINE	HOUR	100	100	70	70	75	70	50	50	585	525	200	200	120	100	60	50	80	
	TOTAL	100	200	270	340	415	480	530	580		525	725	925	1095					
	SP GR																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

Vancy 20 mg IV/P

EPW [redacted] b(6)-4

b(6)-4

EPW [redacted] 25 Aug 03

POST-OP DAY

VITAL SIGNS

22	23	00	01	02	03	04	05	
109/72	101/68		105/60	92/60	93/68	91/68	95/61	
	98.3					98.4		
102	95	101	81	104	112	109	111	
28	30	30	20	18	20	19	19	
96	99	98	99	99	98	96	97	
4L	4L	4L	4L	4L	47	4L	4L	
							POGS	

INTAKE

22	23	00	01	02	03	04	05	8° T
Lav abx		alb			lab		abx	

OUTPUT

120	110	100	100	80	100	100	120	

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

TIME	
MODE	
F_iO_2	
TV	
RATE	
PEEP	
ABG pH	
ABG PCO_2	
ABG pO_2	
ABG HCO_3	
ABG SAT	
ABG BASE	

LABORATORY DATA

TIME	
GLUCOSE	
Na/K	
Cl/CO_2	
BUN/Cr	
WBC/PLATELET	
Hct/Hgb	

ACTIVITIES OF DAILY LIVING

TIME	
MOUTH CARE	
BATH	
SKIN CARE	
FOLEY CARE	
TRACH CARE	
ROM EXERCISES	

TURN

TIME

SUCTION

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE
IV ______
po ______
______
TOTAL ______

OUTPUT
Urine: ______
______
______
TOTAL ______

BALANCE ______

NURSE'S SIGNATURE | INITIALS

[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

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89 b(6)-2

INITIAL SHIFT ASSESSMENT

	TIME	0700	INITIALS [redacted]	b(6)-2	INITIALS	2300	INITIALS [redacted]
NEURO	PUPILS	PERRLA				PERL	
	SENSORIUM	A&O x 3				Alert + Oriented	
						able to communicate needs	
RESPIRATORY	RESPIRATORY PATTERN	Tachypneic, labored				labored, 105	
	BREATH SOUNDS	Coarse + diminished in LLL otherwise CTA				Coarse to LLL	
	SECRETIONS	None				NA	
SKIN	COLOR	Normal for race				normal for race	
	INTEGRITY	Mid-line Abdominal incision Staples intact				abd wound intact c staples	
IV SITE	LOCATION	(R) AC				(R) AC	
	CONDITION	Ø S/S of infection				Swan	
GASTRO	ABDOMEN	Soft, Nontender				Soft - distended	
	BOWEL SOUNDS	Hyporactive				hyporactive bowel sounds	
GU	URINE:	Foley to Gravity				Q1C to BS	
	COLOR/CLARITY	Dark Yellow				Amber urine to drainage bag	
CARDIOVASCULAR	CARDIAC RHYTHM	ST ⅗ ectopy				Q ectopy	
		Cap refill 2-3 secs				Good Cap refill	
		Ø JVD				Edema +0 ↑ + 1	
		Edema BUE + BLE				Differencies noted	
		Skin cool to touch				Skin cool to touch	

LEGEND: Cr - Creatinine; F_IO_2 - Fraction of Inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; S/A - Fractional; SAT - Saturation; TRACH - Tracheostomy

b(6)-2

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC: ICU 1

DATE: 26 Aug 03

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

EP W [redacted] b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE 26 Aug 03 | DX | HOSPITAL DAY 108/18

VITAL SIGNS																		
TIME	06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21	22
BP Arterial Line								91/60		111/64	101/59	98/60	103/61	110/54	[illegible]	[illegible]	[illegible]	
BP Cuff	92/69	104/65	111/60	103/60	98/58	89/59	101/60	117/75		111/67	97/58	90/60	102/55	105/61	100/64	104/64	96/55	
Temperature	97.2				97.5			98.1		98	98.5	97.8				97.3		
Pulse	119	118	117	116	115	118	117	117		110	121	125	104	93	115	83	110	
Respiratory Rate	37	37	32	29	30	32	34	38		38	34	33	29	27	39	35	28	
MAP	77	79	80	75	68	71	86	86		80	73	71	74	74	78	78	71	
SaO2	96	97	98	97	99	98	96	97		98	100	96	98	99	96	97	96	
O2	4L	4L	4L	4L	4L	4L	4L	4L		100%	100%	4L	4L	4L	4L	4L	4L	
Hole	NC	NC	NC	NC	NC	NC	NC	NC		NRB	NRB	NC	NC	NC	NC	NC	NC	
PA								57/23		53/15	54/15	60/18	50/20	46/17	50/18	55/18	48/16	
PCWP								27		32/13								
C.O								3.4		4.1	3.3							
Mean PA								35		31	32	35	31	30	34	32	32	
CVP													13					

INTAKE																		
TIME	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21	8°T
IVPB	50								50	50								
Dobutamine											30							
~~D5W~~ NS												1000						
Aline, PA line								6	6	6	6	6	6	6				
PO	240		240			240			720	240		240						480
TOTALS									776									1600

OUTPUT																			
URINE	HOUR / TOTAL	100	111	70	90	95	95	91	90	742	94	40	90	55	55	120	80	80	564
	SG																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

POST-OP DAY

VITAL SIGNS	22	23	24	01	02	03	04	05	
Art	105/66	109/67	[illegible]/64	109/60	111/64	140/63	98/64	134/69	
NIBP	117/56	109/60	98/58	105/60	97/55	90/59	105/60	105/55	
Temp	98.6			98.8				98.6	
HR	107	108	105	102	104	101	98	111	
RR	29	25	32	29	27	25	26	25	
m	82	78	71	81	71	70	78	73	
SpO2	98	95	96	95	96	97	96	96	
	4L	4L	4L	4L	4L	4L	4L	4L	
	NC	NC	NC	NC	NC	NC	NC	NC	
PA	50/16	55/21	48/22	34/16 54/17	52/16	34/16	44/16	60/20	
m PA	33	34	31	31	31	35	30	33	

INTAKE	22	23	24	01	02	03	04	05	8° T
IVPB	50								
PO	100				120				180
	110								

OUTPUT									
	90	110	65	60	65	55	80	60	585
	X1					X1			X2

ACUITY LEVEL CLASSIFICATION

RESPIRATORY		TIME									
		MODE									
		F_iO_2									
		TV									
		RATE									
		PEEP									
	ABG	pH									
		PCO_2									
		pO_2									
		HCO_3									
		SAT									
		BASE									

LABORATORY DATA	TIME								
	GLUCOSE								
	Na/K								
	Cl/CO2								
	BUN/Cr								
	WBC/PLATELET								
	Hct/Hgb								

ACTIVITIES DAILY LIVING	TIME	0000		
	MOUTH CARE			
	BATH	✓		
	SKIN CARE	✓		
	FOLEY CARE	✓		
	TRACH CARE	/		
	ROM EXERCISES	per self		

TURN — TIME

SUCTION

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE		OUTPUT	
IV	______	Urine:	______
po	______		______
	______		______
TOTAL	______	TOTAL	______

BALANCE ______

[redacted]

b(6)-2

EPW# [redacted] b(6)-4

20 Aug 03

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

INTENSIVE CARE NURSING FLOW SHEET b(6)-2

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0715	INITIALS [redacted]	INITIALS	1900	INI [redacted]
NEURO		PUPILS	PERRLA			PERRLA 3mm Brisk	
		SENSORIUM	A+O x 3			A+Ox3	
						Follows Simple Commands	
						Able to move extremities	
RESPIRATORY		RESPIRATORY PATTERN	Regular, Less labored			RRR	
		BREATH SOUNDS	CTA			CTA (B)	
		SECRETIONS	None			Ø	
						4L NC SaO2 >96%	
SKIN		COLOR	Normal for Race			Normal for Race	
		INTEGRITY	Incision Mid-Abd			Mid Abd Dressing CDI	
			& LLQ			LLQ dressing CDI	
IV SITE		LOCATION	(R) IJ Cordis c̄ Swan			(R) IJ Cordis c̄ Swan Ganz	
		CONDITION	Swan 47cm @ Hub			2 proximal ports patent	
			Cordis, Proximal Ports			(R) Radial A-Line	
			x 2 all patent to			Monitoring PA	
			flush. Ø S/S of				
			infection				
GASTRO		ABDOMEN	Hyp soft, Nontender			Soft Round Nontender	
		BOWEL SOUNDS	Hypoactive			(+)	
			ØN/V				
GU		URINE:	Foley to Gravity			Foley to Gravity	
		COLOR/CLARITY	Dark, yellow			Dark yellow, clear	
CARDIOVASCULAR		CARDIAC RHYTHM	ST c̄ occasional			SR c̄ multifocal PVC	
			PVC, ØJVD			& unifocal PAC	
			Cap Refill < 3 secs			Generalized edema c̄	
			Edema +3 BUE +			+3 pitting to extremities	
			BLE			Cap Refill < 3 sec	

LEGEND: Cr - Creatinine; F_IO_2 - Fraction of inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; S/A - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU1

DATE: 20 Aug 03

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

EPW# [redacted] b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

#[redacted] b(6)-9

DATE 21 Aug 03 DX HOSPITAL DAY

VITAL SIGNS	TIME	06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21	
	BP Arterial Line	106/65	100/61	102/65	125/67	94/69	98/57	114/62	106/65		98/59	104/59	114/68	116/65	105/65	112/62	123/73	89/47	
	BP Cuff	107/66			111/61	99/56	96/64	96/62	105/66		99/59	104/63	96/50	102/61	105/63	104/64	103/62	111/69	
	Temperature	98.8				98.1					97.5				98.0			97.9	
	Pulse	90	95	101	101	99	95	85	81		81	87	76	80	78	77	78	77	
	Respiratory Rate	28	32	33	24	21	23	21	21		22	26	26	19	23	17	31	20	
	MAP	72	75	74	82	65	72	76	77		71	71	81	81	79	80	80	80	
	SaO2	95	97	97	99	100	98	98	97		98	94	97	97	99	97	98	98	
	O2	4L	4L	4L	4L	4L	4L	4L	4L		4L	4L	4L	4L	4L	4L	4L	4L	
	mode	NC	NC	NC	NC	NC	NC	NC	NC		NC	NC	NC	NC	NC	NC	NC	NC	
	PA	48/17	45/14	45/12	46/13	53/15	48/16	40/16	50/15		44/14	46/14	49/15	4/14	44/13	35/13	38/13	34/16	
	PCWP		13												13				
	CO																		
	mean AA	29	28	26	27	30	29	27	27		27	26	27	26	25	25	26	14	
	CVP																		

INTAKE	TIME	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21	8°T
	IVPB		50							50	50								50
	PO	240	118		80			236	60	734		80					60	60	200
																			250
	TOTALS									784									250

OUTPUT		HOUR / TOTAL	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21	8°T
	URINE		60	70	70	60	80	135	90	130	695	80/80	100/180	106/280	86/366	100/466	90/556	100/656	80/736	936
		10 gr																		
		S/A																		
	NG	OUTPUT																		
		pH																		
		GUIAC		+																
	EMESIS			Large Black Tarry Stool					Large Black Tarry Stool					Large Black Tarry Stool				Sm Tar Stool		
	STOOL																			
	DRAINS																			
	TOTALS																			

POST-OP DAY

VITAL SIGNS	22	23	00	01	02	03	04	05	
	124/72	129/65	125/66	124/64	121/63	118/70	121/66		
	110/60	107/52	113/62	104/60	104/59	100/58	104/59		
			98L 98		97L 99				
	78	72	77	78	77	77	80		
	16	18	18	19	21	18	20		
	80	70	80	76	95	80	81		
	98	100	96	97	98	98	100		
	4L	4L	4L	4L	4L	4L	4L		
	NC	NC	NC	NC	NC	NC	NC		
	34/13	47/12	43/12	39/13	37/13	40/13	42/15		
	13				12				
	27	26	26	26	26	26	27		

INTAKE									
									8° T
	50								
	120								

OUTPUT									
	95/95	90/~~105~~	80/~~115~~	80/~~150~~	80/~~135~~	50			

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA										
	TIME	0340	0340							
	MODE	ABG	ABG							
	F_IO_2									
	TV									
	RATE									
	PEEP									
ABG	pH	7.447	7.544							
	PCO_2	21.3	28.2							
	pO_2	66	21							
	HCO_3	23	24							
	SAT	97	44							
	BASE	2	2							

LABORATORY DATA										
	TIME	26Aug 1954	27Aug 0352	1200	2010					
	GLUCOSE	~~147~~ 96	143							
	Na/K		134/3.5							
	Cl/CO_2		102/21							
	BUN/Cr	~~53~~ 38/1.3	47/1.3							
	WBC/PLATELET	57.1/109		53.7/108	31.6/99					
	Hct/Hgb	28.4/8.6		26.7/3.1	25.1/7.8					

DAILY LIVING ACTIVITIES	TIME	0715			TURN	TIME 0715	0808			
	MOUTH CARE									
	BATH	X				1900	2000	2200		
	SKIN CARE	X								
	FOLEY CARE	X			SUCTION					
	TRACH CARE									
	ROM EXERCISES	X								

24 I&O TOTALS

wt Yesterday _____ wt Today _____

	INTAKE		OUTPUT
IV	784	Urine:	695
PO	250		736
TOTAL		TOTAL	

BALANCE _____

NURSE'S SIGNATURE	INITIALS
[redacted]	[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

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	INITIALS	INITIALS	INITIALS
NEURO		0615	[redacted] b(6)-2		
	PUPILS	3mm PERRLA			3mm PERRLA
	SENSORIUM	Alert, able to			A+O x3
		follow simple			able to follow
		commands, oriented			commands
		to person			
RESPIRATORY	RESPIRATORY PATTERN	NL O2 via NC, labored			4L NC SATs @ 99%
	BREATH SOUNDS	~~clear throughout~~			labored breathing
	SECRETIONS	∅ noted @ this time			diminished BBS.
		diminished BBS			
		throughout			
SKIN	COLOR	WWL for race			NER, incision
	INTEGRITY	midline abd incision			to midline abd.
		c̄ staples. 40 drsg soiled			staples c/d/I
IV SITE	LOCATION	(R) LJ cordis c̄ swan			(R) LJ cordis c̄
	CONDITION	swan 47cm @ hub, 2			swan (A) Flush
		proximal ports patent			NS c̄ 2b & @ 85 cc/hr
		+ flush easily, (R) radial			infusing through swan
		A-line, (R) PIV c̄ ∅ S/S of			port. A line to (R) radial
		infection			(A) Flush (A) Zero
GASTRO	ABDOMEN	soft, round, nontender			BS x4 Quad, hyperact.
	BOWEL SOUNDS	(+) hyperactive			soft, round nontender
		(D) nare NGT to LIS			NG tube to (L) Nare
		Brown drainage noted			clamped PF NPO
GU	URINE:	Foley to gravity			Foley to gravity
	COLOR/CLARITY	draining clear			clear yellow urine
		yellow urine			c̄ sedimentation
CARDIOVASCULAR	CARDIAC RHYTHM	SR c̄ couplet + multifocal			multifocal PVCs
		PVCs, +2 palpable			(A) pulses x4
		pulses in all 4 ext. Cap			extremities. <3
		refill <3 sec, generalized			sec cap refill.
		edema throughout			generalized edema
					throughout

LEGEND: Cr - Creatinine; F_IO_2 - Fraction of Inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; FiO2 - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 28 AUG 03

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

[redacted] b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE 28 AUG 03 | DX | HOSPITAL DAY

VITAL SIGNS																			
TIME	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22
BP Arterial Line	130/68	131/65	116/60	124/65	134/71	139/77	124/65	134/76		125/73	121/71	137/76	143/76	147/85	150/85	153/83	162/87
BP Cuff	113/67	116/66	100/70	102/65	102/71	112/63	118/62	129/70		116/65	118/70	131/74	131/76	131/70	131/70	132/82	126/82
Temperature	97.6	97.7	97.9	98.4	97.8	97.9	97.9	98.0		98.0	98.5	97.7	98.0	97.9			
Pulse	116	80	76	78	75	76	71	71		69	72	69	67	69	68	74	69
Respiratory Rate	20	22	18	15	8	14	11	14		12	18	23	19	19	17	14	20
MAP	85	85	82	80	82	78	84	92		86	88	95	95	94	98	94	88
SaO2	98%	96%	100%	99%	100%	99%	99%	97%		98%	98%	98%	99%	98%	97%	99%	99
O2	4L	4L	4L	4L	4L	4L	4L	4L		4L	4L	4L	4L	4L	4L	4L	4L
mode	NC	NC	NC	NC	NC	NC	NC	NC		NC	NC	NC	NC	NC	NC	NC	N3
PCWP	13							13					13				
mean PA	27	27	27	26	27	27	27	26		26	26	26	26	25	26	27	28

INTAKE																			
TIME	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21	8°T
IVPB	50								50	50								
MIVF				75	75	75	75	75	375	75	75	75	75	75	75	75	75	
Blood					350				350									
TOTALS																		

OUTPUT																			
URINE	HOUR / TOTAL	38/38	75/113	60/173	65/238	95/333	48/381	42/423	70/493	493	60/553	55/608	320/928	60/1028	40/1068	200/1268	80/1348	80/1428	1428
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL								X+											
DRAINS																			
TOTALS																			

POST-OP DAY

VITAL SIGNS	22	23	24	01	02	03	04	05
	160/80	149/86	158/81	157/84	154/79	149/85	166/91	167/96
	138/80	125/84	133/85	140/80	138/83	129/78	120/82	123/80
	98	98	98	97	97.5	96	97.9	
	70	71	72	59	73	69	77	75
	23	23	21	21	22	17	16	20
	103	99	103	101	101	97	93	98
	99%	97	97%	97	96	97	96	97
	4L	4L	4L	4L	4L	4L	4L	4L
	NC	NC	NC	NC	NC	NC	NC	NC
	29	32	29	23	24	24	24	26

INTAKE	22	23	24	01	02	03	04	05	8° T
	80								
	75	75	75	75	75	75	75	75	

OUTPUT								
	70/70	80	88	76	72	60	84	

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME									
	MODE									
	F_IO_2									
	TV									
	RATE									
	PEEP									
ARTERIAL BLOOD GAS	A: pH									
	A: PCO_2									
	A: pO_2									
	B: HCO_3									
	B: SAT									
	G: BASE									

LABORATORY	TIME	0437								
	GLUCOSE	120								
	Na/K	123/3.7								
	Cl/CO_2	103/19								
	BUN/Cr	32/0.9								
	WBC/PLATELET	25/104								
	Hct/Hgb	25.4/7.9								

DAILY ACTIVITIES DOCUMENTING	TIME				TURN	TIME			
	MOUTH CARE								
	BATH								
	SKIN CARE								
	FOLEY CARE				SUCTION				
	TRACH CARE								
	ROM EXERCISES								

24 I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE _____

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

M. AL RECORD-SUPPLEMENTAL MEDICAL

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)* QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0700	INTILAS [redacted]	b(6)-2	INTILAS	1900	INTILAS
NEURO	PUPLIS	PERRLA				Perl	
	SENSORIUM	A+O x 3, Follows				Oriented. Able to	
		Commands				commicate needs, follows	
						all commands	
RESPIRATORY	RESPIRATION PATTERN	Regular + Unlabored				19 & unlabored	
	BREATH SOUNDS	Crackles RML otherwise				Ø Secretions	
	SECRETIONS	CTA in all other lobes					
		Ø secretions					
SKIN	COLOR	Normal, For Race				normal for race	
	INTEGRITY	Incision Mid-line				incision to mid-abd.	
		Abdomen, UQ					
IV SITE	LOCATION	(R) IJ Swan				(R) Radial A-line &	
	CONDITION	- Ø S/S of infection				S/S of infection	
		(R) Radial Aline					
		- Ø S/S of infection					
GASTRO	ABDOMEN	Soft, Nontender				slightly distended.	
	BOWEL SOUNDS	Hyperactive				Hyperactive Bowel sounds	
		Ø N/V					
GU	URINE	Foley to Gravity				4/C-LDBS - amber	
	COLOR/CLARITY	Dark Golden Color				color urine noted	
						to foley.	
CARDIOVASCULAR	CARDIACRHYTHM	NSR, Ø ectopy noted				Ø Ectopy. HR 60	
		@ this time				Good Capillary Refill	
		Cap Refill < 3 secs				+ pulse to all extremities	
		Edema +3 BUE + BLE				Edema noted to extremities	

LEGEND

Cr - Creatinine
F_IO - Fraction of inspired O_2
F_IO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Iracheostomy

b(6)-2

(Continue on reverse)

PREPARED BY *(Sign* [redacted] RN/RN

DEPARTMENT/SERVICE/CINC ICU 1

DATE 29 Aug 03

PATIENT'S INDICATIONS *(If typed or written entries give: Name — Last, First, middle; grade; date; hospital or medical facility)*

[redacted]

b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER *(Specify)*

☐ DIGNOSTIC STUDIES

☐ TRETMENT

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

WAMC OP 375 (Redesignated)
1 APR 90 (HSXC - NU)

b(6)-4

DATE 29 Aug 03 | DX S/P Ex [redacted] p, ⓡ ellias Fx | HOSPITAL DAY

VITALS	TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
	BP Arterial line							161/86	137/92		152/88	165/81	148/83	158/86	142/85	140/75	140/83	139/88	
	BP Cuff							150/84	132/78		129/84	127/84	129/87	137/86	121/77	135/81	131/80	110/77	
	Temperature								97.2						97.7				
	Pulse							68	71		72	67	65	70	65	61	61	65	
	Respiratory Rate							18	21		16	19	17	18	19	19	19	23	
	MAP							107	115		105	109	100	106	102	95	100	104	
	SaO2							97	98		97	97	98	98	97	98	98	99	
	O2							4L	4L		4L	4L	4L	4L	4L	4L	4L	4L	
	Mode							NC	NC		NC	NC	NC	NC	NC	NC	NC	NC	
	PAP							39/17	36/15		37/16	DC'd							
	Mean PA							27	29		24								

INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	NS ε 20KCl							75	75	150	75	75	75	75	75	75	75	75	600
	IVPB							50	~~50~~ 100	50							50		50
	PO								478	478					900		240		740
	TOTALS									678									1390

OUTPUT		HOUR / TOTAL	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	URINE								100	100	200	100	30	30	46	20	18	3	3	250
		SP gr																		
		S/A																		
	NG	OUTPUT																		
		PH																		
		GUIAC																		
	EMESIS																			
	STOOL																			
	DRAINS																			
	TOTALS																			

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23
ABP	152/97	145/94	148/93	151/92	144/85	144/82	140/86	154/88
NBP	147/96	126/83	127/86	130/85	118/78	119/79	120/82	124/80
T	97.7			97.5		98		
HR	65	65	65	58	109	66	68	72
R	23	24	25	22	26	16	15	22
MAP	113	108	100	104	103	98	103	105
Sats	96	95	99	97	98	99	96	96
O2	4L	4L	4L	4L	4L	4L	4L	4L
Mode	NC	NC	NC	NC	NC	NC	NC	NC

INTAKE	16	17	18	19	20	21	22	23	8°T
I	75	75	75	75	75	75	75	75	600
							50		50
K		480		120		120			720
E									1370

OUTPUT	16	17	18	19	20	21	22	23	8°T
O	5	3	500/500	15/575	75/650	50/700	100/800	100/900	900
Stool				X11					X2

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME									
	MODE									
	F_IO_2									
	TV									
	RATE									
	PEEP									
ABG	pH									
	PCO_2									
	pO_2									
	HCO_3									
	SAT									
	BASE									

LABORATORY	TIME	0456								
	GLUCOSE	97								
	Na/K	139/3.4								
	Cl/CO_2	104/22								
	BUN/Cr	33/1.1								
	WBC/PLATELET	19/84								
	Hct/Hgb	33.7/9.4								

DAILY ACTIVITIES	TIME				TURN	TIME				
	MOUTH CARE									
	BATCH									
	SKIN CARE									
	FOLEY CARE				SUCTION					
	TRACH CARE									
	ROM EXERCISES									

24°180 TOTALS

WT Yesterday _____ wt Today _____

INTAKE

IV _____

Po _____

TOTAL _____

OUTPUT

Urine: _____

TOTAL _____

BALANCE _____

NURSE'S SIGNATURE | INITIALS

[redacted]

b(6)-2

b(6)-4

EPW #[redacted]

MEDICAL RECORD-SUPPLEMENTAL MEDICAL [redacted]

30AUG03

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

			INITIAS		INTILAS		INTILAS
NEURO	TIME	0710	[redacted]	b(6)-2			
	PUPLIS	PERRLA				PERRL	
	SENSORIUM	A+O x 3				A+O x3 able to follow simple commands.	
RESPIRATORY	RESPIRATION PATTERN	Regular + unlabored				RR+L. CTA Bilat symetrical rise + fall of chest. No use of accessory muscles	
	BREATH SOUNDS	CTA, Diminished Bases					
	SECRETIONS	None					
SKIN	COLOR	Normal for race				NFR	
	INTEGRITY	Mid-line Abd + LLQ Incisions stage II Decub - @ Buttock				Incision Midline to abd stg II Decub to buttock, skin intact	
IV SITE	LOCATION	(R) IJ Cordis				(R) Flank	
	CONDITION	Patent ō S/S of infection (R) Radial A-line Intact ō S/S of infection				(R) IJ cordis (+) Flush ø S/S of infection (R) radial A-line (R) flush, zeroed ø S/S of infection	
GASTRO	ABDOMEN	Soft, Nontender				Soft, round, nontender.	
	BOWEL SOUNDS	Hyperactive ØN/V				Hyperactive BS x4 quad.	
GU	URINE	Foley to Gravity				Foley to gravity	
	COLOR/CLARITY	yellow Purulent drainage noted on penis				minimal amount (30cc/hr) clear yellow urine	
CARDIOVASCULAR	CARDIACRHYTHM	SR ō occasional PVCs Cap Refill <3secs Ø JVD, Edema x2 RLE/BLE				SR ō occasional PVCs. <3 sec cap refill.	

LEGEND			
	Cr - Creatinine	ICP - Intracranial Pressure	S/A - Fractional
	F_IO - Fraction of inspired O_2	PCO_2 - PRESSURE OF ARTRIAL CO_2	SAI - Saturation
	F_IO_2 - Bicarbonate	PEEP - Positive end Expiratory Pressure	TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY ([redacted] SPC/AN b(6)-2

DEPARTMENT/SERVICE/CINC ICU I

DATE 30AUG03

PATIENT'S INDICATIONS (For typed or written entries give: Name—Last, First, middle; grade; date; hospital or medical facility)

EPW #[redacted] b(6)-4

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIGNOSTIC STUDIES
- ☐ TRETMENT

DA FORM 1 MAY78 4700

Proponent Dept of Nurs

WAMC OP 375 (Redesignated) 1 APR 90 (HSXC - NU)

MEDCOM - 17289

EPW#[redacted] b(6)-4

DATE 30AUG03 | DX SP EX [redacted] P, @ ILIAC FX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial line	148/41	135/86	128/75	148/88	154/85	129/84	150/85	168/96		133/78	143/87	140/86	146/90	132/83	143/88	153/91	123/71	
BP Cuff	117/81	130/84	117/72	119/76	134/81	154/83	133/83				127/77	123/77	113/85	118/82				
Temperature	98.1			96		97.4				98.6				98.1				
Pulse	70	65	102	59	62	67	74	70		74	75	71	69	77	69	70	76	
Respiratory Rate	21	15	15	13	21	21	18	27		19	14	16	15	20	13	27	21	
MAP	109	101	89	98	104	114	107	115		93	102	101	102	96	105	109	86	
SaO2	96	98	98	98	100	98	97	98		97	96	96	93	91	97	93	96	
O2	4L	4L	4L	4L	4L	4L	4L	4L		2L	2L	2L	RA	RA	RA	RA	2L	
MODE	NC	NC	NC	NC	NC	NC	NC	NC		NC	NC	NC					NC	

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
NS c̄ 20KCL	75	75	75	75	75	75	75	75	600	75	75	75	75	75	75	75	75	600
IVPB							50		50							50		50
PO				120		120			240	360			180			240		780
TOTALS									890									1430

OUTPUT

		24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
URINE	HOUR	900	100	75	50	100	75	100	150	1550	50	60	70	105	55	66	65	75	546
	TOTAL	900	1000	1075	1125	1225	1300	1400	1550										
	SP gr																		
	S/A																		
NG	OUTPUT																		
	PH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23
	133/83	165/96	144/88	159/91	147/91	151/92	159/91	134/82
	98'							
	72	71	75	75	73	70	75	76
	24	24	24	21	18	16	23	21
	97	118	106	109	108	107	110	97
	97	99	93	97	96	97	96	96
	22	2L	2L	2L	2L	2L	2L	2L
	NC	NC	NC	NL	NC	NC	NC	NC

INTAKE	16	17	18	19	20	21	22	23	8°T
	75	75	75	75	75	75	75	75	
		240	450						

OUTPUT								
	45	40	35	40	38	50	68	100

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME									
	MODE									
	F_IO_2									
	TV									
	RATE									
	PEEP									
ABG	pH									
	PCO_2									
	pO_2									
	HCO_3									
	SAT									
	BASE									

LABORATORY	TIME	0352	1720							
	GLUCOSE	100								
	Na/K	135/4.5								
	Cl/CO_2	105/24								
	BUN/Cr	25/0.6								
	WBC/PLATELET	14.3/88	16.8/112							
	Hct/Hgb	28.8/9.0	31.8/9.8							

DAILY ACTIVITIES DF	TIME				TURN SUCTION	TIME				
	MOUTH CARE									
	BATCH									
	SKIN CARE									
	FOLEY CARE									
	TRACH CARE									
	ROM EXERCISES									

24 180 TOTALS

NURSE'S SIGNATURE [redacted]

INITIALS [redacted]

WT Yesterday _____ wt Today _____

INTAKE

IV _____

Po _____

TOTAL _____

OUTPUT

Urine: _____

TOTAL _____

BALANCE _____

D(6)-2

MEDI[redacted]ECORD-SUPPLEMENTAL MEDICAL DAT[redacted]on General

For use of this form see, AR 40-66; the proponent agency is The Office of The[redacted]on General

OTSG APPROVED (Date) QA Appr 8Mar 89 b(6)-2

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

INITIAL SHIFT ASSESSMENT

	TIME	0800	INTILAS		INTILAS	1830	INTILA[redacted]
NEURO	PUPLIS	PERRA				PERRA
	SENSORIUM	Alert				Alert, speaks in broken
		Verbalizes need				english as appropriate
		appropriately				
RESPIRATORY	RESPIRATION PATTERN	RRR SOB ē ↑				RRR
	BREATH SOUNDS	activity 40 CPM				CTA, slight ↓ (R) base
	SECRETIONS	∅				∅
SKIN	COLOR	WNL Rare				WNL
	INTEGRITY	abd, (R) flank				abd drsg CDI
		dressing D+I				
IV SITE	LOCATION	(R) SC cordis				(R) IJ cordis ~~[illegible]~~
	CONDITION	D+I ∃ infection				Patent (D) s/s of inf
GASTRO	ABDOMEN	Distended but				Round nontender
	BOWEL SOUNDS	non tender				(+) bowel sound x4 quadrants
		Normal BS all				
		quadrants				
GU	URINE	DC foley 0900				Al voiding via urinal
	COLOR/CLARITY	put out 2200 cc				Clear yellow
		2 hours from foley				
CARDIOVASCULAR	CARDIACRHYTHM	NS ē rare PVC				NSR, rate 70-80's, cap
		rate ↓ 80-90's				refill <3 sec
		generalized edema				
		upper/lower ext.				

LEGEND: Cr - Creatinine; F_IO - Fraction of inspired O_2; F_IO_2 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - PRESSURE OF ARTRIAL CO_2; PEEP - Positive end Expiratory Pressure; S/A - Fractional; SAI - Saturation; TRACH - Tracheostomy

(Continue on reverse)

b(6)-2

PREPARED BY (Signature & Title) [redacted] Maj MN

DEPARTMENT/SERVICE/CINC

DATE 3 F AUG 03

PATIENT'S INDICATIONS (For typed or written entries give: Name—Last, First, middle; grade; date; hospital or medical facility)

EPW [redacted] b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIGNOSTIC STUDIES

☐ TRETMENT

DA FORM 1 MAY78 4700

Proponent Dept of Nurs

WAMC OP 375 (Redesignated)
1 APR 90 (HSXC - NU)

MEDCOM - 17292

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial line	152/86	148/86	138/77				130/74	126/69										
BP Cuff	143/80	149/88		123/75	114/72	131/78	117/73			117/73	125/83	141/79	131/71	140/65	146/71	166/73		
Temperature	98.0		98.5		98.1	98.1	97.8			98.2			98.4			98.2		
Pulse	70	72	75	75	74	71	67	69		57	57	66	70	68	72	75		
Respiratory Rate	11	16	18	17	15	18	16	12		18	30	37	24	20	22	24		
O2 SAT	96	97%	97	94	97	97	98	98		97	95	95	94	95	99	94		
Source	NC	NC	NC	NC	NC	NC	NC	NC		NC	NC	NC	NC	NC	NC	NC		
	2L	2L	2L	2L	2L	2L	2L	2L		2L	2L	2L	2L	2L	2L	2L		

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
NS c 20 meq KCl	75	75	75	75	75	75	75	75	600	75	75	75	75	75	75	75	75	600
IVPB							50		50									
P.O.											150						150	300
TOTALS										D/C Foley								

OUTPUT

URINE	HOUR / TOTAL	20	100/120	100/220	200/420	150/570	200/770	250/1020			250/1200				300/1400		300/1600	1600
	SP gr																	
	S/A																	
NG	OUTPUT																	
	PH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	
	145/88	143/79	131/77	140/65	135/74	131/73	130/80	120/80	
	98.0	98.8		98.6	98.6		98.2	98.3	
	67	74	76	82	73	75	75	80	
	29	26	23	23	21	17	23	22	
	94	94	94	93	94	94	95		
	NC	NC	NC	NC	NC	NC	NC	NC	
	2L	2L	2L	1L	1L	1L	1L	1L	

INTAKE	16	17	18	19	20	21	22	23	8°T
	75	75	75	75	75	75	75	75	600 ~~1800~~
							50		50 ~~100~~
		150					50		~~200~~

OUTPUT	16	17	18	19	20	21	22	23	
			350/1850				475/2335		2335

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA	TIME									
	MODE									
	F_IO_2									
	TV									
	RATE									
	PEEP									
ABG	pH									
	PCO_2									
	pO_2									
	HCO_3									
	SAT									
	BASE									

LABORATORY DATA	TIME									
	CLUCOSE									
	Na/K									
	Cl/CO_2									
	BUN/Cr									
	WBC/PLATELET									
	Hct/Hgb									

DAILY ACTIVITIES DONE	TIME				TURN	TIME				
	MOUTH CARE									
	BATCH									
	SKIN CARE									
	FOLEY CARE				SUCTION					
	TRACH CARE									
	ROM EXERCISES									

24 180 TOTALS

NURSE'S SIGNATURE

[redacted]

b(6)-2

WT Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	1900	Urine:	4050 ~~2335~~
Po	500		4050
TOTAL	2400	TOTAL	~~2335~~
		BALANCE	~~+65~~ 1650

M[redacted]L RECORD-SUPPLEMENTAL MEDICAL [redacted]
For use of this form see, AR 40-66; the proponent agency is The Office of [redacted]urgeon General

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

b(6)-2

OTSG APPROVED (Date)
QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

	TIME		INITIAS	0730	INITIAS [redacted]	1900	INITIAS [redacted]
NEURO	PUPLIS			PERRLA.		3mm PERRL	
	SENSORIUM			Oriented, Alert.		Awake & follows	
				MAE purposefully		simple commands	
				& Limited Rom 2°			
				Contractures —			
RESPIRATORY	RESPIRATION PATTERN			O2 1L N/C & SATS		RRR, on O2 ~~NC~~	
	BREATH SOUNDS			95%. BS & End		NC @ 1L & O2 sat	
	SECRETIONS			Exp. Rhonchi, &		≥ 95%. Any fields	
				Lt Bases Esp on		cough.	
				(R). Mouth Breath			
				ACC. & exercise.			
SKIN	COLOR			Membranes pink.		NFR	
	INTEGRITY			Stage (2) decub			
				Coccyx — (R) Buttock			
IV SITE	LOCATION			(R) Cordis & NS &		(L) hand & NS & 20mg	
	CONDITION			20K @ 75°. Site		KCL @ 75cc/hr	
				intact & not ED			
				edema, erythema.			
				\ \ \ \			
GASTRO	ABDOMEN			Obese, soft &		Firm, BS x 4	
	BOWEL SOUNDS			(+) BS in (4) Quads		Gurgle, good appetite	
				Non-Tender & Tympy			
				Black stools. —			
GU	URINE			Voids spontaneously		to urine Q3	
	COLOR/CLARITY			to urinal. —		clear yellow	
CARDIOVASCULAR	CARDIACRHYTHM			SR & HR 80's. (A)		NSR, S1 S2 normal	
				1 R regular.		no ectopy murmur	
				Pretibial edema 3-4+		noted on ankles.	
				CAP Refill < 3 Sec.			

LEGEND
Cr - Creatinine
F_IO - Fraction of inspired O_2
F_IO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Tracheostomy

b(6)-2

(Continue on reverse)

[redacted] [redacted]
DEPARTMENT/SERVICE/CINC: ICU #1
DATE: 1 Sept 03

[redacted] INDICATING (Typed or written entries give: Name—Last, First, middle; grade; date; hospital or medical facility)

HUD [redacted]

b(6)-4

- ☐ HISTORY/PHYSICAL
- ☒ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIGNOSTIC STUDIES
- ☐ TRETMENT

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

WAMC OP 375 (Redesignated)
1 APR 90 (HSXC - NU)

DATE 1 Sept 03 | DX S/P E[redacted] @ Iliac FX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial line																		
BP Cuff	114/80	125/85	129/83	123/81	130/84	124/87	131/83	138/93		130/76	136/76	123/44	125/81	135/76	X	X	X	
Temperature	98.3		98.4		98.4			98.8		X	X	X	X	X				
Pulse	74	74	72	72	83	73	69	78		78	72	80	76	71	67	71	69	
Respiratory Rate	12	18	17	22	21	23	15	16		14	15	16	17	15	22	26	28	
SpO2	95	95	95	97	95	95	95	98		95	96	97	97	97	96	96	97	
Source	NC	NC	NC	NC	NC	NC	NC	NC										
	1L	1L	1L	1L	1L	1L	1L	1L										

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
NS c 20 mEq KCL	75	75	75	75	75	75	75	75	600	75	75	75	75	75	75	75	75	600
IVPB							50		50							50		50
P.O.								480	480									480
TOTALS																		

OUTPUT

		24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
URINE	HOUR	450		450	550	525	450		NM	2475		550		575				400	1602
	TOTAL			900	1450	1975	2425		(L9)										
	SP gr																		
	S/A																		
NG	OUTPUT																		
	PH																		
	GUIAC																		
EMESIS																			
STOOL									L9 Black										
DRAINS																			
TOTALS																			

POST-OP DAY 26

VITAL SIGNS	14	17	18	19	20	21	22	23	
BP	X			132/74	130/71	126/74	117/73	130/75	
T	X	99			99B	99S			
P	66	62		75	76	72	72	77	
RR	15			22	15	17	19	25	
SPO2	95	96		96	96	97	96	96	

INTAKE	14	17	18	19	20	21	22	23	8°T
IV	75	75	75	75	75	75	75	75	

OUTPUT	14	17	18	19	20	21	22	23	
	/	/	/	475	/	500	/	350	

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA										
TIME										
MODE										
F_IO_2										
TV										
RATE										
PEEP										
ABG: pH										
ABG: PCO_2										
ABG: pO_2										
ABG: HCO_3										
ABG: SAT										
ABG: BASE										

LABORATORY DATA										
TIME										
GLUCOSE										
Na/K	/	/	/	/	/	/	/	/	/	
Cl/CO_2	/	/	/	/	/	/	/	/	/	
BUN/Cr	/	/	/	/	/	/	/	/	/	
WBC/PLATELET	/	/	/	/	/	/	/	/	/	
Hct/Hgb	/	/	/	/	/	/	/	/	/	

ACTIVITIES OF DAILY LIVING										
TIME										
MOUTH CARE										
BATCH										
SKIN CARE										
FOLEY CARE										
TRACH CARE										
ROM EXERCISES										
CHG. A	07	1930								

TURN	TIME					
	0700					

SUCTION						

24*180 TOTALS	NURSE'S SIGNATURE	INITIALS
WT Yesterday _____ wt Today _____	b(ie)-7	
INTAKE: IV 1800; Po 500; TOTAL 2400	[redacted]	[redacted]
OUTPUT: Urine: _____; TOTAL _____		
BALANCE _____		

M[redacted]AL RECORD-SUPPLEMENTAL MEDICAL [redacted]

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)* QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

	TIME		INTILAS		INTILAS		INTILAS
NEURO	PUPLIS						
	SENSORIUM						
RESPIRATORY	RESPIRATION PATTERN						
	BREATH SOUNDS						
	SECRETIONS						
SKIN	COLOR						
	INTEGRITY						
IV SITE	LOCATION						
	CONDITION						
GASTRO	ABDOMEN						
	BOWEL SOUNDS						
GU	URINE						
	COLOR/CLARITY						
CARDIOVASCULAR	CARDIACRHYTHM						

LEGEND

Cr - Creatinine
F_1O - Fraction of inspired O_2
F_1O_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CINC

DATE 02 SEP 93

PATIENT'S INDICATIONS *(For typed or written entries give: Name—Last, First, middle; grade; date; hospital or medical facility)*

[redacted] b(4)-4

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER *(Specify)*
- ☐ DIGNOSTIC STUDIES
- ☐ TRETMENT

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

WAMC OP 375 (Redesignated)
1 APR 90 (HSXC - NU)

MEDCOM - 17298

DATE | DX | HOSPITAL DAY

VITAL SIGNS																		
TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial line																		
BP Cuff	148/73	129/73	137/79	134/75	125/76	127/77	134 79	137 76										
Temperature	98.9									98.3								
Pulse	76	73	74	74	70	72	69	73										
Respiratory Rate	22	22	22	16	20	24	18	23										
O_2 SAT	95	93	95	95	94	97	95	97										
Source	NC	NC	NC	NC	NC	NC	NC	NC										
	1L	1L	1L	1L	1L	1L												

INTAKE																		
TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	75	75	75	75	75	75	75	75										
TOTALS																		

OUTPUT																		
URINE	HOUR / TOTAL	300		400			300		400									
	SP gr																	
	S/A																	
NG	OUTPUT																	
	PH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

X - Iliac crest (L)

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: 17AUG03 Anesthesia Type (Circle): (General) Spinal Epidural IV Sedation Nerve Block

Time In:

Allergies: NKDA OR Intake: Crystalloid 1600 cc Colloid Hespan 500 cc

Pre-op V/S: 27/107 OR Output: UOP 450 EBL 100

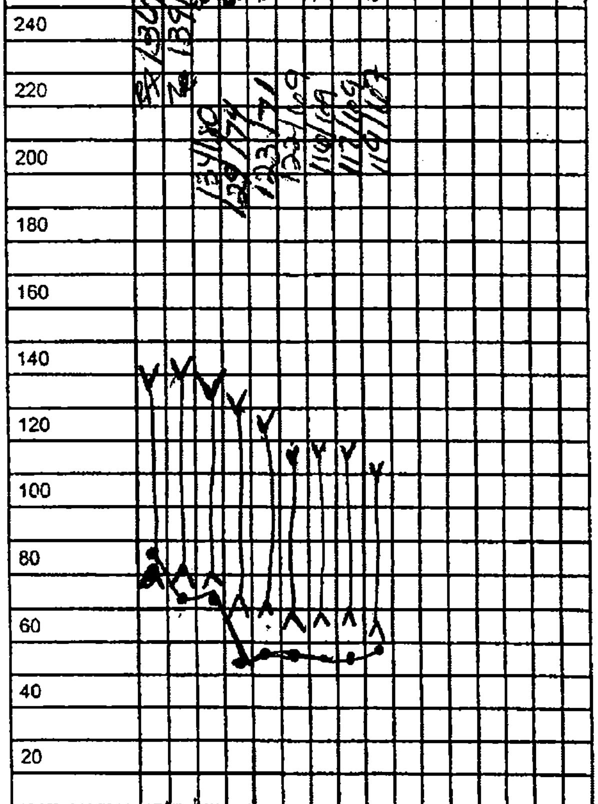
Procedures: I&D shrapnel wound (L) flank / ex lap Meds/Times: ancef / 250 fent vec - reversed @ end 40 Esmolol - HTN

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

peri-rose Biliac

Pre Op Meds: 0900 Rx History

Time	0945	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	D/C ICU2
SaO2	95	100	100	100	100	100	100	100	100	
FiO2	[illegible]	[illegible]	FM	FM	FM	FM	FM	m	m	
Methods			[illegible]	[illegible]	4L	4L	4L	4L	4L	



RR	24	24	22	22	20	20	
T	99		99	98			
Time							
Pain (0-10)							
LOS							

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

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

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: | Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	1
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2	2	2
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	11	11	11

Codes

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

V/S: X = A-line BP, ˇ = Cuff BP, = Pulse

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

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

(Continue on reverse)

PREPARED BY *(Signature & Title)* [redacted] b(6)-2 | DEPARTMENT/SERVICE/CLINIC ICU2 | DATE 17/8/03

PATIENT'S IDENTIFICATION [redacted] *first, middle; grade; date; hospital or medical facility)* Name — last,

[redacted] EPW

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	(D)HP	+	+	P	++	W	Pk
15'		+	+	P	++	W	Pk
30'		+	+	P	++	W	Pk
45'		+	+	P	++	W	Pk
60'		+	+	P	++	W	Pk
90'		+	+	P	++	W	Pk
D/C	(D)HP	+	+	P	++	W	

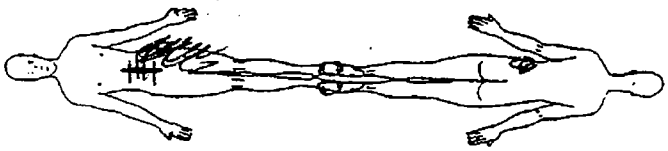
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	~~ABD~~ (D)HP	Dressing	++
30'	~~ABD~~ (D)HP		++
60'	~~ABD~~ (D)HP		++
D/C	~~ABD~~ (D)HP	DRSNG	++



PACU OUTPUT

Time	Source	Color/Appearance	Amount
0600	Foley	Cyan	400 cc

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0040	SB	Ø	Ø

WAMC OP 173-E

NURSING NOTES

Received pt p̄ surgery. He was able to articulate (he was cold and in ↓ pn. as well as how his wound was to the MD. Pt SpO2 ~95% RA. Placed on 6LFM that ↑SpO2 ~100% while sleeping. Pt Able to take deep breaths c̄ encouragement. SB but Ø symptomatic. Drsngs intact. c̄ serosang. drainage noted through silk tape. (D)hip drsng has Penrose drng tubing. Pt currently sleeping c̄ FM on + SpO2 ~95% 4LFM. —CPT [redacted]
Uneventful recovery. Pt cont to sleep c̄ SpO2 100% c̄ 4L FM. Drsngs intact— b(6) 2

CPT [redacted]

Discharge Criteria:
Date: 18/6 **Time:** 0600 **PARS:** 11
BP: 119/67 **T:** **HR:** 58 **RR:** 20 **SaO2:** 100%
Pain Level at D/C (0-10):
Intake: Ø **Output:** —
Additional Data: Ø
Transferred To: Remained @ ICU 2
Report Given To: N-A
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: N/a
Cleared IAW Recovery Room SOP [redacted]
Charge Nurse Signature: CPT [redacted]

b(6) 2

F (3) A

21 AUG 03

ICU Flowsheet — Patient Name: EPW [redacted] — Date: / / 2003

Vital Signs	24	01	02	03	04	05	06	07	08	09	10	11		12	13	14	15	16	17	18	19	20	21	22	23	
Temperature																			97.7			97.9				
Pulse																			88	87	86	88	83	83	81	
~~B/P A Line~~																										
MAP																										
B/P Cuff																			99/58		100/61	102/69	109/68	106/63	97/67	
Respirations																			35		12	36	32	30	30	
Sa02																			99%	100%	100	99	99	97	98	
~~100% NRB~~																					12L	10L	10	10	10	
SOURCE																					NRB	NRB	NRB	NRB	NRB	

Intake	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
IVF																										
LR																			1000	125	125	125	125	125	125	1750
~~LRO~~ 1 Bolus																							500		500	1000
IVPB																				50						50
PO intake																			Ø							
O.R. IN																										
Totals																										~~2850~~ 2800

Output	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
Urine Hourly																			~~50~~ 50	75/75	~~75~~ 75	30/105	30/135	30/165	30/195	195
NG Tube																			Ø							
Drains #1																			Ø							
#2																			Ø							
#3																			Ø							
Emesis/Stool																										
O.R. OUT																										
Totals																										

J96

24 hour input	
24 hour output	
24 hour balance	

MEDCOM - 17302

IV AL RECORD-SUPPLEMENTAL MEDI ATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		Time: 0700 Initals: [redacted] b(4)-2	Time: 2050 Initals [redacted] b(4)-2
NEURO	Pupils	2R	PERRL, 3mm Alert.
	Sensorium	A/O	Moves all extremities. Sensation
	LOC / GCS		intact. Swallows w/ difficulty.
CARDIAC	Cardiac Rhythm	SR w/ ectopy	SR w/ frequent PVC's. Radial/
	PRI: / QRS:		Pedal pulses 3+. Cap refill
	Pulse Strength	2+	<4 sec. 2+ Anasarca. Ø CP
	Cap Refil / JVD		cool extremities.
	Edema	1+	
	Chest Pain	Ø	
RESP	Respiratory Pattern	equal rise/fall	Even, Regular, unlabored.
	Breath Sounds	CTA	Clear all lung fields, + BS.
	Secretions	Ø	Strong cough. Ø secretions.
	Cough	Ø	
SKIN	Color	NFR	WNL, cool extremities. Dry.
	Integrity	COF	2cm pink skin, open to (R) buttock/hip.
	Backside	2cm skin tear to buttocks	Petroleum gauze w/ tegaderm over.
IV	Access Devices	PIV x1	IV (R) AC infusing D5½NS w/
	Location	(R) AC	20 KCl @ 125 cc/hr. Dressing intact.
	Condition	COF	
GI	Abdomen	rnl	Slightly distended. Incision
	Bowel Sounds	(+)	ML abdomen w/ staples intact. Ø
	Stoma/Ostomy	Ø	drainage. Tolerates meals. Ø BM
			ABS x4. Nontender.
GU	Device	foley	Foley replaced. Foley to DD.
	Color / Clarity	yellow, clear	Clear/yellow urine adequate.

(Continue on reverse)

PREP [redacted] b(4)-2 DEPARTMENT/SERVICE/CLINIC b(2)-2 ICU #1, [redacted] DATE 23 Aug 03

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

NAME: EPW # [redacted] RANK: AGE:

UNIT: b(4)-4 GENDER: M

STATUS: US: AD / CIV IRAQI: CIV / EPW

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

USAPPC V2.00

F-139

ICU Flowsheet **Patient Name:** EPW #[redacted] **Date:** 08/23/2003

Vital Signs	24	01	02	03	04	05	06	07	08	09	10	11		12	13	14	15	16	17	18	19	20	21	22	23	
Temperature	96.8 (A)				96.8 (A)					96.7							96.7								97.8 (A)	
Pulse	69	69	69	73	70	69	76	73	71	72	73	74		71	77	76	75	76	66	74	76	71	75	73	71	
B/P A-Line																										
MAP	81	90	86	94	85	94	94	91	94	91	96	89		95	94			90	87	97	91	90	85	90	85	
B/P Cuff	96/69	115/74	110/71	116/77	108/72	119/77	113/83	115/72	119/76	114/71	120/83	124/74		124/74	127/77	ND/66	117/71	119/76	105/67	130/73	124/75	113/73	109/70	117/68	109/70	
Respirations	20	21	24	25	21	21	23	15	20	20	18	18										24	16	24	19	
Sa02	98	96	93%	93%	97%	94%	93%	95%	95	99	95	94		100	95	96	95	97	97	96	96	95	95	97	96	
FiO2	4L	4L	2L	2L	2L	1L	—	1L	2L	2L	2L	2L		2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	
Mode	NC	NC	NC	NC	NC	NC	RA	NC	NC	NC	NC	NC		NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	
Intake	**24**	**01**	**02**	**03**	**04**	**05**	**06**	**07**	**08**	**09**	**10**	**11**	**Total**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**Total**
IVF	125	125	125	125	125	125	125	125	125	125	125	125	1500	125	125	125	125	125	125	125	125	125	125	125	125	1500
				50							50		100			(125 NS)	(125 bolus)		(500 NS)			50				800
PO intake	120		180		210	120	150		1020		240	240	2280			400				400					120	920
O.R. IN																										
Totals													3880													3220
Output	**24**	**01**	**02**	**03**	**04**	**05**	**06**	**07**	**08**	**09**	**10**	**11**	**Total**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**Total**
Urine Hourly	100/100	100/200	100/300	100/400	125/525	100/625	75/700	100/800	30/830	30/860	22/882	140/1022	1022	70/70	30/100	25/125	30/155	34/189	20/209	15/224	15/239	30/539	100/639+	110/749+	65/814+	814+
NG Tube																										
Drains #1																										
#2																										
#3																										
Emesis/Stool																										
O.R. OUT																										
Totals													1022													814+

24 hour input	5700
24 hour output	1836+
24 hour balance	+5864

MEDCOM - 17304

b(a)-2

INITIAL SHIFT ASSESSMENT

		Time: 06 Initials: [redacted]	Time: 1..3 Initials: [redacted]
NEURO	Pupils	PERRLA	PERL. Alert and communicative
	Sensorium	Appear drowsy but easily	needs ⅗ difficult.
	LOC / GCS	arousable. Able to verbalize	
		needs	
CARDIAC	Cardiac Rhythm	Bare PVC, noted gallop	Pulse strong. Good cap.
	PRI: / QRS:	rhythm. Mild JVD (R)	refill. Generalized edema
	Pulse Strength	strong	noted to L+R (B) extremities
	Cap Refil / JVD	<3 sec / ⊖ JVD	
	Edema	generalized edema LE H+	
	Chest Pain	generalized CP (R) chest	
RESP	Respiratory Pattern	Labored @ 2L NC sat 96-98%.	2L O2 via NC Sat 95%.
	Breath Sounds	(L) CTA ⅊ diminished BS (R) L air	Diminished sounds (R) L base
	Secretions	⊖ exchange	
	Cough	⊖	
SKIN	Color	appear jaundice	normal for race.
	Integrity	abd staples intact	Staples intact to abd.
	Backside		
IV	Access Devices	(R) arm D&I PIV	(R) arm PIV D5½NS+20 Kcl
	Location	LR 125 cc/hr	@ 75 cc/hr. PIV patent +
	Condition		intact ⅗ swelling/redness to
			area.
GI	Abdomen	distended but soft staples	Staples intact to abd. Slight
	Bowel Sounds	open to air. BS hyperactive	distention noted.
	Stoma/Ostomy	both quadrants	BS hyperactive.
GU	Device	foley to gravity, yellowish	F/C to BS ⅊ dark yellow
	Color / Clarity	amber colored urine	urine draining

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC (b)(2)-2 ICU #1, [redacted]

DATE

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

NAME: EPW [redacted] b(a)-4 RANK: AGE:

UNIT: ICU 1 GENDER:

STATUS: ~~US: AD / CIV~~ IRAQI: CIV / EPW

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

LSAPPC V2.00

PT'S NAME: EPW [redacted] Dist 4

ID#:

DATE: 24 Aug 03

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01 (25AUG03)	02	03	04	05	06
BP INV																								
BP NIBP	125/81	131/80	127/75	120/82	126/82	116/79	118/76	125/84	123/80	110/71	116/78	113/79	120/82	115/77	124/81	120/75	119/79	120/84	123/82	123/84	127/80	112/77	137/80	117/76
TEMP	98.0			98.2			98.3			98.0		95.7		97.1		97.6			97.9	98.1		97.1		
PULSE	75	75	77	73	72	72	76	80	93	81	89	93	94	102	101	102	102	102	103	103	105	106	102	103
RESP	18	24	18	21	20	15	21	18	26	21	20	29	28	32	32	29	26	27	32	31	34	34	30	26
SP02	98	98	98	96	97	96	96	94	94	96	96	95	94	95	94	96	94	95	94	95	94	93	98	95
FIO2	2L	2L	2L	2L	2L	2L	2L	RA	RA	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L
INPUT																								
IV D5.5 2L	125	125	125	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	
PO	100	50		150			150			150		50		150		150			150	50				
NGT	—																							
O.R. IN	—																							
SUB TOTAL																							1450	
TOTAL																								
UT																								
URINE	100	100	150	100	100	90	100	75	80	90	100	150	80	100	60	60	70	45	60	46	46	100	140	
NGT																							977	
STOOL																								
O.R. OUT																								
SUBTOTAL																								
TOTAL																								
BALANCE																								

MEDCOM - 17306

AL RECORD-SUPPLEMENTAL MED ATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

b(4)-2

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		Time: 0700 Initals: [redacted]	Time: 1945 Initals: [redacted]
NEURO	Pupils	2-R/2R	R PERRL 3mm, Alert. Speaks
	Sensorium	Alert,	little english. Moves all extremities.
	LOC / GCS		Sensation intact.
CARDIAC	Cardiac Rhythm	SR c̄ ectopy	SR c̄ frequent PVC's. Asymptomatic
	PRI: / QRS:		Radial/pedal pulses 3+. Cap
	Pulse Strength	2+	refill < 3 sec. Cool BLE. 2+
	Cap Refil / JVD	< 3 sec / (+)	edema BLE.
	Edema	2(+) LE	
	Chest Pain		
RESP	Respiratory Pattern	equal/nsl/full	Equal, even, unlabored. Mouth
	Breath Sounds	CTA / diminished LL (b)	breather. 4L O2 per NC sats
	Secretions	∅	>96%. Clear all lung fields
	Cough	∅	↓ in bases. ∅ cough.
SKIN	Color	NPR	WNL. Warm, dry, intact c̄ cool
	Integrity	intact	BLE. Incision Midline c̄ staples
	Backside	intact	intact. ∅ drainage. ∅ s/s infection.
IV	Access Devices	PIV (R) AC	IV (R) AC infusing D5½NS c̄ 20KCl
	Location		@125cc. (L) AC SL. Dressing intact
	Condition	CDI	
GI	Abdomen	flat	Soft, nondistended. Nontender.
	Bowel Sounds	(+)	Active bowel sounds x4. ∅ BM.
	Stoma/Ostomy	NA	Swallow H2O c̄ problems
GU	Device	foley	foley to DD. Secured to
	Color / Clarity	yellow / clear	(L) leg. Clear yellow urine.

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC (b)(2)-2
ICU #1, [redacted]

DATE 22Aug03

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

NAME: RANK: AGE:

UNIT: GENDER:

STATUS: US: AD / CIV IRAQI: CIV / EPW

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

DA FORM 4700, MAY 78

USAPPC V2.00

[redacted] b(4)-4

MEDCOM - 17307

22 AUG 03

ICU Flowsheet Patient Name: Date: 8 / 22 / 2003

Vital Signs	24	01	02	03	04	05	06	07	08	09	10	11		12	13	14	15	16	17	18	19	20	21	22	23	
Temperature	96.7						96.4		95.6							95.?						91.8				
Pulse	84	80	81	82	78	77	78	79	80	80	83	80		75	78	69	67	67	67	71	67	68	67	71	68	
B/P A-Line																										
MAP										82	86	90		102		88		86	92	76		88	83	89	93	
B/P Cuff	99/70	90/69	105/73	112/82	100/69	99/67	119/70	114/73	100/64	105/67	106/74	108/79		113/70	99/77	109/75	107/73	110/72	108/81	109/83	107/74	107/76	105/69	113/75	116/75	
Respirations	30	28	30	32	30	24	28	30	20	21	22	22		23	26	26	21	20	23	19	18	24	22	24	21	
SaO2	99	98	100	100	100	100	100	100	100	100	98	99		98	97	95	99	98	97	98	96	97%	95%	95%	99%	
O2	10L	8L	8L	10L	10L	10L	10L	10L	10L	10L	8L	6L		6L	6L	4L	6L	6L	6L	6L	4L	4L	4L	4L	4L	
Source	NRB	NRB	NRB	NRB	NRB	NRB	NRB	NRB	NRB	NRB	SM	SM		SM	SM	SM	SM	SM	SM	SM	NC	NC	NC	NC	NC	
Intake	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
IVF	125	125	125	125	125	125	125	125	125	125	50	50	1350	125	125	125	125	125	125	125	125	125	125	125	125	1500
IVPB									KCL →		75	75	150	75	100 (200ml)					50 (Zosyn)						225
BOLUS																										
											200 LOCHEL	30	200			300				200						
PO intake																						90	90	60	120	860
O.R. IN																										
Totals													1700													2585
Output	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
Urine Hourly	70/90	55/145	50/195	100/295	80/375	80/455	50/505	70/575	50/625	100/725	125/850	125/975	975	125/125	50/175	50/225	100/325	150/475	75/550	100/650	100/750	100/850	100/950	100/1050	75/1125	1125
NG Tube																										
#1																										
#2																										
#3																										
Emesis/Stool																										
O.R. OUT																										
Totals													975													1125

24 hour input	4285
24 hour output	2100
24 hour balance	+2185

[redacted] b(4)-4

MEDCOM - 17308

PATIENT'S CLEARANCE RECORD

For use of this form, see AR 40-2; the proponent agency is OTSG

b(6)-4

#[redacted]

PATIENT'S IDENTIFICATION

DATE OF DISCHARGE: 15SEP03

TIME OF DISCHARGE: @1300

SIGNATURE OF WARD OFFICER: b(6)-2 [redacted]

ACTIVITY CLEARANCE

(The final activity with which the patient must clear will be the disposition office.)

Military	INITIALS*	Non-military	INITIALS*
1. Patient's Trust Fund		1. Patient's Trust Fund	
2. Medical Services Account Officer		2. Medical Services Account Officer	
3. Clothing and Baggage		3. Clothing and Baggage	
4. Medical Holding Unit		4. Postal Service	
a. Supply		5. Change of Address	
b. Pay Section		6. Other *(Specify)*	
c. Service Records		7.	
d. Insurance and Allotments		8.	
5. Postal Service		9.	
6. Change of Address		10.	
7. Other *(Specify)*		11.	
8.		12.	
9.		13.	

REMARKS

DATE	SIGNATURE OF PATIENT ADMINISTRATOR

* INITIALS OF PERSON AUTHORIZING CLEARANCE.

DA FORM 4029, MAR 73 REPLACES DA FORM 6-258, 1 DEC 59, WHICH WILL BE USED USAPPC V1.00

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	A
2. LOCATION (State or Country Code.)	
3. REGISTER NUMBER	[redacted]
NAME (Last, First, Middle Initial)	EPW, # [redacted]
4. PAY GRADE	
5. SEX	M
6. DATE OF BIRTH (Y Y Y Y M M D D)	[redacted]
7. AGE AT ADMISSION	55y
8. RACE	Z
9. ETHNIC BACKGROUND	9
RELIGION	UNK b(6)-4
10. LENGTH OF SERVICE	
ETS	NA
11. FMP	~~99~~ 20
12. SOCIAL SECURITY NUMBER	[redacted]
ORGANIZATION (Active Duty Only)	NA
13. MARITAL STATUS	Z
HOUR OF ADMISSION	0147
BRANCH / CORPS	N/A
14. FLYING STATUS	
15. BENEFICIARY CATEGORY	K7 8
16. ZIP CODE OF RESIDENCE	
17. UNIT LOCATION (State or Country Code)	IZ
18. MOS	
19. TRAUMA	
PREV. ADMISSION YEAR	~~Z~~ NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	0 b(2)-2
WARD	ICU1
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	UNK
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	UNK
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	[redacted]
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE	UNK
21. TYPE OF DISPOSITION	50
22. MTF TRANSFERRED TO	
23. DATE OF DISPOSITION (Y Y M M D D)	030915
24. CLINIC SVC - ADMITTING	ABAA
25. MTF TRANSFERRED FROM	
26. DATE THIS ADMISSION (Y Y M M D D)	030818
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

I&D (L) HIP WOUND

Dx: 80851, 86813, 5789, 486, 24519, E991.9

Px: 7969, 8628, 5411, 8964

b(6)-2

[redacted] (Signature, as required)

Dr. [redacted]

SIGNATURE OF ADMITTING CLERK [redacted]

DA FORM 2085, MAR 80

IN... ...IENT TREATMENT RECORD COVER ...EET

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

1. REGISTER NUMBER [redacted]	2. NAME (Last, First, MI) EPW # [redacted] b(6)-4			3. GRADE EPW	ADMISSION REMARKS
4. SEX	5. AGE M	6. RACE —	7. RELIGION —	8. LENGTH OF SVC —	9. ETS —	10. PREVIOUS ADMISSION NO
11. FMP 99	12. SSN [redacted]	13. ORGANIZATION b(6)-4				14. WARD ICU #2
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 2320	23. CLINIC SERVICE ABAA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK		25. TYPE DISPOSITION 05		26. DATE OF DISPOSITION 23AUG00		b(6)-2
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK		27b. TELEPHONE NO. —		28. DATE OF THIS ADMISSION 16aug03		ADMITTING OFFICER DR [redacted]
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b(2)-2				30. DATE OF INTIAL ADMISSION		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: (R) leg Shrapnal wound

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	8	8

36. [redacted]

a. [redacted] R DAYS b(6)-2	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNAT[redacted] DR [redacted] | SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

DA FORM [redacted] EDITION OF 1 AUG 76 IS OBSOLETE USAPPC V1.10

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

28YO Iraqi male s/p Blast injury
@ EPW CAMP c/o (R) knee pain

All	PMH	PSH	TOB	meds
PCN	Ø	Ø	Ø	Ø

PHYSICAL EXAMINATION

88 107/63 99% SAT

NCAT OP clr TM Clr
Neck NT, NL AROM
Chest CBTA
BACK NT ⊖Deformity
Abd NDNT ⊖ARR Soft
Gu wnl

Ext ① Puncture ② upper Arm
③ (L) volar wrist puncture
③ (R) Ant knee LAC over patella
④ (R) Foot LAC Dorsal

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

A/P 28 yo c̄ surface shrapnel wounds
to OR for washout.

b(6)-2

SIGN [redacted]	DATE 16 AUG 03	IDENTIFICATION NO.	ORGANIZATION
PATI [redacted] ed or written entries give Name last, first, [redacted] le; grade; date; hospital or medical facility)		REGISTER NO.	WARD NO.

[redacted]

b(6)-4

[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

[redacted]

MEDICAL RECORD	PROGRESS NOTES
DATE	
17 Aug 03 0759	Received pt resting in bed, VSS, LSCTAB HRR, pulses equal + strong, IV access (L) ac/fa patent + intact. BS (+), NPO, disc intact to (R) leg. Alert, speaks some English. Pt. to or this am returned by no reg D's. New dig c/d/i, transfer supv/ minimal assist from litter to bed. Able to wiggle toes, foot warm, cap refill brisk, unable to assess pulse due to dig. Small ant incis x1 dry, transfer basin @ BS, Foley patent + intact drainage of yellow urine. Will cont to monitor [redacted] b(6)-2
17 Aug 03 1730	Significant Δs from day shift. Neuro [redacted] status intact. Ace dsg to RLE c/d/i + T. RLE [redacted] complaints voiced. Repositioned for dinner. PN attend/assign c described fluids running VSS/Afeb — [redacted]
2000	— Concerned for assessing [redacted]
18 Aug 03	Pt received sleeping, awake easily to physical stimuli, alert, [redacted] noted c peripheral pulses, lungs CTA b/l, (+) bowel sounds, drsg to (R) LE c/d/i & able to wiggle toes. Cont to monitor. [redacted]

(Continue on reverse side)

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

REGISTER NO. | WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR (41 CFR) 201-45.505
509-111

[redacted]

b(6)-4

PROGRESS NOTES

DATE	
18 Aug 03 1730	Pt. currently resting in NAD. ∅ Sign. Sx for day assessment. RLE dx C, D, + I. Neurovasc status intact. Pt is appo for another trip to O.R. VSS/Afeb. ∅ complaints voiced [redacted] Sgt/LPN
PIV to LVE patent + benign	b(6)-2
18 AUG 03 2145	Ortho Op Note Pre-Op Dx: Open (R) patella fx (2) Open (R) 5th MT fx Post-Op Dx: Same Procedure: (R) I+D (R) patella (2) I+D (R) 5th MT Surgeon: [redacted] Anesthesia: GAN Fluids: LR 900 cc 200 UOP Findings: Wounds clean, devitalized with pulse lavage. Closed in layers. Dry sterile dressing applied. Plan: IV antibiotics x 72 hours, then [redacted] b(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

b(2)-2

ORTHO DISCHARGE SUMMARY- [redacted]

24 AUG 03 PT INJURED IN MOTOR SHELLING 17 AUG 03, SUSTAINED WOUND OVER (R) PATELLA, AS WELL FRACTURE OF (R) 5th METATARSAL. 1 + 2 X 2 BONES, AND WOUNDS CLOSED CAST APPLIED TO (R) FOOT.

PLAN (1) SUTURES, MAY WEIGHT BEAR AS TOLERATED
(2) DAY DRESSING TO (R) KNEE.
(3). CIPROFLOXACIN 500 mG P.O. BID. x 7 DAYS
(4) PERCOCET TABS, 1-2 P.O. Q 4-6 HRS PRN #20
(5) NEEDS TO RETURN FOR CAST CHANGE, SUTURE REMOVAL, IN 5-7 DAYS.

b(6)-2 [redacted]

COL MC

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

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

REGISTER NO. | WARD NO.

EPW [redacted]

b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/199
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1
USAPA V1.

DATE	NOTES
24 Aug 03	PT/ORTHO NOTE
	Pt c̄ (R) 5th metatarsal fx needs crutch training. Pt supine in bed. (I) sit ⇔ stand. Walked approx 100 ft c̄ crutches. Pt did not bear weight because of pain but instructed to do so in future. Placed pt back in bed. [redacted] SPC 9WP1
	b(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 AUG 03 0247	JSS. A&O. BS(+)x4. PERRLA. DSG to (R) knee & foot CDI. LSC/AB (+) pulses to (R) foot. Cool to touch CR sluggish ±3 sec. JS @ 125 cc/hr. Pertz in bed — [redacted] b(6)-2
17 AUG 03 0730	Ortho Op Note
	Pre Op Dx (1) Soft tissue wound (R) knee (2) Open (R) 5th MT Fx
	Post Op Dx (1) Open (R) patellar fx (2) Open (R) 5th MT Fx
	Procedure (1) I+D (R) open patellar fx (2) I+D (R) 5th MT Fx
	Surgeon - [redacted] b(6)-2
	Anesthesia - 100 cc
	Findings - Soft tissue wound over (R) knee extended through entire of fascia. Foreign body found there. (R) 5th MT fracture with some bleeding. Packed
	Plan: DC Ancef and Percocet. Repeat I+D in 48 hours with wound closure

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

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

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

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19Aug 0030	Care assumed @ 0010, transferred from ICU2. VSS, pt is alert and aware c̄ c/o slight pain in r/e. Lungs CTA, bs⊕. Pt c̄ HL in (L) FA, to be replaced when tolerating PO. Cast on RLE CDI, patient c̄ (+) cap refill and able to wiggle toes. Pt s̄ ~~c/o~~ complaints at this time, will continue to monitor. b(6)-2 [redacted] aumc
19Aug03	0620 - Pt alert & oriented lying in bed. VSS, lungs CTA, HR reg, BS⊕, pulses palpable x 3. IV to (R) arm LR @ 125cc/o. (R) leg c̄ splint & ace wrap, ⊕ sensation, able to wiggle toes, skin warm to touch. Voicing Ø complaints at this time. Will cont. to monitor [redacted]
19Aug03 1400	Assumed pt care @ 1300. Pt AAOX3. VSS. lungs CTA, abd firm round nontender nondistented. BS ⊕x4. (R) leg c̄ splint & ace wrap. Pt able to wiggle toes. <3 sec cap refill. LLE c̄ ⊕ pulse. BUE c̄ ⊕ pulses. HL to (L) FA flushes s̄ diff, (D) s/sx of infection noted. (D) c/o pain voiced @ this time. Will cont to monitor — b(6)-2 [redacted] 9lwmc
19Aug03 1915	pt c/o unable to void. Will notify MD for straight cath order — b(6)-2 [redacted] 9lwmc

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

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

ePW
[redacted]
b(6)-4

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)
19Aug03 1930	Told pt if unable to void, he will get a foley. pt voided 800 cc amber color urine. (-) foley needed. — [redacted] 9/WMC
19Aug03 2203	Rec'd c/o pt @ 21:00. Restraints x 21 to (D) wrist. Awake and alert in bed. VS WNL per flow sheet. Skin W/D/I. LCA(B) HRR S1S2. BS(+)x4. HL (R) F/A patent. Upon flushing IV pt c/o pain and site erythematous. New IV initiated (R) F/A. (R) leg splint c̄ ace wrap dsg C/D/I. (+) NVVs to (L) digits. c/o pain to (R) knee. iī Percocet given will mon. [redacted] /AW
22Aug03	Addendum: Heat packs applied to (D) AC will mon [redacted]
20Aug03	1245: Pt alert + oriented OOB x 1 ambulating on crutches to use commode. Had BM x1. VSS, lungs CTA, BS(+), pulses (+)x3. Splint & ace wrap to (R) leg, (+) sensation, able to wiggle toes, skin warm to touch. HL to (R) forearm infusing antibiotics. Voicing no complaints. Will cont to monitor [redacted]
8/20/03	Safety stuff b(6)-2 A11 No complaints. Pain well controlled. D/C Rx in chart
20Aug03 1430	pt care assumed @ 1300. pt AAOX3. VSS. lungs CTA and soft BS(+)x4. (R) leg c̄ splint & ace wrap. (+) sensation, pt able to wiggle toes. UE & BUE c̄ full ROM (+) pulses. HL to (R) FA flushes ẽ diff (+) redness/swelling noted. (+) c/o pain voiced. Will cont to monitor. — [redacted] 9/WMC

b(6)-2 A 11

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	(cont) S1 S2, ⊕ pulses x4; LS CTA ⒷⒷ, equal & unlabored; ⊕ BS x4, abd soft non-tender, pt voiding QS, clear yellow urine via urinal; SL patent & c/o pain/discomfort @ this time; Cont to monitor — [redacted]
	@0700 - I concur w above assessment. — [redacted]
22 AUG 03	0800 VSS A&O x3 Speaks English fluently (L) hand splint patent & intact. Lungs clear. (BSE) x4 good. Abd large soft non-distended. (R) Lower leg splinted. Moves (R) toes freely. (R) toes capillary refill < 3sec. Unsteady when ambulating. Tolerates regular diet. Restraints removed & reapplied. Will check restraints frequently. Will continue to monitor [redacted]
22 Aug 03 @ 2100	Assumed care @ 1900 & receiving report from day shift; All VSS; NVV WNL ⊕ movement & sensation in affected leg; S1 S2, LS CTA ⒷⒷ; ⊕ BS x4; soft splint to (R) LE intact; HL patent; ⊖ c/o pain or discomfort @ this time; Cont to monitor — [redacted]
	@2300 - I concur w above assessment. [redacted]
23 Aug 03	@1000 VSS A&O & oriented. (R) hand Salem lock patent and intact. ADL care done. Moves (R) toes freely. Has sensation to (R) foot/toes & capillary refill < 3sec. Denies pain, numbness or tingling to (R) lower extremity. Stated PO liquid diet. Restraints removed and reapplied. Will check restraints frequently. Will continue to monitor [redacted]
23 Aug 03 @ 2000	Assumed care @ 1900; All VSS; ⊕ movement & sensation in affected; pt neurologically intact; ⊕ ortho tech. came in & placed a hard cast; S1 S2, LS CTA ⒷⒷ; ⊕ BS x4; SL in (R) wrist patent & intact; ⊖ c/o pain or discomfort @ this time; Cont to monitor — [redacted]

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 [redacted]

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)*
20 Aug 03 22:15	Rec'd cb pt @ 2130. Pt. awake and alert. c/o pain to (R) leg. ii Percocet given. Restraint x 1 (L) wrist. Skin W/D/I PERRLA (+) WN2. LCA (B). HRRS, SD. BS (+) x4, (+) PP (B), (+) NV ✓ to (R) digits WN2. Will cont. to mon. [redacted]
0223	Pt c/o pain to (R) leg ii Percocet given [redacted]
21 Aug 03 0840	assumed care @ 0500 - VSS - no c/o pain @ this time - cap refill <2 sec in (R) toes, pt. can wiggle toes, Split cast in place - b/c) - 2 SL patent [redacted] CHAN
21 Aug 03 1500	Received pt via litter for A/E. Pt A&O x 3. (R) FA SL Infiltrated. IV site Dcd to (L) hand SL. x1 attempt. Warm compress placed upon (R) FA IV site. Temp clean. BS (+) x 4 quad. Abd soft, non-distended, intact. Regular diet. Denies pain or discomfort. (R) leg splint with ace wrap dry & intact. Wiggles (R) toes freely. Capillary refill < 3 sec to (R) toes. Dcd. Thus assessed to wiggle toes. Restraints off & checked frequently. Will continue to monitor. [redacted] CTAN
	Assumed care of pt @ 1900 ⊼ receiving report from daysdrift A&O VSS, pt A&O X3, Neuro ✓ WNL; ii perc given for pain ⊼ good relief

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. 2CW2

[redacted]

b(6)-4

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

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)
24AUG03 0900	VSS Pt Alert & Oriented. Speak fluent English. Moves (R) toes freely with full sensation and capillary refill < 3sec. (R) Toes warm to touch & pink in color. Pt ambulatory c crutches with assistance / guidance of Physical Therapist. Continue on PO Cipro & tolerating well. Voiding clear amber urine without difficulty. Restraints removed & reapplied with check restraints frequently. Will continue to monitor b(6)-2 [redacted] CTA. Pt informed of Transfer to EPW camp today. D/C RX filled. Awaiting Transfer. b(6)-2 [redacted] CTA
24Aug03@1945	Assumed care of pt @ 1800; All VSS, pt A&OX3, speaks fluent english; NVU intact, (+) movement; sensation; S1S2, (+) pulses x4 c brisk cap Ref; LS CTA (B); (+) BSX4; pt awaiting transfer to EPW camp; Restraints intact c̄ complications; cont monitor b(6)-2 [redacted]
25AUG03	(1055) Assumed care of pt @ 0000 c̄ report from night shift. Pt alert, speaking small amount of English. VSS. Pt medicated this am c̄ ii Perc for pain c̄ good relief. (R) LE in cast elevated on blanket. Drsg to (R) knee CDI.

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

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

[redacted]

b(6)-4

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
29AUG03	(cont) Pt able to move toes on (R) foot. Cap refill <2secs Voiding ≅ difficulty. Tol. reg diet well. 2 point restraint in place. Will continue to monitor. — [redacted] DAW
	(1345) Pt stable for d/c to EPW camp. Amb c̄ crutches - escorted by MPs. Record taken to PAD. [redacted] DAW
	b(6)-2 A11

NSN 7540-01-075-3786

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

PATIENT'S HOME ADDRESS OR DUTY STATION			ARRIVAL	
STREET ADDRESS			DATE (Day, Month, Year) 16 Aug 03	TIME 2320
CITY	STATE	ZIP CODE	TRANSPORTATION TO FACILITY Medical	

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

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

CHIEF COMPLAINT

CATEGORY OF TREATMENT		VITAL SIGNS					
☐ EMERGENT	TIME 1117	TIME 1117					
☒ URGENT		BP 107/63					
	INITIALS SJ	PULSE 77					
		RESP 18					
☐ NON-URGENT		TEMP					
		WT					

LAB ORDERS					X-RAY ORDERS		
X	CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT		CXR PA & LAT/PORTABLE	C-SPINE
X	URINE C&S	UA MSCC/CATH		CHEM: 17		ACUTE ABDOMEN	LS SPINE
	BLOOD C&S X		X	electrolytes		SINUS	HEAD CT
						ANKLE R/L	X Rt leg

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
	Foley catheter				
2340	IV				
	insert leg				
1118 SJ	Tetanus				
	Morphine	SJ	2340	SJ	

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

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

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

[redacted] b(6)-4

EMERGENCY CARE AND TREATMENT ***(Patient)***
Medical Record

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

NSN 7540-01-075-3786

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

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

See H&P

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

[redacted] b(6)-2

DIAGNOSIS

Frm Wound (R) knee / foot

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(6)-4

EMERGENCY CARE AND TREATMENT ***(Doctor)***
Medical Record

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

ER case

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

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

5. ADDITIONAL INFORMATION: Last PO: ? Medical Hx: see H+P Implants: ? Medications: ?
Jewelry removed: yes/no Family waiting: yes/no
N/A

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

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

#[redacted] 6 (W) - 4

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

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted] b(6)-2 17Aug03 DATE

11. POSTOPERATIVE EVALUATION:

Bovie site: c/i

Drsg: d/i

Breathing: ø SOB

b(6)-2

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title) CPT [redacted]

DATE: 17Aug03 TIME: 0610 b(6)-2

13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title) [redacted] CPTH

DATE: 17Aug03 TIME: 0740

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.01

MEDICAL RECORD — **INTRAO[illegible]RA[illegible] DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM, VIA wheeled litter BY Anesthesia

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

3. DATE 17 Aug 03 TIME PATIENT ARRIVED IN SUITE 0630

4. PATIENT IN ROOM TIME 0630 NUMBER 2-3

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: PCN

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] b(6)-2	RELIEF SCRUB	b(6)-2
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	CPT [redacted] (0700-EOC)

7. POSITION AND POSITIONAL AIDS (Specify)

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

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

8. SKIN PREPARATION

HAIR REMOVAL [X] YES [ ] NO

DONE BY: [X] OR [ ] NURSING UNIT

METHOD: [ ] DEPILATORY [X] RAZOR [ ] CLIP

COMMENTS: no nicks or cuts noted

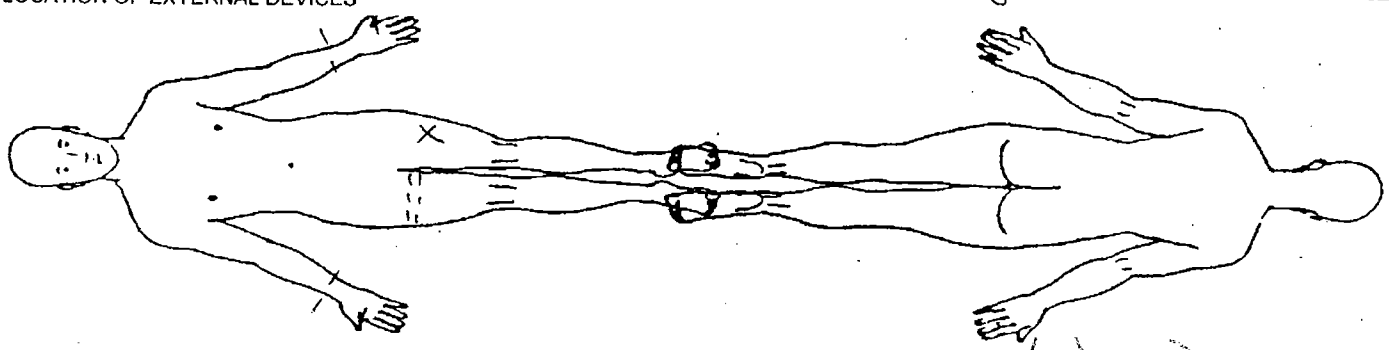
PREP SOLUTION (Specify) Betal Beta

SITE: (R) Leg BY WHOM: [redacted]

SITE: * see BY WHOM: b(6)-2

COMMENTS: no pooling or skin d's noted

9. LOCATION OF EXTERNAL DEVICES



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

b(6)-2

C = Correct I = Incorrect Initial: [redacted] / [redacted]

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

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

[redacted] [redacted]

b(6)-4

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

[X] 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:

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 YES ☐ NO ☒ IF YES, SITE

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs
Kerlix
Ace wrap

19. ADDITIONAL INFORMATION
WC III
Surgeons: [redacted] Anesthesia: [redacted] Anesthesia Type: General

Bovie Pad site intact pre-op ✓; post-op_____ Bovie Settings: 30/35 Coag/Cut
Tourniquet Site intact pre-op ✓; post-op_____

Ancef 1gm Tetnus in ER

20. OPERATION(S) PERFORMED
I+D (R) knee, (R) foot

21. PATIENT TRANSFERRED TO ICU 3 b(6)-2 TIME see D17389 METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] AN

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

MEDCOM - 17329

USAPA V1.01

MEDICAL RECORD — **INTRAO[illegible]A[illegible] DOCUMENT** b(6)-2

For use of this form, see AR 40-66, the propon[illegible]ency 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 18 Aug 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN [redacted] TIME 2018 NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] 91D b(6)-2	RELIEF SCRUB	b(6)-2
ASSIGNED CIRCULATOR	CPT [redacted] 66E	RELIEF CIRCULATOR	MAJ [redacted] (2000-2030)

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS:

8. SKIN PREPARATION

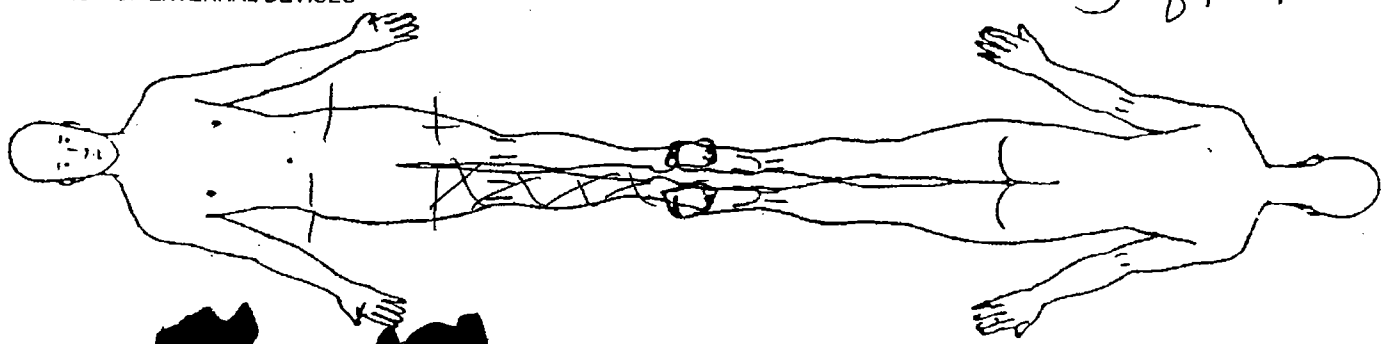
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

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

COMMENTS: no pooling of prep noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND: X G[redacted]ad -- Safe[redacted] === Tourniquet ^XX - prep

C = Correct I = Incorrect

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

H[redacted] b(6)-2

[redacted] b(2)-2

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

CUT 30 COAG 30

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NACL

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*

- fluffs
- kerlix
- ace wrap
- splint

19. ADDITIONAL INFORMATION

WC

Surgeons: [redacted] Anesthesia: Anesthesia Type:

Bovie Pad site intact pre-op N/A; post-op N/A Bovie Settings: Coag/Cut N/A

Tourniquet Site intact pre-op N/A: post-op N/A

20. OPERATION(S) PERFORMED

I&D (R) knee and foot

21. PATIENT TRANSFERRED TO ICU2 TIME 2145 METHOD gurney

22. REGISTERED NURSE SIGNATURE [redacted] CPT AN

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																		
POST- DAY																		
MONTH-YEAR Aug	DAY	17		~~16~~			18											
~~19~~ 2003	HOUR	8	12	1			6											

PULSE (O)	TEMP. F (•)	TEMP. C
	105°	40.6°
180	104°	40.0°
170	103°	39.4°
160	102°	38.9°
150	101°	38.3°
140	100°	37.8°
130	99° / 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

		20	18															
Record special data only when so ordered	BLOOD PRESSURE	123/64	11~~8~~/57	114/63			121/58											
		65	78	74														
		97.2	97.5															
	HEIGHT: WEIGHT →			95.4			98.2											

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] / ICW 1

b(6)-2

VITAL SIGNS RECORDS

Medical Record

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY: 19 20 21 22 23 24

MONTH-YEAR Aug 03 DAY: 19 20 21 22 23 24

HOUR

PULSE (0) / TEMP. F (°) / TEMP. C (Centigrade Equivalents, for Reference only)

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		

RESPIRATION RECORD

BLOOD PRESSURE

SPO2

HEIGHT: WEIGHT →

Record special data only when so ordered

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

EPW [redacted]

b(6)-2

REGISTER NO.

WARD NO. JCW2

VITAL SIGNS RECORDS

Medical Record

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

b(a) -2

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted]	DATE 16 Aug / TIME 1123	SSN/PSEUDO 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 (ar 41-51 mmHg (ven
PO2		80-105 mmHg (ari N/A (ven)
TCO2		23-27 mmol/L (ari 24-29 mmol/L (ve
HCO3		22-26 mmol/L (ari 23-28 mmol/L (ve
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmo
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. RANG
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE

b(a) -4

======= PICCOLO =======
16/08/03 23:59
REFERENCE RANGE: MALE
PATIENT #: [redacted]
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: [redacted]3 DR #: 000
SERIAL #: [redacted]

ALB	4.5	3.3-5.5	G/DL
ALP	79	26-84	U/L
ALT	55*	10-47	U/L
AMY	43	14-97	U/L
AST	<5*	11-38	U/L
TBIL	1.4	0.2-1.6	MG/DL
BUN	23*	7-22	MG/DL
CA++	9.6	8.0-10.3	MG/DL
CHOL	151	100-200	MG/DL
CRE	1.4*	0.6-1.2	MG/DL
GLU	153*	73-118	MG/DL
TP	8.1	6.4-8.1	G/DL

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE

======= PICCOLO =======
16/08/03 23:57
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	153*	73-118	MG/DL
BUN	20	7-22	MG/DL
CRE	1.6*	0.6-1.2	MG/DL
CK	124	39-380	U/L
NA+	129	128-145	MMOL/L
K+	3.0*	3.3-4.7	MMOL/L
CL-	97*	98-108	MMOL/L
tCO2	17*	18-33	MMOL/L

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

						tCO_2		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: FMT	REQUESTING PHYSICIAN: [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. b(6)-4 [redacted]	DATE 11/17/03 / TIME 1137	SSN/PSEUDO SSN:

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

POC Protein - 35H - Large . 3+ mucus - hazy
Bill → 1L70 - Neg
Ketones Acetest - Small
WBC - 10-20
RBC 1-3

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT	14.9	9.8-13.6 secs
APTT	28.7	21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

b(6)-2

PRE-ANESTHETIC ASSESSME ND PLAN OF CARE

AGE: 28 Days Mos Yrs

GENDER: (X) Male ( ) Female

ALLERGIES: PCN

P S: 1 2 3 4 5 E

WT:_____Kg/Lb HT:_____In.

PROPOSED PROCEDURE: Open (R) Patella Fx; (R) Foot Fx

SURGICAL SERVICE: Ortho

NPO SINCE:

PREOP DX / MECHANISM OF INJURY: S/P Blast Injury (shrapnel wounds) (R) leg

HABITS:

Tobacco: Ø

EtOH:

Drugs:

CURRENT MEDICATIONS:

( ) = ordered as premed

( ) Ancef 1gm

( ) Morphine 5mg EMT

( ) Tetanus

( )

( )

( )

PREMEDICATIONS:

None / Yes @ _____Hrs

LABORATORY STUDIES:

29	97	20	153
3.0	17	1.6	

14.4	17.3	304	
	51.6		

Other:

PAST MEDICAL HISTORY / SYSTEMS REVIEW

Cardiovascular:
- Hypertension N Y
- Angina N Y
- MI N Y
- CVA N Y
- Other N Y

Pulmonary:
- Asthma N Y
- URI N Y
- COPD N Y
- Other N Y

Renal System:
- ARF/CRF N Y Foley - Cloudy yellow
- Other N Y

Gastrointestinal:
- Hepatitis N Y
- Hiatal Hernia N Y
- GERD/PUD N Y

Endocrine:
- Diabetes N Y
- Steroids N Y
- Thyroid N Y

Neurological:
- Seizures N Y
- Neuropathy N Y

Gynecological:
- Pregnancy N Y N/A
- Other N Y

Other Problems: N Y

Familial Hx N Y

Speaks English

SURGICAL HISTORY

Ø

PHYSICAL EXAMINATION 99%

BP: 107/63 HR: 88 RR:____ T:____

Pain (0/10 Scale):

Airway Exam:

Dentition: Intact

Trachea

TMJ/C-spine

Oropharynx: MP II-III

Chest:

Lungs: CTA

Heart

IV Access: 16g (L) Arm

Ulnar Filling:

Back:

Other:

ANESTHETIC PLAN: ( ) Local/MAC ( ) Regional: _____ (X) General: Intubation / Mask-LMA Notes:

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives, and risks of anesthesia including death have been explained to and discussed with patient and/or legal guardian. The patient/legal guardian seems to understand and agrees to proceed. Questions answered.

[redacted] b(6)-2

( ) Sedated/nonresponsive/minor patient with no family or guardian present.

Signe[redacted]KWA CRT Date: 16 Aug 03 Time: 2340

PATIENT IDENTIFICATION:

#

[redacted]

b(6)-4

POST-ANESTHESIA EVALUATION AND NOTE:

( ) No apparent anesthetic complications.

( ) Other (see progress notes)

Signed:_____Date:_____Time:_____

Nursing Unit: EMT

28TH COMBAT SUPPORT HOSPITAL & MEDICAL TASK FORCE-BAGHDAD

MEDCOM - 17337

28 yo.

MEDICAL RECORD - ANESTH

(this form, see AR 40-66; the proponent agenc, OTSG

allergic to PCN

CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION															
DRUG	(Units)														
Fentanyl	(mcg)	50 –	<150>	50											
Midazolam	(mg)	2													
Lidocaine	(mg)	50													
Propofol	(mg)	200													
Sux	(mg)	100													
MSO4	(mg)		4	2	2	2									
VOLAT AGENT	ISO % del		1.5 ~ 1.2	1.2	1.2	X									
	% e.t.														
AIR	L/Min														
N2O	L/Min														
O2	L/Min	10 ~ 2	2	2 – 6											

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

INE site															
16G (DA)	☒ Warmed	AS – #1													
	☐ Warmed														
	☐ Warmed														
	☐ Warmed														
SSES	EST BLOOD LOSS														
	URINE -		200												

TOTALS	TOTAL EBL
0520	Min
	TOTAL URINE
1010	100

FLUIDS - SUMMARY

CRYSTALLOID- LR-1000

COLLOID-

BLOOD-

REMARKS

Code drugs with numbers, events with letters

1. Pre-op assessment
2. Room, monitors induced
3. LR + soft tube blade

0730 – sort resp, opened eyes, extubated, suctioned, TO ICU

YS STATUS 2 3 4 5 (E)

DY WEIGHT: 90 (KG) LB

MATOCRIT: 51.6

TIAL DATA: 17.63 / 88

UIP CHECK - (Y) N

ENT RECHECK or CEDURE? JR - 0600

TIME →	0630	0700	30	0800
VT - ml	–	900	860	860 / 700
f - breaths/min	–	8	8	7 / 13
Peak inf pres / PEEP		23	23	23
MODE - S(pon), A(ssist), C(on)	S –	C	C	C / SC
BP/Auto Cuff / ET CO2 (torr)	38	30	29	30 / 26
BP/oth / FIO2 (Frac or %)	0.88	0.88	0.81	.88 / .88
ART line / SpO2 (%)	100	100	100	100 / 100
Steth- PC/ES / ECG	SR	SR	SR	SR / SR
Gas analyzer / TEMP-site	ST 34°C	34°C	34	
N-M Block (T/4)	BS	+	+	4/4 ST
ning blkt / warmer	X Blanket →			

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

ters & symbols, REMARKS — EVENTS → 1 2 3 — Position: arms <90° abducted, padded

RECOVERY AT:

PACU ICU (Specify)

OTHER SPR

CONDITION:

RESP: R SpO2: 96%

BP: 106 HR: 105

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0615	0630	0800
	Ready	Begin	End
PROC	0640	0700	0730

S and CPT Codes: (R) knee / I+D (R) foot

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

[redacted]

b(6)-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

G-ETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: DLx1 Miller 3 Grade 1 view, 8.0 ETT stylETTed, 8 mL air cuff, + BBS + Sust ETCO2

SURGEONS: [redacted]

PROCEDURE LOCATION: 2

DATE: 17 Aug 03

PAGE 1 OF

MAJ/CRNA

b(6)-2

2840 — Fixed 48, Cp10 48

HI: PCA

MEDICAL RECORD - ANESTH

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

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

DRUG	(Units)																		
Versed	( )	1-2																	
Fentanyl	( )	50/100	50			50													
Propofol	( )	200					40/40/40/40/40												
Lidocaine	( )	100		100															
	( )																		
	( )																		
VOLAT AGENT	150 % del % e.t.	X/2.0/1.0/1.0/1.0/0.6/X/0/Y																	
AIR	L/Min																		
N2O	L/Min																		
O2	L/Min	8/2/3/3/3/3/3/2/2																	

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

TOTALS: 5, 150, 100, 200

TOTAL EBL: MIN

TOTAL URINE: 200

FLUIDS SUMMARY: CRYSTALLOID- 100; COLLOID- Ø; BLOOD- Ø

FLUIDS

LINE site																		
R/C	☐ Warmed	LR1		500		#2 300												
	☐ Warmed																	
	☐ Warmed																	
	☐ Warmed																	

LOSSES: EST BLOOD LOSS; URINE - 200

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 90 KG LB

HEMATOCRIT: 51.6

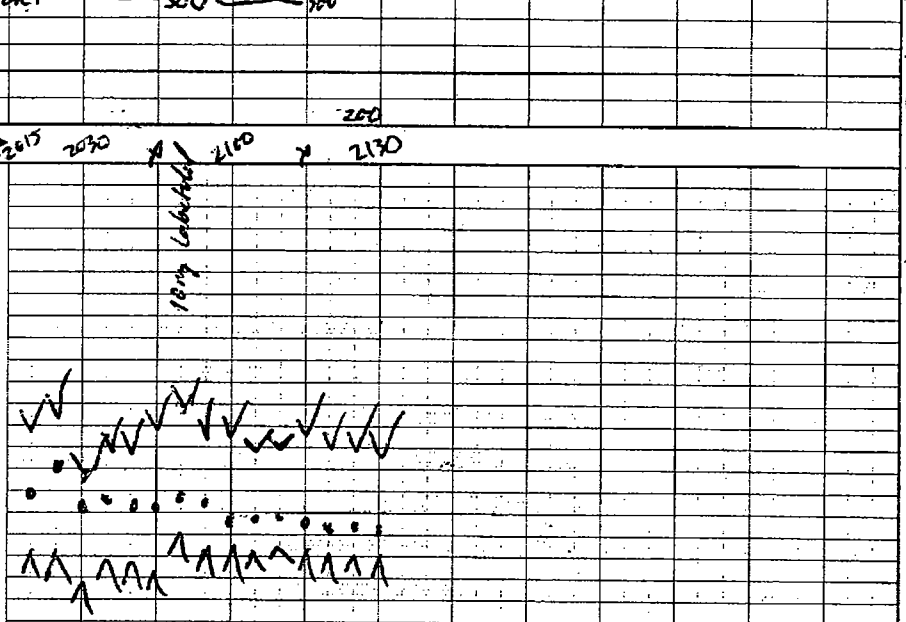
INITIAL DATA: BP- 107/63; HR- 88

EQUIP CHECK: OK?- Y N

PATIENT RECHECK: OK for PROCEDURE? Y; TIME- 1630

TIME → 2015, 2030, A, 2100, X, 2130

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



VENTIL

	2015	2030		2100		2130
VT - ml	210	220	200	230	240	200
f - breaths/min	22	10	17	15	17	11
Peak inf pres / PEEP	/	/	/	/	/	/
MODE - S(pon), A(ssist), C(on)	S	S	S	S	S	S

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	43	52	52	50	51	51
BP/oth	✓ FIO2 (Frac or %)	.63	.63	.63	.63	.63	.63
ART line	✓ SpO2 (%)	99	99	99	99	99	99
Steth- PC/ES	✓ ECG	SR	SR	SR	SR	SR	SR
Gas analyzer	✓ TEMP-site	Axil					
	✓ N-M Block (T/4)	Axil					
Warming blkt							
Conv warmer							

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

REMARKS

Code drugs with numbers, events with letters

2000 pt ID, chart reviewed, Ø change from Preop Hx.
2018 RM, O2, monitors
2028 LMA #4 placed
2138 pt ∑ LMA removed
2142 RPT TO [redacted] RN

RECOVERY AT 2140; PACU ICU 2 (Specify); OTHER

CONDITION: RESP- 15; SpO2- 97; BP- 124/82; HR- 77

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	2000	2018	2145
PROC	Ready	Begin	End
	2035	2046	2131

PROCEDURES and CPT Codes: I&D @ LEG + FOOT

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GAE LMA

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

[redacted] b(6)-4 TCW 1

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: #4 LMA placed atraumatically x 1 attempt, soft BS in place

[redacted] b(6)-2

ANESTHE[redacted]

PROCEDURE LOCATION:

DATE: 18 AUG 03

PAGE 1 OF 1

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4 [redacted]

NURSING UNIT | ROOM NO. [redacted] | BED NO.

DATE OF ORDER	TIME OF ORDER	HOURS	LIST TIME ORDER NOTED AND SIGN
17 Aug 03	0100		
(1) Admit toward			
(2) Dx: (R) leg injury			
(3) Condition stable			
(4) IVF LR @ 125 cc/hr			
(5) NPO			
(6) Elevate (R) foot			
(7) Ancef 2gm q 8°			

PATIENT IDENTIFICATION

8/16/24

DATE OF ORDER	TIME OF ORDER	HOURS
MSO4 2-6mg IVP q 2° PRN pain		
Phenergan 12.5mg IVP q 6° PRN nausea		
(8) Foley to gravity drainage		
(9) On call for OR		
(10) allergy PCN b(6)-2		
(11) D. [redacted]		

NURSING UNIT | ROOM NO. | BED NO.

b(6)-2

PATIENT IDENTIFICATION

b(6)-4 [redacted]

DATE OF ORDER	TIME OF	HOURS
17 AUG 03	0[redacted]	
(1) RESUME PREVIOUS ORDERS		
(2) RESUME DIET		
(3) N' LR ST 125cc/hr HOLD LOCK WHEN FLUSH PRN WORK		
(4) TYLENOL 650mg P.O. Q 4-6hrs PRN		
(5) PERCOCET 1-2 P.O Q 4-6hrs PRN		
(6) MSO4 2-6mg IVP Q 2 hrs PRN		
(7) Pyromax 25mg IVP or P.O. Q 6 hrs PRN		
(8) ANCEF 1 gm IVPB Q 8 hrs		
(9) CIPRO BLOXSUN 400mg IVPB Q 12 hrs		

[redacted]

NURSING UNIT: 1CW#1 | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

NURSING UNIT: 2A | ROOM NO.: 2000 | BED NO.: Transfer [redacted]

b(6)-2

DA FORM 1 APR 79 4256 REPLACES EDITI[redacted]UL 77, WHICH MAY BE USED.

☆ U.S. GOVERNMENT PRINTING OFFICE: 1990—409-924

"USE BALL POINT PEN—PRESS FIRMLY! NO CARBON PAPER REQUIRED"

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

NURSING UNIT	ROOM NO.	BED NO.
24 V/S	0040	19 Aug 03

DATE OF ORDER: 18 AUG 03 TIME OF ORDER: 2130 HOURS

b(6)-2 [redacted]

1. RESUME PREVIOUS ORDERS
2. RESUME DIETS
3. LR at 125 cc/hr [illegible] WITH FLUSH P.D. WITH
4. B/C PORTA b(6)-2 [redacted]

LIST TIME ORDER NOTED AND SIGN: 0840 [illegible]

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

NURSING UNIT	ROOM NO.	BED NO.
24 V	2300	22 Aug 03

Noted 22 Aug 03 [redacted]

DATE OF ORDER: 8/22/03 TIME OF ORDER: 1400 HOURS

- D/C IV Ancef
- D/C IV Cipro
- Heplock IV
- Start Cipro 500 mg PO BID

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

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.
ICW	24	8/24/03 2340

DATE OF ORDER: 8/24/03 TIME OF ORDER: 0840 HOURS

1. DISCHARGE TODAY AFTER P.T., TO EPW.
2. CIPRO 500 mg P.O. BID
3. PENICILLIN 1-2 P.O. Q 4-6 hrs [illegible] 20.

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

Noted 8/24/03 [redacted]

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.

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. 8 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED: 16	17	18	19	20	21	22	23	24	25	26	27
17	[redacted]	LR@125cc/hr	5	[redacted]											
	[redacted]	HL when taking po well	7	[redacted]											
17	[redacted]	Ancef 2gm q8°	8	X											
		IV	16	X											
			24	EWT											
17	[redacted]	Ancef 1 gm q8°	06	/	/	[redacted]									
	[redacted]	IVPB	14	/		[redacted]									
			22	/		[redacted]									
17	[redacted]	Ciprofloxacin 400mg	10	/		[redacted]									
	[redacted]	IVPB Q12°	22	/		[redacted]									
17	[redacted]	Ancef 1 gm Q8°	08			[redacted]									
	[redacted]	IVPB	16			[redacted]									
			24			[redacted]									
17	[redacted]	Cipro 400mg IVPB	12			[redacted]				2W					
		Q12	24			[redacted]									
22Aug03	[redacted]	Heplock IV	07							8W					
		N	19							[redacted]					
22Aug	[redacted]	Start Cipro 500mg	10							[redacted]					
		P.O BID	22							[redacted]					

Δ'd 17 Aug 03 0900

D'C

D'C

Δ'd 22 Aug 03

Δ'd

ALLERGIES: ☒ YES ☐ NO PCN

PRIMARY DIAGNOSIS: (R) Ulg shrapnel injury

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

#[redacted] b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo Aug Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
	-----					

	-----	b(6)-2 A11				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
17 20	[redacted]	MSO4 2-Lemg IVP Q20 prn pain	D/T													
-----	-----		D/I													
17	[redacted]	Phenergan 12.5mg IVP Q6° PRN	D/T													
-----	-----		D/I													
17	[redacted]	Phenergan 25mg IVP Q6 p.o. Q6 prn	Date													
-----	-----		Time													
			Dose													
			Int													
17	[redacted]	Percocet 1-2 po Q 4° prn pain	Date	19 Aug 03	19 Aug 03	20 Aug 03	20 Aug 03	21 Aug 03	22 Aug 03	23 Aug 03						
			Time	1100	1100	1100	1100	2100	2145	0135						
			Dose	[redacted]												
			Int													
			T/E													
		Tylenol 650mg P.O. 4-6° prn														

A'd 17 Aug 03 0900

V1.00

USAPA V1.00

b(6)-2 All

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. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 16	17	18	19	20	21	22	23	24	25
17	[redacted]	NPO	5	X									
			17	X		D/C	17 Aug 03						
17	[redacted]	Elevate (R) foot	5	[redacted]									
			17										
17	[redacted]	Foley to gravity	5										
			17			D/C							
17	[redacted]	Regular Diet	05 17										
			17 05										

ALLERGIES: ☒ YES ☐ NO — PCN

PRIMARY DIAGNOSIS: ~~GHE~~ (R) leg shrapnel injury

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

b(6)-4

[redacted]

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

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

GREEN SHEET

MEDCOM - 17344

b(6)-2A11

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
17	[redacted]	Admit to ward, stable				
17	[redacted]	O/C to OR, [redacted]				
18	[redacted]	D/C Coley	18 Aug	0830	2300	[redacted]
24	[redacted]	D/C today p P.T.	8/24			

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

USAPA V1.00

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 17
Time In: 0735
Allergies: PCN
Pre-op V/S: 157/63 ; 88
Procedures: (R) [illegible] foot [illegible]

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1000 Colloid —
OR Output: UOP 100 EBL —
Meds/Times:

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

Pre Op Meds

History

Time	0745	0800	0815	0830
SaO2	97	97	95	94
FiO2				
Methods	RA	RA	RA	RA
240				
220				
200				
180				
160				
140				
120				
100				
80				
60				
40				
20				
RR	17	20	16	23
T	97.8	98	96	98
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	Codes
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2		AIRWAY A = Ambu BB = Blow-by M = Mask FT = Face Tent RA = RoomAir NC = Nasal Cannula
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		V/S X = A-line BP ' = Cuff BP = Pulse
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2		
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2		TEMP S = Skin O = Oral A = Axillary T = Tympanic R = Rectal
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2	2		LOS C = Cervical T = Thoracic L = Lumbar S = Sacral
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	11	12		

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:

DATE: 17 Aug 2003

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

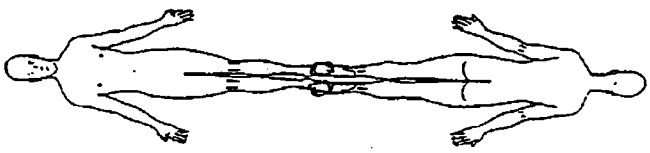
MEDICATIONS						
Allergies:						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

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

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

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

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



PACU OUTPUT			
Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

0735 pt adm via litter sleepy but arousable correct to stable oxygen to (R) leg from above R. ear to toe c̄ ace wrap foley to gravity drain, peripheral IV 16 G left a. c̄ IV fluid NS infusing c̄ difficulty palpable on R. leg via tube breath sounds CTA all fields heart sounds S1S2 present ō MSR skin color WNL no pain ō operative site complaint of HA PERL. [redacted]
0800 urine clear c̄ amount sediment [redacted]

b(6)-2 A11

Discharge Criteria:
Date: 17 Aug 03 Time: 0845 PARS: 12
BP: 125/65 T: 96.7 HR: 92 RR: 20 Sa02: 94
Pain Level at D/C (0-10):
Intake: 120 Output: 100 cc
Additional Data:
Transferred To: [redacted]
Report Given To: [redacted]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Recovery Room SOP [redacted]
Charge Nurse Signature: [redacted]

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

DTSG APPROVED (Date)

ASA II
90KG

Date: 18 AUG
Time In: 2140
Allergies: PCN
Pre-op V/S: 107/63 98%
Procedures: (R) Cog IID

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 900LR Colloid
OR Output: UOP 200 FTG EBL MIN
Meds/Times:

230 Fent
184 5 versed
Propofol

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

Pre Op Meds

History

Time	2140	2145	2150	2210	2220	2230	2240								
SaO2	99	98	96	100	98	100	99								
FiO2	RA	RA	RA	RA	RA	RA	RA								
Methods															
240															
220															
200															
180															
160															
140															
120															
100															
80															
60															
40															
20															
RR	16	20	18	20	20	18	20								
T	99			98			96								
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	1	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP +/- 20 of Pre-op (1) SBP +/- 20-50 of Pre-op (0) SBP +/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	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

PRE[redacted]

b(6)-2 [redacted] 1UT DH

DEPARTMENT/SERVICE/CLINIC: TU#2

DATE: 18 AUG 03

PATIENT'S [redacted] written entries give: first, midd[redacted] al facility) 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 USAPPC V2.00

b(6)-2 A11

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	LLE	TOES	+	UTA	BR	COOL	NL
15'							
30'	LLE	TOES	+	UTA	BR	COOL	NL
45'							
60'	LLE	TOES	+	UTA	BR	COOL	NL
90'							
D/C							

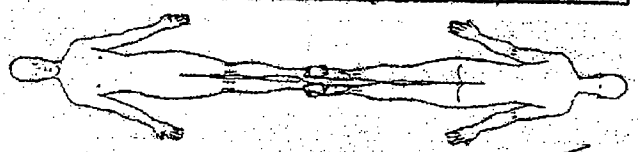
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	LLE	BULKY DSG	Ø
30'			
60'			
D/C	LLE	BULKY DSG	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

2330 D/C FOLEY DTV @ 0530. VSS. TO TRANSFER TO IEW 2 [redacted]

[redacted]

Discharge Criteria:
Date: 18 AUG 03 **Time:** 2330 **PARS:** 9
BP: 128/86 **T:** 96.9 **HR:** 88 **RR:** 20 **SaO2:** 100% RA
Pain Level at D/C (0-10): Ø
Intake: Ø **Output:** 300
Additional Data: Ø
Transferred To: IEW 2
Report Given To: SPC [redacted]
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Re[redacted] SOP B-3
Charge Nurse Sig[redacted] b(6)-2

PATIENT'S CLEARANCE RECORD

For use of this form, see AR 40-2; the proponent agency is OTSG

PATIENT'S IDENTIFICATION	DATE OF DISCHARGE	TIME OF DISCHARGE
# [redacted] b(6)-4	25AUG03	1345

SIGNATURE OF WARD OFFICER

[redacted] b(6)-2

ACTIVITY CLEARANCE

(The final activity with which the patient must clear will be the disposition office.)

Military	INITIALS*	Non-military	INITIALS*
1. Patient's Trust Fund		1. Patient's Trust Fund	
2. Medical Services Account Officer		2. Medical Services Account Officer	
3. Clothing and Baggage		3. Clothing and Baggage	
4. Medical Holding Unit		4. Postal Service	
a. Supply		5. Change of Address	
b. Pay Section		6. Other *(Specify)*	
c. Service Records		7.	
d. Insurance and Allotments		8.	
5. Postal Service		9.	
6. Change of Address		10.	
7. Other *(Specify)*		11.	
8.		12.	
9.		13.	

REMARKS

DATE	SIGNATURE OF PATIENT ADMINISTRATOR

* INITIALS OF PERSON AUTHORIZING CLEARANCE.

DA FORM 4029, MAR 73 REPLACES DA FORM 6-258, 1 DEC 59, WHICH WILL BE USED. USAPPC V1.00

ADMISSION AND CODING INFORMATION

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

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

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
		Z	Z	—

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 / [redacted]
—	Z	2320	— b(6)-4

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	~~K 7 8~~ K78	

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

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

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
[redacted] b(2)-2	unk

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
unk

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
0 5		0 3 0 8 2 3

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
A E A A		0 3 0 8 1 6

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

FOR LOCAL USE

Dx: (R) leg Shrapnal wound

832.1
825.35
280.03
881.02
E993

17 Aug 03
79.69
79.67
18 Aug 03
86.28
86.59
93.50

Dx: 81510
8221
E9919

Px: 7963
7966

[redacted] ure, as required)

[redacted] b(6)-2

SIGNATURE OF ADMITTING CLERK

INPATIENT TREATMENT RECORD COVER SHEET

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

1. [redacted]			2. NAME (Last, First, MI) EPW # [redacted] b(6)-4			3. GRADE EPW	ADMISSION REMARKS
4. SEX M	5. AGE 30	6. RACE —	7. RELIGION —	8. LENGTH OF SVC —	9. ETS —	10. PREVIOUS ADMISSION 100	
11. FMP 99		12. SSN [redacted]		13. ORGANIZATION —		14. WARD IW2	
15. FLYING STATUS —	16. RATING/DSG —	17. DEPT./BEN K70		18. BRANCH/CORPS —	19. UIC/ZIP —	20. TYPE CASE NBI	

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct FROM ER	22. HOURS OF ADMISSION: 0130	23. CLINIC SERVICE: AEAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: unk	25. TYPE DISPOSITION: 50	26. DATE OF DISPOSITION: 17Aug03	b(6)-2
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): unk	27b. TELEPHONE NO.: unk	28. DATE OF THIS ADMISSION: 17Aug03	ADMITTING OFFICER: DR [redacted]
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] b(6)-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

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: (R) Leg (L) heel fragment

35. Total Days This Facility

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

36. Total Days All Facilities

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

SIGNATURE OF ATTENDING MEDICAL OFFICER: DR [redacted]

SIGNATURE OF [redacted] RECORDS OFFICER

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

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

EPW s/p Fragment (L) Lower leg
(L) Skull

PHYSICAL EXAMINATION

Gen = CTA (D)
♡ = RRR
ABD = BS

(L) Lower Extr pulses intact
mild wounds
Head (L) 2 small wounds.

X-ray = Skull
Ø Fx

8.4 / 4.7 250

15/34 (125) / 101 / 19 / 111
PT/PTT 40

(L) tib Fragment away from bone. Ø Fx.

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

- Fragment wounds
  - Head (L) side
  - (L) Lower Extr

Admit
- Abx
- pain control
- DSG Δ / clean

SIGNATURE OF PHYSICI[redacted] | DATE 17 Aug | IDENTIFICATION NO. | ORGANIZATION

PATIENT'S IDENTIF[redacted] ten entries give Name last, first, date; hospital or medical facility) | REGISTER NO. | WARD NO.

b(6)-2

[redacted]

b(6)-4

ICW I

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

[redacted]

:DICAL RECORD

AUTHORIZED FOR LOCA

PROGRESS NOTES

DATE	NOTES
17Aug03 0200	Rec'd Pt from E.R. via Litter Pt in NAD. A&O, coherent / cooperative NAE, lungs CTA, abd. soft NT/ND (+)BS, dsg to LLE C.D.&I. PIV to RFA HL'd.
VSS/Afeb.	Restraints placed. ∅ complaints voiced. Comfort measures given. Adm. process & Pt. teaching done needs reinforcement / translator- [redacted] Sgt /LPN.
0215	- I concur c above assessment [redacted]
17Aug03 0330	Dsg taken ↓ by M.D. - undr Mitigated / cleaned. Superficial undrs to (L) foot beefy red / clean. dry dsg placed / Physician. Dsg Δ tol. well / [redacted] Sgt/LPN
17Aug03 @0700	- Assumed care ~~AX~~ ox3. ∅ c/o pain or discomfort @ this time. Lungs CTA HRRR S1 S2 present Active BS. Dressing to LLE intact C.D.I. Wound care done will cont to monitor [redacted]
17Aug	D/C Sang Amb / tol (L) foot PO / AF / pain ↓ Fung wound blunt trauma to (L) Hand b(6)-2 Cont Abx D/C SPW Camp [redacted] / WNA
17Aug03 1000	I concur c above shift assessment. Pt prepared for D/C to SPW Camp. Transportation pending. Will continue monitoring. Neurovascular intact [redacted]

INSHIP TO SPONSOR

SPONSOR'S NAME

LAST | FIRST

/SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO

[redacted] SPW

b(6)-4

ICW I

PROGRESS NOTES
Medical Record

STANDARD FORM 50

Prescribed by GSA/ICMR FPMR (41 CFR) 1

	FIRST NAME	MIDDLE INITIAL	ID NUMBER

TE	NOTES
17 Aug 03 1350	D/C to EPW Camp escorted by MP. Med. record & Radiology films to PA [redacted] b(6)-2

:DICAL RECORD

AUTHORIZED FOR LOCAL RI

PROGRESS NOTES

DATE	NOTES
17 Aug	D/C Summary

Admitted p̄ EPW camp Blanst.
Hand w (L) sided head blunt trauma → pain.
2 frag wound x2 small ⊘bleeding
2. (L) lower ext. Frag wounds. X-ray ⊘Fx (+) Frag.

(A) Frag / blunt trauma
(P) PMF / pain control

[redacted] RTD EPW camp

b(6)-2

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

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (F

b(2)-2

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT (Patient)

LOG NUMBER | TREAT[redacted]

RECORDS MAINTAINED A[redacted]

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

SEX: M

DUTY/LOCAL PHONE: AREA CODE | NUMBER

AGE: 30

HOME PHONE: AREA CODE | NUMBER

MILITARY STATUS

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

ARRIVAL

DATE (Day, Month, Year): 16/08/03 | TIME: 1115

TRANSPORTATION TO FACILITY: Medevac

THIRD PARTY INSURANCE

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

CURRENT MEDICATIONS: denies

ALLERGIES: NKDA

CHIEF COMPLAINT: Lt GSW

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CATEGORY OF TREATMENT

☐ EMERGENT
☐ URGENT
☐ NON-URGENT

TIME

INITIALS

VITAL SIGNS

TIME	2315			
BP	143/82			
PULSE	89			
RESP	18			
TEMP	98.9			
WT				

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

X-RAY ORDERS: CXR PA & LAT/PORTABLE | ACUTE ABDOMEN | SINUS | ANKLE R | C-SPINE | LS SPINE | HEAD CT

☒ AP and Lateral Skull

☒ PULSE OX 95%

ORDERS

☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
2315	Ancef 1.0gm IV	2320			
2315	Morphine 4mg IV	[redacted]			
2315	Tetanus 0.5mg IM				
0050	5mg MSO4 IV				

b(6)-2

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 ☐ DETERIORATE

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

EPW

[redacted]

b(6)-4

EMERGENCY CARE AND TREATMENT (Patient)
Medical Record

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

NSN 7540-01-075-3786

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

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL GSW to left foot Good Pulse distal to injury. IV infusing
NAS 50 c/o pain left temporal lobe

See H&P

CONSULT WITH	TIME	ACTION

DIAGNOSIS

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE A[redacted]

[redacted] b(6)-2

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

b(6)-4

[redacted]

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY															
POST-	DAY														
MONTH-YEAR	DAY	17 Aug													
19	HOUR	0700													

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD: 18

BLOOD PRESSURE: 124/68

HEIGHT: H 79

WEIGHT: T 98.2

WT 190

RA

Record special data only when so ordered

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

[redacted] EPW

b(ce)-4

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

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

Ward/Section:	REQUESTING PHYSICIAN:			LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI.		DATE	TIME	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
W		
RI		
Hg		
Hc		
M(		
Plt		
Ly		
(		
Segs		Mono
Bands		Eos
Lymph		Baso
Atyp		Imm
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

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

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	15.2	9.8-13.6 secs
APTT	34.4	21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

b(6)-2

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted] b(6) - 2		CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: b(6)-2 [redacted]	DATE 16Aug03	TIME 2338	SSN/PSEUDO SSN:

(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		
~~Pt/PT~~ ~~INR~~		

(Piccolo) Chemistry 12 TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l

(Piccolo) Metabolic Panel TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl

======= PICCOLO =======
16/08/03 23:42
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	3.8	3.3-5.5	G/DL
ALP	55	26-84	U/L
ALT	51*	10-47	U/L
AMY	60	14-97	U/L
AST	41*	11-38	U/L
TBIL	0.7	0.2-1.6	MG/DL
BUN	8	7-22	MG/DL
CA++	8.9	8.0-10.3	MG/DL
CHOL	159	100-200	MG/DL
CRE	1.1	0.6-1.2	MG/DL
GLU	110	73-118	MG/DL
TP	7.6	6.4-8.1	G/DL

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

======= PICCOLO =======
16/08/03 23:44
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	111	73-118	MG/DL
BUN	♦♦♦	7-22	MG/DL
CRE	♦♦♦	0.6-1.2	MG/DL
CK	135	39-380	U/L
NA+	125*	128-145	MMOL/L
K+	4.0	3.3-4.7	MMOL/L
CL-	101	98-108	MMOL/L
tCO2	19	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 0 , LIP 2+, ICT 0

REMARKS:

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

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] b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 17 Aug | TIME OF ORDER: 0130 | HOURS | LIST TIME ORDER NOTED AND SIGN

Adult Pers
Dx = Frag wound (2) head (2) leg
Cond = stable
VS = per protocol
ALL = NKDA
Act = SPW restart
Wound = Dsg Δ q6°; clean wound

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

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

Diet - Reg
Labs = Ø
IV = Heplock / saline lock ~~p~~ IVBAC
Meds = Keflex 250mg QID po
Percocet ii po q4° PRN pain
Motrin 800g + po q8° PRN

[redacted]

PATIENT IDENTIFICATION: b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE [redacted] | TIME OF ORDER | HOURS

- Bath patient
- Clean & dress wounds b(6)-2
- OLE = sterile dressing

[redacted]

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

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 17 Aug | TIME OF ORDER | HOURS | b(6)-2

DLC SPW (Aug.

[redacted]

b(6)-2

[redacted] 17 Aug 03 1000

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1986—409-924

"USE BALL POINT PEN—PRESS FIRMLY! NO CARBON PAPER REQUIRED"

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)

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

Mo. ____ Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 16	17
17	[redacted]	VS = PROTOCOL	5	X	[redacted]
			17	PM	
17	[redacted]	EPW RESTRAINT	5	X	[redacted]
			17	PM	
17	[redacted]	Drsg Δ Q60, clean wound	6	X	[redacted]
			12	X	[redacted]
			18	X	
			24	6AM	
17	[redacted]	DIET: Regular	5	X	[redacted]
			17	PM	
		b(6)-7			

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: ① head ② leg Fragwound ③

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

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

EPW

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 4677, 1 OCT 78

EDITION OF 1 DEC 77 MAY BE USED.

USAPA V1.00

[redacted]

b(4)-2

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo _____ Yr 2003

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
17	[redacted]	admit IAW #1, stable	17 Aug 2003	[redacted]		
17	[redacted]	D/C EPW Camp	17 Aug			

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

USAPA V1.00

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. ____ Yr. ____

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED
17	[redacted]	IV: SL		16 17
			5	X [redacted]
17	[redacted]	KEFLEX 250mg	17	N
		+ po QID	6	X [redacted]
			12	X [redacted]
			18	X
			24	X

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: (L) heel (D) leg FRAG WOUND

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

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

EPW

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

A FORM 4677, 1 OCT 78

EDITION OF 1 DEC 77 MAY BE USED.

USAPA V1.00

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo _____ *Yr* _____

Verify by Initialing: Order Date	Verify by Initialing: Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
	-----					

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
17	[redacted]	Percocet ++ po q4° PRN PAIN	D/T													
-----	-----	b(u)-2	D/T													
17	[redacted]	Motrin 800mg+po q8° PRN	D/T													
-----	-----		D/T													
-----	-----															
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USAPA V1.00

ADMISSION AND CODING INFORMATION

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

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

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
	030	2	2	unk

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	2	0130	— b(6)-2

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
NU	K78	

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
I 2		9	YEAR ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0 b(2)-2	IEW2	unk
[redacted] b(2)-2		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): unk
		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: unk

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
50		030817

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
AEAA		030817

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

FOR LOCAL USE

Dx: (1) head (2) Leg fragment

Dx: 891D
8998

Px: 8086
8302

873.8
891.3
E993

ADMITTING OFFICER (Signature, as required): DR. [redacted]

SIGNATURE OF ADMITTING CLERK: [redacted]

b(6)-2

DA FORM 2985, MAR 89

USAPPCV1.0

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER [redacted]	2. NAME (Last, First, MI) EPW# [redacted] b(6)-4			3. GRADE EPW	ADMISSION REMARKS
4. SEX M	5. AGE 28	6. RACE —	7. RELIGION —	SVC —	8. ETS —	10. PREVIOUS ADMISSION NO.
11. FMP —	12. SSN [redacted]		13. ORGANIZATION b(6)-4			14. WARD ICW2
15. FLYING STATUS —	16. RATING/DSG —	17. DEPT/BEN K78	18. BRANCH/CORPS —	19. UIC/ZIP —		20. TYPE CASE WIA

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

22. HOURS OF ADMISSION: 0130

23. CLINIC SERVICE: AEAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: unk

25. TYPE DISPOSITION: 50

26. DATE OF DISPOSITION: 26aug03

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

27b. TELEPHONE NO.: unk

28. DATE OF THIS ADMISSION: 14aug03

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

30. DATE OF INITIAL ADMISSION:

32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED:

ADMITTING OFFICER: DR. [redacted] b(4)-2

31. [redacted]

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: multiple Shrapnal wounds

874.9
822.1
823.90
825.1
E 991.2
E 991.9

06.09
79.69
79.66

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 OFFICER: DR. [redacted]

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

MEDCOM - 17368

DA FORM 3[illegible], MAY [illegible]

EDITION OF 1 AUG 78 IS OBSOLETE

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

Diagnosis fracture wrist (R) distal radius (R) thumb and (L) knee and (L) foot (L) foot (R) thigh pain
No Abd pain
C/o (R) chest wall pain
Rust ↓
Rt ↓

PHYSICAL EXAMINATION

Wrist medial (R) deviation
by CTA
Knee right
Abd appears NT, FAST exam negative

PROGRESS (Enter date of discharge and final diagnosis)

Injury wrist and knee thru
[redacted] b(6)-2
Pt [redacted] c DX syncope
Wrist cast ~~left~~ wrist

DATE	IDENTIFICATION NO.	ORGANIZATION
8/11/08		

PA[redacted] (Written entries give Name last, first, date; hospital or medical facility)

REGISTER NO.	WARD NO.
	ICU2

EBW [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	PROGRESS NOTES
DATE	NOTES

8/17/03 Brief op note
Pre Op Dx: (R) supracondylar humeral
Post Op Dx SAME
Procedure (R) supracondylar Elbow
Surgeon Masamoto
Assist Nelly
Fung gray Kirschner (R) elbow
Anesthesia Sole trace
Cycle ∅

[redacted] b(4)-2

5/17/03 Ortho Op Note
0840 Pre-Op Dx: (1) Open (L) knee joint
(2) fragment wounds (L) leg
Post-Op Dx: (1) Open (L) knee intercondylar fracture, MFC.
(2) Open (L) tibia fracture
(3) Open (R) calcaneus
Procedure: (1) I+D (L) knee with arthroplasty
(2) I+D (L) tibia fx, (3) I+D (R) calcaneus

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

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

REGISTER NO. | WARD NO.

EPW [redacted] b(4)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

DATE	NOTES
	Surgeon - [illegible]
	Findings - Fragment entered (L) knee joint lodged in (L) MFC. Fragment shrapnel entry of (L) tibia. Fragment demonstrated [illegible] wound. I&D's irrigated. Puncture in (L) knee wound left open in slings. Open knee skin closed locally, but effusion left open
	PLAN: I&D in 48 hours
	[redacted] b(6)-2

Progress Note

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
02 1700	Nursing Note: Pt. is A+Ox3. Pupils Perrla. Lungs clear; Active BS x4; palpable pulse x4 extremities. Capreffill <3secs. x4 extremities. IV (R) AC infusing @ LR @ 150cc/hr. HL to (L) AC; Pt. received 1 gram of Ancef in the O.R. @ 2400. Foley to gravity @ clear and yellow urine. Shrapnel injuries to chest X 5, @ no or minimal drainage; shrapnel to (R) leg @ drainage noted on dsg. dsg (L) foot @ drainage noted to (L) ankle area. No injuries to back. Pt. is NPO for O.R. will continue Neuro vascular checks all normal. b(6) CPT [redacted]
03 1700 May 03 0900	Nursing Note: Neuro checks normal CPT [redacted] pt returned from OR via litter. pt awake, not fully awake and aware of surrounding from anesthesia. S/P (L) leg debridement under general anesthesia. Received 900ccs of crystalloid in OR. Minimal blood loss. placed pt on ICU monitor BP 144/62, HR 116 RR 25 SaO2 97% in RA. Pupils - 2mm PERL.

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

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

REGISTER NO. | WARD NO.

[redacted] b(6)-4

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	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17Aug03 0905	moves all extremities. limited ROM to (L) leg. Skin warm and dry. small lacerations noted (R) shoulder, abd. and (R) index finger. (L) leg drsg secure & dry. Airway intact. (R) neck drsg dry & intact. (R) antecubital PIV intact site free of infection (LR) @ 150 cc/hr via dialaflow. Lungs - poor inspiratory effort. No resp distress noted. Lung - equal expansion. Lungs - CTA bilaterally. Heart S1 S2 Ø murmers. Ø peripheral edema noted. Capillary refill < 2 sec. Radial pulses strong @ 3+. Abd. flat, non-tender. Active bowel sounds x 4 quad. Dorsalis pedal pulses strong & equal. Foley intact & draining minimal yellow color urine. pt nauseated. Vomited approximately 50 cc's brown liquid c̄ blood tinged drainage. pt resting c̄ eyes closed. no signs of agitation or restless noted. continue to monitor for nausea b(4)-2 [redacted]
0950 ~~1000~~	
1000	
1010	Ancef given @ 1010 - scheduled for 0800 pr Dr. Surgery SGT [redacted] 91WM6
1200	noted c/o throat pain & erythema c̄ exudate (-) lymphadenopathy noted SGT [redacted] b(4)
1800	RECEIVED REPORT FROM DAY SHIFT SGT [redacted] PT IS CURRENTLY AWAKE AND ALERT C̄ PUPILS 3MM BRISK BILATERALLY FOLLOWS SIMPLE COMMANDS. MAE (B)UE C̄ EQUAL STRENGTH (B)LE ABLE TO WIGGLE TOES C̄ DIFFICULTY. (L)LE LIMITED ROM 2° TO IJD. RESP

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-600

Progress Notes

24Aug 03 1730: Assumed care @1400, T-98.6°F P- R-16 BP-117/55 SpO2-100%
Lung sounds clear, Abd. soft & nondistended, BS x4. Lac to (R) clavicle - sutures CD+I, ACE wrap to (L) leg CD+I, No % pain or discomfort. NC-WNL. Will continue to monitor. [redacted]

25Aug03 assumed care @2200 - no % pain @ this time - [redacted] b(6)-2
0030 encouraged pt. to ambulate c̄ crutches during day -
BP 116/57 ace wrap CDI on (L) leg, neuro V's WNL in (L) foot -
P 62 reported limited ROM in (L) knee, told pt. to exercise
T 99.1 that knee, stated understanding - [redacted] CH+AW
R 16
SpO2 98

0400 BP 118/54 R-14 HR 58 T-98.2 b(6)-2

25Aug 1200 Pt. asleep in bed easily aroused by verbal stimuli. VSS. HR Regular, lung sounds clear bilat, bowel sounds (+) X4 quads. Pt. c̄ IV access. Ace wrap to (L) LE CDI, (+) sensation, full ROM of digits, cap refill < 3sec. DSG d/d to (R) ater thigh, wound c̄ s/s of infection. Sutures to incision on (R) clavicle intact, site approximated well c̄ s/s of infection. AM care completed. Pt. up to ambulate X1. Pt. c̄ complaints @ this time. Will continue to monitor. [redacted] (AW)
b(6)-2

5Aug03 1625: Assumed care @1400, T-98.8 P-64 R-12 BP 118/45 SpO2-99%
A+O x3, Denies pain or discomfort @ this time. Ambulates c̄ crutches. Sutures above (R) clavicle intact. Dressing to (L) lower extremity CD+I. Will continue to monitor. [redacted]
b(6)-2 [redacted] CO, AW

5Aug03 2200 - PT VS are P-78, BP 116/72, T-98.5, R-18, SpO2-97 - SPC [redacted] 9IW.

26Aug03 0100 PT Vital Signs taken BP 110/86 P 59 T 98.4 R 12 ~~SpO2~~ SpO2 100 - SPC [redacted] 9IW10

1120 - Pt A+O x3, VSS, lungs CTA, BS+ x4, pulses (+) x4 ~~sleep~~ Sutures intact to (L) knee & ankle, ø s/s infx. Sutures intact to (R) upper chest, some redness noted but ø drainage. Voiced ø complaints at this time - Will cont to monitor - [redacted] SPC
b(6)-2

EPW [redacted] b(6)-4

ICW2

26 Aug 03 1500: Assumed care @ 1400. T- 96.9°F P- 75 R-16 BP- 102/74 SpO2-98%
Denies pain or discomfort @ this time, HR-reg. Lung sounds clear bilat. Abd. soft, non distended, BS x4, Sutures to (R) clavicle CD+I. Sutures to medial portion of (L) knee intact, Sutures to (L) foot/ankle intact, Ambulates c̄ crutches, Will continue to monitor. [redacted]

2200 98.8
P-66
R-24
99%
139/89
Ø

26 Aug 03 assumed care @ 2200 - VSS - no c/o
2345 pain @ this time - wound edges well approximated, sutures removed, Steristrips on (R) clavicle, (L) knee, (L) foot/ankle - ambulating c̄ crutches, limited ROM in (L) knee - awaiting transport to EPW camp, meds @ bedside, DC Summary in chart [redacted]

27 AUG 03 0400 P 54, BP 111/54, BR 99, T 96.5 [redacted]

26 Aug 03 0913 Pt ambulatory c̄ complaints @ this time. HR Reg, Lung sounds clear bilat, bowel sounds (+) x 4 quads. Horizontal incision to (R) clavical approximated well c̄ steri strips intact. (L) LE pedal pulse palpable (+) sensation, cap refill < 3 sec, limited ROM of knee, steri strip to ankle intact, D/C summary & order in place, meds @ bedside. Pt. awaiting [redacted] EPW camp. Will continue to monitor. [redacted]

27 Aug 03 1643. Assumed care @ 1400. T-98.7 P-76 R-16 BP 115/70 SpO2-100%
D/C'd to EPW Camp @ 1545 c̄ discharge summary + meds [redacted]

bl(e)-2
A11

BS 98
972 20
115/57

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
0500	VSS. Pt denies pain. MSO4 effective for pain. Ø Void @ this time. Will continue to monitor. [redacted]
13Aug03 0600	Pt resting comfortably in bed. NO complaints [redacted]. Respirations even and unlabored. BBS CTA. Palpable pulses ⓑ. NO edema noted. Abd soft NT, NP c̄ active bowel sounds. IVF LRC 150/hr running freely. Drsg. to ⓑLE. CPT ~~Caution~~ Ace bandage to (L)LE CDI. No distress noted. [redacted]
18Aug03 1400	Pt resting in bed. No complaints voiced. NPO. Dr [redacted] discussed plan of care c̄ pt. VSS. Drsg Δ'd to shrinker sites. Will cont. to monitor. [redacted] b(6)-2
18 AUG 03 1745	Critical Care Note
	Pre Op Dx: ① Open fx (L) knee PFC ② Open (L) tibia fx ③ Open (L) calcaneus
	Post Op Dx: same
	Procedure: I&D wounds
	Surgeon: [illegible]
	EBL: MIN BLOOD: 1 LRBC
	Findings: wounds clean. All injured structures secured. Closed in surgery.
	Plan: IV antibiotics x 72 hours. b(6)-2
	[redacted]

STANDARD FORM 600 (REV. 6-97) BACK
*U.S. GPO: 2002 - 491-600/50618

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	20 BPM EVEN UNLABORED BBS CTA SaO2 99% ON ROOM AIR CV S1,S2 (+) HR 60-70s NSR ∅ ECTOPY PULSES 2+ RADIAL 2+ DP BILATERALLY. CAP REFILL BRISK THROUGHOUT. GI BS(+) x4 QUADS ∅ TENDERNESS PT NPO TO ADVANCE AS TOLERATED GU FOLEY C̄ CLEAR YELLOW URINE >40cc/HR. SKIN SCATTERED SHRAPNEL WOUNDS THROUGHOUT. STITCHES TO (R) CHEST NEAR CLAVICLE APPROX 3" WELL APPROXIMATED ∅ DRAINAGE NOTED; 1.5" INGUINAL LOWER ABD WELL APPROXIMATED ∅ DRAINAGE NOTED; LLE WRAPPED S/P I/D NO DRAINAGE NOTED @ THIS TIME. LINES 18G PIV TO (R) AC C̄ LR @ 150cc/HR. NO S/S OF INFECTION IV INTACT / PATENT. WILL CONTINUE TO MONITOR [redacted]
2000	VSS. PT WANTS TO TRY TO EAT. PT GIVEN [redacted] 240cc AND CRACKERS. PT TOLERATED WELL C̄ DIFFICULTY / WILL MONITOR FOR EPISODES OF N/V. [redacted] b(6)-2
2100	FOLEY D/C'D. DTV @ [redacted] INFORMED OF DTV. WILL MONITOR [redacted]
2200	VSS. PT [redacted] STING ∅ PAIN. WILL CONTINUE TO MONITOR THROUGHOUT SHIFT [redacted]
18 AUG 05 0200	VSS. Pt received [redacted] for pain to LLE. LLE ↑ on blankets. NV done C̄ 2+ pulse DP and Brisk Cap Refill. Pt able to wiggle toes and left leg upwards. Will continue to monitor [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	RECORDS MAINTAINED AT
	[redacted]	

SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR
	[redacted]	

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

REGISTER NO. | WARD NO.

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18AUG03 2030	Assumed care of pt @ 1800. VSS, afebrile. lung sounds clear bilaterally, apex to base. RR equal + unlabored. O_2 Sat 98% RA. Radial pulses strong + equal to palpation. (R) Pedal pulse strong + palpable. Unable to assess (L) pulse due to bandage. Cap Refill to all extremities <3sec. PERRLA 3mm. Mucous membranes moist. Pt to start Reg diet when fully awake. BS active x 4 Quad Soft, non-distended, non-tender. Pt has Complete ROM to BUE + RLE. Pt can wiggle toes to LLE c̄ movement from hip. Pt has Kerlix + ace wrap dressing to LLE mid thigh to toes, CDI. Pt has 2x2 dressing to (R) hip, small amt of drainage. Pt has multiple small schrapnell wounds pt has stitches, le, to (R) collar bone, open to air, Ø drainage, slightly red. Pt also has 1" cut c̄ 2 stitches to LUQ. Pt has HL to (R) ac. Pt has 18G IV to (L) ac c̄ LR @ 125cc/hr. Will continue to monitor for Δ's ——— blue-2 SPC [redacted] 9/WM
19AUG03 0004	Q6° VS: 125/70, HR 68, RR 18, O_2 Sat 100% RA, temp 98.7 - SPC [redacted]
19AUG03 0600	Received report from outgoing shift VS 120/62 T 97.2 HR 60 R 14 SaO_2 99 RA. pt Resting c̄ eyes closed easily roused A+O x 3 speaks English denies pain @ this time pt semi fowler position HOB ↑ 75° R-even unlabored LS CTA color good ABD soft NT (-) DTN (-) rigidity BS hypoactive x 4 Capillary bush x 4 Skin warm to touch Dig (L) leg CDI NVI Sutures (R) collarbone intact noted ecchymosis NT

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. 9 B2

EPW# [redacted]

blue-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

125/-

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19Aug03	0600 cont. numerous sm scrapped wounds on body (-) drainage will cont to monitor. SGT [redacted] 91W M6
19Aug03 ~~0930~~ 1000	bed bath given, pt washed c̄ assist, oral care given pt shaved face given A. c/o pain given percocet II tabs po for (D) leg pain NAD. SGT [redacted] 91WM6
19Aug03 ~~1130~~	—
19Aug03 1730	Pt transferred from ICU, in stable cond. PERRLA. Lungs CTA bilat, ⊘ resp distress. NSR. Abd soft, non-tender, bowel sounds active x4 quads. Incision to (R) clavicle area c̄ sutures intact, open to air. Dsg to (R) thigh CDI. Ace wrap from (L) toes to mid thigh. Strong pulses and brisk cap refill to bilat LE. ⊘ complaints — [redacted] 91W/MN
2040	Care assumed @ 2100. VSS, a+o x3, c/o pain only when he moves his lle. Lungs CTA, b+(+). Pt c̄ incision to (R) chest/shoulder, sutures CTA CDI. Dsg to (R) thigh CDI. Dsg c̄ Ace wrap to lle CDI, pt able to wiggle toes on (L) foot, slight edema noted. No complaints at this time, will continue to monitor. — [redacted] 91WM6

b(6)-2A

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-600/50618

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)
20 Aug 03 0600	Pt. awake & alert. HOB @ 45°. HR Regular, Lung sounds clear bilat, bowel sounds x4 x4 quads. Sutures intact to horizontal incision on (R) side of neck, site ↓ S/S of infection. Dsg to (R) upper thigh CDI. Ace wrap to (L) LE CDI, full ROM in digits, (+) sensation, <3 sec cap refill, digits cool to the touch. IV in (L) FA ↓ S/S of infection. VSS. Pt. ↓ complaints @ this time. Will continue to monitor. [redacted] CT/AN
	b(6)-2
20 Aug 03	[redacted] Staff
	No complaints. Afeb VSS, Dressing clean & dry. Dressing D tomorrow.
	[redacted]
	b(6)-2
20 Aug 03 1330	Pt awake and alert. Lungs CTA bilat, Ø resp distress. NSR. Abd soft, non-tender bowel sounds active x4 quads. Incision to (R) clavicle CDI, sutures open to air. Dsg to (R) thigh CDI. Ace wrap + dsg to (L) leg from toes to AKA. Strong pulses and brisk cap refill to bilat LE. Ø complaints [redacted] CT/AN
	b(6)-2
1400	Neurovascular check grossly intact. PERRLA. Pt awake and alert. Strong

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

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

REGISTER NO.	WARD NO.
	1CW2

SPN [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)
	pulses and brisk cap refill to all 4 extremities. Bilaterally equal strength to upper and lower extrem. [redacted] c/on
20 Aug 2000	Care assumed @ 2000. VSS, AOX3, no c/o pain. Lungs CTA, bs(+)x4, unable to assess pulse on lle. Dsg on lle CDI, pt able to wiggle toes and c(+) capr refill. Wound on chest c̄ staples CTA CDI ∅ s/s infection. Pt c̄ 2x2 on thigh and calf of (R) leg dsg's d'd, wounds c̄ minimal drainage and no s/s infection. HL on LFA flushes well. Will continue to monitor. [redacted] Nurse
21 Aug 03 0830	assumed care @ 0500 - VSS - no c/o pain @ this time - dsg CDI on multiple schrapnel wounds - neuro V's WNL, PERRLA, answered orientation questions appropriately c̄ interpreter S2 patent - sutures intact on (R) clavicle [redacted]
21 Aug 03 1530	Received pt via litter from air evac. VSS. PERRL. Lungs CTA(B). Resp. distress. GI (+) BS x 4 quads. Cell voids per urinal. MAE. Neurovascular WNL. Multiple healing shrapnel wounds. Dsg to (R) lateral shin & (R) thigh CDI. Ace wrap to LLE. Sutures to (R) collar CDI. Erythema to area. HL DFA. Area c̄ gran. infusing WNL. Denies discomfort. Continue to monitor for s/s of infection. [redacted]
22 Aug 0733	RNS BP 128/84, HR 60, T 97.9, HR 60, SPO2 9[redacted]
22 Aug 03 1130	Pt. awake & alert in bed c̄ complaints @ this time. VSS. HR Regular, Lung sounds clear bilat, bowel sounds (+) x 4 quads. Sutures to (R) side of neck intact c̄ s/s of infection, wound well approximated. HL in (L) FA flushed well c̄ 5cc NS. Multiple shrapnel wounds to (R) LE removed c̄ s/s of infection. Ace wrap to (L) LE intact

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

b(2)-2

NSN 7540-01-075-3786

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

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 16 May | TIME: 2340

TRANSPORTATION TO FACILITY: Medevac

SEX: M

AGE

DUTY/LOCAL PHONE: AREA CODE | NUMBER

~~**HOME PHONE**: AREA CODE | NUMBER~~

MILITARY STATUS

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

THIRD PARTY INSURANCE

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

CURRENT MEDICATIONS

ALLERGIES

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: GSW / Mortar

CATEGORY OF TREATMENT

☐ EMERGENT
☐ URGENT
☐ NON-URGENT

TIME

INITIALS

VITAL SIGNS

TIME	2345					
BP	125/58					
PULSE	91					
RESP	20					
TEMP						
WT						

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
	.5 Tetanus				
	5 morphine				
	15mg Fucet				
	Foley to gravity				

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 ☐ DETERIORATE

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(2)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

NSN 7540-01-075-3786

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

TEST RESULTS

CBC		SMAC				ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
WBC 17.5		138	105	9		SUP 02	PH	PO2	RESULTS CXR - Eshaped - [illegible]	
H/H 13/39		3.2	39	127	1.5	PCO2	SAT	OTHER		
PLT 280										
PT 15.2						U/A DIP			EKG INTERPRETATION	
APTT 24.0		BHCG	ETOH	GLU		MICRO				

PROVIDER HISTORY/PHYSICAL

5 EPW Injury s/p MVA [illegible]
Arrived via Airway on part of MASS CAL

G: WD, WN, NAD, AOX3 @ PSM. Ambulating well
H: NCAT @ PERRL Sclera [illegible]
PO: [illegible]
L: CTA ⓐ
Chest @ shrapnel over R clavicle + [illegible]
Footpulse

A/P to OR after other surgeries..

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

b(6) - 2

PROVIDER SIGNATURE AND STAMP

[redacted]

DIAGNOSIS

Shrapnel to to chest wall

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(6) - 4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

510-112

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
21AUG03	2145=		VSS, A+O x3, speaks English, ∅ c/o pain @ this time, Wounds to (R) LE dsg CDI, (R) thigh ≈ 2x2 CDI, wound to (R) upper chest / (R) clavicular area ≈ sutures approximated CDI. IV to (L) FA patent, continuing IV antibiotics routinely, will continue to monitor. No other remarkable assessment findings. [redacted] b(6)-2

(Continue on reverse side)

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

#[redacted]

b(6)-2

REGISTER NO.	WARD NO.

NURSING NOTES

Medical Record

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

510-112

NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes) b(6)-2 AN

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
20Aug03	1130		All ROM of digits, cap refill <3sec, (+) sensation. Pt. ∅ other abnormalities noted from assessment. Will continue to monitor [redacted] RT/AN
		1954	
		2003	Pt-care assumed @ 1500. VSS. HR Reg, lungs CTA, BS (+) X4. Drsngs to (R) leg CDI. NV checks to (R) ext. WNL. Pt. c/o pain to (R) leg when weight bearing. Pt. has ∅ pain when resting in bed. Sutures to neck line OTA, CDI. Incision slightly ~~edematous~~ erythematous [redacted] reddened ∅ purulent drainage skin cool, dry. Will cont. to monitor [redacted]
22Aug03		2315	pt care assumed @ 2300. pt resting quietly easily aroused to verbal stimuli. VSS. Sutures to area above clavicle on (R) side intact OTA free of s/sx of infection. lungs CTA, abd soft nontender BS(+) x4 quads. LLE c̄ ace wrap from thigh to toes CDI. pt able to wiggle toes. RLE c̄ (+) pulse. BUE c̄ (+) pulses. CTA c̄ HL flushes well. (-) redness/swelling noted. Drsng to (R) index finger CDI. Y Juro ✓s WNL. (-) c/o pain/discomfort voiced @ this time. Will cont to monitor [redacted]
23Aug 0734			Pt VS BP 117/52, HR 64, T 99.0, RR 18, SPO2 99% [redacted]
	1215		Pt alert & oriented OOB x2 utilizing crutches. P.T. in with pt. VSS, lungs CTA. b(6)-2

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

(Continue on reverse side)

REGISTER NO. [redacted]

EPW [redacted]

b(6)-4

NURSING NOTES
Medical Record

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

b(4)-2 A11

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
Cont.			BS⊕, pulses ⊕ x4. Incision intact to ⓡ upper chest, ∅ s/s of infx. Ace wrap to ⓛ leg, ⊕ sensation, able to wiggle toes, skin warm to touch. Voicing ∅ complaints. Will cont to monitor [redacted]
		1720	Pt. care assumed @ 1500. HR Reg lungs CTA, BS⊕ XY. ⓛ LE drsng CDI c̄ pulse 2+, brisk capr refill, ⊕ sensation. Pt. c/o ↓ pain. Pt. ambulated c̄ crutches, able to bear some weight on ⓛ LE. will cont. to monitor. [redacted]
23Aug03		2330	Pt awake and alert. Lungs CTA bilat ∅ resp distress. NSR. Abd soft, non-tender bowel sounds active x4 quads. Incision to ⓡ clavicular area reddened c̄ minimal swelling. Sutures intact open to air. Drsg to ⓡ leg CDI. Ace wrap to ⓛ leg CDI, pt wants to bend ⓛ knee. Strong pulses & brisk cap refill to bilat LE. ∅ complaints [redacted]
24Aug03	0700		VS BP 116/61, HR 65, T 98.7, RR 16, SpO2 98%
	1110		BP 115/57, HR 86, T 98.3, RR 16, SpO2 100% [redacted]
	1239		VSS, lungs CTA, BS⊕ x4, pulses ⊕ x4, A+O x3, Incision to ⓡ clavicular area ∅ drainage noted. Sutures intact. Splint & ace wrap intact to ⓛ leg. Ambulated x2. Will cont to monitor [redacted]

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

STANDARD FORM 510 (REV. 7-91) BACK

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

4. PROPOSED SURGICAL PROCEDURE:

(R) Neck Exploration I & D (L) Knee / Foot

5. ADDITIONAL INFORMATION: Last PO: Medical Hx: Implants: Medications:
Jewelry removed: yes/no Family waiting: yes/no

See H&P

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

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

H[redacted]

b(6)-4

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; shock; previous surgery	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. 4 o Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to sedation; pain; injury E.2. ✓ Potential discomfort due to injury; pain	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. ✓ Disminished visual perception due to being injury; sedation; F.2. ✓ Potential for decreased communictaion due to language barrier; sedation F.3. Potential injury due to dentures.	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from either side. o Validate pt.'s understanding of verbal communications. o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS. Or continuation of above interventions.

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted] MAJ AN 17 Aug 03 DATE

11. [redacted] ATION: Pt awake. VSS. No complaints verbalized Dsgs dry & intact. Bovie pad site intact.

b(6)-2

12. PREOPERTIVE [redacted] (Signature and Ti[redacted]	13. PREOPERTIVE [redacted] BY (Signature and [redacted]
DATE: 17 Aug 03 TIME: 0830	DATE: 17 Aug 03 TIME: 0855

REVERSE OF DA FORM 5179, JUN 91 USAPA V1.01

b(6)-2 A11

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA litter BY Anesthesia [redacted]
2. PATIENT [redacted] VERIFIED [redacted] REVIEWED AND PROCEDURE CPT/A2
3. DATE 17 Aug 03 TIME PATIENT ARRIVED IN SUITE 0725
4. PATIENT [redacted] TIME 0725 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	
	Maj [redacted]		

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS: Arms tucked @ sides. Roll under back

8. SKIN PREPARATION

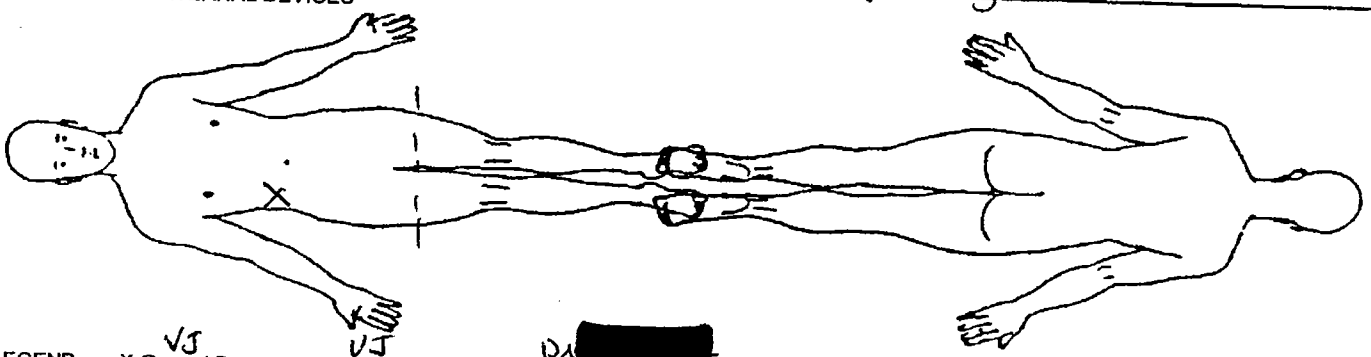
HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☒ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP

COMMENTS: ∅ Knicks or cuts

PREP SOLUTION (Specify) Betadine/Betadine
SITE: neck-chest-abd. BY WHOM: CPT [redacted]
SITE: (L) knee to foot BY WHOM: MAJ [redacted]

COMMENTS: ∅ pooling

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad (VJ) -- Safety Strap (VJ) === Tourniquet (DA [redacted]) @ 0808 @ 275 mmHg ↓ @ 0829 = total time 21 min

10. COUNTS

C = Correct I = Incorrect Initial BTC [redacted] / CPT [redacted]

		Initial Count	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No	C	C	C	[redacted]	[redacted]
Needle Sharp	☒ Yes ☐ No	C	C	C		
Instrument	☐ Yes ☐ No					
Other	☐ Yes ☐ No					

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

[redacted]

b(6)-4

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

out 30 coag 30

☒ ESU NO: Valleylab
GROUND PAD: BRAND Valleylab
LOT NO:

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

13. PROSTHESIS, LANT ☐ ES ☒ NO IF YES NAME: ID NUMBER; M UFAC. RER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY
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 ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
4x8 dsg / tape
fluffs, kerlix/ace wrap

19. ADDITIONAL INFORMATION
WC I
Surgeons [redacted] Anesthesia: General Anesthesia Type:
[redacted]

Bovie Pad site intact pre-op VJ ; post-op ~~change~~ Bovie Settings: Coag/Cut 30/30
Tourniquet Site intact pre-op VJ : post-op ~~change~~
b (6) -2 All

20. OPERATION(S) PERFORMED

I; D (L) knee and foot; (R) neck wound exploration

21. PATIENT TRANSFERRED TO Tell 2 TIME 0855 METHOD Lifter

22. REGISTER [redacted]

REVERSE O[redacted]

MEDCOM - 17390

USAPA V1.01

MEDICAL RECORD b(u)-2 **INTRAOPERA DOCUMENT**

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

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

2. PATIENT IDENTIFIED [redacted] ED AND PROCEDURE
VERIFIED BY CPT [redacted] b(u)-2

3. DATE 18AUG-03 TIME PATIENT ARRIVED IN SUITE 1555

4. PATIENT IN ROOM TIME 1555 NUMBER 2-3

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] 91D b(u)-2	RELIEF SCRUB	N/A
ASSIGNED CIRCULATOR	CPT [redacted] RN	RELIEF CIRCULATOR	N/A

7. POSITION AND POSITIONAL AIDS (Specify) Pt on padded OR bed, Head on folded towel, Arms Extended to sides < 90° in CAP, secured to padded armboards c̄ safety straps. LLE prepped into sterile field.

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

COMMENTS: Proper Body Alignment maintained

8. SKIN PREPARATION

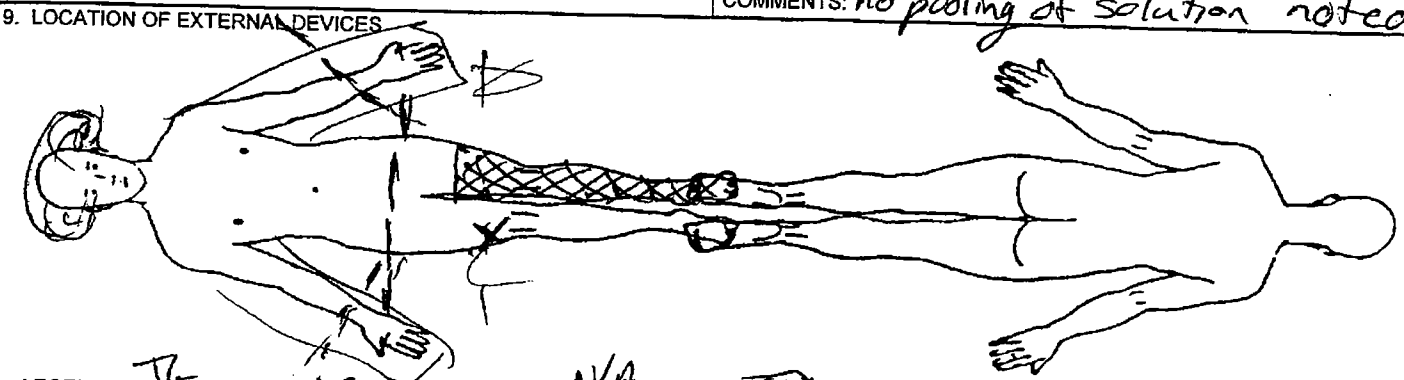
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION (Specify) Betadine / Betadine b(u)-2
SITE: LLE BY WHOM: CPT [redacted]
SITE: (as below) BY WHOM:

COMMENTS: no pooling of solution noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad ⊕ Safety Strap N/A ||| Tourniquet prep

10. COUNTS

C = Correct I = Incorrect

		Initial Other	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes ☐ No	C		C	SPC [redacted] 91D	CPT [redacted] RN
Needle Sharp	☑ Yes ☐ No	C		C	"	
Instrument	☐ Yes ☑ No					
Other	☐ Yes ☑ No					

b(u)-2

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

[redacted]

b(u)-4

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

☒ ESU NO: 3 SN 000417
GROUND PAD: BRAND Valleylab Polyhesive II REM
LOT NO: 68936 / 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; MANU CTURER

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 - QS.

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
Kerlex Fluffs, Kerlex Roll, ACE

19. ADDITIONAL INFORMATION
WC II
Surgeons: Dr [redacted] Anesthesia: MAJ [redacted] Anesthesia Type: GEN/LMA
b(e) - 2 MAJ [redacted] CRNA

Bovie Pad site intact pre-op CI; post-op CI Bovie Settings: Coag/Cut
Tourniquet Site intact pre-op N/A post-op_____

DA Form 5179 Previously done

20. OPERATION(S) PERFORMED
I+D (L) Foot, Heel, + Knee

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU 2	1225	Wheeled litter

22. REGISTERED NURSE SIGNATURE

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY | HOUR

Aug 19 | 17 | 2:30 3:00 5:00 6:00 7:00 8:00 9:00 10:00 11:00

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

	2:30	3:00	5:00	6:00	7:00	8:00	9:00	10:00	11:00
Pulse									
Temp. F									
Temp. C									
Respiration	20	20	20	20	20	20	20	20	20
Blood pressure	125/66		110/68						
	130/67		102/70						
	48/47								

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.

A [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

1-119

MEDICAL RECORD

NSN 7540-00-634-41

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR August 19

DAY: 10 20 21 21 August 23

HOUR

PULSE (O) | TEMP. F (•) | TEMP. C

105° 180 104° 170 103° 160 102° 150 101° 140 100° 130 99° 98.6° 120 98° 110 97° 100 96° 90 95° 80 70 60 50 40

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. 1CW2

[redacted] 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

TWENTY-FOUR HOUR PATIENT IN... AND OUTPUT WORKSHEET	FROM ___ HOURS TO 18 HOURS	TOTAL HOURS COVERED	DATE 17 Aug

INT

~~ORAL~~ Urine O/P				INTRAVENOUS					
TIME	TYPE	AMOUNT	ACCUM TOTAL	TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
02	~~45~~ Urine	950	950	02	1000	LRG 150			
03		100	1050						
04		100	1150						
05		120	1270						
06	Urine	100	1370						
07									
08	Surgery								
09									
10									
11									

~~INTERMITTENT~~ (N/G, Bladder, etc.)			
TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
06			
07			
08			

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

OTHER INTAKE			
TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

INTAKE EQUIVALENTS (*Serving levels cc*)

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

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

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/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

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

---

i-STAT CREA

Pt: [redacted]

Pt Name:_____

Crea_____1.5 mg/dL

Sample Type_:

---

i-STAT 6+

Pt: [redacted]

Pt Name:_____

Glu_____127 mg/dL

BUN_____9 mg/dL

Na_____138 mmol/L

K_____3.2 mmol/L

Cl_____105 mmol

Hct_____39 %PCV

Hb*_____13 g/dL

*via Hct

Sample Type_:

17AUG03 00:56

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

17/08/03 00:29

REFERENCE RANGE: MALE

PATIENT #: [redacted]

METLYTE 8 b(a)-4

DISC LOT #: 3151AA4

OPER #: [redacted] DR #: 000

SERIAL #: b(a)-7 [redacted]

GLU	134*	73-118	MG/DL
BUN	♦♦♦	7-22	MG/DL
CRE	♦♦♦	0.6-1.2	MG/DL
CK	280	39-380	U/L
NA+	126*	128-145	MMOL/L
K+	3.1*	3.3-4.7	MMOL/L
CL-	100	98-108	MMOL/L
tCO2	20	18-33	MMOL/L

INST QC: OK CHEM QC: OK

HEM 0 , LIP 1+, ICT 0

b(a)-2

REPORTED BY: [redacted]	DATE: 8-17-03	LAB ID NO.:

Ward/Section:	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. b(6)-4 [redacted]	DATE	TIME	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
W			Segs		
R			Bands		
H			Lymph		
H			Atyp		
M			RBC Morph		
P			Spun Hematocrit		42-52% (M) 37-47% (F)
L			Sed Rate		
			Other		

Mono			
Eos			
Baso			
Imm			

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	15.2	9.8-13.6 secs
APTT	24.0	21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

MEDICAL RECORD - ANESTHESIA

For us[e of th]is 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
phenergan (mg)	12.5						
MSO4 (mg)	<10>						10
propofol (mg)		100/60					
sux (mg)		100					
( )							
( )							
VOLAT AGENT Iso % del / % e.t.		1.5	1.5	2.0	1.5	1.0 ✗	
AIR L/Min							
N2O L/Min							
O2 L/Min	6 — 1 — 1 — 1 — 1 — 2 — 6						

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS → ① ②

TOTAL EBL: min

TOTAL URINE: 200

FLUIDS SUMMARY

CRYSTALLOID- 900

COLLOID- Ø

BLOOD- Ø

FLUIDS

LINE site	Warmed	
16g R AC	☐ Warmed	LR 600 ↑ —— / #2 —— 700
18g L AC	☐ Warmed	heplock
	☐ Warmed	
	☐ Warmed	

LOSSES

EST BLOOD LOSS

URINE - Foley —— 200

PHYS STATUS: ①2345 Ⓔ

BODY WEIGHT: 75 KG

HEMATOCRIT:

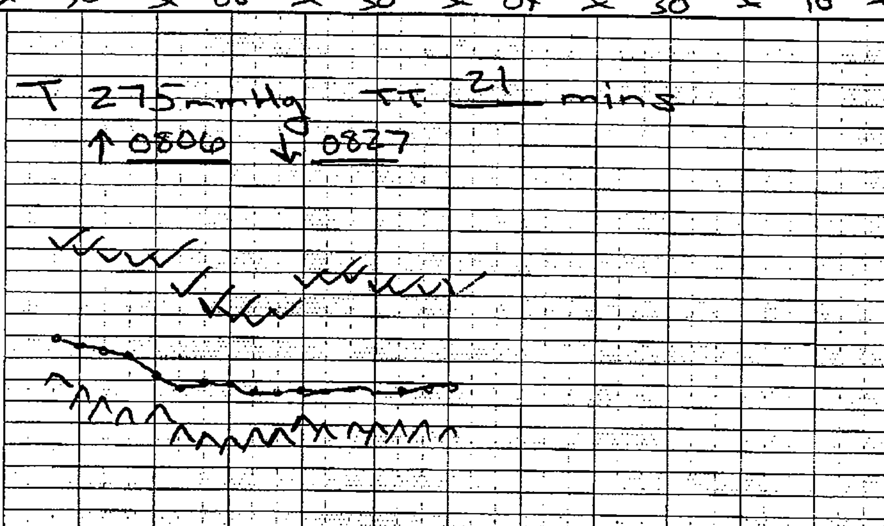
INITIAL DATA: BP- 130/72 HR- 92

EQUIP CHECK OK?- Ⓨ N

PATIENT RECHECK: OK for PROCEDURE? ✓ TIME- 0715

TIME → x 30 > 08 x 30 > 09 x 30 > 10 x

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



VENTIL

VT - ml		740	740	780	210	320	420
f - breaths/min		10	10	9	20	18	18
Peak inf pres / PEEP		17	17	20	—	—	—
MODE - S(pon), A(ssist), C(on)	S	C	C	C	S	S	S

MONITORS/ACCESSORIES

✓BP/Auto Cuff	✓ET CO2 (torr)	38	34	31	31	32	38	
BP/oth	✓FiO2 (Frac or %)	0.7	0.7	0.7	0.7	0.7	0.7	0.7
ART line	✓SpO2 (%)	100	100	100	100	100	100	
Steth- PC/ES	✓ECG	SR	SR	SR	SR	SR	SR	
Gas analyzer	TEMP-site							
	N-M Block (T/4)							
Warming blkt								
Conv warmer								

Mark with letters & symbols, explain under REMARKS EVENTS Position → Arms tucked O—I ——→ ——→

REMARKS

Code drugs with numbers, events with letters

Pt s chart r/v. OK to proceed.
① To room via litter, SOC mons applied, pre O2.
② Smooth IV RSI s̄ c̄ ccp.
③ Suctioned & extubated. Post-extub L spasm. easily relieved c̄ PP. To ICW stable

RECOVERY AT: PACU (ICU) [illegible] (Specify)

OTHER

CONDITION: RESP- 24 SpO2- 100 BP- 144/62 HR- 124

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0715	0725	0900
	Ready	Begin	End
PROC	0735	0754	0840

PROCEDURES and CPT Codes: Rt neck exploration; Arthrotomy/I&D Lt knee; I&D Lt Foot/ankle; I&D Rt thigh

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GETA

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

#[redacted] b(6)-4

20 yo Iraqi EPW

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* Eyes taped, DL x1 s̄ trauma, ⊕ ETCO2 BBS. 8.0 ETT secured 23 cm @ teeth. [redacted]

SURGEONS: [redacted]

ANESTHETISTS: [redacted] b(6)-2

[redacted] MAJ, CRNA

PROCEDURE LOCATION: 1-1

DATE: 8-17-03

PAGE 1 OF 1

DA FORM 7389, FEB 1998

MEDCOM - 17398

[P]ATIENT'S MEDICAL RECORD

USAPA V1.00

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)												
Versed	(mg)	3/2											
Fent	(µg)	50		25/25									
Ketamine	(mg)	100											
propofol	(mg)	100											
Lido	(mg)	25											
MSO4	mg)			(5)(5)									
VOLAT AGENT	Forane del	1.5	1.5	2.0	1.5	1.5							
	% e.t.												
AIR	L/Min												
N2O	L/Min												
O2	L/Min	10	2	2	2	2							

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

FLUIDS

LINE site LR												
☐ Warmed												
☐ Warmed												
☐ Warmed												
☐ Warmed												

LOSSES: EST BLOOD LOSS; URINE -

TOTALS: 5mg; 10mg

TOTAL EBL: MCI SR

TOTAL URINE: —

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

REMARKS

Code drugs with numbers, events with letters

1555 in OR, monitors applied.
1600 #5 Prosea placed one attempt, ⊕ BS ⊕ ETCO2
~~1836~~ 1730 Spont Resp prosea out
Spont Resp to PACU mask O2
Report given

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: ~~[illegible]~~ 85 KG LB est

HEMATOCRIT:

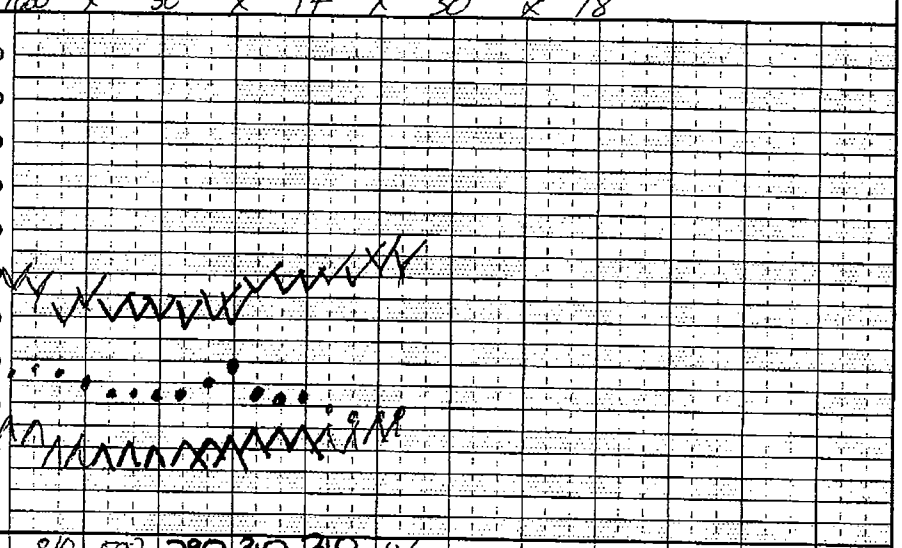
INITIAL DATA: BP- 113/55; HR- 72

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? TIME- 1530

TIME → 1100 x 30 x 17 x 30 x 18

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



VENTIL

VT - ml	810	500	290	310	310	SV	2012
f - breaths/min	9	7	19	19	18		
Peak inf pres / PEEP	17	15	—	—	—		
MODE - S(pon), A(ssist), C(on)	S-CV	CV	SV	SV	SV	SV	

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	44	46	46	44	48	46
BP/oth	FIO2 (Frac or %)	.81	.81	.80	.80	.81	.83
ART line	SpO2 (%)	100	100	100	100	100	
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	
Gas analyzer	TEMP-site SKIN			35			
	N-M Block (T/4)						
Warming blkt							
Conv warmer							

Mark with letters & symbols, explain under REMARKS EVENTS *Position* → a — arms < 90° abducted

RECOVERY AT: ICU2

PACU ICU ____ (Specify)

OTHER Spont Resp

CONDITION: 798-3

RESP- 22 SpO2- 100

BP- 143/66 HR- 75

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1530	1555	1830
PROC	Ready	Begin	End
	1605	1620	1766

PROCEDURES and CPT Codes: IeD(L) foot

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

[redacted] b(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
GA c̄ Prosea LMA #5

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* #5 prosea LMA placed one attempt, secured c̄ tape b(2)-2

SURGEON: [redacted] b(6)-2

ANES: [redacted] RNA

PROCEDURE LOCATION: [redacted]

DATE: 8/13/03

PAGE 1 OF 1

PRE-ANESTHETIC ASSESSMENT AND PLAN OF CARE

AGE: 28 Days Mos (Yrs) GENDER: (✓) Male ( ) Female ALLERGIES: NKDA

P S: 1 2 3 4 5 E WT: 75 (Kg)/Lb HT: ___ In.

PROPOSED PROCEDURE: Zone I neck exploration
SURGICAL SERVICE: GS/CT
NPO SINCE: 2400

PREOP DX / MECHANISM OF INJURY: S/p Blast Injury

HABITS:

Tobacco: Ø
EtOH: Ø
Drugs: Ø

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) None
( )
( )
( )
( )
( )

PREMEDICATIONS:

None / Yes @ ___ Hrs
None

LABORATORY STUDIES:

Other: ___

PAST MEDICAL HISTORY / SYSTEMS REVIEW

Cardiovascular:		
Hypertension	N	Y
Angina	N	Y
MI	N	Y
CVA	N	Y
Other	N	Y
Pulmonary:		
Asthma	N	Y
URI	N	Y
COPD	N	Y
Other	N	Y
Renal System:		
ARF/CRF	N	Y
Other	N	Y
Gastrointestinal:		
Hepatitis	N	Y
Hiatal Hernia	N	Y
GERD/PUD	N	Y
Endocrine:		
Diabetes	N	Y
Steroids	N	Y
Thyroid	N	Y
Neurological:		
Seizures	N	Y
Neuropathy	N	Y
Gynecological:		
Pregnancy	N	Y
Other	N	Y
Other Problems:	N	Y Shrapnel wounds
Familial Hx	N	Y

Pt. speaks english (Pt distressed during admission)

SURGICAL HISTORY

?

PHYSICAL EXAMINATION

BP: 125/58 HR: 69 RR: 12 T: ___

Pain (0/10 Scale): ___

Airway Exam:
Dentition: intact
Trachea: Midline
TMJ/C-spine: ___
Oropharynx: MP I

Chest:
Lungs: CTA(B) =
Heart: RRR(S) =

IV Access: 18G (R) ar

Ulnar Filling: ___

Back: ___

Other: ___

ANESTHETIC PLAN: ( ) Local/MAC ( ) Regional: ___ (✓) General: Intubation / Mask-LMA Notes: ___

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives, and risks of anesthesia including death have been explained to and discussed with patient and/or legal guardian. The patient/legal guardian seems to understand and agrees to proceed. Questions answered.

[redacted] b(6)-2

( ) Sedated/nonresponsive/minor patient with no family or guardian present.

Signed: [redacted] Date: 8-17-03 Time: 0007

PATIENT IDENTIFICATION: [redacted]

[redacted]

b(6)-4

POST-ANESTHESIA EVALUATION AND NOTE:

( ) No apparent anesthetic complications.
( ) Other (see progress notes)

Signed: ___ Date: ___ Time: ___

Nursing Unit: ICW2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 17 Aug 03 TIME OF ORDER: 0100 HOURS

LIST TIME ORDER NOTED AND SIGN

1) Admit IEU #2
2) Dx [redacted] Shrapnel wound
3) Vital q1 hour neuro check
4) Activity bedrest b(6)-2
5) Diet NPO
7) IV Lactat 150cc/hr

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER

8) Pending OR by 0800 hours
9) Ancef 1gr IV q8h
10) MSO4 2-8mg IV q1hr prn
11) Called MD if T>101.F, SBP<100 or chg neuro status

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER [redacted] HOURS

NO VS Q6° & NV(J) TO LLE. [redacted]

NOTED 17AUG03 1842 [redacted]

b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 18 AUG 03 TIME OF ORDER 1700 HOURS

1) Resume previous orders
2) Percocet, 1-2 PO q 4-6 hrs prn
3) Resume diet
4) Tylenol 650 mg PO q 4 hrs prn
5) NS KVO at 125cc/hr. Hep Lock when IV out PO. WBI

18AUG03 [redacted] 1800

[redacted]

b(6)-2

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

© U.S. GOVERNMENT PRINTING OFFICE: 1980—409-824

"USE BA" 1 POINT PEN—PRESS FIRMLY. NO CARBON PAPER REQUIRED"

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

EPW [redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 17 AUG 05 TIME OF ORDER _____ HOURS | LIST TIME ORDER NOTED AND SIGN

1) To ZW
2) Dx or suspected [illegible] Neck Edema
   ⊙ Open bone explore
3) Cordotomy
4) Urbol q10 x 4 then q90
   with neurovascular check

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER _____ HOURS

5) Activity Bedrest
6) Diet Advance as tolerated
   when alert and
7) IV LR at 125 cc/h
   heparin when fully awake
8) MEDS
   MSO4 2-8 mg IV q1-2 prn
   or

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER _____ HOURS

Fentanyl 2 mg q4°
Zofran 4 mg IV q1° prn
Ancef 1 gm IV q8°
9) labs CBC Chem with
10) call MD Tr > 104.5, SBP > 180
    Cr > 2, UOP < 30 cc/h

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER [redacted] HOURS

b(6)-2

PATIENT IDENTIFICATION

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.
24 V/S	2250	19 Aug 03

DATE OF ORDER: 19 Aug 03 TIME OF ORDER: 1720 HOURS

Transfer to ICW 2

Continue all previous orders

V/O Dr. [redacted]

LIST TIME ORDER NOTED AND SIGN

PATIENT IDENTIFICATION

EPW

[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW	24 Chart ✓	[redacted]

DATE OF ORDER: 8/22/03 TIME OF ORDER: 1920 HOURS

b(6)-2

✓ - D/C Ancef

✓ - Keflex 500mg PO QID

✓ - PT for crutch training today

✓ - Heplock IV

[redacted]

noted 22 Aug 03 1940

b(6)-2

903 [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER: 24 Aug 03 TIME OF ORDER: 1200 HOURS

(1) CBC, Chem 7, LFT's ASAP

b(6)-2

[redacted]

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

EPW

[redacted]

b(6)-4

Noted 25 Aug 03 1545

[redacted]

DATE OF ORDER: 25 Aug 03 1540 HOURS

D/C Q4 vitals, Δ to q shift.

Dressing Δ to @ LE & day.

V.O. from Dr. [redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW	5	13

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

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

U.S. GOVERNMENT PRINTING OFFICE: 1996—409-924

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

Noted 26 Aug 03 1710 b(6)-2 [redacted] AN

NURSING UNIT	ROOM NO.	BED NO.
24P	V0005	27

DATE OF ORDER: 26 AUG 03 TIME OF ORDER: 1650 HOURS

LIST TIME ORDER NOTED AND SIGN

1. DISCHARGE TO FPW CLINIC
2. KEFLEX 250 mg P.O. QID x 10 DAYS #40
3. MOTRIN 800 mg TID PRN #30

Aug 03 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER [redacted] b(6)-2 HOURS

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

DA FORM 4256 REPLACES EDITION OF 1 JUL 72 USED

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

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

XR - Lateral (L) Ankle
Lateral (L) Knee

[redacted]

[redacted]

b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

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

b(a)-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. 8 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 16	17	18	19	20	21
17 Aug 03	[redacted]	Vitals q4h with	06	[redacted]					
		neuro vascular checks	18	[redacted]				AB	17 Nurses Hall
17 Aug 03	[redacted]	Activity bed rest	06			[redacted]			
			18	[redacted]					
[redacted]									
17 Aug	[redacted]	Q6° VS C NV (J) TD	06			[redacted]			
		LLE.	18			[redacted]			
18 Aug	[redacted]	Regular diet	06			[redacted]			
			12			[redacted]			
			18			[redacted]			

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: multiple shrapnel wounds

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted] b(a)-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 [illegible] MAY BE USED. — USAPA V1.00

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 8 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
17 Aug 03	[redacted]	admit to ICU #2	17 Aug 03	ASAP	0145	[redacted]
17 Aug 03	[redacted]	Pending OR	17 Aug 03	ASAP		
	-----	XR - Lateral (L) [illegible]			[illegible]	[redacted]
18 Aug	[redacted]	~~Resume~~ Lateral (L) Knee			[illegible]	[redacted]
18 Aug	[redacted]	Resume previous orders	18 Aug	Now	1735	[redacted]

	-----	b(6)-2				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
17 Aug	[redacted]	Call MD for T > 101.1,														
-----	-----	SBP > 180 < 90, change														
-----	-----	in neurovascular status														
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															

USAPA V1.00

b(6)-2

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. 8 Yr. 2003

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED
				(19 20) 20 23 24 25 26 27 28
Copied	[redacted]	Activity - BR	05	[redacted]
			13	[redacted]
			21	[redacted]
Copied	[redacted]	Walker	06	[redacted]
		Neuro	10	[redacted]
		Δ d to Q shift	14	[redacted]
		25 Aug 03	18	[redacted]
			22	[redacted]
			00	[redacted]
Copied	[redacted]	Log diet	06	[redacted]
			09	[redacted]
			17	[redacted]
Copied	[redacted]	call HD T>104.5 or	05	[redacted]
		BBP >180	13	[redacted]
25 Aug	[redacted]	Dressing Δ to D&E	20	[redacted]
		Q day		
25	[redacted]	Vitals QS	04	[redacted]
			12	[redacted]
			20	[redacted]

Dec 27 Aug 03 1545 [redacted]

ALLERGIES: ☐ YES ☐ NO PRIMARY DIAGNOSIS: Limb trauma/Orthopedic wounds

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

PATIENT IDENTIFICATION: [redacted]

b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

b(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo. 8 Yr. 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
		~~CBC, Chem Profile in am~~				
22Aug	[redacted]	PT for crutch training today	22Aug today		[redacted]	DC'd 27Aug03 1545 [redacted]
22Aug	[redacted]	D/C to Fbw camp c̄ Keflex & Motrin				

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

USAFA V1.00

b(6)-2

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 16	17	18	19	20	21	22	23	24	25
[redacted]													
(7 Aug 03)	[redacted]	Cincef 1 GM IV	00	[redacted]									
		9sh	08										
			14										
18 Aug	[redacted]	IV LR @ 125/hr	06										
		Heplock when tolerating	18										
		PO well											
19 Aug	[redacted]	Heplock IV	05										
			13 AW										
			21 PP										
22 Aug 03	[redacted]	Keflex 500mg po QID	06										
			12										
			18										
			24										

D/C'd 22 Aug 1400 [redacted]

rewritten see below

D/C 23 Aug

D'd 27 Aug 1545 [redacted]

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: multiple strapped wounds

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION: [redacted]

b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

blu-2 All

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 8 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
	-----	~~Pen~~ error				
27Aug	[redacted]	D/c to EPW camp	27Aug	ASAP	D/C'd 27Aug03 1545	[redacted]
	-----	blu-2				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION / TIME/DATE DISPENSED													
17Aug03	[redacted]	Ltrso + 2-8mg IV	4mg IVP													
-----	-----	q1h PRN	0200 18Aug	D/C 18Aug03 [redacted]												
18Aug	[redacted]	Percocet 1-2 PO	1700 PO 2100	19Aug 0600 TTPO	19Aug 1600 TTPO	19Aug 2330 TTPO	20Aug 1400 TTPO	21Aug03 0030 TTPO								
-----	-----	q4-6° prn	1900	[redacted]			[redacted]	[redacted]								
18Aug	[redacted]	Tylenol 650mg PO														
-----	-----	q4° prn														
17Aug 03	[redacted]	MSO4 2-8MG IVP	10MG IVP													
-----	-----	Q1 HR PRN	2130 10MG IVP													
-----	-----															
20Aug	[redacted]	Zofran 4mg IV q6° PRN														
-----	-----															
-----	-----															
-----	-----															

D/C'd 27Aug03 1545 [redacted]

USAPA V1.00

Patients Name: EPW# [redacted] Date: 19AUG03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line	~~120~~						118																			
NBP	~~62~~						64																			
TEMP	97*						98.8																			
HR	60						66																			
RR	14						16																			
SaO2	99						100																			
FiO2	~~0~~						RA																			
Source	~~0~~						–																			
MAP	–						–																			

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Tot
IVF LR	125																									
IVPB																										
NGT																										
P																										
.al	125																									

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE	~~0~~			500			450																			
NGT	–																									
STOOL	~~0~~																									
DRAIN	–																									
Total																										

MEDCOM - 17412

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

OTSG APPROVED (Date)

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

Date: 17 Aug 03
Time In: 0900
Allergies: NKDA
Pre-op V/S: 99/72 92
Procedures: I+D
Wt: 2 Thigh

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block ASI I
OR Intake: Crystalloid 900 Colloid
OR Output: UOP 200 EBL mn.
Meds/Times:

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

Pre Op Meds History

Time																								
	0900	0930	0945																					
SaO2	100%	100%	100%																					
FiO2	0																							
Methods																								
240																								
220																								
200																								
180																								
160																								
140																								
120																								
100																								
80																								
60																								
40																								
20																								
RR	20																							
T	98.1																							
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		
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1		
Blood Pressure (2) SBP +/- 20 of Pre-op (1) SBP +/- 20-50 of Pre-op (0) SBP +/- 50 of Pre-op	2		
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1		
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2		
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	1		
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.			

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
LDS
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 (Sign): SGT [redacted] 91WM6
DEPARTMENT/SERVICE/CLINIC: ICU2
DATE: 17 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

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

ICU1

Patients Name: # [redacted] (PW) Date: 17Aug03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line			S																							
NBP	102/70	130/70		196/62	128/68	124/72	126/66	122/58	118/62	120/58	118/64	130/84		118/60				119/60				114/52				
TEMP	99	99	U	96.4			98.4			99				100.5	100.5			100.0				99.0				
HR	70	90	R	98	102	100	98	92	96	88	92	88		79				70				68				
RR	20	22		18	16	22	24	20	18	22	24	18		22				20				22				
SaO2	100	100	G	100	100	100	99	100	100	99	99	98		99				99				100				
O2	0	0		0	0	0	0	0	0									RA				RA				
Source			C																							
MAP																										
			R																							
			Y																							

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
IVF	150	150	900	150	150	150	150	150	150	150	150	150		150	150	150	150	150	150							
IVPB	100										100									50						
NGT																										
P																										
al																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE	80	110		120	80	70	170	100	80	80	90	110		210			150									
NGT																	N/C									
SOL																	Foley									
DRAIN																										
Total																										

MEDCOM - 17414

143/64 22 100 75 98 8

MEDICAL RECORD SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-68; the proponent agency is the Office of The Surgeon General.

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

OTSG APPROVED (Date)

Date: 18 Aug 03
Time In: 1735
Allergies: NKDA
Pre-op V/S: 113/55 72
Procedures: I+D (2) wg (22 100 75)
Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1000 Colloid
OR Output: UOP 5 EBL 50
Meds/Times: 5 versed 10 mg MSO4 Fent 100 mcg

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

Pre Op Meds

History

Time	1735	1740	1745	1800	1815	1830
SaO2	100	100	100	96	94	[illegible]
FiO2	8L			8L	8L	RA
Methods						
240						
220						
200						
180						
160						
140						
120						
100						
80						
60						
40						
20						
RR	22		15	20	20	15
T	98.8					

Time	
Pain (0-10)	
LOS	

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	1	1	1
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	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	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	/	/	/
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	7	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

b(6)-2 [redacted] CPT

DEPARTMENT/SERVICE/CLINIC: ICU 2

DATE: 18 Aug 03

PATIENT [redacted]TION (For typed or written [redacted]: first, mi[redacted]ate; hospital or medical facility)

Name - last,

[redacted]

b(6)-4

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

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	L leg			+		W	P
15'	"			"		"	"
30'	"			"		"	"
45'	"			"		"	"
60'	"			"		"	"
90'							
D/C	"			"		"	"

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

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) leg		CPI
30'			
60'			
D/C			

PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

1735 Arrived from OR
Extremely drowsy Respiration
even and unlabored Capreft
<3 sec. No distress no c/o pain
N/V [redacted]

b(6)-2

Discharge Criteria:
Date: 18AUG03 Time: 1845 PARS: 9
BP: 126/63 T: 99.3 HR: 83 RR: 15 SaO2: 98 RA
Pain Level at D/C (0-10): Ø
Intake: _____ Output: _____
Additional Data: _____
Transferred To: ICU 2
Report Given To: N/A
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: SPC [redacted] 91WM4
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: b(6)-2

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION
A 1 1 D 1	I 2 (State or Country Code.)

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
	EPW # [redacted] b(6)-4		M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
	028	Z	Z	unk

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	ADMISSION	BRANCH / CORPS
	Z	0130	b(6)-4

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

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION YEAR	
I 2		9		X NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0	ICW2	unk

	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
b(2)-2 [redacted]	unk

	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
	unk

21. TYPE OF DISPOSITION	MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
50		030826

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
AFAA		030816

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

FOR LOCAL USE

Dx: multi shrapnel wounds

Dx: 8910
8922
8920

Px: 7166X3
8365X2
8302X2

b(6)-2

ADMITTING OFFICER (Signature, as required)

DO [redacted]

[redacted] OF ADMITTING CLERK

DA FORM 2985, MAR [redacted]

MEDCOM - 17417

USAPPCV1.0

[redacted]

IN[redacted]TENT TREATMENT RECORD COVER [redacted]EET

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

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

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M.	24y	X	MUSLIM	—	—	NO.

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99	[redacted]	— b(6)-4	ICW1

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

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct from the ER.	0130.	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
UNK	D/C TO CAMP.	18 AUG 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
UNK	UNK	17 AUG 03.	

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
[redacted] b(2)-2		

31. SELECTED ADMINISTRATIVE DA[redacted]

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

MORTAR ROUND BLAST INSIDE EPW CAMP.

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: Shrapnel Wounds / Partial TOE Amputation.

873.41
892.0
890.0
895.0
893.0
891.0
E979.9

84.11
86.28
86.59

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL O[redacted] SIGNATU[redacted]AL RECORDS OFFICER

DR. [redacted]

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

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

24yo Iraqi male s/p Blast @ EPW camp
c/o (B) leg pain !
Last meal 2000

All Ø meds Ø PMH - Ø PSH Ø

PHYSICAL EXAMINATION

102 123/4K 98% SAT
small inc to (L) cheek
Neck NT (-) Deformity ROM
Back - NT (-) injury
Chest - CSTA
Abd ND soft NT
rectal Heme (-) Rectone
GU WNL

Vasc: 2+ PP throughout
Ext (1) penetrator over (R) Lat Gastroc Muscle
(2) wound (L) lat injured calf
(3) Pepper (R) Ankle Hrg.
(4) Rt Foot wound c̄ ST Defect
(5) near Amp (L) 2nd + 3rd toes

PROGRESS (Enter date of discharge and final diagnosis)

A/P (1) (R) low ext wound
(2) Traumatic Amp (R) toes
(3) Hip penetrat c/o Pelvic injury.

b(6)-2

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

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

REGISTER NO.	WARD NO.
	ICW 1

EPW [redacted]

b(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
539-106

117

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17 AUG 03 0217	VSS. AOx3. (+) Pulses. PERRLA. BS (+) x4. DSG's to (R) foot @ (L) check CDI. LSC, LAB. S1, S2. FTG Jowling light amber urine quantity sufficient. Denies pain @ this time NPO after MN. Rectal confusion in [redacted] b(6)-2
17 AUG 03 0930	Brief Op Note Preop Dx: Shrapnel wounds (B) L E Postop Dx: Same Procedure: I&D wounds, completion partial foot amputation (L) 2nd toe Surgeon: [redacted] Esti: Ø Fluids: 1000cc Findings: multiple soft tissue shrapnel wounds (B) L E, partial amputation (L) 2nd toe Cx: Ø Post Op Plan: tx x, heavy D's [redacted] b(6)-2
17 Aug 03 @1000	OMFS Brief procedure note Closure of left cheek laceration c̄ 5.0 prolene suture 5 complications in OR. b(6)-2 [redacted] MAJ/DC OMFS

STANDARD FORM 509 (REV. 5/1999) B.
USAPA

DATE	NOTES
7 Aug 03 1621	Received pt resting in bed, USS, A+O×3, LSCTAB, HRE, BS(+)×4, ABD SNT, pulses equal + strong. Dress intact. Pt to OR, recovery then back to ICW1 this shift. Pt returned w/ LSCTAB, USS, A+O×3, BS(+), and SNT. Drsg on (R) LE c/d/i, (L) LE noted to have some seroserang drainage, drsg intact. Toes warm, cap refill good, able to wiggle toes. Ir patent + intact. meal x2 w/ 2mg MSO4 per MD order. Will cont to monitor. [redacted] b(6)-2
17 AUG 03 1930	USS. c/o B/E foot pain & given 2mg MSO4. DSG's CDI. Voiding light amber urine. Quantity sufficient. Minimal PO intake this PM. Pain in left. — [redacted]
18 Aug 03 0545	Pt received awake & alert c/o pain, given MSO4 2mg IV, ½, ½ noted ē bilat UEs (+) peripheral pulses, bilat LE ē drsg (L) LE ē dried bloody drainage otherwise CDI ē good capillary refill, warm to touch & able to wiggle toes, drsg to (R) thigh CDI, drsg to (L) inner thigh CDI, lungs CTA bilat, (+) bowel sounds, cont. to monitor. — b(6)-2 [redacted]
18 Aug 03 0940	Pt received 2mg IVP MSO4 [redacted] c/o pa[redacted]. Will monitor for effect. — [redacted]
18 Aug 03 1115	Pt resting in bed's complaints — [redacted] b(6)-2
18 Aug 03 1336	Pt transferred to ICU #2 via litter. Report given to CPT(P) [redacted] — [redacted] b(6)-2

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

EPW [redacted]
b(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8/18/03	D/C Summary
	This Iraqi male sustained shrapnel wound to both legs and a partial left 2nd toe amputation on 8/16/03. His wound are clean and should continue to remain clean & dry. Oral antibiotics should be continued. Weight bearing as tolerated.
	[redacted] b(6)-2

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

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

[redacted] b(6)-4

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

USAPA V2.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18Aug03 1500	assumed care when pt. transferred from ICW1 @ 1430 - VSS, T 100.8 - 9/10 pain in feet, given Co 50mg PO tylenol - NS @ 125cc/hr infusing into (L) AC IV - lungs CTA (B) - (+) BS - restrained (R) wrist, (L) ankle - (L) foot c̄ Kerlix & ace wrap, small amount of drainage near 4th toe, (+) sensation, (+) movement, neuro v's WNL - (R) foot c̄ Kerlix & ace wrap CDI, (+) movement, (+) sensation, neuro v's WNL - pt. speaks limited english and understands english - pt. has dc orders for 19 Aug 03 b(6)-2 [redacted] RTAN
18Aug03 2000	daily dsg Δ done @ 1700 - (L) thigh wound dressed, (L) foot 2nd toe packed c̄ iodoform, Kerlix placed over 3 other schrapnel wounds then ace wrap, (R) thigh wound loosely packed, other schrapnel wounds on (R) thigh covered c̄ 2x2 & Kerlix, (R) foot 2nd toe sutures intact and 3rd toe suture intact dsg placed on toes, Kerlix & ace wrap - sutures on (L) foot and lower (R) thigh intact and dressed b(6)-2 [redacted] CRTAN
19 Aug 0100	Care assumed @ 2100. VSS, pt a&o x3, 2 percocet given for pain @ 2115. Lung sounds CTA, bst x4 quads

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

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

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)*
19 Aug 0100	HL @ lac intact, IV ABX @ 2200. Dsgs on (L) le and dsg on (R) foot all CDI. Pt can wiggle toes and has (+) sensation on both feet. Has d/c orders for 19 Aug, with summary, will continue to monitor. [redacted] Assume
19 Aug 03	0605 Assume pt care @ 0500. Pt asleep easy to awake. A+O x 3. VSS. HR reg. Lungs CTA. Abd soft BS x 4. HL (+) AC (+) flush 5 redness/infiltration. Dsg to (L) shin CD+I. Dsg's to (L) + (R) foot CD+I (+) sensation to toes. C/o pain percocet given @ 0600. Pt has Discharge orders/summary meds @ pharmacy. Will cont. to monitor [redacted]
19 Aug 03 1500	Pt stable. Dog A's done this am. Pt not ambulatory at this time. To be returned to EPW camp. Meds and xrays at bedside. Discharge instructions to PAD. To be escorted by MP. — [redacted]
1545	Pt discharged to EPW Camp IAW MP escort. Meds and D/C instructions to pt. — [redacted] b(6)-2 All

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

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

[redacted]

b(6)-4

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

NSN 7540-01-075-3786

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

PATIENT'S HOME ADDRESS OR DUTY STATION			ARRIVAL	
STREET ADDRESS			DATE *(Day, Month, Year)* 16 Aug 03	TIME 1142 pm
CITY	STATE	ZIP CODE	TRANSPORTATION TO FACILITY	

SEX	DUTY/LOCAL PHONE		MILITARY STATUS				THIRD PARTY INSURANCE		
M	AREA CODE	NUMBER	ITEM	YES	NO	N/A	ITEM	YES	NO
			PRP				ADDITIONAL INSURANCE		
AGE 24	HOME PHONE		FLYING STATUS				DD 2568 IN CHART		
	AREA CODE	NUMBER	MEDICAL HISTORY OBTAINED FROM				NAME OF INSURANCE COMPANY		

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

CHIEF COMPLAINT Shrapnel wound

CATEGORY OF TREATMENT		VITAL SIGNS					
☐ EMERGENT	TIME 1143	TIME 1143					
☐ URGENT		BP 123/45					
	INITIALS ST	PULSE 91					
☒ NON-URGENT		RESP 18					
		TEMP 99.3					
		WT					

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

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
2347	2 gms ANCEF	DR. [redacted]	CPT [redacted]	2350	
2347	MSO4 10 ml	DR	CPT	2350	b(6)-2
2347	0.5 ml, IM TETANUS	DR. [redacted]	CPT [redacted]	2350	
0010	4 mg SOM	PA. [redacted]	CPT	0010	

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

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

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

[redacted] b(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Doctor)*	TIME SEEN BY PROVIDER 23:50

TEST RESULTS

CBC		SMAC				ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
WBC 19.8			122	101	17	SUP 02	PH	PO2	RESULTS Feet	(+) 2, 3 toe Fx (L)
H/H 13.1/40.9					MD	PCO2	SAT	OTHER		(+) shaped (R) Rear ∅ Fx ∅ pelvic Fx
PLT 374			3.4	17						
PT 19.1						U/A DIP			EKG INTERPRETATION	(+) shaped (R) foot c ? Fx 5th toe
APTT 33.0	BHCG	ETOH	GLU			MICRO				

PROVIDER HISTORY/PHYSICAL

S: 24 y.o. ♂ c/o slip shaped wounds feet (B) (R) arm, (R) thigh, (+) loc. (L) cheek - face 60' retained
Back: clear

O: VSI stable
Gen: WDWN 24 y.o. ♂, A+O x 3, (+) speaks English, (+) mod. distress 2° pain
(R) 3 toe amputation
HEENT (+) superficial lac (L) cheek
U/S Sq Dr Dougan ∅ Free Fluid check + liver, spleen
CV: CTA (B) RRR
ABD soft, NT, ND ∅ masses
Ext: (+) partial amputation 2nd toe (L) foot c̄ 2 (+) PP pulse
(+) 3½cm avulsion Posterior (R) foot, (+) lac. 5th toe (R) foot
(+) multiple fragment wounds (L) shin c̄ (+) 2 fragment wounds (L) forearm, (+) 1 fragment wound (L) hip
(L) back wounds c̄ (+) partial amputation 2nd, 3rd toes, (+) (R) lower ext. shaped wound
(+) (R) hip injury ? partial pelvis

CONSULT WITH	TIME	ACTION
ortho	12:00	wounds examined
Surg	12:00	U/S done, wounds examined

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP [redacted] / [redacted]

DIAGNOSIS
- partial toe amputation (L) (+) facial lac - superficial
- shaped wounds (R) leg
- (R) hip hip shaped wound

CODES [redacted] b(w)-2

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

[redacted] b(w)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

MEDICAL RECORD	**PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT** For use of this form, see AR 40-66; the proponent agency is The Office of the Surgeon General.
1. AGE: 24 HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): 3. PREVIOUS SURGERY [ ] NO [X] YES (type):

4. PROPOSED SURGICAL PROCEDURE:
I+D 1 (L) toe amputation

5. ADDITIONAL INFORMATION: Last PO: Medical Hx: Implants: Medications:
Jewelry removed: yes/no Family waiting: yes/no

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

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

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

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

Sgt [redacted] CPT1AN 17 Aug 03 DATE

11. POSTOPERATIVE EVALUATION:

Bone Site:

Drsg:

Breathing:

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)	13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)
Sgt [redacted] CPT1AN	Sgt [redacted] CPT1AN
DATE: 17 Aug 03 TIME: 0810 b(6)-2	DATE: 17 Aug 03 TIME: b(6)-2

MEDICAL RECORD — **INTRAOPERA DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY Anesthesia

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

3. DATE 17 Aug 13 TIME PATIENT ARRIVED IN SUITE 0855

4. PATIENT IN ROOM TIME 0855 NUMBER 2-4

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: nkda

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted]	RELIEF SCRUB	b(6) - 2 A 11
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, arms extended at less than 90° on padded armboards, position approved by surgeon + anesthesia

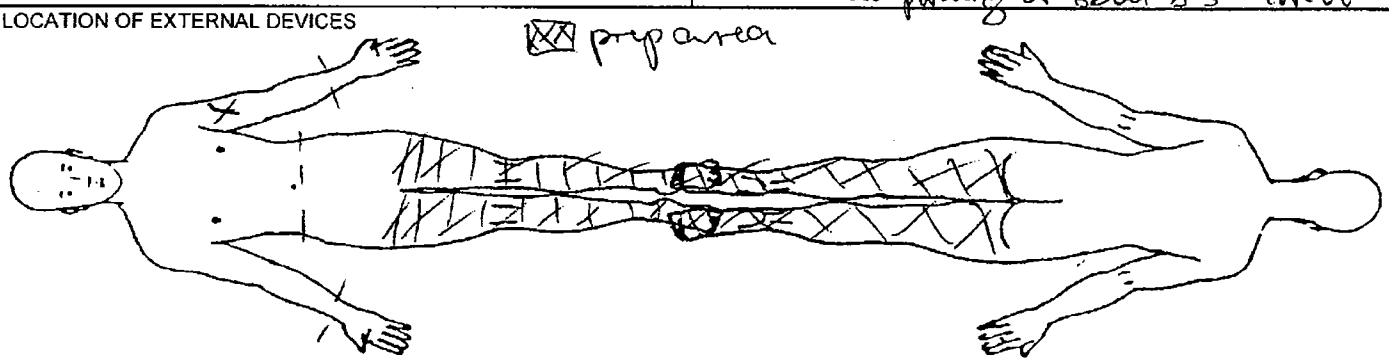
8. SKIN PREPARATION

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

COMMENTS:

PREP SOLUTION *(Specify)* Betadine Betadine
SITE: (R) Leg BY WHOM [redacted]
SITE: (L) Leg BY WHOM [redacted]
#See 9
COMMENTS: no peeling or skin s's noted

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

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

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

[redacted]
ICW,

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

[X] ESU NO: VL Force 2 #3 (00047)
GROUND PAD: BRAND VL Ram Pathesive II
LOT NO: 68936 2005-03

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

[ ] BIPOLAR NO:

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

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 [redacted]

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	1/2 in Iodoform	1/2 in Iodoform	
SITE	(R) foot (R) thigh	(L) right calf	

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs
Kerlix
Acewrap
4x8's, Tape

19. ADDITIONAL INFORMATION
WC III
Surgeons: [redacted] Anesthesia: [redacted] Anesthesia Type: General
b(6)-2
Bovie Pad site intact pre-op ✓; post-op _____ Bovie Settings: Coag/Cut 30/35
Tourniquet Site intact pre-op —: post-op — N/A

20. OPERATION(S) PERFORMED
I+D multiple shrapnel wounds (R) leg + (L) leg + bilat feet
Amputation 2nd toe (L) foot, Repair facial laceration

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU 3	See DA7389	Litter

22. REGISTERED NURSE SIGNATURE
[redacted] CPT IAN

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

b(6)-2

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR Aug ~~19~~ 2003 | DAY 17 18 19 | HOUR 07 12 07

PULSE (O) | TEMP. F (°)

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

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

TEMP. C: 40.6° 40.0° 39.4° 38.9° 38.3° 37.8° 37.2° 37.0° 36.7° 36.1° 35.6° 35.0°

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD: 20 18 16 18

BLOOD PRESSURE: 121/72 132/68 130/60 129/78

125

99.6

HEIGHT: WEIGHT →

98% RA 98% 97% 98%

130/72

107

54.1.

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. ICW1/2

[redacted] ICW1

b(a)-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	HOUR

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

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

Ward/Section: CMT	REQUESTING PHYSICIAN:	DATE 16 Aug 03	TIME 2310	SSN/PSEUDO SSN: [redacted] b(6)-4
LAST, FIRST, MI. [redacted] b(6)-4				

(Hematology) CBC

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

(Hematology) Manual Differential

		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	19.5	9.8-13.6 secs
APTT	33.0	21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Urinalysis

TEST	RESULT	REF. RANGE
Color	yellow	N/A
App	CLR	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	Tr	Negative
SG	1.030	N/A
Bld	mod	Negative
pH	5.0	N/A
Prot	Tr-2+	Negative
Urob	norm	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

Acetest 3mg/l
WBC - 1-3
RBC - 8-10
mucus - mod

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: b(4)-2

REPORTED BY: [redacted]

DATE: 17Aug03

LAB ID NO.:

Ward/Section: CMT	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, M [redacted] b(6)-4	DATE 16 Aug 03	TIME 2350	SSN/PSEUDO-SSN [redacted] b(6)-4

(Hematology) CBC			Urinalysis			Misc. Serology		
RESULT		REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
		8-10.8 x 10³	Color	yellow	N/A	RPR		Negative
			App	CL	N/A	Mono		Negative
			Glu	neg	Negative	**Microbiology**		
			Bili	neg	Negative	Source		
			Ket	Tr	Negative	Gram Stain		
			SG	1.030	N/A	Occ Bld		Negative
			Bld	mod	Negative	H. pylori		Negative
			pH	5.0	N/A	Micro Parasites		
			Prot	Tr 2+	Negative	Malaria		
			Urob	norm	0.2-1.0	O & P		
			Nit	neg	Negative	Other		
			Leuk		Negative	**Microscopic Urinalysis**		
			HCG		Negative	Alkst + 3m211 RBC - 1-3 RBC - 8-10 mucus - mod		

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	19.5	9.8-13.6 secs			
APTT	33.0	21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS:

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

b(6)-1

Ward/Section: EMT	REQUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] b(6)-4	DATE 16 AUG 03 / TIME 2350	SSN/PSEUDO SSN: # [redacted] b(6)-2

i-STAT CREA

Pt: [redacted]

Pt Name:_____

Crea_____1.4 mg/dL

Sample Type_:

17AUG03 01:00

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

** PRINT CANCELLED **

Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANG
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

NGE	TEST	RESULT	REF. RANGE
ol/L	ALB		3.5-5.5 g/dl
I/L	ALP		26-84 u/l
I/L	ALT		10-47 u/l

======= PICCOLO =======
17/08/03 00:32
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-2 [redacted]

GLU	142*	73-118	MG/DL
BUN	♦♦♦	7-22	MG/DL
CRE	♦♦♦	0.6-1.2	MG/DL
CK	199	39-380	U/L
NA+	122*	128-145	MMOL/L
K+	3.4	3.3-4.7	MMOL/L
CL-	101	98-108	MMOL/L
tCO2	17*	13-33	MMOL/L

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

(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

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:

REPORTED BY:	DATE:	LAB ID NO.:

NKDA — Procedure at cuffed

24yo

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)	0:00	0:30	1:00	1:30	2:00	2:30	3:00	3:30	4:00	4:30	5:00	5:30
fentanyl	(ug)	250											
propofol	(mg)	150											
Ecl	(mg)	100											
	( )												
NBM	(ug)	2	2	6	4 (c)		4 (c)						
	( )												
VOLAT AGENT	% del		2.0	2.0	2	2	2 X						
	% e.t.												
AIR	L/Min												
N2O	L/Min												
O2	L/Min	6	2	2	2	2	2	6					

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

FLUIDS

LINE site		0:00	0:30	1:00	1:30	2:00	2:30	3:00	3:30	4:00	4:30	5:00	5:30
18G	☐ Warmed	NS											
PIC	☐ Warmed												
	☐ Warmed												
	☐ Warmed												

LOSSES

		0:00	0:30	1:00	1:30	2:00	2:30	3:00	3:30	4:00	4:30	5:00	5:30
EST BLOOD LOSS													
URINE -													

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 70 KG LB

HEMATOCRIT: 40.9

INITIAL DATA: BP- 123/75 HR- 104

EQUIP CHECK OK?- Y N

PATIENT RECHECK

OK for PROCEDURE? Y

TIME- 0900

TIME → 0900 x 30 x (1000) x 30 x (1100)

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

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

VENTIL

	0:00	0:30	1:00	1:30	2:00	2:30	3:00	3:30	4:00	4:30	5:00	5:30
VT - ml		140	130	160	150	230	240					
f - breaths/min		13	13	18	14	10	12					
Peak inf pres / PEEP												
MODE - S(pon), A(ssist), C(ont)	S	S	S	S	S	S	S					

MONITORS/ACCESSORIES

		0:00	0:30	1:00	1:30	2:00	2:30	3:00	3:30	4:00	4:30	5:00	5:30
BP/Auto Cuff	ET CO2 (torr)		47	47	47	37	32	30					
BP/oth	FIO2 (Frac or %)	.90	.93	.90	.90	.89	.90	.90					
ART line	SpO2 (%)	100	100	100	100	100	99	99					
Steth-PC/ES	ECG	NS	NS	NS	NS	NS	NS	NS					
Gas analyzer	TEMP-site	36.0		34	34	35	35	X					
	N-M Block (T/4)		4/4 ST										
Warming blkt		Wool blanket/head wrap											
Conv warmer													

Mark with letters & symbols, explain under REMARKS — EVENTS Position → cuffs 290° inducted/padded

TOTALS	TOTAL EBL
250cc	min
	TOTAL URINE
30mL	100

FLUIDS - SUMMARY

CRYSTALLOID- 1000

COLLOID- NS

BLOOD-

REMARKS

Code drugs with numbers, events with letters

0955 - Met - 10mg

IV in place → Prep done w/ 3 wt loss - Drape - Monitors - induction & intubation

1055 - Spot neg breath sounds - Suction & extubate to ICU

RECOVERY AT

PACU ICU (Specify) OTHER stable

CONDITION: RESP 14 SpO2- 96% BP- HR- 140

ANESTHESIA / PROCEDURE TIMES:

ANES	Start	Room	End
	0845	0855	1110
PROC	Ready	Begin	End
	0910	0930	1040

PROCEDURES and CPT Codes: D-D Amputation (L) TOE

PATIENT IDENTIFICATION: Typed or written name, Grade/Rate, Medical facility [redacted]

[redacted] b/w - 2

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA - #8 cuffed ETT taped 22 cm teeth → #2 [redacted] Eyes taped ROTK & ET secured with tape. GCA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Preop - TSF - DL x1 GI view. ETT easily passed. Post-op - Manual teeth ok

SURGEONS: [redacted]

ANESTHETISTS: [redacted]

PROCEDURE LOCATION: #2

DATE: 17 AUG 05

PAGE 1 OF 1

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

MEDCOM - 17436

PRE-ANESTHETIC ASSESSMENT AND PLAN OF CARE

AGE: 24 Days Mos Yrs | GENDER: (X) Male ( ) Female | PS: 1 2 3 4 5 E
ALLERGIES: NKDA | WT: 70 Kg/Lb HT: ____ In.

PROPOSED PROCEDURE: I&D bilateral legs / Ex tap
SURGICAL SERVICE: Ortho / Gen
NPO SINCE: 2000

PREOP DX / MECHANISM OF INJURY: s/p Blast Injury (shrapnel injury bilateral legs / pelvis)

HABITS:

Tobacco: 0
EtOH: 0
Drugs: 0

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) Tetnus
( ) Ancef
( ) MSO4 10mg
( ) EMT
( )
( )
( )

PREMEDICATIONS:

None / Yes @ _____ Hrs

LABORATORY STUDIES:

Other: _____

PAST MEDICAL HISTORY / SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	
Angina	N	Y	
MI	N	Y	
CVA	N	Y	
Other	N	Y	
Pulmonary:			
Asthma	N	Y	
URI	N	Y	
COPD	N	Y	
Other	N	Y	
Renal System:			
ARF/CRF	N	Y	Foley cath
Other	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	
Hiatal Hernia	N	Y	
GERD/PUD	N	Y	
Endocrine:			
Diabetes	N	Y	
Steroids	N	Y	
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	
Gynecological:			
Pregnancy	N	Y	N/A
Other	N	Y	
Other Problems:	N	Y	
Familial Hx	N	Y	

SURGICAL HISTORY

PHYSICAL EXAMINATION

BP: 123/45 HR: 104 RR: 20 T: ____ 96% RA

Pain (0/10 Scale): _____

Airway Exam:
Dentition: Intact
Trachea
TMJ/C-spine
Oropharynx

Chest:
Lungs
Heart

IV Access: 18g (L) AC

Ulnar Filling: _____

Back: _____

Other: _____

ANESTHETIC PLAN: ( ) Local/MAC ( ) Regional: _____ (X) General: Intubation / Mask-LMA Notes: _____

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives, and risks of anesthesia including death have been explained to and discussed with patient and/or legal guardian. The patient/legal guardian seems to understand and agrees to proceed. Questions answered.

[redacted] blue-2

( ) Sedated/nonresponsive/minor patient with no family or guardian present.

Sign[redacted] KWA Date: 2345 Time: 16 Aug 03

PATIENT IDENTIFICATION:

#[redacted] blue-4

POST-ANESTHESIA EVALUATION AND NOTE:

( ) No apparent anesthetic complications.
( ) Other (see progress notes)

Signed: _____ Date: _____ Time: _____

Nursing Unit: EMT

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 01:30 HOURS | LIST TIME, ROOM, NOTES AND SIGN

8/17 Admit ICU-1 / surgery
Shrapnel wounds / partial toe amputations
stable condition
vitals as per routine
NKDA
Bedrest
Diet - NPO

PATIENT IDENTIFICATION

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

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER 01:30 HOURS

8/17 IV: NS @ 125 cc/HR
Meds
2 mg MgSO4 IV q 6 PRN pain
Lasix 20 mg Phenergan IV q 6 PRN nausea
NCC, clear-8 tube pus
other
- Pt to OR today for toe amputation

PATIENT IDENTIFICATION

b(6)-2 [redacted]

NURSING UNIT | ROOM | BED NO.

27°/2000 Max wgn

DATE OF ORDER | TIME OF ORDER [redacted] HOURS

8/17 - Foley to Gravity [redacted]
- Resume pre op orders, meds
- D/C foley
- Ancef 1gm IVPB q 8°
- Daily dressing D's, dry
- Regular Diet [redacted] b(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER 0900 HOURS

8/15/-3
- D/C to EPW camp tomorrow
- Re on chart
- Δ dressings & remove packing prior to D/C [redacted]

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	LIST TIME OF ORDER NOTED AND SIGN
#[redacted] blw-2				Transfer ICW2 [redacted] blw-4	HOURS	[redacted] 18 Aug 03 1336
NURSING UNIT	ROOM NO.	BED NO.				
ICW2		7				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
[redacted] EPW				18 Aug 03 Taken by [redacted] ① HL IVF blw-3 ② Tylenol 650mg mg PO q4-6° prn pain ③ Percocet 1-2 tabs PO q4-6° prn severe pain Per Dr. [redacted]	1600 HOURS	[redacted] 2000
NURSING UNIT	ROOM NO.	BED NO.				
ICW2	24VS	7				
PATIENT IDENTIFICATION				19Aug0100 [redacted] blw-2	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.

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"USE BALL POINT PEN—PRESS FIRMLY. NO CARBON PAPER REQUIRED"

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. 8 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 16	17	18	19
17	[redacted]	VS: ROUTINE	5	X	[redacted]		
			1	[redacted]			
17	[redacted]	BR	5	X	[redacted]		
			17	[redacted]			
[redacted]	[redacted]	Foley to gravity	5	X	[redacted]	7 D/C	
			17	[redacted]			
17	[redacted]	Daily dressing Δ's, daily	10	/	/	BRS 170 [redacted]	
17	[redacted]	Diet regular	06	/	/	[redacted]	
			12	/	/		
			17	/	[redacted]		

D/C [redacted] 19 Aug 03

ALLERGIES: ☐ YES ☑ NO
NKDA

PRIMARY DIAGNOSIS: shrapnel wounds/partial toe amp

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

#61

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