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	LIST TIME ORDER NOTED AND SIGN
VO Dr. [redacted] / [redacted]	HOURS	
Phenergan 12.5 mg IVP x1 now		b(6)-2
[redacted]		

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.

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 | HOURS | LIST TIME ORDER NOTED AND SIGN

20 Aug 03

1 - CXR

2 - KUB 3 done

3 - CBC & Chem 7 in AM [redacted]

b (6) -2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

20 Aug

March [redacted]

b(2)-2

[redacted]

b(6) -2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

20 Aug 03 2045

Send CBC, chem 8

flat plate, upright [redacted]

abdomen & chest

Develop signs of [redacted]

agent in [redacted]

b(6) -2 [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.

☆ U.S. GOVERNMENT PRINTING OFFICE: 1986—409-92A

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

CLINICAL RECORD - DOCTOR'S ORDERS

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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.

LCWH

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

21 Aug 03

1 - Reglan 10 mg IVPB q 4 0

2 - Amoxicillin q 4 0

3 - Bath in AM

4 - Call PA VO (30 cc/hr

HR 70/120 BP 120/90

O2 SAT <90% RA [redacted]

5 - CBC/chem 7 & Am [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

21 Aug 03 b(6)-2

1 - Phenergan 25 mg IVPB q 6 0 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

ORP 2300 21 Aug 03 [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

22 Aug 03 2300

DC Reglan and Phenergan

V.O. from Dr [redacted]

NURSING UNIT | ROOM NO. | BED NO.

b(6)-2

24° ✓ 23 Aug 03 0700 [redacted]

PATIENT IDENTIFICATION

EPW b(6)-4 [redacted]

38

DATE OF ORDER | TIME OF ORDER | HOURS

23 AUG 03 0700

1. OOB to chair at TID & Ambulation
2. ~~Dc Foley pt to void by~~
3. incentive spirometry
4. KUB HB AM (a-d CXR PA LAT [redacted]
5. ~~CBC Normal~~

23 Aug 1056

NURSING UNIT | ROOM NO. | BED NO.

CW2 | 5 | C

[redacted]

DD FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 72 WHICH MAY BE USED

24 Aug 03 0030

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

b(6)-2

8/24/03 ① D/c Foley pt to void w/~ 8hrs. or call MD

Noted 24Aug03 1700

[redacted]

b(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

DATE OF ORDER: 25Aug03 TIME OF ORDER: 2230 HOURS

Malox 30cc PO x1 Now

V.O. from [redacted]

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

NURSING UNIT: ICW2 ROOM NO.: 5 BED NO.: C

24V 26Aug03 0045 [redacted]

PATIENT IDENTIFICATION: Noted 26Aug03 1400 [redacted] b(6)-2

DATE OF ORDER: 26AUG03 TIME OF ORDER: 1700 HOURS

① D/C Ancef

b(6)-2 [redacted]

NURSING UNIT: ICW2 ROOM NO.: 5 BED NO.: C

24V 0001 27Aug03 [redacted]

PATIENT IDENTIFICATION: EPW [redacted]

DATE OF ORDER: 27 AUG 03 HOURS:

1- Demerol 25mg q6° PRN PAIN

2- Cont A.M. LABS [redacted]

3. D/C MSO4

4. Percoset 5/325 po q4-6° [redacted]

b(6)-2

NURSING UNIT: ICW2 ROOM NO.: 5 BED NO.: C

PATIENT IDENTIFICATION: EPW [redacted] 27 1625 b(6)-4 [redacted] b(6)-4

DATE OF ORDER: 27AUG03 TIME OF ORDER: 1623 HOURS

Cardiolyte 8mg Q6°

Zantac 50mg IVQ8°

CBC, Chem 7 in AM

Malox 30cc NG Q6°

Clear Liq

[redacted]

NURSING UNIT: ICW2 ROOM NO.: 5 BED NO.: 6 24V 26Aug03 [redacted] b(6)-2

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL [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, 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)-2

Noted 28 AUG 03 0900 [redacted] b(6)-2

NURSING UNIT	ROOM NO.	BED NO.
ICW 1		

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

28 AUG 03

1- [illegible] due to [illegible] 125cc/hr

2- [illegible] + [illegible] 7 qd

3- KUB in AM [redacted]

PATIENT IDENTIFICATION: [illegible] 8/28 [redacted] b(6)-2

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 8/28 / TIME OF ORDER 1600 / HOURS

① clear OK

[redacted] b(6)-2

[illegible] [redacted] AN 28 AUG 03 2038

PATIENT IDENTIFICATION: b(6)-2 Noted [redacted] 28 AUG 03 1112

NURSING UNIT	ROOM NO.	BED NO.
	[redacted]	

DATE OF ORDER / TIME OF ORDER / HOURS

30 AUG 03

1- Rec. diet [redacted]

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

NURSING UNIT	ROOM NO.	BED NO.
[illegible]	[illegible]	[illegible]

DATE OF ORDER 8/30 / TIME OF ORDER / HOURS

① D/C IV zantac ✓

② D/C maldox ✓

③ D/C [illegible] ✓

④ D/C Amloxi ✓

[redacted] b(6)-2

DA FORM 1 APR 79 4256 REPLACES EDITION [redacted] 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.
ICW #1		

↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED & SIG
	8/31	1700 HOURS	
6	D/C for EPW camp today		
2	NO meds ordered b(6)-2		[redacted]
	[redacted]		

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(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. Y 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	26	27	28	29
17 Aug 03	[redacted]	Vitals q2hr c sys	06		[redacted]												
		F10	18														
17 Aug 03	[redacted]	Act. OOB TID	06														
			18														
17 Aug 03	[redacted]	Foley to gravity	06														
			18														
17 Aug 03	[redacted]	[redacted]	06														
			18														
17 Aug	[redacted]	pt may have signs	06														
		of water	18														
18 Aug	[redacted]	CBC q am chem 7	06														
18 Aug	[redacted]	VS Qe°	06	X	X	X											
			18	X	X												
21	[redacted]	Amb q4o	07-18														
			18-19														
23 Aug	[redacted]	OOB to chair TID	07-07														
		c ambulation	07-15														
			15-23														
23 Aug	[redacted]	Incentive Spirometry	23-07														
			07-15														
			15-23														
28 Aug	[redacted]	Clean lip dent	23-07														
			06														
			18														

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: s/p ex lap SB repair cond. stable

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION: EPW # [redacted]

b(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 4677, 1 OCT 78 EDI

bld-2 AM

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 8 Yr 2003

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
17 Aug 03	[redacted]	Admit ICU 2	17 Aug 03	0230	0230	[redacted]
17 Aug 03	[redacted]	CBC, Chem 8, Chem 12 in am	17 Aug 03	0400	done	
17 Aug	[redacted]	CBC @ 0830	17 Aug	0830		
20 Aug	[redacted]	CBC and Chem 7 in am	21 Aug	0/am		
20 Aug	[redacted]	CBC Chem 8	Done	Done	WB	[redacted]
20 Aug	[redacted]	Abd XRay	Done	Done	2/7x	[redacted]
21	[redacted]	CBC/Chem 7 in AM	Done	done	done	
21	[redacted]	KUB in am	done	done		
24	[redacted]	DC Foley Pt to void w/i 8 hrs or call (MD)	24 Aug	1645	1645	[redacted]
25 Aug	[redacted]	CBC & Chem 7	26 Aug	in AM		[redacted]
28 Aug	[redacted]	KUB in AM	31 Aug			
31 Aug	[redacted]	D/C to EPW camp today (No meds needed)				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED
		call MD no <32	
		HR >120 SBP <90	
		RR >30 O2	
		Sat <90%	

USAPA V1.00

b(6)-2 A71

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. 08 Yr. 2003

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 30	31	1
18	[redacted]	CBC, chem 7 QAM	05	[redacted]		DLC 8/30
18	[redacted]	VS Q6°	6	[redacted]		
			18	[redacted]		
18	[redacted]	AMB QA°, OOBTC TID	6	[redacted]		
			18	[redacted]		
18	[redacted]	Incentive Spirometry	6	[redacted]		
			18	[redacted]		
18	[redacted]	Clear liquid diet	6	[redacted]		
			18	DLC		
30 AUG 03	[redacted]	Reg diet	06	[redacted]		
			18	[redacted]		

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: ex-lap c̄ SB repair

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
3/	[redacted]	PT D/C to EPW camp today;				
		no meds needed				
		b(6)-2				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED												
17	[redacted]	Call MD for UO<30cc/hr													
		HR>120, SBP<90,													
		RR>30, O2Sats<90%													
		b(6)-2													

USAPA 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	26	27	28	29
17 Aug 03	[redacted]	IVF LR @150cc/hr	06	[redacted]													
			18														
17 Aug 03	[redacted]	ancef 1 GM IV	00														
		q8h	08														
			16														
21	[redacted]	Reglan 10mg q 4°	02	X													
			06														
			10														
			14														
			18														
			22														
21	[redacted]	Phenergan 25mg IVPB 4°	6	X	X	X	X	X									
			12	X	X	X	X	X									
			18	X	X	X	X	X									
			24	X	X	X	X	X									
17	[redacted]	Ancef 1 Gm IV	08														
		Q8h	14														
			22														

[redacted]

Dcd 22 Aug 03 2315 [redacted]

Dcd 26 Aug 03 1840 [redacted]

b(6)-2

ALLERGIES: ☐ YES ☐ NO — NKDA

PRIMARY DIAGNOSIS: SP ex lap SB repair cond. stable

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

EPW # [redacted]

b(6)-4

EDW # [redacted]

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. 8 Yr. 03

Verify by Initialing: Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
20 Aug	[redacted]	Qac & Qhs - Bisacodyl	20 Aug	0845	0845	[redacted]
20 Aug	[redacted]	Reposition 2°	20 Aug	2400	(H)	
21 Aug	[redacted]	Phenergan 12.5 g IVP x 1	21 Aug	0520	0550	[redacted]
23 Aug	[redacted]	KUB & CXR PA & Lat this Am	23 Aug	—	done	[redacted]
25 Aug	[redacted]	Maalox 30 cc PO x1 NOW	25 Aug	1030	1030	[redacted]

b(6)-2 AU

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	TIME/DATE DISPENSED															
17 Aug 03	[redacted]	MSO4 2-10 mg IV q 1 hr PRN pain	17 Aug 0745 5mg IVP Am	17 Aug 1345 5mg IVP Pm	17 Aug 1600 5mg IVP	17 Aug 2200 5mg IVP	18 Aug 0400 5mg IVP	18 Aug 0700 5mg IVP	18 Aug 1000 3mg IVP	18 Aug 1340 3mg IVP	18 Aug 1700 5mg IVP	18 Aug 2020 5mg	18 Aug 2330 5mg	19 Aug 0400 5mg	19 Aug 0910 3mg	19 Aug 03 Cont		
17 Aug 03	[redacted]	Tylenol 650 mg PO q6h PRN pain	0430 27 Aug BLS IT															
19 Aug	[redacted]	MSO4 2-10 mg IV q 1 hr PRN pain	19 Aug 1200 5mg IVP	19 Aug 1330 5mg IVP	19 Aug 1600 3mg IVP	19 Aug 2240 3mg IVP	19 Aug 2310 2mg	19 Aug 2315 3mg	20 Aug 0015 5mg	20 Aug 0500 5mg	20 Aug 0800 5mg	20 Aug 1530 5mg	20 Aug 2200 5mg	23 Aug 0500 5mg	23 Aug 1530 5mg	23 Aug 2145 5mg		
		phenergan 25 mg IVP q6°	1520 23 Aug	DIC order verified														
19 Aug	[redacted]	MSO4 2-10 mg IV q1° PRN pain	24 Aug 0010 5mg	24 Aug 0165 5mg	25 Aug 0000 5mg	26 Aug 03 0100 BLS	26 Aug 03 0100 5mg IVP	27 Aug 0130 5mg IV BLS										

USAPA V1.00

b(6)-2 A

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 27	28	29	30	31	1	2	3	4	5	6	7	8	9
17 Aug	[redacted]	[redacted]	[redacted]														
			[redacted]														
			N														
27 Aug	[redacted]	IVF LR @ 150 cc/hr	[redacted]														
			18	[redacted]													
28 Aug	[redacted]	Complete 1st Stage															
		Q 6															
				Not available													
27 Aug	[redacted]	Zantac 50 mg IV	08	[redacted]													
		Q 8°	14	[redacted]													
			20														
27 Aug	[redacted]	maloox down	06														
		NG 30 cc Q 6 hr	12	N													
		Clamp for 1 hr	18	[redacted]													
			20														
28 Aug	[redacted]	Δ IVF to	06	[redacted]													
		D5 1/2 NS c 20 meq	18	[redacted]													
		KCl/Re c 125 cc/hr	X														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P Exp lap SB repair

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION:

EPW # [redacted]

b(6)-4

[redacted]

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

USAPA V1.00

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo._____ Yr._____

Verify by Initialing: Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
31	[redacted]	Dulcolax suppository x1 now	31	0900		[redacted]

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	TIME/DATE DISPENSED													
27 Aug	[redacted]	Demerol 25 mg	27 AUG 0440 25mg	28 AUG 25mg												
		Q1° PRN pain	[redacted]													
28 AUG	[redacted]	Percoset ii q4-6° prn pain	28 AUG 0300 2	28 AUG 1420 ii	28 AUG 1930 ii	29 AUG 0300 ii	30 AUG 1335 ii	30 AUG 1755 ii	30 AUG 2345 ii							
			[redacted]													
		b(6)-2 A11														

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 Aug 03
Time In: 02-30
Allergies: NKDA
Pre-op V/S: 41 192/79
Procedures: ex lap SB repair

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 3200 Colloid 1000
OR Output: UOP 275 EBL 400
Meds/Times: see DA 7889

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

Pre Op Meds

History: cystitis

Time	0230	0245	0300	0315	0330	0345	0400
SaO2	98	100	100	100	100	92	98
FiO2	2	100	0	100	96	92	
Methods	RA	NC	NC	NC	NC	RA	NC
240							
220							
200							
180							
160							
140							
120							
100							
80							
60							
40							
20							
RR	28	28	26	18	18	16	
T	96						
Time							
Pain (0-10)							
LOS							

Pacu Intake

Time	Solution	Amount	Site	By	Infused
PACU	NR	1000cc	Lara	OK	1000 cc

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.	9	9	9

Codes

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

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

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

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

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

b(6)-2

PREPARED BY (Signature & Title): [redacted] OPT HN

(Continue on reverse)

DEPARTMENT/SERVICE/CLINIC: PCU #3

DATE: 17 Aug 03

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

EPW

[redacted]

b(6)-4

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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
0230	10	MSO4 5mg	IV	10	I	[redacted]
0235	10	MSO4 5mg	IV	10	I	
0240	10	MSO4 5mg	IV	10	I	
0245	10	MSO4 5mg	IV	except	E	

NEUROVASCULAR

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

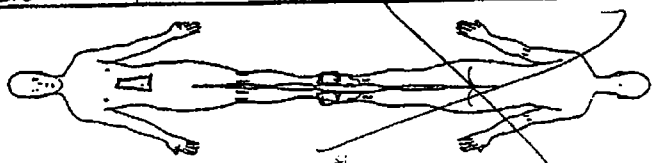
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	ABD	Gauze	-0-
30'	ABD	Gauze	sm. amt
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
PACU	Urine	yellow	350

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0230	Stach	no	no
0330	Stach	no	no

NURSING NOTES

0230 Pt received from OR via gurney; accompanied by OR staff. O2 via NRB @ 10LPM placed for sats 88%. Pt moaning & holding on to abd. See med section. Dressing clean dry & intact. Monitors placed - see vitals. Will continue to monitor - [redacted] CPT/A

0330 - Pt sleeping comfortably - VSS. No issues at this time - Pt meets PACU discharge criteria. Pt to remain in ICU 2. [redacted] CPT/A

b(6)-2 A/N

Discharge Criteria:
Date: 17 Aug 03 **Time:** 0330 **PARS:** 9
BP: 146/83 **T:** **HR:** 106 **RR:** 12 **Sa02:** 98
Pain Level at D/C (0-10):
Intake: 1L **Output:** 350
Additional Data:
Transferred To: Remained in ICU 2
Report Given To: myself CPT [redacted]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: N/A
Cleared IAW Recovery Room SOP B-3 [redacted]
Charge Nurse Signature: [redacted] CPT/A

b(6)-2

WAMC OP 173-E

MEDICAL RECORD-SUPPLEMENTAL MEDICAL

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 08MAR8

INITIAL SHIFT ASSESSMENT

		Time: 1900 Initals: [redacted] b(6)-2	Time: Initals:
NEURO	Pupils	3mm brisk Perrl's	
	Sensorium	A+O interacts c̄ staff	
	LOC / GCS	using sign language and	
		other pt.	
CARDIAC	Cardiac Rhythm	ST 100's S1 S2 present	
	PRI: / QRS:		
	Pulse Strength	2+ x4 distal extremities	
	Cap Refil / JVD	<3sec x4 extremities	
	Edema	Ø edema noted	
	Chest Pain	denies @this time	
RESP	Respiratory Pattern	even + unlabored	
	Breath Sounds	clear in uppers and diminished	
	Secretions	in bases Ø secretions noted	
	Cough	Ø cough	
		SATS 95-98% on RA	
SKIN	Color	warm + dry	
	Integrity	dsg to midline abdomen CDI	
	Backside	(R) Lower abdomen bloody drainage	
		noted. small puncture wound	
IV	Access Devices	(L) Forearm Hep L	
	Location		
	Condition	flushes well Ø s/s of	
		infection	
GI	Abdomen	distended in pain	
	Bowel Sounds	(+) x4 quads hypoactive	
	Stoma/Ostomy	MD called @ change of shift.	
		NGT placed to LIS	
GU	Device	Foley to gravity	
	Color / Clarity	Yellow urine	
		QS	

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC
ICU3, [redacted] b(2)-2

(Continue on reverse)

DATE

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

A FORM 4700, MAY 78

USAPPC V2.00

ICU1

Patients Name: [redacted]

Date: 17 Aug 03

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																								
NBP	100/72		110/72		104/56		94/53		101/50		118/66		120/78		118/69		139/83		140/81		136/78		138/79	
TEMP	99.4		99		99.4		100.1		100.2		100.1		99.8		98.8		98.4		98.8		97.8		98.8	
HR	120		128		130		114		116		126		122		123		101		100		103		106	
RR	18		22		24		22		24		22		24		22		20		18		16		20	
SaO2	98		97		99%		96		97		96		97		96		96		95		96		95	
FiO2	0		RA		RA		RA		RA		RA		RA		RA		RA		RA		RA		RA	
Source																								

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 LR	150	150	150	150	HOLD	150	150	1150	150	150	150			100						50						
IVPB																										
NGT																										
Blood				350		375										x2										
Emesis					X1 every 8 hours																					
Total																										

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	Tot
URINE		110	80	60	40	40	30	50	45	50	60	80		110		250		150		200		150		150		
NGT																350								200		
STOOL																										
DRAIN																										
Total																										

MEDCOM - 17659

MED[illegible] RECORD-SUPPLEMENTAL MEDICAL

For use of this for[illegible] 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 08MAR8

b(6)-2

INITIAL SHIFT ASSESSMENT

		Time: 0600 Initals [redacted]	Time: Initals:
NEURO	Pupils	3mm brisk perrla cons/ NV1	
	Sensorium	A+O x3 interactive	
	LOC / GCS	communicates by sign,	
		interpretor & other pts	
CARDIAC	Cardiac Rhythm	ST 100's	
	PRI: / QRS:		
	Pulse Strength	2+ x 4 extremities	
	Cap Refil / JVD	+ 2 sec x 4 extremities	
	Edema	(-) edema	
	Chest Pain	denies CP	
RESP	Respiratory Pattern	even unlabored	
	Breath Sounds	CTA bilat diminished lower lobes	
	Secretions	(-) noted secretions	
	Cough	(-) cough R - 18 SaO2 96%	
		RA.	
SKIN	Color	pink, warm dry	
	Integrity	dig midline abd CDI	
	Backside	(R) lower abd bloody dig noted	
		(+) sm puncture wound Dig A'ed	
IV	Access Devices	(L) FA 18g LR Run 150cc/hr	
	~~Location~~	patent flushes well (-)	
	Condition	S+S infiltrate or infx	
GI	Abdomen	(+) DIN noted tender	
	Bowel Sounds	BS hyporactive x 4 (-) rigidity	
	Stoma/Ostomy	NGT (R) nare patent on	
		LIS drainage cloudy watery	
GU	Device	Foley to gravity yellow	
	Color / Clarity	urine (-) noted sediment	
		(-) odor	

(Continue on reverse)

PREPARED BY [redacted] 9/11/06 b(6)-2

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

DATE 18 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

DA FORM 4700, MAY 78

USAPPC V2.00

ICU1

Patients Name: EPW [redacted] 3

Date: 18 AUG 03

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	135		132		127		117		109			135							147						144	
NBP	79		70		89		76		77			64							80						83	
TEMP	98.8		98.8		99.4		99.6		97.8			100.8							100.1						98.8	
HR	100		98		125		114		118			130							123						112	
RR	18		20		24		18		20			22							20						20	
SaO2	96		96		96		97		97			97							97						95	
FiO2	RA		RA		RA		RA		RA			RA							2L						2L	
Source																										
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	Total
IVF	150	150	150	150	150	150	150	150	100	150	150	150		150	150	150	150	150	150	150	150	150	150	150	150	
IVPB			350									50								50	-					
NGT	[redacted]	[redacted]																								
J																										
Total																										

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	40		200		150		125		110		150								500						550	
NGT	30		5		10		15		120		10														400	
STOOL	Ø		Ø		Ø		Ø		Ø		Ø															
DRAIN																										
Total																										

MEDCOM - 17661

ME[illegible] RECORD-SUPPLEMENTAL MEDICA[illegible]TA[illegible] 19 Aug 03

For use of this fo[illegible], 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 03MAR8

INITIAL SHIFT ASSESSMENT

		Time: Initals:	Time: 0600 Initals [redacted]
NEURO	Pupils		MOB
	Sensorium	[redacted]	3mm Reactive
	LOC / GCS		follows commands
CARDIAC	Cardiac Rhythm		S.S2 NSR
	PRI: / QRS:		
	Pulse Strength		+2 x4 extremities
	Cap Refil / JVD		
	Edema		Ø
	Chest Pain		Ø
RESP	Respiratory Pattern		unlabored equal
	Breath Sounds		CTA
	Secretions		
	Cough		
SKIN	Color		WNL for race
	Integrity		intact
	Backside		intact
IV	Access Devices		Ø wnst
	Location		CDI
	Condition		
GI	Abdomen		Distended & tender
	Bowel Sounds		+ x4 quads
	Stoma/Ostomy		Ø
GU	Device		via foley
	Color / Clarity		

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC (b)(2)-2 DATE
ICU3, [redacted]

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

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

DA FORM 4700, MAY 78

MEDCOM - 17662

USAPPC V2.00

ICU1

Patients Name: EPW # [redacted]

Date: 17 Aug 03

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																								
NBP	142/84						140/86						142/86						142/82					
TEMP	98.4						99.7						97.8						99					
	108						110						112						112					
RR	14						16						22						22					
SaO2	99						99						96						95					
FIO2	2l						2l						2l						2l					
Source	NC						NC																	

WBC	8.2
RBC	2.8
Hgb	8.1
Hct	25.
MCV	90.
MCH	28
RDW	22
Lym%	15.
Lym#	1.3

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	150	150	150	150	150	150	150	150	150	150	150	150		150	150	150	150	150	150	150	150	150	150	150	150	
IVPB			50								50									50						
NGT	[redacted]						[redacted]																			
																				200	200	150	150	150	150	
											200									2700	3,000				3,600	
Sub Total			200																							

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	To
URINE	120						550							490												
NGT	10						250							35												
STOOL	0						0							0												
DRAIN																										
																									700	
Total																										

MEDCOM - 17663

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF: A i l D l
2. MTF LOCATION (State or Country Code.): I Z
3. REGISTER NUMBER: [redacted]
NAME (Last, First, Middle Initial): UNK - NAME
4. PAY GRADE: EPW
5. SEX: M
6. DATE OF BIRTH (YYYYMMDD): Z
7. AGE AT ADMISSION: 24 Y
8. RACE: X
9. ETHNIC BACKGROUND: 9
RELIGION: MUSLIM
10. LENGTH OF SERVICE: Z
ETS: UNK
11. FMP: 99 70
12. SOCIAL SECURITY NUMBER: [redacted]
ORGANIZATION (Active Duty Only): —
13. MARITAL STATUS: Z
HOUR OF ADMISSION: 0200
BRANCH / CORPS: b(2)-4
14. FLYING STATUS: —
15. BENEFICIARY CATEGORY: K 7 8
16. ZIP CODE OF RESIDENCE: Z
17. UNIT LOCATION (State or Country Code): —
18. MOS: —
19. TRAUMA: 1
PREV. ADMISSION YEAR: NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: Ø
WARD: ICU2
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: —
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] b(2)-2
21. TYPE OF DISPOSITION: Ø 5
22. MTF TRANSFERRED TO:
23. DATE OF DISPOSITION (YYMMDD): 0 3 0 8 3 1
24. CLINIC SVC - ADMITTING: A B A A
25. MTF TRANSFERRED FROM:
26. DATE THIS ADMISSION (YYMMDD): 0 3 0 8 1 ~~2~~ 17
27. LOCATION OF OCCURRENCE (Battle Casualty Only):
28. MTF OF INITIAL ADMISSION:
29. DATE INITIAL ADMISSION (YYMMDD):

FOR LOCAL USE

DX: (1) Shrapnel Wounds
(2) s/p Ex-lap. S-B repair

Trauma 9 Injury 549

Dx 868.19 959.8 E991.9

Px 46.73 87.79 99.04

b(2)-2

ADMITTING OFFICER (Sign [redacted]

SIGNATURE OF ADMITTING [redacted]

DR. [redacted]

DA FORM 3985 MAR 89

INPATIENT TREATMENT RECORD COVER SHEET

For use of this form, see AR 40-400; the proponent agency is OTSG b(2)-4

1. REGISTER NUMBER [redacted]	2. NAME (Last, First, MI) EPW # [redacted]				3. GRADE EPW	ADMISSION REMARKS
4. SEX M	5. AGE 22	6. RACE —	7. RELIGION —	8. [redacted]	9. [redacted]	10. PREVIOUS ADMISSION NO
11. FMP 99X20	12. [redacted]		13. ORGANIZATION b(2)-4			14. WARD ICU2
15. FLYING STATUS NO	16. RATING/DSG —	17. DEPT./BEN K-78	18. BRANCH/CORPS —	19. UIC/ZIP —		20. TYPE CASE WIA
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from ER				22. HOURS OF ADMISSION 0649	23. CLINIC SERVICE AEAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE Unk			25. TYPE DISPOSITION 50		26. DATE OF DISPOSITION 24Aug03	b(2)-2
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) Unk			27b. TELEPHONE NO. Unk		28. DATE OF THIS ADMISSION 18Aug03	ADMITTING OFFICER Dr [redacted]
29. [redacted] b(2)-2					30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA [redacted]

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

mortar Attack

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: Gsw open (R) frontal depression

Dx: 80359

Px: 0202 Stoff Orde

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	6	6

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTH[redacted]	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFIC[redacted] b(2)-2 SIGN[redacted]AL RECORDS OFFICER

Dr [redacted]

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

Iraqi EPW wounded in mortar attack 8/16 w/ (L) Frontal fragements penetrating (L) frontal skull. Had been GCS 15 by report of 21st CSH. Taken to OR with debridement local & irrigation and closure of skin. X-rays pre-op (L) frontal depressed skull fragments w/ retained metal (L) frontal lobe.

PHYSICAL EXAMINATION ~~Awakens, Alert & Appropriate although moderately Apathetic~~
(L) Forhead Incision ~~with~~ stapled w/ Brain Extrusion from Defect.

Pupils: OS oval with hippus o/w Briskly Reactive
Som: normal gaze
Neck: (-) TENDERNESS
Chest: No lesions
Lungs: CTA

Heart: RRRS mm
Abd: (+) BS NT/ND ∅ HSM
Thin Scaphoid.
Ext: ∅ deformity
Back:

PROGRESS (Enter date of discharge and final diagnosis)

(D). Pt to OR for GETA w/ (L) frontal wound revision.

[redacted] b(6)-2

[redacted]	IDENTIFICATION NO.	ORGANIZATION
8/17/03		

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

REGISTER NO.	WARD NO.
	ICU 2

[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]

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
17 Aug 03	Summary
1400	22 y.o. ♂ Iraqi arrived c̄ left frontal open
NKDA	skull injury and exposed brain. GCS 15.
PMH/PSH: ⊖	Few scattered frag wounds to back.
Meds:	C-spine: neg
MSO4	CXR: neg
Anef	Skull: ⊕ frontal skull fx c̄ frags + ?
Dilantin	bone in frontal lobe
	Surgery this AM @ 0200 c̄ debridement
	of necrotic brain, irrigation + skin (only)
	closure c̄ stapler.
	Stable since surgery. GCS 15
	AVSS during transport
	Dx: open skull injury
	Tx: Evac to [redacted] CSA (b)(2)-2
	[redacted]
	b(2)-2 COL MC
	[redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.
IRAQI, [redacted] b(2)-4		

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
17 Aug 03 0800	Surgery → Pt taken to OR and wound / Brain Skin closed loosely over exposed brain material. → General anesthesia → b(a)-2 [redacted] TC/MC
17 Aug 03 0715	Pt left for Surgery via litter and returned @ 0900
17 Aug 03 0900	A+O x 3, PERRLA, Skin w/D to touch, Resp even / unlabored O2 sat @ 100%. HR regular 84-90 bpm. Lungs CTA. Head c̄ Drsg CDI. Neck c̄ Soft collar, Abd Soft / flat and nontender. ↓ B.S. X4 quads. IV N.S. Δ to LR @ rate / patent in (L) antecubital ∅ redness or swelling. full ROM x 4 ext. Cap refill nail bed <3 sec. able grip c̄ some weakness (D) side. VSS @ Resp distress Will monitor for Δ's. HL (R) dorsal arm patent c̄ flush b(a)-2 [redacted] TC/BN
17 Aug 03 0900	Dilantin 100 mg IVPB infusing into (R) HL well flush, p̄ finished VSS remain stable PERRLA will continue to assess [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			[redacted] (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.

IRAQI # [redacted]
b(a)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
8/17/03	Nursing Brief OP Note
1700	Pre-op Dx: ① Frontal open Depressed Skull fx.
	Post-op Dx: ① Frontal open Depressed Skull fx
	Procedure: ① Frontal debridement/Wound Revision
	Cranial plating covering of defect
	Surgeon: TEFT — Finding: Single Scalp layer opened, Necrotic Brain
	Anesth: GETA — Herniating, depressed ① Frontal skull w/
	EBL: 200cc — Epidural bleeding, Resected Bone/Necrotic Brain Debris
	Count: Correct
	Fluids: 1000 NS U/O: 900cc
	Drains: Ø
	Compl: Ø — b(6)-2 [redacted]

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

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

REGISTER NO.

WARD NO. ICU 2

EPW [redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17Aug03	1734 [illegible] from OR c [illegible] [illegible] on ICU bed. [illegible] [illegible] to verbal stimuli [illegible] [illegible] [illegible]. Follows commands [illegible] [illegible] unknown VS (B) ESS CTA. currently on RA c SpO2 @ 100%. [illegible] [illegible] c [illegible]. F/U [illegible] [illegible] c [illegible] yellow [illegible]. [illegible] line in place. [illegible] [illegible] [illegible] [illegible]. [illegible] [illegible]
18AUG03	Neurosurgery PGD 1
0642	S/O VSSA.
	Closure healthy.
	Neuro normal.
	Tolerating clears.
	A/P Doing well s/p I/D ODSF.
	Advance diet [redacted] activities.
	Foley at [redacted] b(6)-2
	[redacted] Jeff 4797

HOSPITAL OR MEDICAL FACILITY	[redacted]	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN [redacted]	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* | REGISTER NO. | WARD NO. ICU 2

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)*
18AugØ3 ØØØØ	Pt resting in bed. VSS. Head wound closed with ~~staples~~ sutures open to air. Free of sts of infection. Pt refuses to eat breakfast. Will continue to monitor throughout shift. SPC [redacted] 91WM6 b(6)-2
12ØØ	VSS. Pt refuses to eat or drink anything. Had interpreter try to help explain why he should eat and he still refused to eat or drink. SPC [redacted] 91W
17ØØ	Pt. rested all day. VSS throughout the shift. Neuro: no changes throughout the shift; Neuro was stable throughout the shift. Drained 1ØØ cc clear yellow urine from foley before D/C'd. Pupils brisk equally reactive. Equal strength bilaterally arms and legs. Follows simple commands. Forehead wound closed c̄ sutures open to air - Ø Drainage. Wound Free of sts of infection. SPC [redacted] 91WM6 b(6)-2
18Aug03 1930	received pt. from ICW2 ~ 1800 IR stable condition - IV SL'd in (R) AC, site S S/S infection - pt. ambulated c̄ some assistance - PERRLA, follows simple commands - sutures intact on forehead, site S S/S infection - lungs CTA (B), (+) BS, (+) peripheral pulses x 4 extremities - tol. regular diet [redacted]

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

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

#[redacted] EPW b(6)-4

ICW2

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)
8-19-03 0017.	Pt. care assumed @ 2100. HR reg, lungs CTA, BS (+) X4. Sutures to forehead OTA, C.D.I. Pt follows simple commands, tol P.O well. HC intact. Will cont. to monitor — [redacted]
19Aug03	0645 - pt alert & oriented lying in bed. VSS, temp 100.2 gave Tylenol 650mg. Lungs CTA, HR reg., BS(+), pulses (+) x4. Stitches intact to forehead, ∅ S/S of infx. Will cont. to monitor — [redacted] 2LtAu
19Aug03 0651	Neurosurgery (S/O) Low grade fever overnight. Awake, alert, eating breakfast Cleare healthy. No meningismus. (A/P) Stable ↑ Elevation (L) Frontal DSF. Ward Care until stable for EPW Comp. [redacted] 4757
19Aug03	2200 - pt [redacted] to chair. Am care given while in chair. Tolerated sitting in chair 30 minutes. Will cont to monitor — [redacted]
19Aug03 1335	Assumed pt care @ 1300. pt awake & alert VSS. Stitches to forehead intact OTA (-) S/Sx of infection noted. lungs CTA, abd soft, nontender, nondistended BS(+)x4 quads. pulses (+)x4. (-) IV access noted. (-) complaints voiced @ this time. Will cont to monitor — [redacted] 9LWMC

STANDARD FORM 600 (REV. 6-97) BACK

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

NSN 7540-00-634-4175

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19 Aug 03 21:48	Rec'd c/o pt @ 21:00. Restraints x2 @ wrist/ankle. VS WNL per flow sheet. Awake and alert in bed. Skin W/D/I. Sutures to frontal lobe intact OTA & apparent s/s infection scant amt ecchymosis to OS periorbital area. LCA ⊕ BS ⊕ x4. ABD soft non-tender. ⊕ PP ⊕. Pt able to tell me his name. c/o pain @ this time. Pt transfer from bed to chair ~ difficulty. Will mon [redacted] /AN
20 Aug 03	1220: Pt alert & oriented OOB to chair ~ difficulty. A little unstable when transfering from bed to chair. VSS, lungs CTA, BS ⊕, pulses ⊕ x4. Sutures intact to forehead. Tylenol given for pain. C/o dizziness. Will cont to monitor [redacted] b(6)-2
20 Aug 03 1340	Assumed pt care @ 1300. pt c/o dizziness while sitting in chair. VSS temp 101.6 given ii Tylenol. Sutures to forehead intact ⊖ s/sx of infection noted. Both eyes swollen c̄ bruising. Lungs CTA, abd soft BS ⊕ x4. ↓ ET ↑ ext c̄ full ROM ⊕ pulses. ⊖ complaints voiced @ this time. Will cont to monitor [redacted] 91WM6
20 Aug 03 21:45	Rec'd c/o pt @ 21:00. Restraints x2 @ wrist/ankle. VS WNL per flow sheet ~~x~~ ↑ temp 100.5° ii Tylenol given will retake temp and mon. throughout shift. Skin W/D/I

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.
FPW [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)
	suture site to frontal lobe well approx, edema noted b/t sutures sutures OTA. Ecchymosis noted @ periorbital. Awake and alert LCA@ HPP S,S,S2 WNL, BS(+)x4. (+) PP@ & c/o's will cont. to mon [redacted] RT/AN
21:55	Pt COB to AMB within unit. c/o dizziness. Amb c assist 5 difficulty. [redacted] RT/AN b(6)-2
Addendum	Pt. extremely diaphoretic. Undersheet saturated. Will remove blanket and retake temp in 1° [redacted] RT/AN
0004	Temp ↓ 99.4 [redacted] RT/AN
21Aug03 1030	assumed care @ 0500 - VSS - no c/o pain @ this time - staples intact on forehead incision - slight bruising remains on eyelids and below eyes - pt. refused breakfast only drinking juice - pt. obeys simple commands, very quiet, unable to assess orientation @ this time due to pt not speaking English b(6)-2 [redacted] cn
21Aug03 1215	Received pt from Squad facility in stable condition. VSS, transferred to bed, restraints in place, sutures OTA + intact, ∅ drainage noted [redacted] b(6)-2
21Aug03	2130: VSS T 100.5, 650mg Tylenol po given, will reevaluate (T), wound to (L) side of forehead c̄ sutures approximated neurologically WNL, periorbital bruising to both eyes, other assessment findings unremarkable, ∅ IV access, will continue to monitor [redacted] RT/AN
22Aug03 0700	PTVS BP 124/81, HR 115, RR 24, T 98.3, SPO2 96% [redacted] RW b(6)-2

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

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)
22 Aug 03	1125		Pt. awake & alert ∃ complaints @ this time. HR Regular, lung sounds clear bilat, bowel sounds (+) x 4 quads. Pt. ∃ IV access. MD in this AM to remove sutures to forehead incision, sutures removed & wound reopened. MD now wants dry DSO's to forehead Δ'd QD. OD sclera red on (R) side of iris, bruising noted to lids bilat. All other assessment findings WNL. Will continue to monitor. b(6)-2 [redacted]
22 Aug 03		1930	Assumed care @ 1700. Awake + Alert. VSS. Lung sounds clear bilat. Abd soft, nondistended, BS x 4. Dressing to Forehead CD+I. No % pain @ this time. Will continue to monitor [redacted]
23 Aug 03	0415		Late entry for 1700 22 Aug 03. T-100.2°F P-74 R-16 BP-104/53 SpO2-98% b(6)-2 [redacted]
23 Aug 03	0723		PIVS. BP 109/53, HR 77, T 99.2, RR 16, SpO2 97% [redacted]
	1123		Pt. alert & oriented OOB x1 to chair. Ad Am care in chair. VSS, HR reg, BS @ x4, pulses @ x4. Incision to forehead, open to air, some dried drainage noted. No new drainage this AM. Voicing ∅ complaints. Will cont to monitor. b(6)-2 [redacted]
		1630	Pt. care assumed @ 1500. Pt. stable c̄ ∅ complaints. HR Reg, lungs CTA, BS @ x4. Incision to Forehead OTA. Pt has hematoma to lateral edge of incision about ½ size of golf ball & is TTP. Will cont. to monitor. b(6)-2 [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. ICW2

EPW b(6)-4 # [redacted]

NURSING NOTES

Medical Record

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

B(a)-2A

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
8-23		2034	Pt - ambulated length of hallway x2. Gave Pt. 650mg Tylenol for low grade fever — [redacted]
23Aug03 2330			Pt awake and alert. PERRLA. Pupils ↓ brisk response to light. Incision to (L) forehead CDI, sutures remove, hematoma noted to lateral side of incision. Lungs CTA bilat, Ø resp distress. NSR. Abd soft, non-tender, bowel sounds active x4 quads. Ø complaints — [redacted]
24AUG 0743			PTVS BP 116/61, HR 65, T 98.7, RR 16, SpO2 99% — [redacted]
	1107		BP 85/43, HR 69, T 99.0, RR 18, SpO2 98% [redacted]
	1120		BP RETAKEN MANUALLY 100/64 — [redacted]
	1300		Pt A&O x3, VSS, lungs CTA, HR reg, BS(+), pulses (+)x4, Incision to forehead Ø drainage noted D/C orders to camp written — [redacted]
		1531	Pt. care assumed @ 1400. Pt. c̄ low grade temp of 100.1. Pt. given 650mg Tylenol and assisted c̄ ambulation length of hallway x2. HR Reg, lungs CTA, BS(+)4. Sutures to forehead CDI. Pt awaiting transport to EPW camp — [redacted]
24 Aug 2200			Pt vital signs taken BP 105/51 P 74 R 16 T 98.8° SpO2 98 — SPC [redacted]

NSN 7540-01-075-3786

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

PATIENT'S HOME ADDRESS OR DUTY STATION			ARRIVAL	
STREET ADDRESS			DATE *(Day, Month, Year)* 17 AUG 03	TIME 1545
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	HOME PHONE		FLYING STATUS				DD 2568 IN CHART		
22	AREA CODE	NUMBER	MEDICAL HISTORY OBTAINED FROM				NAME OF INSURANCE COMPANY		

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

CHIEF COMPLAINT GSW

CATEGORY OF TREATMENT		VITAL SIGNS					
☐ EMERGENT	TIME 1545	TIME	1545				
☐ URGENT		BP	110/48				
	INITIALS	PULSE	96				
		RESP	22				
☒ NON-URGENT		TEMP	99.4				
		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

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		I have received and understand these instructions.		
☐ DETERIORATE	TIME OF RELEASE	PATIENT'S SIGNATURE		

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

EPW #[redacted] b(4)-4

[redacted]

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

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: 22 HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): mkda 3. PREVIOUS SURGERY [X] NO [redacted] YES (type):

4. PROPOSED SURGICAL PROCEDURE:
I+D Skull fx

5. ADDITIONAL INFORMATION: Last PO: ? Medical Hx: see H+P Implants: ? Medications: ? see chart
Jewelry removed: yes/no Family waiting: yes/no
wedding Band
OR → unable to remove

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]

blw-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	✓ 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. ✓ 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. ✓ Check that rings have been removed. unable to remove Ring (R)
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to sedation; pain; injury E.2. ✓ Potential discomfort due to injury; pain	✓ Pt. will be transferred to OR table without difficulty. ✓ Pt. will not experience unnecessary physical discomfort.	✓ Have sufficient people available for transfer. ✓ Insure proper body alignment. ✓ Allow patient to lie in position of comfort while waiting for surgery. ✓ Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. ✓ Disminished visual perception due to being injury; sedation; F.2. ✓ Potential for decreased communictaion due to language barrier; sedation Iraqi Navy F.3. Potential injury due to dentures.	✓ Pt. will be made aware of surroundings prior to anesthesia induction. ✓ Pt. will be transferred safely to OR table. ✓ Pt. will be able to understand instructions. ✓ Minimize danger of injury during intraop period.	✓ Introduce self. Keep pt. informed as to where he/she is and what is happening. ✓ Inform pt. in which direction to move and assist if necessary. ✓ Speak clearly and slowly. ✓ Address pt. from either side. ✓ Validate pt.'s understanding of verbal communications. 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] CPT USN 19 Aug 03 DATE

11. POSTOPERATIVE EVALUATION:

Bowie Site: c/i

Dsg: c/d/i

Breathing: extubated

b(6)-2 AM

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

DATE: 17 Aug 03 TIME: 1625

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

DATE: 17 Aug 03 TIME: 1730

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

MEDICAL RECORD — **INTRAOPERATI\ CUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY Anesthesia / Surgeon	2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted] b(6)-2
3. DATE 17 Aug 03 TIME PATIENT ARRIVED IN SUITE 1615	4. PATIENT IN ROOM TIME 1615 NUMBER 2-5

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: nkda

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: proper body alignment maintained, head on foam donut, Darm flexed at hip, Darm extended on padded armboard at less than 90°, position approved by surgeon + anesthesia

8. SKIN PREPARATION

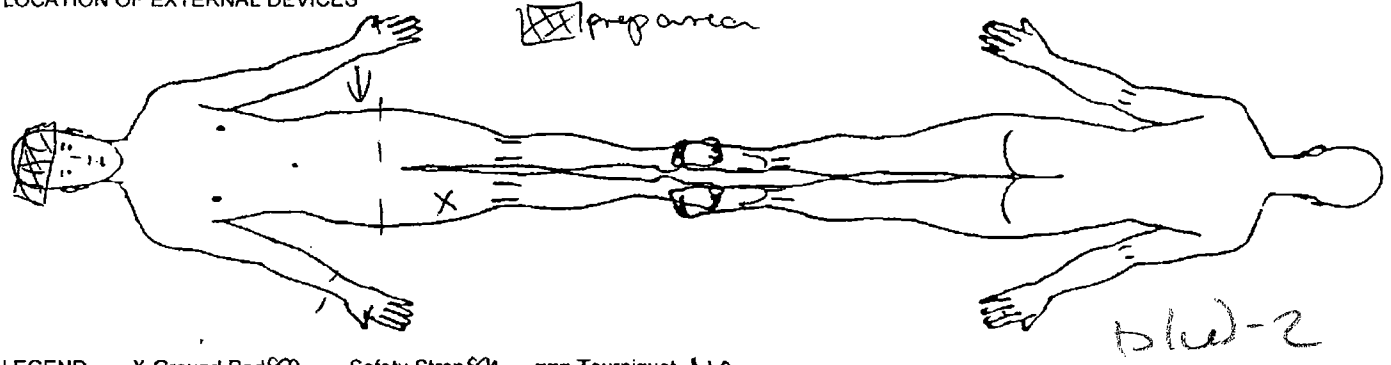
HAIR REMOVAL [X] YES [ ] NO Dr. Teff
DONE BY: [X] OR [ ] NURSING UNIT
METHOD: [ ] DEPILATORY [X] RAZOR [ ] CLIP

COMMENTS: no nicks or cuts noted

PREP SOLUTION *(Specify)* Betadine / Betadine
SITE: Forehead BY WHOM: Dr. [redacted] b(6)-2
SITE: BY WHOM:
see #9

COMMENTS: no pooling or skin s's noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad SM – Safety Strap SM === Tourniquet NA

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] b(6)-2	[redacted]
Needle Sharp	[X] Yes [ ] No	C	C	C		
Instrument	[ ] Yes [X] No	NA	NA	NA	NA	NA
Other	[ ] Yes [X] No					

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

#[redacted]
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
50150 LOT NO: 68936 2005-03

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

[X] BIPOLAR NO: VL Force 2 #3
50

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

Biplate Neurosurgical Plating System CMS #05 22201 — Burrhole Cover 81-2054 x1 — 1.5mm Screws size 5 X 3

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Thrombin 5000 u	QS	I10	Topical	[redacted]	Dr. [redacted]
Gelfoam	QS	I10	Topical	[redacted]	Dr. [redacted]
Avitene (Collagen Hemostat)	QS	I10	Topical	[redacted]	Dr. [redacted]
					b(6)-2

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

OTHER ORDERS	TIME	CARRIED OUT BY
16 F FIC to bladder - clear, yellow urine return	I10	[redacted]
[redacted]		b(6)-2

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

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

YES [ ] NO [X]

16. LABORATORY SPECIMENS

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

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

	1.	2.	3.
TYPE/SIZE	16 F FIC		
SITE	Bladder		

18. DRESSING/IMMOBILIZATION *(Specify)*

4x8

Tape

19. ADDITIONAL INFORMATION

WC I

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

Bovie Pad site intact pre-op ✓; post-op ✓ Bovie Settings: Coag/Cut 50/50

Tourniquet Site intact pre-op NA : post-op NA

20. OPERATION(S) PERFORMED

ITD compressed frontal skull fx

21. PATIENT TRANSFERRED TO	TIME See	METHOD
ICU 2	DA7389	Litter

22. REGISTERED NURSE SIGNATURE [redacted] TIAN

b(6)-2

REVERS[redacted]M 517[redacted]

MEDCOM - 17681

USAPA V1.01

ICU1

Patients Name: EPW #[redacted] 22 y/o Date: 18-19 AUGUST 2003

66 kg

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																										
NBP	117/60	115/59	117/66	124/68	105/54	108/64	117/69	115/63	107/64	115/61	113/67	114/66														
TEMP	98.4	98.6	98.1	98.5	98.2	98.6	98.4	98.6	99.0	98.9	99.1	99.5														
HR	97	88	94	86	87	88	99	104	93	93	92	100														
RR	14	15	16	15	15	14	16	17	14	13	15	18														
SaO2	94	94	96	95	94	98	96	92	97	93	95	97														
FiO2	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA														
Source																										
MAP																										
[illegible]	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓														

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	Tota
IVF																										
IVPB																										
NGT																										
Sub Total																										
[illegible]tal																										

PUT	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		150	100	100	100	125	75	150	100	200																
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 17682

MEL ECORD-SUPPLEMENTAL MEDICAL

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA APPR 08MAR8

INITIAL SHIFT ASSESSMENT			
		Time: 1800 Initals: [redacted] b(6)-2	Time: Initals:
NEURO	Pupils	3mm Reactive	
	Sensorium	Moves all extremities	
	LOC / GCS	Alert – Awake primary language	
		∅ Eyes	
CARDIAC	Cardiac Rhythm	NSR continuously monitored	
	PRI: / QRS:		
	Pulse Strength	Strong	
	Cap Refil / JVD	∅ JVD < 3 sec cap refill	
	Edema	mild edema and (L) medial ankle area	
	Chest Pain	∅ C/O	
RESP	Respiratory Pattern	even regular unlabored	
	Breath Sounds	CTA	
	Secretions	∅	
	Cough	∅ Head injury ∅ incentivized	
SKIN	Color	WFR	
	Integrity	intact	
	Backside	intact	
IV	Access Devices	X2 PIV	
	Location	(R) posterior forearm 18G (L) AC 18G	
	Condition	Patent	
		A-line D/C'd 12 hrs	
GI	Abdomen	Soft non distended	
	Bowel Sounds	x4 quad x4	
	Stoma/Ostomy	∅	
GU	Device	FTC 16 Fr con D/C'd hourly urine	
	Color / Clarity	yellow clear	

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC b(2)-2 ICU3, [redacted]

DATE 17 Aug – 18 Aug 03

[redacted]'S IDENTIFICATION *(For typed or written entries give: Name – last, middle; grade; date; hospital or medical facility)*

[redacted] b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

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

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

USAPPC V2.00

ICU1

HOB 45° EDW b(6)-4 [redacted] b(6)-4 Dr [redacted] b(6)-2

Patients Name: $ [redacted] - ~~Admitted~~ - 22 yo Date: 17-18 AUG OCT 03 65 kg

Transferred from 2nd SSH 16 Gr FK

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	Keep MAP 70-90											121/61	117/59	117/59	121/67	113/64	119/65	117/65	113/63	119/69	121/62	120/66	120/61	121/66	107/61
NBP	CALL HO SBP >150																								
TEMP												99.4	99.4		99.2			100.2	98.7			98.7		99.2	
HR												88	86	86	90	95	83	83	86	75	81	72	73	86	92
RR												12	12	12	12	14	12	12	14	14	14	12	14	11	16
SaO2												96	100	100	100	100	100	98	98	96	97	96	96	95	
FiO2												RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
Source																									
MAP			(70-90)									✓		88	88	83	84	85	82	88	89	86	85	89	79
[illegible]	✓											✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

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	NS @ 125cc/h											125		125	125	125	125	125	125	125	125	125	125	125	125	
IVPB	Ancef 1gm																	50								
~~NGT~~	Diet Regular when fully awake																									
PO																										
Zantac																		150 mg								
Dilantin																		300 mg								
H_2O																		30								
Sub Total																		205								
Total												125		250	375	500	625	830	955	1080	1205	1330	1455	1580	1705	

PUT	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												140		140	140	140	140	350	300	350	350	400	—	400	200	
NGT																										
STOOL												∅		∅	∅	∅	∅	∅	∅	∅	∅	∅	∅	∅	∅	
DRAIN																										
Sub Total												140	140	140	140	140	140									
Total												140	140	280	420	560	700		1700	2050	2400	2800	3200	3600	4000	5000

Condition: stable SIP (L) frontal open Depression - Skull Fx - Revision of wound Dural Closure

Took off Neuro A-line

Mouth dry and [illegible] coming open

MEDCOM - 17684

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

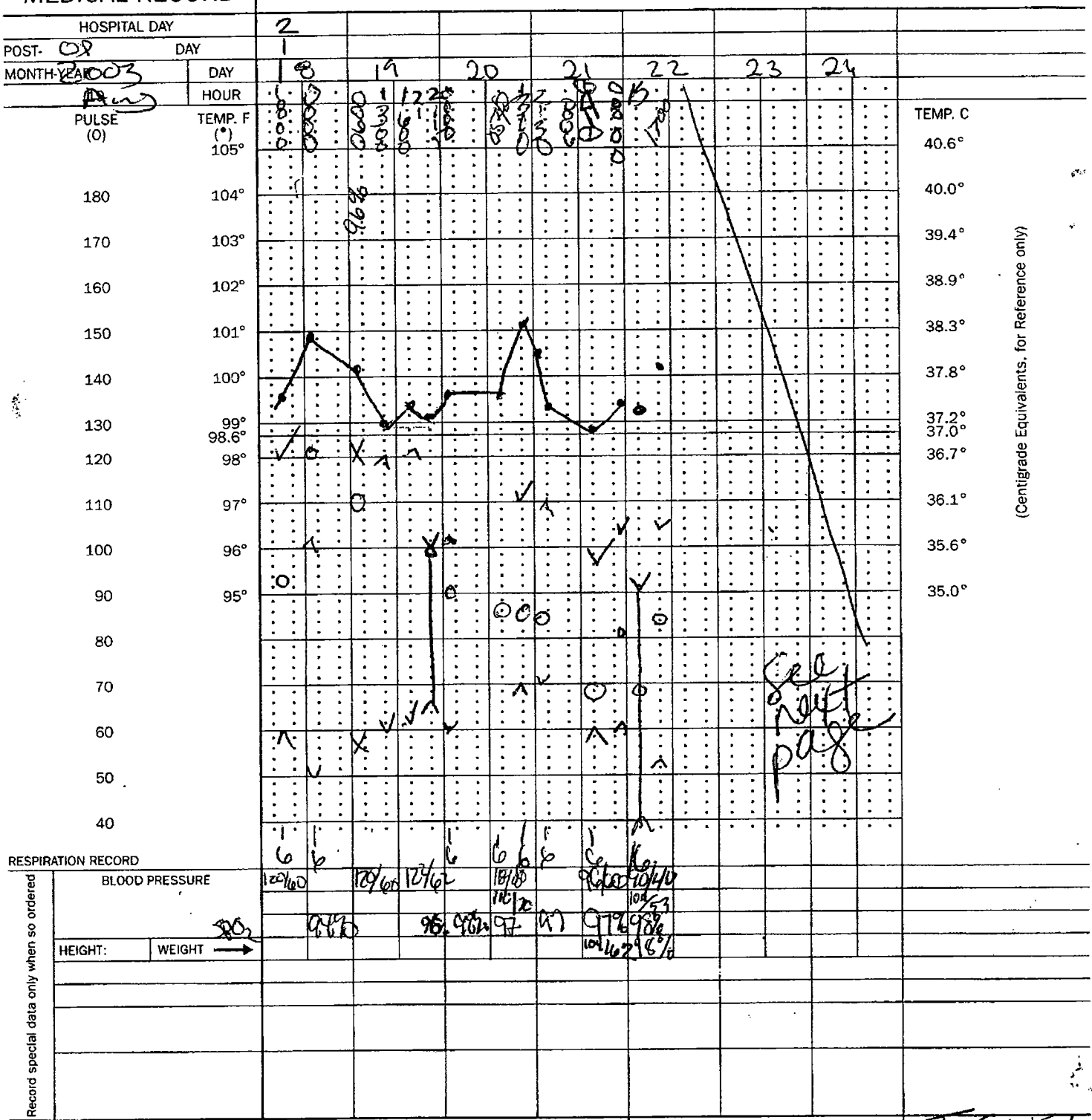
HOSPITAL DAY

POST- OP DAY

MONTH-YEAR 2003 DAY

HOUR

PULSE (O) — TEMP. F (°) — TEMP. C



RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICW2

EP W [redacted] b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY

19 HOUR

21Aug03 22Aug03 23Aug03

2130 0530

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

HEIGHT: WEIGHT →

Record special data only when so ordered

	21Aug03	22Aug03	23Aug03
BP	102/50	104/56	86/105/55
P	74	81	111/58
R	16	18	100
		02	99
	RA	RA	

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**

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)						
Fentanyl	(mg)	100	50	25/25			
propofol	(mg)	100					
sux	(mg)	100					
vec	(mg)	6					
	( )						
	( )						
VOLAT AGENT — Isoflurane	% del	1.5	1.5	1.2	1.0	1.0	
	% 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		①②	③		④		

FLUIDS

LINE site 18g RW ☐ Warmed	NS 1000↑		600	700			
18g LAC ☐ Warmed	LR 600↑		300				
☐ Warmed							
☐ Warmed							

LOSSES

EST BLOOD LOSS				200			
URINE -				900			

TOTALS	TOTAL EBL
200	200
	TOTAL URINE
	900

FLUIDS SUMMARY

CRYSTALLOID- 1000

COLLOID- Ø

BLOOD- Ø

REMARKS

Code drugs with numbers, events with letters

① To room, SOC mons, pre O2.
② Smooth IV indx, intub.
③ Rt radial a-line placed
④ Reversal 3mg neostig & 0.4mg Robinul
⑤ Responsive, suctioned & extubated. To ICU stable. Report given

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 65 KG LB

HEMATOCRIT:

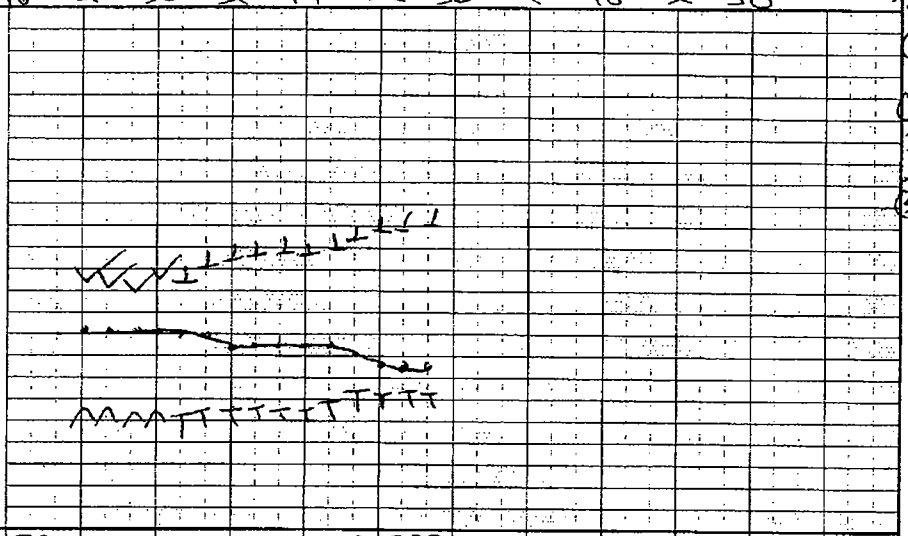
INITIAL DATA: BP- 116/52 HR- 91

EQUIP CHECK: OK?- Y N

PATIENT RECHECK: OK for PROCEDURE? Y TIME- 1610

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

TIME → 16 x 30 x 17 x 30 x 18 x 30



VENTIL

VT - ml	730	730	730	730	760	280
f - breaths/min	10	10	9	9	8	12
Peak inf pres / PEEP	20	21	21	21	20	—
MODE - S(pon), A(ssist), C(on)	S	C	C	C	C	S

MONITORS/ACCESSORIES

✓BP/Auto Cuff	✓ET CO2 (torr)	32	30	28	28	32	44
BP/oth	✓FIO2 (Frac or %)	0.9	0.9	0.9	0.9	0.9	0.9
✓ART line Rt	✓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)		0/4	2/4	3/4	3/4	4/4 & sust tet any
Warming blkt							
Conv warmer							

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

RECOVERY AT

PACU ICU 2 (Specify)

OTHER

CONDITION:

RESP- SpO2- 100
BP- 121/61 HR- 92

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1610	1615	1740
	Ready	Begin	End
PROC	1620	1630	1725

PROCEDURES and CPT Codes: I & D of Open depressed skull fx

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GETA 8.0 ETT 3 miller

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* Eyes taped DL x1 3 trauma, ⊕ETCO2, BJEB. Secured 23 cm @ teeth

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

[redacted] b(6)-4 ICU 2
22 yo ♂ EPW b(6)-2
Trf in from [redacted]

SURGEONS: [redacted] b(6)-2

ANESTHESIOLOGISTS: [redacted] MAJ CRNA

PROCEDURE LOCATION: 2

DATE: 8/17/03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 — MEDCOM - 17687 [redacted] NT'S MEDICAL RECORD — USAPA V1.00

[redacted] b(6)-1

PATIENT IDENTIFICATION

EPW # [redacted]

b(6)-2

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 18AUG03 TIME OF ORDER 0644 HOURS

LIST TIME ORDER NOTED AND

1. D/C Foley. 18Aug03 17[redacted]
2. SL IV. 18Aug03 17[redacted]
3. up to chair or walk ξ shift. [redacted]

b(6)-2

[redacted] 4797

PATIENT IDENTIFICATION

EPW # [redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 18AUG03 TIME OF ORDER 1630 HOURS

1. Transfer ICW 2 - Neuro - Teff
2. Dx S/P Craniotomy 17AUG.
3. Condition Good.
4. Vitals ξ 4°
5. Activity ad-lib.
6. Nursing ad-lib.
   Soft restraints pm.

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

7. Diet Regular.
8. IV Saline Lock.
9. meds Percocet 1-2 po ξ 4° pm severe pain
   Tylenol 325-650 mg po ξ 4° pm mild pain
   Ranitidine 150 mg po BID
   Dilantin 300 mg po ξ HS

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER b(6)-2 HOURS

10. Lab none.
11. X-ray none

[redacted]

b(6)-2 [redacted] 4797

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
		3-40V5

[redacted]

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

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 19AUG03 | TIME OF ORDER: 0653 HOURS | LIST TIME ORDER NOTED AND SIGN

(1) Up to chair [redacted] walk & shift. [redacted] 1797 b(6)-2 [redacted] 19 Aug 03 [redacted]

24° J Con [redacted] 27/AN

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

NURSING UNIT: ICW2 | ROOM NO.: 5 | BED NO.: D

DATE OF ORDER: 24AUG03 | TIME OF ORDER: 0881 HOURS

(1) Discharge to MP custody. [redacted] 1797 b(6)-2 [redacted] Noted 8-24-03 0855 [redacted] mAl/An

24° V 25Aug03 0600 [redacted] 3A

PATIENT IDENTIFICATION: 1

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER HOURS

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

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.

☆ U.S. GOVERNMENT PRINTING OFFICE: 1996—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

[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 8/27/03 TIME OF ORDER 1737 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit to ICU
2. Dx: S/P (D) Frontal open Depressed Skull Fx. Revision of Wound w/ Dural Closure
3. Stable
4. Vitals w/ neuro V's q1° until awake, then [redacted] b(6)-2
5. IV ~~D5 1/2 NS w/ 20 KCL~~ @ 125 cc/hr
6. Foley to gravity
7. MODS: ~~Dilantin 300 mg PO q 8 hrs~~ ~~Sodium 75 mg PO BID~~
8. HOB @ 45° until awake, then ad-lib. Gen'l pharma
9. I/O's
10. MAP 70-90 Call for SBP > 150 [redacted]
11. ~~CBC, chem 7~~ [redacted] MD

b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER HOURS

1. Diet: Regular when fully awake
2. Meds: Percocet 1-2 po q 4° pm pain.
3. Tylenol 650 mg po q 4° pm mild pain.
4. Ranitidine 150 mg po BID
5. Dilantin 300 mg po q HS
6. D/C Foley at nurse's discretion.
7. D/C Art Line at nurse's discretion.

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME [redacted] HOURS

8. Soft Restraints pm [redacted]
9. Ancef 1 gram IV [redacted] 4797

b(6)-2

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: 1996—409-924

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

Gr 2 Sheet

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	18	19	20	21	22	23	24	25	26	27	28	29	30
17aug	[redacted]	Vitals V/S &	06	[redacted]													
		Neuro Q1° until	18														
		awake, Then Q4°															
17aug	[redacted]	Foley to Gravity	06	[redacted]													
		(16Fr)	18														
17aug	[redacted]	↑ HOB 45° until	06	[redacted]													
		awake, then ad-lib	18														
17 aug	[redacted]	I & O's	06	[redacted]													
			18														
17aug	[redacted]	Keep MAP 70-80	06	[redacted]													
		call MO. SBP >150	18														
17aug	[redacted]	Diet: Regular	06	[redacted]													
		when fully awake	18														
17aug	[redacted]	Soft Restraints	06	[redacted]													
		PRN	18														
17aug	[redacted]	b(6)-2															

D/C 18 Aug 03 1700 [redacted]

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Condition: Stable

unknown S/P @ Frontal open depressed skull, Revision of wound & Dural closure

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(e)-2

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo Aug Yr 03

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
17 aug03	[redacted]	admit to ICU	17 aug 03	done		[redacted]
17 aug	[redacted]	D/C foley @ nurses discretion	17 aug 03			
17 aug	[redacted]	D/C art line @ nurses discretion	17 aug 03	2200 17 AUG	2200 17 AUG	[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 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 18	19	20	21	22	23	24	25
18	[redacted]	Vitals Q4°	04	/	[redacted]						
			08	/							
			12	/							
			16	/							
			20								
			24								
			/								
18	[redacted]	activity-ad lib	05	/	[redacted]						
			13								
			21								
18	[redacted]	diet-regular	05	/	[redacted]						
			13								
			21								
19	[redacted]	OOB to chair QS	05		[redacted]						
			13								
			21								

ALLERGIES: ☐ YES ☐ NO PRIMARY DIAGNOSIS: S/P craniotomy 17 Aug

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

PATIENT IDENTIFICATION: EFW [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(e)-2 AM

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
18	[redacted]	transfer to ICW2 neuro-Tel	18		1800	[redacted]
18	[redacted]	(condition good)		noted		
18	[redacted]	labs none/X-rays none		noted		

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

USAPA V1.00

b(6)-2 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. ____ Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 17	18	19	20	21	22	23	24	25	26	27	28	29	30
17 aug 03	[redacted]	NS @ 125 c/hr	06	[redacted]													
			18														
17 aug 03	[redacted]	Ranitidine 150 mg p.o. BID	10														
			22														
17 aug	[redacted]	Dilantin 300 mg p.o. QHS	22														
17 aug	[redacted]	ancef ÷ gm IV Q8° X3	06														
			14														
			22														

ALLERGIES: ☐ YES ☐ NO

unknown

PRIMARY DIAGNOSIS: Cerebellar : stable

S/P (L) Frontal open depression skull FX : Reunion of wound : Dural closure

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

#[redacted]

b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				Mo. _____ Yr. 2003
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED													
1 May	[redacted]	Percocett 1-2 P.O. Q4° PRN pain														
.....	.....	DOC														
1 May	[redacted]	Tylenol 650 mg PO Q4° PRN pain														
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															

b(2)-2 b(2)-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 18	19	20	21	22	23	24	25
18	[redacted]	SL-Flush QS	05	/ [redacted]							
			13	[redacted]				D/C			
			21	[redacted]							
			/								
18	[redacted]	Zantac 150mg PO BID	07	/ [redacted]							
			17	[redacted]							
			/								
18	[redacted]	dilantin 300mg PO QHS	22	[redacted]							
			/								

ALLERGIES: ☐ YES ☐ NO b(2)-2

PRIMARY DIAGNOSIS: S/P craniotomy (7 Aug)

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

PATIENT IDENTIFICATION: [redacted] EPW [redacted] b(2)-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 medications

Percocet 1-2 po q4° prn
severe pain

Tylenol 325mg-650mg PO q4° prn-mild pain	19 Aug 0638 TT DM	20 Aug 0900 TT DM	20 Aug 1340 TT UP	20 Aug 21:2150 TT PO EM	21 Aug 03 2130 650mg RD	22 Aug 1700 (650mg PO) CT	23 Aug 2000 650mg PO ABS
	8:24 1432 TT ABS						

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 Aug 03
Time In: 1730
Allergies:
Pre-op V/S:
Procedures:

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1000 Colloid
OR Output: UOP 9 EBL 200
Meds/Times:

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

Pre Op Meds History

Time																
SaO2																
FiO2																
Methods																
240																
220																
200																
180																
160																
140																
120	^	^		^	^	^										
100																
80	•	•	•	•	•	•										
60	v	v	v	v	v	v										
40																
20																
RR																
T																

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	2		
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	2		
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			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	10		

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

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

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

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

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

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 17 Aug 03

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

[redacted] b(6)-4

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

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

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

C-SECTIONS

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

DRESSINGS

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

PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

[redacted]

b(6)-2

Discharge Criteria:
Date: **Time:** **PARS:**
BP: **T:** **HR:** **RR:** **SaO2:**
Pain Level at D/C (0-10):
Intake: **Output:**
Additional Data:
Transferred To:
Report Given To:
Transferred Via: W/C Litter Gurney Ambulance
Transferred By:
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:

ADMISSION AND CODING INFORMATION

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

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

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
	0 2 2	Z	Z	unk

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	Z	0649	b(6)-4

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø	ICU2	unk
		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): unk
[redacted]	b(2)-2	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: unk

21. TYPE OF DISPOSITION	TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
S O		0 3 0 8 2 4

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
A E B A		0 3 0 8 1 8

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

FOR LOCAL USE

Dx: CSW: ① open frontal depression mortar attack

ADMITTING OFFICER (Signature [redacted] b(6)-2

ADMITTING CLERK [redacted] b(6)-2

DA FORM 2985, MAR 8[redacted] USAPPCV1.0

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) [redacted]				3. GRADE EPW	ADMISSION REMARKS
4. SEX M	5. AGE 18y	6. RACE UNK	7. RELIGION UNK	8. LENGTH OF SVC —	9. ETS —	10. PREVIOUS ADMISSION N
11. FMP 99	12. SSN [redacted]		13. ORGANIZATION blue			14. WARD ICW1
15. FLYING STATUS —	16. RATING/DSG —	17. DEPT./BEN K78	18. BRANCH/CORPS —	19. UIC/ZIP —		20. TYPE CASE WIA
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION direct from ER				22. HOURS OF ADMISSION 1540	23. CLINIC SERVICE ARAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK			25. TYPE DISPOSITION xfer to 28BF CSH		26. DATE OF DISPOSITION 20 Aug 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK			27b. TELEPHONE NO. UNK		28. DATE OF THIS ADMISSION 17 Aug 03	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b(2)-2					30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA [redacted]

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

V58.43

GSW (R) flank

S/p ex lap liver laceration

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	3	3

36. Total Days All Facilites

a. ABSENT SICK DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
[redacted]	b(1)-2	[redacted]		

SIGNATURE OF ATTENDING [redacted]

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18 AUG 03	History and physical
	18 yo male EPW says he was WL by
	RPG. to FST where ex Lap performed
	for Hemoperitoneum. findings @ Rt Lobe
	Liver Lac. Hemostasis Achieved EBL 200.
	JP left in Abd. Now Tx for care.
	NKDA Psm as Above meds
	PMH Ø TOB Ø
	exam
	NCAT Back
	Neck NT Ø deformity
	Chest CBTA
	ext Ø CCE Abd NABS
	TTP ND
	Lid wnl
	LABS 14.9 / 47.6 244 136 / 104 / 3.7 / 23 / 0.6 7 / 100 TP 6.6 Alb 3.4
	LFT wnl
	A/P Liver Lac stable post op.
	Admit ICW x24hrs
	WF
	Checks.

b(6)-2

[redacted]

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

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* b(6)-1 REGISTER NO. WARD NO. FCV2

EPW [redacted]

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

USAPA V2.00

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18 Aug 03 1715	Received on unit via stretcher accompanied by FMT staff. A+O x3, speaks English fluently. Pupils 2-3mm & brisk. NSR c̄ HR in 90's. Palpable pulses in all extremities. IV infusing @ 150cc/hr via 18ga in (R) forearm. Lungs CTA bilaterally c̄ O_2 sats 97-100% on room air. Abdomen c̄ dsg covering incision. Small amt of drainage noted. JP drain to (R) lower quad c̄ small amt of serous sanguinous fluid noted. Foley to gravity draining adequate amt of dark yellow urine. Denies discomfort @ present time. IV [redacted] b(6)-2 continue to monitor — M/m
18AUG03 1837	Assumed care of pt @ 1800. Vss, temp 99.9°. A+O x3. lung sounds clear bilaterally, apex to base. RR 20, O_2 Sat 100% RA. HR 88, RRR. Radial + Pedal pulses strong + equal to palpation. Cap Refill <3sec to all extremities. Pt has LRC @ 150cc/hr to 18G (R) ac, site without signs of redness or infiltration. PERRLA. Mucous membranes moist. Clear liquid diet. BS active x4 quadrants. Non-distended, tender to palpation. Pt has dressing to midline abdomen, small amt of old drainage noted. Pt also has JP drain to RUQ, dressing CDI. Pt has foley to gravity draining concentrated urine. ROM to all extremities complete. Will continue to monitor for Δ's - sec [redacted]
2130	Pt c/o pain to abdomen. Given 4mg MSO4 IVP, will monitor for effectiveness + medicate as needed — sec [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

b(6) - 2 A11

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19 AUG 03 0540	Pt received 4mg MSO4 IVP prior to getting up to chair. Pt up to chair c̄ little assist, but lots of encouragement needed. Will continue to monitor. — SPC [redacted] 91WM6
19 Aug 03 0700	Pt up to chair ambulated x1 Ox3. Follow commands. VSS Respirations even and unlabored c̄ BBS CTA SpO2 96-100% RA palpable pulses ⓑ edema noted. Abd soft, tender to touch active bowel sounds. Midline abdominal incision c̄ dressing CDI. JP drain to bulb suction IVF LR @150/hr IV site s̄ s/s infection. foley cath BSD c̄ clear yellow urine. Denies any distress — [redacted]
19 Aug 03 1600	Pt resting in bed Medicated c̄ Percocet for pain relief. Ambulated and up to chair s̄ complications. No distress noted. Will cont to monitor — [redacted]
17 19 Aug 03 1715	Pt transferred to ICW2 - No changes in status. [redacted]
19 Aug 03 1800	Pt admitted from ICU2 in stable condition. Awake, alert and ambulatory. Lungs CTA bilat, ⊘ resp distress. NSR. Abd soft, non-tender, bowel sounds active x4 quads. Midline incision to abd c̄ staples intact. ⊘ drainage noted, wound edges well approximated. Dsg to RUQ CDI, ⊘ new drainage noted — [redacted]

STANDARD FORM 600 (REV. 6-97) BACK

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19 Aug 03 -	SIP X/Ly Dry well lyed Delt. Will DC JP today
	[redacted] b(6)-2
20AUG03	PROGRESS NOTE PT STABLE S/P JP-LAP T LIVER LOC VSS Tmax 101 LUNGS: CTA CVS: RRR ABD: SOFT, MILD TTP BBS EXT: STABLE PLAN Close leaving DOT Ambulate DC Foley

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)*
20Aug03 1330	Pt awake and alert. Lungs CTA bilat, Ø resp distress. NSR. Bowel sounds active x4 quads, abd soft, non-tender. Midline incision to abd CDI, staples intact, Ø S/S infection. I.V to LFA KR @ 150cc/hr. Ø complaints [redacted]
20Aug03 2300	Care assumed @ 2100. VSS, AOX3, C/O small amount of pain to abdominal. Lung sounds CTA, pulses ⊕ x4, bs present x4 quads, slightly hypoactive. Midline abd incision C staples OTA CDI, C/O pain upon palpation. IV to LFA intact, pt on IV ABX. To be transferred to [redacted], will continue to monitor [redacted]
b(2)-2 2305	Pt slightly tachycardic and hypertensive Ø C/O pain, will continue to monitor. [redacted]
0030	⅌ percocet given for pain. [redacted]
0745	assume care @ 0600 - VSS - no C/O pain @
21Aug03	this time - ⊕ BS, hypoactive - staples intact on abdomen, no drainage noted from incision - Pt. awaiting transport to [redacted]

b(2)-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. ICW

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

NSN 7540-01-075-3786

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

PATIENT'S HOME ADDRESS OR DUTY STATION			ARRIVAL	
STREET ADDRESS			DATE *(Day, Month, Year)* 18 Aug	TIME 1300
CITY	STATE	ZIP CODE	TRANSPORTATION TO FACILITY Medevac	

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

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

CHIEF COMPLAINT

CATEGORY OF TREATMENT		VITAL SIGNS					
☐ EMERGENT	TIME		FO2	99%	99%	99%	
		TIME	1300	1340	1514		
☐ URGENT		BP	156	106	134		
	INITIALS	PULSE	125	133/61	152/86		
		RESP	20	18	16		
☒ NON-URGENT		TEMP	100	100.3	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 8 Pde 1-yes		ACUTE ABDOMEN		LS SPINE
	BLOOD C&S X								SINUS		HEAD CT
									ANKLE R/L		

ORDERS

☒ PULSE OX 99% ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1418	30 mg toradol	[redacted]			
1516	12.5 mg phenergan				
1520	4 mg Mscorp		[redacted]		b(6)-2

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

Bun 6 Crit 0.6

TEST RESULTS

CBC		SMAC		ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
WBC 14.9		136	3.7	SUP 02	PH	PO2	RESULTS	
H/H 14.8		104		PCO2	SAT	OTHER		
PLT								
PT				U/A	DIP		EKG INTERPRETATION	
APTT	BHCG	ETOH	GLU		MICRO At Flank			

PROVIDER HISTORY/PHYSICAL

S) 18 yr old with GSW - ~~abdomen~~ on 17 August - Exploratory lap - (liver laceration), hemoperitoneum

MEDS: None
Allergies - NKA
O) PMH none

PMH: 0

HEAD - Normocephalic
Neck - Supple

Eye - PERRA, EOM +
Throat - mucosa - dry

Lungs - clear
Heart - RRR no M
Abd - abdomen dressing - TTP ↑ no B.S
Extremities ~~Extremities~~ - No edema : Pulse ~~2+~~ DP - 2+

CONSULT WITH	TIME	ACTION	RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP
			PROVIDER SIGNATURE [redacted]

DIAGNOSIS
1) GSW (Rt) Flank
Laceration Liver Rt lobe
s/p Exploratory

CODES

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

EPW [redacted]

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

NSN 7540-00-634-4124

1-119

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY	2	3	4	5	6			
POST-OP DAY	1	2	3	4	5			
MONTH-YEAR Aug 2003 DAY	19	20	21	22	23	24	25	
HOUR	12	12	12					

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 | 32 | 86

BLOOD PRESSURE: 120/78 | 132/96 | 140/90 | 146/92

SpO2: 98 | 96 | 96

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICW2

[redacted] EPW

b(6)-4

MEDCOM - 17710

VITAL SIGNS RECORDS

Medical Record

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

i-STAT 6+

Pt: [redacted] b(6)-4

Pt Name:_____

Glu_____84 mg/dL

BUN_____7 mg/dL

Na_____134 mmol/L

K_____3.7 mmol/L

Cl_____103 mmol/L

Hct_____40 %PCV

Hb*_____14 g/dL

*via Hct

Sample Type_:

19AUG03 04:37

Oper: [redacted] b(6)-2

Physician:_____

Ser# [redacted]

Ver: JAM5046A
CLEW A93

---

i-STAT EC8+

Pt: [redacted] b(6)-2

Pt Name:_____

Glu_____90 mg/dL

BUN_____7 mg/dL

Na_____136 mmol/L

K_____3.7 mmol/L

Cl_____104 mmol/L

TCO2_____23 mmol/L

AnGap_____14 mmol/L

Hct_____46 %PCV

Hb*_____16 g/dL

*via Hct

pH_____7.427

PCO2_____33.2 mmHg

HCO3_____22 mmol/L

BEecf_____-2 mmol/L

Sample Type_:

18AUG03 13:12

Oper: [redacted]

Physician: b(6)-4

Ser# [redacted]

Ver: JAM5046A
CLEW A93

b(6)-2

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. b(6)-4 [redacted]	DATE 18 Aug	TIME 1305	SSN/PSEUDO SSN: [redacted] b(6)-4

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

TEST	RESULT	REF. RANGE
Color		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

[redacted]

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	

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] **DATE:** 18 Aug 03 **LAB ID NO.:**

b(6)-2

Ward/Section: EMT	REQUESTING [redacted] N: b(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] b(6)-4	DATE: 18 Aug	TIME: 1305	SS[redacted] SSN: [redacted] b(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl

```
======= PICCOLO =======
18/08/03          13:13
REFERENCE RANGE:      MALE
PATIENT #: [redacted]
GENERAL CHEMISTRY 12
DISC LOT #:        3142AA4
OPER #: [redacted]  DR #: 000
SERIAL #: [redacted]
...b(6)-4.....
ALB   3.4   3.3-5.5   G/DL
ALP   81    26-84     U/L
ALT   22    10-47     U/L
AMY   26    14-97     U/L
AST   46*   11-38     U/L
TBIL  0.9   0.2-1.6   MG/DL
BUN   6*    7-22      MG/DL
CA++  9.0   8.0-10.3  MG/DL
CHOL  94*   100-200   MG/DL
CRE   0.6   0.6-1.2   MG/DL
GLU   100   73-118    MG/DL
TP    6.6   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
GLU		73-118 mg/dl
[illegible]TN		7-22 mg/dl
[illegible]++		8.0-10.3 mg/dl
[illegible]E		0.6-1.2 mg/dl
[illegible]+		128-145 mmol/l
		3.3-4.7 mmol/l
[illegible]		98-108 mmol/l
[illegible]O_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
[illegible]B		3.3-5.5 g/dl
[illegible]P		26-84 u/l
[illegible]T		10-47 u/l
[illegible]MY		14-97 u/l
[illegible]ST		11-38 u/l
[illegible]BIL		0.2-1.6 mg/dl
[illegible]GT		5-65 u/l
[illegible]P		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
[illegible]A+		128-145 mmol/l
[illegible]		3.3-4.7 mmol/l
[illegible]L-		98-108 mmol/l
[illegible]CO_2		18-33 mmol/l

REMARKS:

b(6)-2

REPORTED BY: [redacted]	DATE: 18 Aug 03	LAB ID NO.:

b(6)-2

CHEMISTRY RESULT FORM

(Subject to the Privacy Act of 1974)

Ward/Section:	REQUESTING PHYSICIAN:		
1GH 2	Dr. [redacted]		
LAST, FIRST, MI.		DATE	TIME
[redacted]		18MAR23	2107

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

b(6)-2

b(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) 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) Metlyte 8

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

(Piccolo) 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.:

b(6)-2

Ward/Section: ICU 2	REQUESTING PHYSICIAN: Dr [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST [redacted], MI. b(6)-4	DATE 18AUG03 / TIME 2107	SS[redacted]O SSN: b(6)-4

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

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

REMARKS: b(6)-2

REPORTED BY: [redacted]	DATE: 18 Aug 03	LAB ID NO.:

b(6)-2

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

Ward/Section: ICU 2

REQUESTING PHYSICIAN: Dr. [redacted]

DATE: 19AUG03 TIME: 0412

SSN/PSEUDO SSN: [redacted] b(6)-4

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

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metabolic Panel

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

(Piccolo) Metlyte 8

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

```
======= PICCOLO =======
19/08/03              04:38
REFERENCE RANGE:        MALE
PATIENT #: [redacted]
GENERAL CHEMISTRY 12
DISC LOT #:          3142AA4
OPER #: [redacted]   DR #: 000
SERIAL #: [redacted]
.........................
ALB   3.0*  3.3-5.5   G/DL
ALP   64    26-84     U/L
ALT   39    10-47     U/L
AMY   24    14-97     U/L
AST   44*   11-38     U/L
TBIL  0.6   0.2-1.6   MG/DL
BUN   5*    7-22      MG/DL
CA++  8.8   8.0-10.3  MG/DL
CHOL  53*   100-200   MG/DL
CRE   0.7   0.6-1.2   MG/DL
GLU   109   73-118    MG/DL
TP    5.0*  6.4-8.1   G/DL

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

REMARKS: b(6)-2

REPORTED BY: [redacted]

DATE: 19Aug03

LAB ID NO.:

b(u)-4 b(u)-2 b(u)-4

Ward/Section: ICU 2	REQUESTING [redacted]: Dr. [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
[redacted]ST, MI.	DATE 19AUG03 / TIME 0412	SSN/PSEUDO SSN: [redacted]

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

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

REMARKS:

REPORTED BY: [redacted]	**DATE:** 19 Aug 03	**LAB ID NO.:**

b(u)-2

CBC Chem8 Chem12

Ward/Section:	REQUESTING PHYSICIAN:		LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
Icu			
LAST, FIRST, MI. [redacted] b(6)-4	DATE 20Aug	TIME 0400	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		

Coagulation Studies

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

Urinalysis

TEST	RESULT	REF. RANGE
Color		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

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

UNIT	TYPE	CROSSMATCH

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	

REMARKS:

REPORTED BY: [redacted]	DATE: 20 Aug 03	LAB ID NO.:

b(6)-2

Chem 8 Chem 12

Ward/Section:	REQUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, F[redacted] b(6)-4	DATE 20Aug	TIME 0400	SSN/PSEUDO SSN:

(ESTAT)			(Piccolo) Chemistry 12			(Piccolo) Metabolic Panel		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Na		138-146 mmol/L	ALB		3.5-5.5 g/dl	GLU		73-118 mg/dl
K		3.5-4.9 mmol/L	ALP		26-84 u/l	BUN		7-22 mg/dl
Cl		98-109 mmo				C		8.0-10.3 mg/dl
pH		7.31-7.45						
PCO2		35-45 mmH 41-51 mmHg						
PO2		80-105 mmH N/A (ven)						
TCO2		23-27 mmol/l 24-29 mmol/l						
HCO3		22-26 mmol/l 23-28 mmol/l						
sO2		95-98%						
BEecf		(-2) – (+3) mmol/L						
AnGap		10-20 mmol						
Ca		1.12-1.32 m						
BUN		8-26 mg/dl						
GLU		70-105 mg/						
Creat		0.7-1.5 mg/						
Hct		38-51% PC						
Hgb		12-17 g/dl						

Misc. Chemistry		
TEST	RESULT	REF. RA
Troponin-I		
Drug of Abuse		

======= PICCOLO =======
20/08/03 06:07
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: b(6) 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	88	73-118	MG/DL
BUN	4*	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	932*	39-380	U/L
NA+	130	128-145	MMOL/L
K+	3.5	3.3-4.7	MMOL/L
CL-	96*	98-108	MMOL/L
tCO2	24	18-33	MMOL/L

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

======= PICCOLO =======
20/08/03 05:51
REFERENCE RANGE: MALE
PATIENT #: [redacted]
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	2.9*	3.3-5.5	G/DL
ALP	66	26-84	U/L
ALT	22	10-47	U/L
AMY	39	14-97	U/L
AST	33	11-38	U/L
TBIL	0.5	0.2-1.6	MG/DL
BUN	3*	7-22	MG/DL
CA++	8.9	8.0-10.3	MG/DL
CHOL	115	100-200	MG/DL
CRE	0.7	0.6-1.2	MG/DL
GLU	91	73-118	MG/DL
TP	6.0*	6.4-8.1	G/DL

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

REMARKS:

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

b(6)-2

CBC chem8+12

Ward/Section: ICW	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. [redacted] b(6)-2	DATE 21Aug	TIME 0420	SSN/PSEUDO SSN:

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

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

REMARKS: b(6)-2

REPORTED BY [redacted]	DATE: 21 Aug 03	LAB ID NO.:

CBC
met 8 met 12

Ward/Section: CW2	REQUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST FIRST MI. [redacted] b(6)-4	DATE 21 Aug	TIME 0400	SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE

======= PICCOLO =======
21/08/03 04:49
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	98	73-118	MG/DL
BUN	5*	7-22	MG/DL
CRE	1.0	0.6-1.2	MG/DL
CK	432*	39-380	U/L
NA+	131	128-145	MMOL/L
K+	3.2*	3.3-4.7	MMOL/L
CL-	97*	98-108	MMOL/L
tCO2	23	18-33	MMOL/L

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE

b(6)-4
======= PICCOLO =======
21/08/03 04:33
REFERENCE RANGE: MALE
PATIENT #: [redacted]
GENERAL CHEMISTRY 12
DISC LOT #: 3204AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	2.8*	3.3-5.5	G/DL
ALP	57	26-84	U/L
ALT	12	10-47	U/L
AMY	80	14-97	U/L
AST	25	11-38	U/L
TBIL	0.5	0.2-1.6	MG/DL
BUN	3*	7-22	MG/DL
CA++	9.3	8.0-10.3	MG/DL
CHOL	105	100-200	MG/DL
CRE	0.7	0.6-1.2	MG/DL
GLU	102	73-118	MG/DL
TP	5.8*	6.4-8.1	G/DL

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

REMARKS:

REPORTED BY: b(6)-2 [redacted]	DATE: 21 Aug 03	LAB ID NO.:

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT: ICU2 | ROOM NO. | BED NO.

DATE OF ORDER: 18 AUG 03 | TIME OF ORDER: 1540 HOURS

1) Admit to ICU
S/p ex Lap Liver Laceration
cond stable
Vitals Q1° i SAT 1/D
All Ø
ACT - OOB to chair
Nurse - IP to Bulb suction

Nell
18 Aug 03
1530

[redacted]

b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER HOURS

Foley to gravity.
Diet Clears
IVF LR @ 150 cc/hr
meds
MSO4 2-10 mg IV Q1° PRN pain
Ancef 1gm IV Q8°

Pharmacy done

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER HOURS

LABS CBC @ 2100
then CBC, chem 8, chem 12 Q am.

[redacted]

b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 19 Aug 03 | TIME OF ORDER: 1301 HOURS

Percocet 1-2 PO q 4-6° prn pain
Tylenol 650mg PO q 4°-6° prn fever

[redacted]

b(6)-2

19 Aug 03
1400
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	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted]	19AUG03	HOURS	
	1. Cefazolin 2g po bid		[redacted] 19Aug03 1505
	[redacted]		b(6)-2
NURSING UNIT / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
E & W b(6)-4 [redacted]	19Aug03	1700 HOURS	
	@ Ventilator cycle		
	@ Cent venous catheter order		
	b(6)-2		
NURSING UNIT: ICW2 / ROOM NO. / BED NO.	[redacted]		

PATIENT IDENTIFICATION	DATE OF ORDER	
E & W b(6)-4 [redacted]	20AUG03	
	1- DC Foley	[redacted]
NURSING UNIT: ICW2 / ROOM NO. / BED NO.		[redacted]

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
E & W b(6)-4 [redacted]	8/20/03 (b)(2)-2	HOURS	2400
	Transfer [redacted]		
	b(6)-2		
NURSING UNIT: ICW2 / ROOM NO. / BED NO.	[redacted]		

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

☆ U.S. GOVERNMENT PRINTING OFFICE 1980—409-924

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 19 20 21 22
Copied	[redacted]	Vitals qu°ts 05/		
		13		
		21		
Copied	[redacted]	Activity-OOB to	05/	
		Chair	13	
			21	
Copied	[redacted]	Foley to gravity	05/	D/C [redacted] 11/Apr
			13	
			21	20 Aug 03
Copied	[redacted]	CBC, Chem 8, Chem 12	[redacted]	
		qam		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P exlap liver laceration

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

Epro [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. DSAPA V1.00

b(6)-2 A1

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
20 [redacted]		DC Foley (b)(2)-2 [redacted]				[redacted]
20 [redacted]		+ Cons Gen Ps [redacted]	20	ASAP		

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

USAPA V1.00

b(6)-2 A4

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.

Month Year 2003

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

VERIFY BY INITIALING: ORDER DATE	CLERK/NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 18	19	20	21	22	23
18Aug	[redacted]	Ancef 1 gm IV Q8°	08 / 16 / 24	[redacted]					
18Aug	[redacted]	LR @ 150cc/hr	06 / 18	[redacted]					
19Aug	[redacted]	Cefaclor 100mg PO BID	10 / 22	/ [redacted]					
19Aug	[redacted]	LR @ 150cc/hr	05 / 13 / 21	/ [redacted]					
18Aug	[redacted]	Ancef 1gm IV QB	12 / 20 / 04	— [redacted]					

Rewritten see below

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: Condition = Stable

S/P ex lap liver laceration

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

USAPA V1.00

DA FORM 4678, 1 FEB 79

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

b(6)-2

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. Aug Yr. 2003

Verify by Initialing: Order Date	Clerk/Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
18 Aug	[redacted]	admit to ICU	18 Aug 03		done	[redacted]

b(6)-2

Order/Expir Date	Clerk/Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED											
18 Aug 03	[redacted]	MSO4 2-10 mg IV Q10 prn pain	18 Aug 03 2136 4mg IVP	19 Aug 03 0245 4mg IVP	19 Aug 0535 4mg IVP	19 Aug 2045 4mg IVP	20 Aug 0250 [redacted]							
19 Aug	[redacted]	Tylenol 650mg PO Q 4-6° prn fever	19 Aug 03 1100											
19 Aug	[redacted]	Percocet 1-2 PO Q 4-6° prn pain	19 Aug 1400 2	19 Aug 1930 1	20 Aug 0000 1	20 Aug 0000 1	21 Aug 03 1430 PO [redacted]							

b(6)-2

b(6)-2

USAPA 71.00

ADMISSION AND CODING INFORMATION

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

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

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19850101	18Y	X	9	UNK

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
—	—	~~99~~ 20	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—	Z	1540	b(6)-4

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

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

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

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	NAME AND LOCATION OF PRIMARY TREATMENT FACILITY	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
UNK	[redacted] b(2)-2	UNK

21. TYPE OF DISPOSITION	MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYYYMMDD)
~~50~~ 05		20030820

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
ABAA		20030817

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYYYMMDD)
1Z		

FOR LOCAL USE

GSW @ flank

ADMITTING OFFICER (Signature, as required)

[redacted] b(6)-2

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) [redacted] b(6)-4			3. GRADE N/A	ADMISSION REMARKS
4. SEX F	5. AGE 62	6. RACE UNK	UNK	8. LENGTH OF SVC N/A	9. ETS N/A	10. PREVIOUS ADMISSION NO	
11. FMP 99		12. SSN [redacted]		13. ORGANIZATION b(6)-N/A		14. WARD ICU 1	
15. FLYING STATUS N/A	16. RATING/ OSG	17. DEPT./ BEN K-78 N/A	18. BRANCH/CORPS N/A	19. UIC/ZIP		20. TYPE CASE	

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: DIRECT FROM EMT	22. HOURS OF ADMISSION: 2130	23. CLINIC SERVICE	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: UNK	25. TYPE DISPOSITION: 01	26. DATE OF DISPOSITION: 20 AUG 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK	27b. TELEPHONE NO.: UNK	28. DATE OF THIS ADMISSION: 19 AUG 03	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] b(2)-2		30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: CLOSED HEAD INJURY — Trauma
RT TYMPANIC RUPTURE - 872.61 — 9
DX: 8505
9181
E9889 — Injury
999

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	2	2

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
b(6)-22	0	0	0	b(6)-22	2

SIG [redacted] SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER [redacted]

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
20 Aug 03	NOTES Nursing Assessment Continued.
1000	and (R) forehead (+) bruise to (R) temporal. Continues to be NPO. Lungs CTA Heart NSR abd. soft non-tender c̄ (+) BS X4. MAE. (+) grip both hands.
See Flow Sheet for Neuro VS	(+) extension of feet (-) dorsi flexion feet. VSS. Temp 99°. Mouth dry. IV to (L) wrist patent c̄ NS @ 100cc/hr. Continues c̄ BR. Neuro team visited pt this AM. Continue c̄ neuro ✓ q°. Ø acute distress @ this time. Continue to monitor. [redacted]
1100	Nursing Ø Δ in neuro status. [redacted]
1200	~~Ato~~ Neuro ✓ Ø Δ in status / complaints [redacted]
1300	Neuro ✓ is ⅤS Δ. Back pain improved c̄ blanket roll to spine. [redacted]
1400	Neuro ✓ ⅤS Δ. Bruises noted to top (L) shoulder. Tiny Back drainage from posterior cephalus. Responds appropriately to verbal stimuli. Ribs ache states she does not remember being in an explosion she was sitting at the end and woke up here in the bed c̄ the above noted complaints VSS 163/83 79 20 99°. Continues NPO. [redacted]
1500	Nursing: Ø Δ in neuro status. Stable [redacted]
1600	Nursing Ø Δ in neuro status. Ø c̄o pain to IV site Ø S/Sx of complications.

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

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

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/199
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1
USAPA V1.0

b(6)-2
A11

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
	Neurosurgery Narrative
8/20/03 0900	62yo German National married to an Iraqi injured during bomb blast at UAE. Had CHI and initial confusion/disorientation upon admission w/ Ruptured (R) TM. ? Corneal laceration on OS. Currently markedly improved awake alert appropriate follows commands briskly no focal deficits no drift. SOMI on OS, Dressing over OS. A/P: Sent to Germany for CT Head vs. Iron Sense CT. PMHx significant for prior (L) Subcomptal craniotomy.
	[redacted]
	b(6)-2
20Aug03 1000	Nursing Assessment note: Pt A&O to self, condition. Responds to verbal stimuli appropriately. Able to voice her needs & concerns. dsg to OS which is closed when attempted to open clear fluid leaked. Pt is aware. States OS feels like something is in it. OD can open and see. denies blurry vision unable to maintain OD in open position for a period of time. C/O pain to (R) temper

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	SPONSOR'S ID NUMBER (SSN or Other)
	[redacted]	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT
	b(6)-2	

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

PROGRESS NOTES
Medical Record

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

Progress Note
3F Form 509

b(6)-2

20 Aug 03 1700 — Neuro Status is improved, [redacted] Dsg to OS is removed by eye team member. Continues to be unable to use OS. OS Clear c̄ movement. [redacted]

1800 — New orders noted. Neuro ✓ Stable pt ↑ to BSC c̄ assist. Voided x1 large amt amber color. Diet advanced. Pt took 1120 + applesauce c̄ difficulty is resting quietly. Neuro V's Δ to q4°. [redacted]

31 August 0930 — Pt resting in bed. A&Ox3. VSS. LCTA (B). BS x4 hypoactive. Pt diet status Δ'd to adv as tolerated. ↓ appetite. Pt has small cut and bruise to (R) temporal area. Denies HA/N/V/D. Pt states does have some dizziness when she gets up. Pt's (L) eye has been weeping and she states its very painful to open. Pt states she thinks her vision is fine, she just wont open that eye. Pt states (R) eye is fine. Opto does notified and will be in late to evaluate patient. Will continue to monitor & support [redacted]

31 Aug 03 1300 — Pt discharged home assisted by family and friends. Erythromycin ointment given to pt for corneal abrasion on (L) eye. Cleared by Neuro. Pt c̄ no questions @ this time [redacted]

b(6)-2

b(6)-4

[redacted]

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	Neurosurgery Narrative
8/21/03 12:44	62yo m q SIP CHI after UN attack @ Baghdad on 8/19.
	Pt had LOC awake with mild disorientation no focal
	neurologic deficits. After 24° had normal speech, mentation
	and sensorimotor function.
	Pt. noted to have also small corneal abrasion w/o loss or
	d's in vision.
	Remainder of exam/C-Spine/CXR were normal
	no extremity injuries.
	A/P: Plan for D/C to home. F/u with Family
	practioner in 2-3 weeks, Progressively ↑ activity
	over next 3 week. Regular Diet & Ambulation.
	[redacted]

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

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

[redacted] B(a)-4

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

NSN 7540-01-075-3786

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

PATIENT'S HOME ADDRESS OR DUTY STATION			ARRIVAL	
STREET ADDRESS			DATE *(Day, Month, Year)* 19 Aug 03	TIME 1942
CITY	STATE	ZIP CODE	TRANSPORTATION TO FACILITY medevac	

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

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

CHIEF COMPLAINT

CATEGORY OF TREATMENT		VITAL SIGNS					
☐ EMERGENT	TIME 1940	TIME	1940				
☒ URGENT	[redacted]	BP	139/70				
		PULSE	71				
		RESP	18				
☐ NON-URGENT		TEMP	97.3				
		WT	87 kg 98%				

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: 12 14 YES		ACUTE ABDOMEN	LS SPINE
	BLOOD C&S X						SINUS	HE[redacted]
							ANKLE R/L	[redacted]

ORDERS

☒ PULSE OX 95% ☒ MONITOR b(6)-2 ☐ ECG

TIME	ORDERS	COMPLETED BY	TIME	PATIENT'S RESPONSE
2000	Tovadal 30mg	[redacted]		

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 [redacted]

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

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							
	H/H			SUP 02	PH	PO2	RESULTS	
	PLT			PCO2	SAT	OTHER		
PT				U/A	DIP		EKG INTERPRETATION	
APTT		BHCG	ETOH / GLU		MICRO			

PROVIDER HISTORY/PHYSICAL

5). Involved hotel explosion (German / National)

PMH: ?
allergies: ?

GCS - 13

0) Awake, answer questions
Eye - PERRLA Ear - Rt TM - rupture Lt TM - clear
Nose - clear Throat - clear.
Heart - RR NO (M)
Lungs - clear.
Extremities - Bruising over Bilateral Shoulders

Abd soft, N.T

CXV
~~Bilat~~ Humerus - Bilateral Shoulder.

CONSULT WITH	TIME	ACTION	RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP
Dr. [redacted]	2015	FCW - ad.	
			PROVIDER SIGNATURE AND STAMP
			[redacted] Blue - 2

DIAGNOSIS
1.) CHI
2.) Ruptured TM - Rt
3

CODES

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

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

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
19 AUG 03		2130	Received pt from ER. 62 y/o female closed head injury, RT Tympanic Rupture. Pt is only Alert to person. Answers some questions appropriately, but is not able to tell the year or what happened to her. She has a small wound on left side of hedd. Pt Lungs CTA B, breathing even, unlabored. Card: S.S2, NSR + 2 pulses, <3 sec cap refill. Pt has +BS x 4 qds. Pt states that she needs to urinate but doesn't understand that she has to go on a ped pan. Pt has IV to left arm NS@100cc/hr. Pt VSS. Pt states she has pain when you move her head to the right side. Pt has hx of brain tumor removal. Will continue to do neuro checks q1° (Pupils were perla but could not follow my pen with her eyes) [redacted]
		2230	I concur c above assessment. [redacted]
		2230	Neuro checks done. Pt shows improvement. Remembers the year + month. Used BSC ——— Sig [redacted]
		2330	Neuro checks. Alert to person + time. Able to purposefully move all extremities ——— Sig [redacted]
		[redacted]	Neurocheck. A&O x 2. Pt left eye watering, notified doctor. Dr states she may have a laceration instructed to put a patch over. eye. ——— Sig [redacted]

b(6)-2 All

(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.

NURSING NOTES

Medical Record

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY																
POST-	DAY															
MONTH-YEAR	DAY		20	20		21										
19	HOUR	2300	0600	1300		0400										

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			162/73	155/55	131/71	164/79										
			76		72	74										
		97%			99.1	99										
HEIGHT:	WEIGHT →															
	MR			68												

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted]

bwt-d

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT	14.6	9.8-13.6 secs
APTT	24.4	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: b(6)-2

REPORTED BY: [redacted]	**DATE:** 19 AUG 03	**LAB ID NO.:**

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted] b(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI. [redacted] b(6)-4	DATE 18 Aug	TIME 2020	SSN/PSEUDO SSN: [redacted] b(6)-2

(i-STAT)			(Piccolo) Chemistry 12			(Piccolo) Metabolic Panel		
TEST	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*
Na		138-146 mmol/L	ALB		3.5-5.5 g/dl	GLU		73-118 mg/dl
K		3.5-4.9 mmol/L	ALP		26-84 u/l	BUN		7-22 mg/dl
Cl		98-109 mmol/L	ALT		10-47 u/l	CA^{++}		8.0-10.3 mg/dl
pH		7.31-7.45	AMY		14-97 u/l	CRE		0.6-1.2 mg/dl
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)	AST		11-38 u/l	NA^{+}		128-145 mmol/l
PO2		80-105 mmHg (art) N/A (ven)	TBIL		0.2-1.6 mg/dl	K^{+}		3.3-4.7 mmol/l
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)	BUN		7-22 mg/dl	CL^{-}		98-108 mmol/l
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)	CA^{++}		8.0-10.3mg/dl	tCO_2		18-33 mmol/l
sO2		95-98%	CHOL		100-200 mg/dl	**(Piccolo) Liver Panel Plus**		
BEecf		(-2) – (+3) mmol/L	CRE		0.6-1.2 mg/dl	*TEST*	*RESULT*	*REF. RANGE*
AnGap		10-20 mmol/L	GLU		73-118 mg/dl	ALB		3.3-5.5 g/dl
Ca		1.12-1.32 mmol/L	TP		6.4-8.1 g/dl	ALP		26-84 u/l
BUN		8-26 mg/dl	**(Piccolo) Metlyte 8**			ALT		10-47 u/l
GLU		70-105 mg/dl	*TEST*	*RESULT*	*REF. RANGE*	AMY		14-97 u/l
Creat		0.7-1.5 mg/dl	GLU		73-118 mg/dl	AST		11-38 u/l
Hct		38-51% PCV	BUN		7-22 mg/dl	TBIL		0.2-1.6 mg/dl
Hgb		12-17 g/dl	CRE		0.6-1.2 mg/dl	GGT		5-65 u/l
Misc. Chemistry			CK		39-380 u/l (M) 30-190 u/l (F)	TP		6.4-8.1 g/dl
TEST	*RESULT*	*REF. RANGE*	NA^{+}		128-145 mmol/l	**(Piccolo) Electrolyte**		
Troponin-I			K^{+}		3.3-4.7 mmol/l	*TEST*	*RESULT*	*REF. RANGE*
Drug of Abuse			CL^{-}		98-108 mmol/l	NA^{+}		128-145 mmol/l
			tCO_2		18-33 mmol/l	K^{+}		3.3-4.7 mmol/l
						CL^{-}		98-108 mmol/l
						tCO_2		18-33 mmol/l

REMARKS:

b(6)-2

REPORTED BY: [redacted]	DATE: 19 AUG03	LAB ID NO.:

				Limits	
WBC	[illegible] H	x10³/µL		4.5	10.5
RBC	[illegible]	x10⁶/µL		4.00	6.00
Hgb	[illegible]	g/dL		11.0	12.0
Hct	[illegible]	%		35.0	40.0
MCV	93.3	fL		80.0	99.9
MCH	29.7	pg		27.0	31.0
MCHC	31.8 L	g/dL		33.0	37.0
Plts	259.	x10³/µL		150.	450.
LYM%	6.5	%		20.5	51.1
LYM#	1.2	x10³/µL		1.2	3.4

---

i-STAT EC8+

Pt: [redacted]

Pt Name:_____

Glu_____149 mg/dL

BUN_____17 mg/dL

Na_____137 mmol/L

K_____4.0 mmol/L

Cl_____109 mmol/L

TCO2_____26 mmol/L

AnGap_____8 mmol/L

Hct_____40 %PCV

Hb*_____14 g/dL

*via Hct

pH_____7.449

PCO2_____36.0 mmHg

HCO3_____25 mmol/L

BEecf_____1 mmol/L

Sample Type_:

19AUG03 20:28

Oper: [redacted] b(u)-2

Physician:_____

Ser# [redacted]

Ver: JAM5046A
CLEW A93

---

i-STAT CREA

Pt: [redacted]

Pt Name:_____

Crea_____1.1 mg/dL

Sample Type_:

19AUG03 20:29

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAM5046A
CLEW A93

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 _____ HOURS | LIST TIME ORDER NOTED AND SIGN

1) Admitt ICU
Dx: Closed head injury Rt TM rupture
2) Neuro check q 1 hour
3) I.V. - Nrml Saline at 100cc/hr
4) V.S. q 4 hour
5) NPO
6) Activity : Bedrest

PATIENT IDENTIFICATION

[redacted]

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

7) ~~Urgent~~ evac
Evac for C.T. - scan

8) Notify Neuro team patient [redacted] admission [redacted]

b(6)-2

20P/0215 20Aug03 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

20 Aug 2003 | 1800 HOURS

1) Advance diet as tolerated
2) D/C q° neuro V's
3) neuro ✓ q 4°; elevate HOB 30°
V/O Dr [redacted] / [redacted]

Noted [redacted]

MM 20 Aug 03 1800

b(6)-2

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

8/20/03

1) D/C to home

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

b(6)-2

CLINICAL RECORD — For use of this form, see AR 40-400; the proponent agency is the Office of The [redacted] — Mo. ___ Yr. 2005

VERIFY BY INITIALING [redacted] INITIAL [redacted] UMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 19	DATE DISPENSED 20
8/19	[redacted]	VS q 4°	05	/	[redacted]
			17	[redacted]	[redacted]
			/	/	
	[redacted]	Neuro checks q 1°	05	/	[redacted]
20 Aug	[redacted]	q 4°	17	[redacted]	[redacted]
			/	/	
	[redacted]	IV NS @ 100cc/hr	05	/	[redacted]
			17	[redacted]	[redacted]
			/	/	
	[redacted]	NPO	05	/	[redacted]
20 Aug	[redacted]	Advance as tolerated	17	[redacted]	[redacted]
			/	/	
	[redacted]	Act: BR C HOB ↑	05	/	[redacted]
20 Aug	[redacted]	30°	17	[redacted]	[redacted]

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: CHI, (R) TM rupture

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

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

b(2)-2

Initialing | (MEDICATIONS) | Mo. Yr. 2003

Order Date	Clerk/ Nurse	[redacted]BLE ORDER, PRE-OPERATIVES	[redacted]e to [redacted]ives	Time to be Given	Time Given	Initials
19AUG	[redacted]	Admit ICW 1	19AUG			[redacted]
19AUG	[redacted]	Dx: Closed head injury RT TM Rupture	19AUG			
19AUG	[redacted]	Evac for CT soon				

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

USAPA V1.00

M[redacted] RECORD-SUPPLEMENTAL MEDIC[redacted]

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA APPR 08MAR8

INITIAL SHIFT ASSESSMENT b(6)-2

		Time: 1000 Initals: [redacted]	Time: 1100 Initals: [redacted]
NEURO	Pupils	~~1000~~ OD 3→1 does not [illegible] spontaneously OS Reacts to light	OS Closed not examined OD (+) reacts to light 3→1
	Sensorium	Eyes closed OS. injured clear fluid ooze c̄ opening. A&O to person/place	Ø Δ in LOC & Pain as noted to head + eye
	LOC / GCS	Response appropriately to stimuli c̄o Pain to OS like something in it, c̄o Pain to stimuli & (+) PRD 4/10	
CARDIAC	Cardiac Rhythm	Regular Sinus Rhythm	
	PRI: / QRS:		
	Pulse Strength	NPC + strength x4 ⇒ 2+ (-) dorsiflexion to LE	(+) plantar + dorsiflexion to LE possibly due to ineffective communication
	Cap Refil / JVD	WNL	
	Edema	Ø	
	Chest Pain	Ø	
RESP	Respiratory Pattern	Regular	
	Breath Sounds	CTA	
	Secretions	Ø	
	Cough	Ø	
SKIN	Color	WNL c̄ regard to ethnicity warm	
	Integrity	dry intact	
	Backside	not checked	
IV	Access Devices	Peripheral IV (R) FA	
	Location		
	Condition		
GI	Abdomen	Soft nontender	
	Bowel Sounds	(+) active x4	
	Stoma/Ostomy	NA	
GU	Device	Ø	
	Color / Clarity	Ø	

(Continue on reverse)

PR[redacted] BY *(Signature & Title)* [redacted] b(6)-2

DEPARTMENT/SERVICE/CLINIC (b)(2)-2 ICU3, [redacted]

DATE

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

DA FORM 4700, MAY 78

USAPPC V2.00

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]	[redacted] b(6)-2		F

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
	6 2 y	4	9	UNK

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
N/A	u	2130	N/A b(6)-4

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
O	ICW 1	UNK
		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: UNK

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
0 1		0 3 0 8 2 0

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
		0 3 0 8 1 9

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

FOR LOCAL USE

DX: CLOSED HEAD INJURY
RT TYMPANIC RUPTURE.

b(6)-2

ADMITTING OFFICER (Signature, rank and title)	SIGNATURE OF ADMITTING CLERK
[redacted]	b(6)-2 [redacted]

INPATIENT TREATMENT RECORD COVER SHEET

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

1. [redacted]			2. NAME [redacted] EN b(6)-2			3. GRADE N/A	ADMISSION REMARKS
4. SEX M	5. AGE 29y	6. RACE Z	7. [redacted] Unk	8. [redacted] N/A	9. [redacted] ETS N/A	10. PREVIOUS ADMISSION NO	
11. FMP 99 b(6)-2		12. SSN [redacted]		13. ORGANIZATION N/A		14. WARD ICU3	
15. FLYING STATUS N/A	16. [redacted] DSG	17. DEPT./BEN K70 9/		18. BRANCH/CORPS N/A	19. UIC/ZIP	20. TYPE CASE WIA	

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from ER	22. HOURS OF ADMISSION	23. CLINIC SERVICE: ABAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: Unk	25. TYPE DISPOSITION: Trans	26. DATE OF DISPOSITION: 26 Aug 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): Unk	27b. TELEPHONE NO.: Unk	28. DATE OF THIS ADMISSION: 19 Aug 03	ADMITTING OFFICER
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.

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Repair Facial Laceration
Repair Rupture Globe
Open (L) Humerous Fx
Open (L) Radius Fx

DX; 51352
8712
80151
81250
8731
87330
87210
8749
8702
8832
E993

Px; 1682
8659
2181
184
0881
0859

Trauma
1
Injury
459

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	8	8

36. Total Days All Facilites

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

SIGNATURE OF ATTENDI[redacted] b(6)-2

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER [redacted]

DA FORM 3647, [redacted] b(6)-2

EDITION OF 1 AUG 78 IS OBSOLETE

USAPPC V1.10

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

29 yo Iraqi male Explosion hx
multiple shrapnel wounds
(L) Orbital (L) Frontal (L) arm and (C) knee
Pmh of
PTSD
Meds Valium 5 BID
NKDA

PHYSICAL EXAMINATION

(L) orbital [illegible]
(R) chest [illegible] not the [illegible]
(L) neck wound into [illegible]
lung CTS
(L) hand multiple [illegible]
(R) shoulder [illegible]
Abdomen (right [illegible]

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

2yr Multiple shrapnel wounds
Most significant [illegible] orbital
arm open fx (L) arm

b(6)-2

[redacted]

	DATE	IDENTIFICATION NO.	ORGANIZATION
	14 AUG 03		

(*Typed or written entries give Name last, first, rank; grade; date; hospital or medical facility*)

REGISTER NO.	WARD NO.

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

539-108

[redacted]

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
19AUG03	Neurosurgery Admit
2031	27 y/o male Iraqi Civilian suffered injuries in blast injury during UN Bombing today. Pt suffered penetrating injuries to his left face and eye, left shoulder, elbow, and wrist, and right shoulder and hand. He was stabilized at [redacted] and sent to [redacted]. b(2)-2
	PMH (-) allergies
	Takes Voltaren BID
	Exam lacerations (L) forehead, eye, upper and lower lip, and left cheek. There is a superficial left neck injury preserving the platysmus. There are superficial right and shoulder and dorsal hand lacerations, and left elbow & wrist, and left knee.
	Heart RRR.
	Lungs clear.
	Abdomen benign. Fast Scan negative
	Perineum benign.
	Back nontender. AP/Lat Skull - (L) orbit Fx.
	Neuro intact. Lat C-Spine - negative
	(over)

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)

Civ II [redacted] b(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

NSN 7540-00-634-4178

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
19 AUG	S: 29 yo ♂
17:20	IV started SCI (R) AC (L) open wrist fracture
	BP 91/59 (L) open elbow fracture, wrist
	Temp extensors injured
	Pulse 83 (L) knee laisoration sensation
17:25	BP: 103/67 in tact all 3 nerves.
	Pulse: Ultra sound (−)
	(L) laisoration erotion over (L) face
	ear (L) lip lac. no vision (L) eye
	Awake alert good on commands
	GCS - 15
	Rectal (−) normal tone pt rolled
1730	Dopu [redacted] 1825 no injuries identified on back side
	XRAYS Requested
	- AP/lat (L) WRIST, (L) ELBOW, (L) Knee
1735	Recd 290♂ from triage - pt involved in explosion at UN. Pt is GCS 15 RTS 12 BP 107/68 P88 RR22 SAO2 99% RA. Pt has large facial laceration & he is able to maintain his airway. He has a large superficial head wound. His (L) arm & wrist are deformed & he has a splint in place. His right is at 3 cm but he can only move his index finger. 2nd BP @ 1740 108/66 P88 RR22 — [redacted]

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

[redacted] b(6)-2

[redacted] b(6)-4

ICU

(b)(2)-2

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

2

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
1750	Pt remain A&OX4, GCS 15, RTS 12, pt complain nothing from blood 2° facial wound. Difficult in able to maintain his airway. Dr [redacted] has seen pt & we are awaiting X-rays at this time. Plan is to continue to monitor [redacted] & maintain airway. SAT 100% RA — [redacted]
1810	X-ray here, pt given 3mg MS SIVP for procedure. BP 91/59 P74 RR20 — [redacted] Lt AN
1825	X-rays completed, (R) radial is strong & palpable, unable to palpate (L) radial due to splint. Pt remains able to move only (L) index finger. — [redacted] Lt AN
1830	Dr [redacted] here, H&H ordered, no Δ in pt A [redacted]
1840	Lab here to draw H&H — [redacted] Lt AN
1845	Ancef 1gm IVPB ↑ — [redacted] Lt AN
1850	BP 94/55 P88 RR22 SAO2 99% RA — [redacted] Lt AN
1855	Lab results HCT 30 Hb 10 — [redacted] Lt AN
1905	Pt to 21CSN. BP 92/50 P88 RR22 SAO2 99% RA, no Δ in status. — [redacted] Lt AN
1906	Ancef 1gm IVPB completed. — [redacted] Lt AN
	b(6)-2
1912	98/76 (R) pulse, (L) too tachycardic
	P-103 LS clear @ Bilat
	SaO_2 - 99%; 15LPM
[redacted]	(b)(2)-2

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
0600 21	Aug 03 Received report from previous nurse, Pt asleep but awakens easily, Pt c/o back pain, positioned for comfort, will monitor b(6)-2 [redacted] CPT/BSN
0715	Anesthesia in for pre-op eval, chart & CRNA to OR, Pt to OR & CRNA @ 0800, [redacted] CPT/BSN b(6)-2
1145	Pt back from OR accompanied by anesthesia in PA sets in the hi 90's; positioned in bed supine but appropriate, VSS, unable to move (L) thumb but able to move (L) fingers. Dr [redacted] ~~notified~~ ~~no further o~~ Pre op orders renewed, pain meds ordered. [redacted] b(6)-2
	BP-125/65 RR-20 HR-104 Sats-100 T [redacted] 98.3
1150	121/64 ~~105~~ 8 103 100 b(6)-2
1155	123/57 10 106 100
1200	130/64 8 97 100 - 98.2
1215	119/59 10 97 100
1230	123/68 9 103 100
1245	118/62 8 97 100 - 98.5
	Pt more awake, conversant & appropriate, Ø c/o pain since arrival, still unable to move (L) thumb [redacted] CPT b(6)-2
1830	VSS, bed report from day shift. Pt sleeping in bed c̄ no c/o pain. b(6)-2 [redacted] 9/wrong
	(over)

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. ICU3

[redacted] b(6)-4

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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

Impression / Plan:

1. Face / Scalp lacerations – 1° closure.
2. Orbit / globe injury – per ophth.
3. Extremity injuries – per Ortho.

[redacted]

[redacted] 797

[redacted] b(u) - 2

20AUG03 Op Note – Neurosurg [redacted]

0129 Prep Dx Facial lacerations

Procedure 1° repair scalp + facial lacerations.

Surgeon [redacted]

EBL 250

Findings > 20 lacerations left face, neck, ear, mouth, nose, and eye. Orbital portion left to ophthalmology. Extremity injuries left to Ortho.

Complications None.

[redacted] b(u) - 2

[redacted] 797

RELATIONSHIP TO SPONSOR	[redacted] S NAME: LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)
DEPART./SERVICE	HOSPITAL O[redacted]ITY	RECORDS MAINTAINED AT		

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

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
20 Aug 03	27 Y/O male civilian suffered blast injury in UN bombing suffered multiple penetrating facial, forehead deep lacerations. Stabilized @ [redacted] sent here intubated pain to my exam
(b)(2)	
	unfortunately exam in OR face wrapped hx of vigorous arterial bleeding - waited to OR to take down bandages
	EXT very large soft tissue defect over medial canthus forehead, brow, full thickness incisions involving margin of upper & lower lid
	penlight 4L (see above) segmentary notches thru lids only inferior sutures same as corneal large full thickness oblique laceration across central cornea & into sclera. Pc & view definite, flat, uveal tissue non visible between lids
	iris - ? partial avulsion, O iris outside wound

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 see p 2		
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)		REGISTE[redacted]		WARD NO.

b(2)-2

[redacted]

b(2)-4

[redacted]

ITC

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	P. 2 NOTES
20 Aug 03	c̄ orbital uvea extruded.
	Imp ① ruptured globe c̄ extruded vitreous & uvea OS
	② severe facial lacerations, large soft tissue medial canthal defect
	③ sig lid lacerations OSL involving margin
	Plan: To OR repair FEUA
	Op Note
	Preop dx ① ruptured globe c̄ extruded uvea & vitreous cannot r/o IOFB OS
	② severe NGL lid lacerations, large medial canthal defect c̄ soft tissue/skin loss, lid loss involve margin
	③ hand lacerations
	Postop dx SAME
	Surg [redacted] b(6)-2
	Proc repair ruptured globe
	repair lid lacerations involving margins upper & lower
	medial canthoplasty
	repair facial lacerations
	repair lid laceration
	Findings ruptured globe extruded vitreous
	lens not apparent flat chamber c̄ heme [redacted]
	uvea outside wound

b(6)-7

STAN[redacted] 9991 BACK
USAPA V1.00

[redacted]

b(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
96.8 - 130 -	C10 623 Facial trauma 6810 erythaloid 4u PRBC
24 - 132/91	EBL 350 ET @ 23cm Fentanyl 250 Versed 5 mg in the OR.
100% 50%	
FIO_2	
20 Aug 03	Pt received from the OR, agitated post sedation in the
0345	OR. Pt vented, setting TV 700, SIMV 13, PEEP 5, FIO_2 50%
	ET 23 cm @ the lip. Multifacial trauma + stitches noted
	c̄ bloody free. (L) arm appear to be deformed c̄ bulky
	dressing, radial pulse palpable c̄ circulation on the fingers
	< 5 seconds. (R) knee extending to mid calf wrapped c̄
	ace wrap. Pedal pulse strong c̄ adequate circulation to
	the affected (R) LE (toes). Foley draining amber/yellow urine.
	Refer to OR report above. VS 96.8 - 130 - 24 - 132/91 - 100% sat
	on 50% FIO_2. Pt VS was taken when awaken from sedation.
	[redacted] Maj/Bn b(6)-2
0400	Pt BP↓ SBP < 100 after given Fentanyl 250 mg c̄ Versed 5 mg
T 100.1 - 109 -	taken for sedation. Same values LR + fluids, BP returning
35 - 97/65	to normal. Pt closely monitored. IV @ 50cc/hr, Versed 1 mg/hr
MAP: 76	Fentanyl 3 mcg/hr to start + titrate to effect. Pt is calm
	fully sedated. b(6)-2 [redacted] Maj/Bn
0500	Pt awaken, follows command. Motion to remove tube (ET), explained
	procedure. Started titrating FIO_2 by 5% q 15 minutes

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
20 Aug 03	Foley drained 650 cc / amber yellow urine. Continue to
0530	titrate FIO2 ↓ 30% sat 100%.
0555	ABG sent to the lab. attached see result. Pt breathing
	over the vent, RR 13 – pt 50 BPM. Follows simple
	command. Mutism to take ET out.
20AUG03	Neurosurgery
0708	(S/O) Stable overnight.
	Nurse reports F/C when up from sedation.
	Closures healthy.
	(A/P) Stable ∫ closure facial lacerations.
	Extubate this Am.
	Will work on placement today.
	[redacted] b(6)-2
	[redacted] 159
0600	Received report from [redacted] Pt comfortable ∫ vent
	∫ sedation, will plan for extubation ∫ monitor [redacted] cont/pain
0745	Dr [redacted] in for extubation, Versed off since 0700, pt following
	commands, able to lift head up, HOB elevated.. OPT suctioned, oral
	cavity suctioned, Pt extubated ∫ incident. Placed on NRB. Then
	RA in 15 min sats 100%, Pt vomited blood upon extubation but
	had good strong cough. VSS, will continue to monitor [redacted]
(1800)	Received Report from day shift. Pt VSS, Ø c/o
	pain. b(6)-2 [redacted] Flowers
(2000)	Pt resting in Bed VSS, Ø c/o pain. Fentanyl ∫ Sedation
	∫ good effect - Will continue to monitor. b(6)-2 [redacted] Flowers
(2200)	Pt's VSS, Ø c/o pain resting in bed. b(6)-2 [redacted] Flowers
21AUG03 (0200)	VSS, Pt received 650 mg Tylenol for headache NPO since 2300
	for OR call in AM. b(6)-2 [redacted] Flowers

STANDARD FORM 600 (REV. 6-97) BACK

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
	② large soft tissue defect over medial canthus
	③ lip margin lacerations involving vermilion
	④ 3 cm hand lacerations
	720 facial lac - sutured by nursing
	Compl none b(6)-2 [redacted]
	OpNote [redacted]
21AUG03	PreOp Dx: Open ① humerus Fx, Open ② [redacted] OTC Fx
	Lacerations, Extensor tendons at wrist
	Post Op Dx: Same
	Procedure: Repeat ITD, Repair ECRL, ECRB, common extensor ② wrist
	Surgeon: Oliverio
	EBL: minimal
	Fluids: 1700cc
	Cx: ø
	Pt Opinion: IV ABX, drug [redacted] Splint on extension, OT rehab b(6)-2
	[redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] b(6)-4

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

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Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
21AUG03	(2100) Pt sleeping in bed. Ø c/o pain. Rotating position in bed c [redacted] assistance. Pt's blue QS. Will continue to monitor. [redacted] Gwrong
22AUG03	(0100) Pt resting in bed, VSS, will continue to monitor Pt. [redacted] Gwrong
	(0400) Pt's VSS, sleeping in bed. Will continue to monitor Pt. [redacted] Gwrong
	b(6) -2 A11

STANDARD FORM 600 (REV. 6-97) BACK
USAPA V2.00

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

22 AUG 03 ORDERS

- TO ICU 2
- DRESS BLAST WOUNDS
- CONTINUE STAPLE
- VS - MONITOR
- BED REST
- BLOTTING TO WOUNDS BID
- FOLEY TO GRAVITY
- ~~NEBULIZER~~ CLEAR DIET. ADVANCE AS TOLERATED
- IV - LR AT 125cc/HR
- TYLENOL 650 mg P.O. Q 4-HRS PRN
- PERCOCET 1-2 P.O. Q 4-6 HRS PRN
- MSO4 2-6 mg IVP Q 2 HRS PRN
- ANCEF + ORZMS IVPB Q 12 HRS PRN

b(6)-2

- Δ ANCEF TO 1 gm IVPB q 8h
- BACITRACIN TOPICAL OINTMENT TO FACIAL SUTURES BID
- ERYTHROMYCIN OPHTH OINTMENT TO SUTURES/LASHES WOUND LEFT EYE / EYELIDS b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT
24° chart ✓ done	22 Aug 03 @ 2400 m2	

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

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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b(6)-4

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
22Aug03 1030	Report given by Air evac. Assumed care of pt p report given. See ICU Flow sheet. No chart accompanied the pt. New orders recieved by Col. [redacted] b(6)-2 Will cont. to monitor [redacted]
1500	Bacitrolin oint applied to wounds [redacted] on face neck & (R) Arm & (R) hand staples. Erythromycin Ophth Ointment to sutures / staples & eyelids [redacted]
1505	H/A Chart arrived from [redacted] b(2)-2
1630	T 100.8A Tylenol 650 mg po given. Will monitor [redacted] b(6)-2
1725	T 100.5A Will cont. to monitor [redacted]
1804	T 100.4A Will cont. to monitor [redacted]
1800 (Late entry)	Percocet "i" given po for H/A & (R) ear pain. Will monitor [redacted] b(6)-2
1908	Resting in bed @ present time - [redacted]
22Aug03 1940	Received pt @ 1900. Pt. resting in bed. Easily arousable. A&Ox3 (R) pupil @ 3mm & reactive. Resp. even, unlabored. SpO2 98% RA. Lungs CTA. NSR 2(+) pulses x3, cap refill brisk x4. Abd. soft, flat (+) BS x4. Foley to gravity c̄ clear, yellow urine. LR @ 125 cc/hr infusing into (R) AC 5 difficulty. Multiple blast injuries to → b(6)-2 [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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29 y/o Iraq Civ

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	~~WAS~~ FA IV 3 S/S of infection or infiltration noted. LR @ 125 cc/hr via (R) FA. Skin w/ & b to touch. (L) Arm & hand = cast/Ace bandage CDI. Pt able to move fingers on (L) hand. Cap refill < 3 sec @ (L) fingernail beds. Pt can feel when nurse touches fingers on (L). (L) knee Ace bandage CDI. Lung sounds clear bil BS (+) in all 4 quads. (R) radial pulse (+) (L) unable to assess due to cast/Ace bandage on Arm & hand. Pedal pulse (+) bil. Mid back area = 44 DSG CDI. Will cont. to monitor [redacted]
0100	Foley to gravity = clear yellow urine noted. [redacted]
0130	Bacitracin ointment to facial sutures. Nystatin oint applied to sutures/cheeks (L) eye lid. Tylenol 650 mg po given @ 0800 for (L) eye pain. Will cont. to monitor [redacted]
0840	(L) eye oozing yellow drainage. (L) eye [illegible] = 44. Will cont. to monitor [redacted]
0900	ii Percocet given po for (L) eye pain. Will cont. to monitor [redacted]
1300	MD (Dr. Olivier) b/d (L) Arm/hand DSG [redacted] ace wrap. Will cont. to monitor [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORD MAINTAINED AT
			b(6)-2A11
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	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
23Aug03	Percocet 1 tab PO given for pain @ Arm. Will [redacted] to
1330	Monitor. Hemmle @ bedside. [redacted]
1480	No c/o pain while monitor [redacted]
1500	Face @ side. Cleaned up [redacted] due to @ eye [redacted]
	yellow drainage. Reapplied [redacted]
1600	Transfer pt to ICW2 report given to [redacted]
	b(6)-2 A11

STANDARD FORM 600 (REV. 6-97) BACK

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
22Aug03 1940 cont.	(L) face. Sutures to (L) eye intact. Some serous drainage from (L) eye. (L) UE wrapped c̄ ACE bandage. (+) csm. Blast injury to (L) LE, (L) knee wrapped c̄ ACE bandage. Pt. has ∅ c/o @ this time. Will cont. to monitor. [redacted] LE/AN
23Aug03 0110	Serous drainage noted to be oozing from sutures & eye [redacted] (L) side of face. Face wiped c̄ sterile H2O soaked 4x4. Bacitracin applied to sutures & erythromycin applied to (L) eye @ 2200. Pt. Verbalizes concerns about his appearance. Asked about the swelling in his face but said he did not want to look in a mirror yet. Stated that his face feels like a "piece of leather." Pain controlled c̄ Percocet ii tabs. Pt. Sleeping at this time. Will cont. to monitor. [redacted] LE/AN
23Aug03 0450	Am care done. Small wound to center of back, skin tear c̄ some blood noted. 4x4 applied to site. 2 lacs to (R) shoulder c̄ staples intact. 1 lac to (R) hand c̄ staples intact. Face cont. to ooze serous fluid.
23Aug03 0500	Pt. c/o facial pain. Medicated c̄ Percocet 2 tabs PO. Tmax through the night 99.8 Ax. IV site (R) AC A'd. Pt. c/o site "hurting". ∅ signs of infiltration. Old site d/c'd c̄ catheter intact. New site placed (R) FA 20g. ∅ other A's. [redacted] LE/AN
0700 23Aug03	Assumed care of pt. ~~p night shift report given. Pt Alert & Oriented x3. (R) eye PERRL @ 2mm. (L) eye sutured shut. Sutures noted to (L) side of head from skull to neck & nose to ear. Open wound on chin approx about 2cm x 2cm red & pink noted. All sutures intact (R) UE Arm c̄ staples CDI. (R) hand c̄ staples CDI (R)~~

STANDARD FORM 509 (REV. 5/1999) BACK

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MEDICAL RECORD | PROGRESS NOTES

DATE | NOTES

Recommendations:

- Needs to have facial sutures, including 5-0 Prolene tied over silicone bolsters at medial canthus, and 6-0 silk suture tarsorrhaphy tied over silicone bolsters removed 27-29 August.
- Will require delayed enucleation of ruptured left globe within next 7-10 days. Can be fitted for ocular prosthesis 4-6 weeks after enucleation (Recommend waiting until 1 September before enucleating the left eye to allow eyelid and medial canthal injuries to stabilize).
- Need orthopedics to examine left arm and wrist. Will eventually require physical therapy.

Transfer Medications:

- Bacitracin Topical Ointment to facial sutures BID
- Bacitracin or Erythromycin Ophthalmic Ointment to lashes and eyelid wounds BID

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

DEPART/SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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USAPA V1.0

[redacted]

Ci[redacted] b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	- Keflex 500mg PO QID - Percocet I-II PO q4-6h PRN Pain.
	[redacted] b(6)-2 [redacted] MD LTC, MC, US ARMY COMMANDER [redacted] SURGICAL TEAM [redacted] (b)(2)γ DIRECTOR, OPHTHALMIC PLASTIC, ORBITAL & RECONSTRUCTIVE SURGERY DIRECTOR, OCULAR TRAUMA [redacted] USA b(6)-2 [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
23AUG03	Neurosurgery POD 4
0847	(80) VSA.
	Alert, in good spirits.
	(L) Peripheral Facial palsy.
	Closures healthy.
	(Afp) (1) Facial lacerations - healing.
	(2) Facial weakness - possible exploration later.
	(3) (L) arm/leg injuries - per ortho.
	(4) (L) Eye injury - per opthalmo.
	(5) Placement - Contact Family / UM today.
	[redacted] 1791
	b(6) -2

STANDARD FORM 509 (REV. 5/1999) BACK

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MEDICAL RECORD | Doctor's Orders ~~PROGRESS NOTES~~

DATE	NOTES
23AUG03 1406	(1) Transfer ICW 2 ✓
	(2) Diagnosis: Facial lacerations, LUE/LLE injuries. ✓
	(3) Condition: Good. ✓
	(4) V/S/S: Q-Shift. ✓
	(5) Activity: Up ad-lib with assist
	(6) Nursing: w/Cleanse/bacitracin Facial closures q-shift. Δ dressings LUE/LLE q-shift.
	(7) Diet: Regular ✓
	(8) IV: None
	(9) meds: Erythromycin Ophth Ointment (L) eye closure q-shift ✓
	Tylenol 650 mg po q 4° prn. ✓
	Keflex 550 mg po TID x 3 days ✓
	b(6)-2 b(6)-2
	(10) Lab: None. ✓
	(11) X-ray: None. [redacted]
	23 Aug 03 1720
	[redacted] Jeff 4797
24° Chard ✓	[redacted]

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

DEPART./SERVICE	HOSPITAL [redacted] ICAL FACILITY	RECORDS MAINTAINED AT

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

Civ #[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
24Aug03	(1) Percocet 1-2 po q 4° pm
0711	(2) Elevate LUE on pillow or sling.
	[redacted] 4797 b(6)-2
24Aug03	(1) Clean/bacitracin abrasions q shift
0822	(2) Afrin nasal spray 1 each nostril BID x 5 days.
	[redacted] b(6)-2
	24° chart ✓ [redacted] 25 Aug 0125

Noted 24Aug03 [redacted]

b(6)-2

noted 24Aug03 [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

24 Aug 03 1700

TRANSFER SUMMARY b(4)-4

27yo Iraqi M, [redacted], was working for the UN when the UN Embassy was bombed 19 Aug 03 [redacted] He was transported to the [redacted] where he was evaluated and found to have open left humerus fracture, open left radius fracture and lacerations with extensive lacerations to extensor tendons left wrist. He also had lacerations to (L) knee. b(2)-2

Extensive lacerations and avulsions to left face to include forehead, eyelids, medial canthus, cheek and lips. Ruptured left globe with no vision OS. He was taken to the OR and underwent washout of (L) arm and leg wounds, then repair ECRL & ECRB and common extensor of left wrist. (L) wrist splinted.

Left globe was explored and found to have large rupture involving length of cornea and onto sclera at 12 o'clock limbus. Extensive extrusion/prolapse of uveal/vitreal tissue. (patient had no light perception vision preoperatively).

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/155
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.205(b)(1
USAPA V1.1

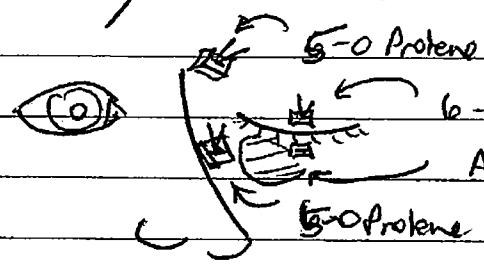
[redacted]

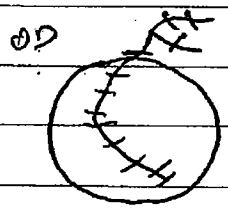
b(4)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES

No iris details visible due to extensive bleeding into anterior chamber. Globe hopelessly ruptured and not deemed salvageable — however, wounds closed with interrupted and running 8-0 & 9-0 Nylon and plan for delayed enucleation.
Forehead and cheek lacerations repaired.
Upper and Lower transmarginal lacerations repaired with 7-0 and 8-0 Silk. 5-0 Prolene passed through skin and tied over silicone bolsters to reduce soft tissue and skin defects.
Eyelids closed with suture tarsorrhaphy using 6-0 silk tied over silicone bolsters.
A 1cm x 1cm defect remained in medial left lower eyelid. Underlying orbicularis oculi muscle mobilized to close defect and to serve as scaffold for skin reepithelialization by secondary intention.





Received 4u PRBCs intraop.

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

24 Aug 03 2339 - assumed pt care @ 2300. pt has orders for dressing Δ to LUE & LLE q Shift. pt refused to have LUE dressing Δd. Dressing to LUE c̄ splint & ace wrap CDI. RUE c̄ staples to (R) shoulder intact OTA, RAC redden c̄ sm pustules. (R) hand c̄ sutures intact OTA. pt c/o itching to staple sites. requested something for itching. Spoke c̄ Dr. [redacted] for orders, MD states "its normal to itch, he doesn't need Benadryl." lungs CTA, abd soft BS (+) x4 quads. LLE c̄ dressing CDI. RLE c̄ (+) pulse full rom. Will cont to monitor [redacted] 91WM6

0400 V/S 110/64 P 115 R 16 T 97.7 [redacted]

25 Aug 03 0545 - pt c/o HA. given ii Tylenol per prn orders. [redacted] 91WM6

b(6)-2

25 Aug 03 0855 Assume pt care @ 0600. Pt awake A+O x3. Amb c̄ difficulty. VSS. Splint c̄ ace wrap CD+I to RUE, pt states the MD told him to keep splint x10 days. Will clarify. Dsg to RLE Δd stitches intact. c/o itching @ staples on LUE and old IV site, bacitracin applied. ace sutures intact to face, bacitracin applied. HR reg. Lungs CTA. Abd soft. BS x4, no BM since pt has been in hosp. x4 days. Will cont. to monitor. [redacted] 91WM6

1400 Staples removed from (R) hand/shoulder, order for bacitracin to AC area and (R) hand and shoulder. Ambien ordered for QHS prn. Do not Δ dsg to (R) LE. [redacted] 91WM6

b(6)-2

25 Aug 03 1522: Assumed care @ 1400. VS @ 1200 = T - 100.2°F P - 97 R - 16 BP 119/107 SpO2 - 100%. HR - regular. Lung sounds clear - bilat. Abd soft, nondistended. c/o headache, Tylenol 650mg PO given. Erythromycin oint. to (L) eye, Sutures to (L) side of face & forehead intact. Thick yellow drainage from OS noted. Splint to (L) LE CD+I. Sm. rash to (R) AC. Wounds to (L) LE open to air c̄ No s/s of infection. Will continue to monitor. [redacted]

[redacted] b(6)-4

b(6)-2

25 Aug 03
2350 pt care assumed @ 2200. pt resting quietly.
2200 99.9 facial sutures intact OTA c̄ bacitracin applied.
87 OS sutured shut. lungs CTA, BS ⊕x4 quads. ⊕↑ et ↓.
100% ext c̄ strong ⊕ pulses. LUE c̄ splint et ace wrap, drainage
24 CDI. LLE OTA ⊕ s/sx of infection noted, ⊕ pulse. ⊕
119/73 c/o pain voiced. will cont to monitor — [redacted] 91WM6
26 Aug 0400 ⊕s BP 110/70 R 14 T 97.1 P 66 Reg NW 91WM

26 Aug 03 0500 pt c/o HA given ii Tylenol per prn orders — [redacted] 91WM6

26 Aug 03 0737 VS T 99.3 P 84 R 20 BP 120/68, pt c/o HA 5/10 Tylenol given @ 0500. pt waiting for AE to Jordan

Nursing discharge summary.

pt being transferred to Jordan by A/E
Discharge orders, summary and medications complete.
pt teaching done c̄ meds. pt understands meds
and wound care. — [redacted] 91WM6

b(6)-2

MEDICAL RECORD	PROGRESS NOTES
DATE	
26 AUG 03	ORTHopaedic Summary Mr. [redacted] sustained injuries to his left upper extremity in the U.N. blast incident on the 19th AUG 03. His injuries include 1) Open left distal humerus fracture (non displaced) 2) Open left distal radius fracture 3) Transection of wrist and finger extensor tendons, Extensor radialis brevis, extensor radialis longus, and all common extensor (4th compartment) 1) Humerus fracture is avulsion of bone of lateral aspect of humerus. It is extra-articular and has been debrided with wound closure. Gentle range of motion exercises should commence at one week. 2) Radius fracture was small dorsal lip fracture which was reapproximate with periosteal suture and splinted after debridement. Treatment should mimic that necessary for tendon repair. 3) All tendons have been repaired. If occupational therapy is available, then a gauntlet and splint allowing active flexion with resting/passive extension should be initiated. If OT is not available, the wrist and fingers should be splinted in extension followed by range of motion exercises. (cont) [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. [redacted] b(2)-2

4) Remove sutures/Staples in one week

[redacted]

PROGRESS NOTES (2) Medical Record

MAJ MC

CHIEF ORTHOPAEDIC SURGERY SERVICE

[redacted]

b(2)-2

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

558-104

7540-01-075-378

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER | TREATMENT FACILITY [redacted] b(2)-2

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS: CIV 123

CITY | STATE | ZIP CODE

SEX: M

AGE: 29

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

ARRIVAL

DATE *(Day, Month, Year)*: 14 Aug 03

TIME: @ 1950

TRANSPORTATION TO FACILITY: AFM

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS: Ø

ALLERGIES: NKDA

INJURY OR OCCUPATIONAL ILLNESS

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

HOW

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: Trauma

CATEGORY OF TREATMENT

☒ EMERGENT

☐ URGENT

☐ NON-URGENT

TIME: 1937

INITIALS: [redacted]

VITAL SIGNS

TIME	1938	2020			
BP	107/50	106/49			
PULSE	98	103			
RESP	18	16			
TEMP	Dnu				
WT 500	99				

LAB ORDERS

☒ CBC/DIFF	☒ ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT
URINE C&S	☒ UA MSCC/CATH		CHEM: 12 Elyte
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 b(6)-2 ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1950	MSO4 5mg	[redacted]			
1950	1 Sig Tubes	[redacted]			

DISPOSITION: ☐ HOME ☐ FULL DUTY

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

MODIFIED DUTY UNTIL

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

[redacted] b(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

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

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

S: Involved in explosion today. Came to field team & stabilized

(L) knee
(L) eye

O: (L) eye injury - severe
(L) orbital injury & neck laceration
Evaluated by surgical team to x-ray & Dr. [redacted] (b)(6)
and then to OR. Pt stable

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

DIAGNOSIS

CODES

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

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

b(w)-4

[redacted]

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
231630 Aug 03	—	—	NURSING NOTE: Pt transferred to ward via w/c ~ difficulties. However, upon transfer to bed, pt began to complain that the bed was not soft enough, that his pillow was not soft enough. After explaining that this was the only bed style available and that this would be the bed he would sleep in. Multiple facial lacerations c̄ sutures intact, bandaids applied. Airway intact, breathing even and unlabored, LS CTA(B), Abd soft, nontender, ~ distention. BS(+)x4. Voiding per Foley. ROM to RUE and RLE, Neurovascularly intact to all extremities. RUE splinted c̄ ace wrap, CDT. LLE has ACE c̄ Kerlix, some serosanguinous drainage noted. Stitches to (R) hand are CDT. (L) eye covered c̄ erythromycin ointment. Also has some purulent drainage (L) eye seem shut. IV DC'd intact c̄ DC order written — b(4)-2 [redacted]
23 1800 Aug 03	—	—	NURSING NOTE: Foley DC'd intact. Pt voiding s [redacted]
24 Aug 03	0210		assumed pt care @ 2300. pt awake. VSS. Sutures to (L) side of forehead, cheek, ear & lip intact CTA, (L) eye sutured shut. Lungs CTA, BS(+)x4. R↓ & ↑ ext c̄ full ROM (+) pulses. LLE c̄ ace & Kerlix dressing, old drainage noted. LLE c̄ splint & ace wrap. (D) c/o pain voiced. Will cont to monitor — [redacted] 91WM6 b(4)-2
24AUG03	0708		Neurosurgery (S/O) Stable overnight in ICW. Uncomfortable. Exam Stable. (A/P) Injuries (L) face/arm/leg. Treatment per EYE.

(continue on reverse side) [redacted]

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

[redacted] NURSING NOTES Medical Record

[redacted] RD FORM 510 (REV. 7-91) [redacted] bed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

b(4)-2

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
24 Aug 03	0729		0715 VS - BP - 107/62 HR 94 Temp 97.8 RR 22 Sat 100% Pt VS WNL. A+Ox3. Skin W/D/I. All sutures to scalp intact, sutures to OS intact c̄ white foam padding intact. Face cleansed and Bacitracin re applied to all sutures. Yellow/white drainage noted ā cleansing sutures and OS. OD ⊕ EOM PERLA WNL ⊕. Steaks ⊖ visual Δ's. Staples to ⓡ shoulder intact. Redness noted @ staple insertion sites. Bacitracin applied. Staples to ⓡ hand intact Bacitracin applied. Splint cast to ⓛ UE intact ⊕ NV ✓s to ⓛ digits. LCA ⓑ. HRRS, S_2 WNL. BS ⊕ x4. ABD soft/non-tender. Appetite excellent. Bacitracin applied to aprasions ⓑ LE's. ACE wrap dsg to ⓛ LE CDI ⓛ LE digits ⊕ NV ✓s WNL. C/o pain x1 ii Tylenol given. Pt stated @ 0855 Tylenol "provided significant relief." Will cont to mon [redacted]
24 Aug 03		1615	Assumed care @ 1400. T-100.7°F P-109 R-16 BP-119/63 SpO_2-100%. HR-regular. Lung sounds clear bilat. Abd. soft, nondistended. BS x4. Multiple lac. to face - cleansed and treated c̄ bacitracin. Erythromycin to OS. Thick yellow drainage from OS. Staples to Shoulder intact Staples to ⓡ hand intact. ACE wrap to ⓛ leg intact & clean. Splint to ⓛ arm CD+I - sensation present to fingers c̄ good capillary refill. Tylenol 650mg PO given for fever and pain. Will continue to monitor. [redacted]

25AUG2003 – 2133

Discharge Summary, Patient #[redacted] b(6)-4

History: This is a patient who suffered multiple penetrating injuries during the UN bombing on 19AUG2003. These included glass fragments embedded in and causing lacerations to the left face, eye, and neck. He also suffered injuries to his left arm and leg. He presented awake and alert with an admission glascow coma score of 15. Left facial weakness was present on admission. He had no central paresis of his extremities.

b(6)-2

Hospital Course: The patient was transferred directly to the operating suite, where repair of his facial lacerations was performed concurrently to irrigation and debridement of his extremity injuries. After facial injuries were repaired, his care was turned over to Dr [redacted] from Ophthalmology. He performed initial repair of the tissue loss in and around the left eye. Postoperatively the patient was left intubated overnight. He was routinely extubated the following morning and has been stable thereafter. Given his options of remaining in Baghdad or being flown to Jordan for his ongoing care, he elected to travel to Jordan. He was released on 26AUG2003.

b(6)-2

Disposition: Sutures may be removed from the face at any time. Eye per Dr [redacted] Extremity injuries per Dr [redacted] Orthopedics. Treating physicians are encouraged to contact me with any questions or concerns.

[redacted] MD b(6)-2

[redacted] b(2)-2

MEDICAL RECORD	**PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT** For use of this form, see AR 40-407; the proponent agency is The Office of the Surgeon General.
1. AGE: 29 HEIGHT: 183 cm WEIGHT: 86 Kg	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): NKDA 3. PREVIOUS SURGERY [X] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE:
Closure of Fore'D Laceration / I&D (L) arm / I&D (L) leg

5. ADDITIONAL INFORMATION:
TOS-0 PRO-1500
Egos-0

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL X 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 X Potential for respiratory dysfunction due to sedation; positioning; injury; previous medical condition	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 X Potential impairment of skin integuity due to bovie pad; poistion; 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

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION X Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; 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. X Potential impairment of mobility due to sedation; pain; injury E.2. X 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. X Potential for decreased communictaion due to languag e barrier; sedation; pain; injury F.3. Potential injury due to dentures.	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from _____ side. o Validate pt.'s understanding of verbal communications. o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS. Or continuation of above interventions.

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

[redacted] 19 Aug 03 DATE

11. POSTOPERATIVE EVALUATION:

Gallbladder

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title) [redacted] b(6)-2

DATE: 19 Aug 03 TIME: 2044

13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Titl [redacted] b(6)-2

DATE: 19 Aug 03 TIME: 0330

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.0

MEDICAL RECORD — **INTRAOPERA OCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY Orderlies

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

3. DATE 19 Aug 03 TIME PATIENT ARRIVED IN SUITE 2052

4. PATIENT IN ROOM TIME 2052 NUMBER 2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: 29 y/o male diaphoretic & respiratory.

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted] b(6)-2	RELIEF SCRUB	
	SGT [redacted] / SPC [redacted]		
ASSIGNED CIRCULATOR	MAJ [redacted]	RELIEF CIRCULATOR	
	CPT [redacted]		

7. POSITION AND POSITIONAL AIDS *(Specify)*
Pt in proper body alignment. (1) Arm on arm board @ <90°. Left arm on two arm boards serving as an arm table.

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

COMMENTS: Tourniquet on left thigh. 10/5 w-drape isolating tourniquet for prep.

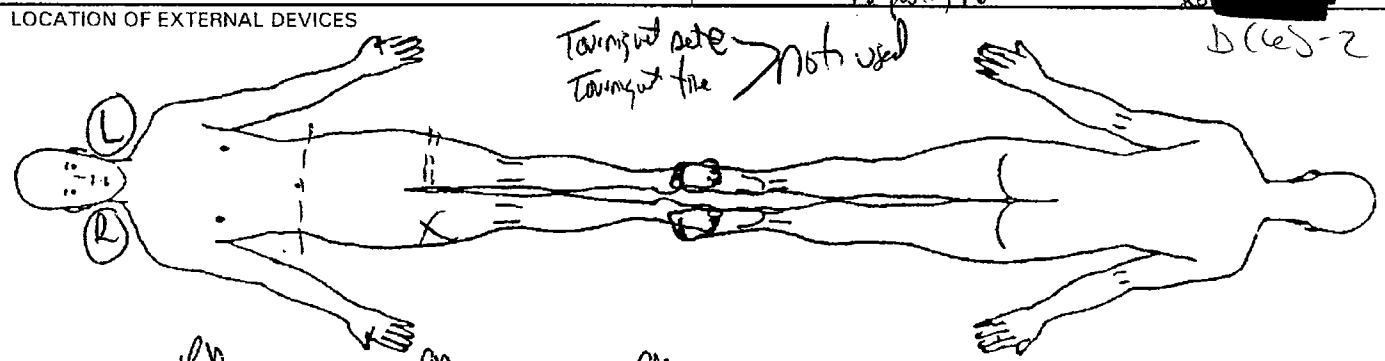
8. SKIN PREPARATION

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

COMMENTS:

PREP SOLUTION *(Specify)* Betadine scrub/paint
SITE: Face, neck, scalp BY WHOM: Dr [redacted]
SITE: left arm BY WHOM: MAJ
SITE: left leg By whom: CPT [redacted]
COMMENTS: no prolin noted SPC [redacted] b(6)-2

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad (RO) -- Safety Strap (RO) = = = Tourniquet (RO)

10. COUNTS — C = Correct I = Incorrect

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

b(6)-2

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

[redacted] b(6)-4

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

☒ ESU NO: #3
GROUND PAD: BRAND Valleylab
LOT NO: 69671

☐ 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
Bacitracin ointment	OS	intraop	topical	[redacted]	Dr [redacted]
					b(6)-2

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

OTHER ORDERS	TIME	CARRIED OUT BY
[redacted]		

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

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 3/8" Penrose	2.	3.
SITE	1. left leg	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs, DDD, Kelly, Ace – Left [redacted]
Fluffs, Kelly, Ace – Left leg

19. ADDITIONAL INFORMATION
Surgeons – Dr [redacted] Dr [redacted] Dr [redacted], Dr [redacted]
Anesthesia – CPT [redacted] / CPT [redacted]
b(6)-2

#8 continued – Repaired left eyelid, eyelashes & surrounding tissue between points – CPT [redacted]

20. OPERATION(S) PERFORMED
① Closure of Facial Lacerations ② I&D left Arm ③ I&D ⓛ leg ④ Ruptured Globe Repair OS
⑤ Repair upper lid & lower lid OS ⑥ I&D ⓡ hand / shoulder

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU-[redacted]	0330	Litter

22. REGISTERED NURSE SIGNATURE [redacted]

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

For use of this form, see AR 40-407, the prop[illegible]t agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Gurney BY Anesthesia

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

3. DATE 21 Aug 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME NUMBER 2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

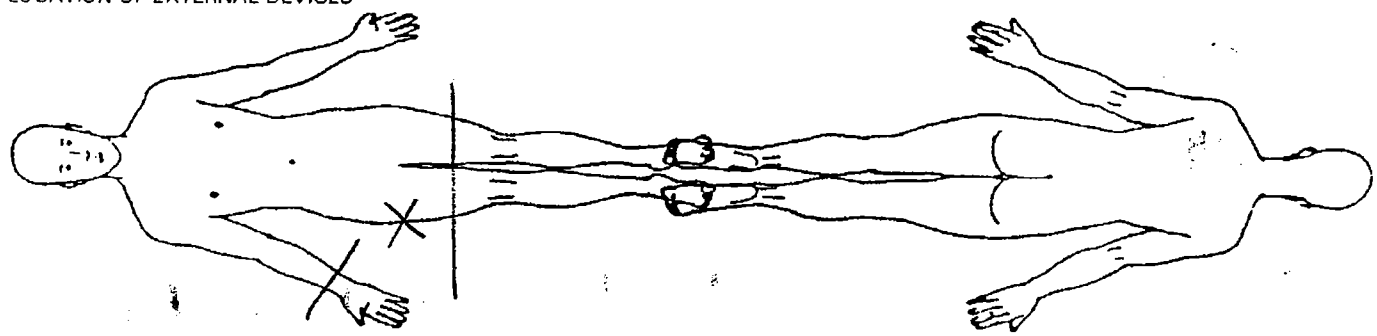
COMMENTS:

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine soap/sol.
SITE: Lt. arm BY WHOM: LTC [redacted] b(6)-2
SITE: BY WHOM:
COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



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

b(6)-2

C = Correct I = Incorrect

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

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

#[redacted]
b(6)-4

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

☒ ESU NO: Valleylab Force 2 #3
GROUND PAD: BRAND Polyhesive REM
LOT NO: 68936

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

cut: 30 coag: 30

DA FORM 5179-1, OCT 87 REPLACES D[illegible] [illegible]CH IS OBSOLETE. USAPA V1.00

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NaCl -

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE [redacted]

15. X-RAY IN 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. 1/2" penrose	2.	3.
SITE	1. ~~the~~ wound Lt arm	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

fluffs
kerlix
webril
splint
ACE

19. ADDITIONAL INFORMATION

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

Anesth: LTC [redacted] CRNA

20. OPERATION(S) PERFORMED

21. PATIENT TRANSFERRED TO	TIME	METHOD
b(6)-2 ICU	1130	via Gurney b(6)-2

22. REGISTERED NURSE SIGNATURE

[redacted] LTC, AN [redacted] Maj AN

21 AUG 03

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR August 2003 DAY 24

19 HOUR 1400 1500 1820

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

Record special data only when so ordered

BLOOD PRESSURE

HEIGHT: WEIGHT →

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

REGISTER NO.

WARD NO.

Civ[redacted]

b(4)-24

VITAL SIGNS RECORDS

Medical Record

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

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted] b(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, M: b(6)-4 [redacted]	DATE 19Aug	TIME 2000	SSN/PSEUDO SSN: [redacted] b(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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: [redacted] b(6)-2	DATE: 19 Aug 03	LAB ID NO.:

i-STAT 6+

Pt: [redacted] b(6)-2

Pt Name:_____

Glu_____183 mg/dL

BUN_____14 mg/dL

Na_____140 mmol/L

K_____4.0 mmol/L

Cl_____109 mmol/L

Hct_____24 %PCV

Hb*_____8 g/dL

*via Hct

Sample Type_:

19AUG03 20:05

Oper: [redacted] b(6)-2

Physician:_____

Ser# [redacted]

Ver: JAM5046A
CLEW A93

---

i-STAT CREA

Pt: [redacted]

Pt Name:_____

Crea_____1.0 mg/dL

Sample Type_:

19AUG03 20:04

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAM5046A
CLEW A93

ID [redacted] 19-AUG-03
20:00

			Patient Limits	
WBC	21.6 H	x10^3/uL	4.5	10.5
RBC	3.25 L	x10^6/uL	4.00	6.00
HGB	9.8 L	g/dL	11.0	18.0
HCT	30.4 L	%	35.0	60.0
MCV	93.5	fL	80.0	99.9
MCH	30.1	pg	27.0	31.0
MCHC	32.2 L	g/dL	33.0	37.0
PLT	289.	x10^3/uL	150.	450.
LYM%	11.5 * L	%	20.5	51.1
LYM#	2.5 *	x10^3/uL	1.2	3.4

29/m 86 Kg NKDA

MEDICAL RECORD - ANESTHES

...of this form, see AR 40-66; the proponent age... the OTSG

VOLTAREN. Ø PSH (-) PMH.

DRUG (Units)													
Versed (mg)		2											
Fentanyl (mcg)		100			50					50			
Propofol (mg)		100											
Sch (mg)		100											
Nimbex (mg)			10		4		10				10		
Neostigmine (mg)			150				100						
VOLAT AGENT	ISO % del		0.4	0.4	.6	.6	.6	.6	.8	0.8	0.8	.8	.8
	% e.t.												
AIR L/Min													
N2O L/Min													
O2 L/Min		8	2	2	1	1	1	1	1	1	1	1	1

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

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

TOTALS	TOTAL EBL
2	350
200	
TOTAL URINE	
800	

FLUIDS - SUMMARY
CRYSTALLOID- 6400
COLLOID-
BLOOD- 4 UNITS

FLUIDS — LINE site: ☐ Warmed
LR 14ga ☒ Warmed — 1000 / 2400 / 3000 / 5200
LR 18ga ☒ Warmed — 500 / 1500 / 1600
☐ Warmed

LOSSES: EST BLOOD LOSS 100 / 200 / 100/200 / 150/350
URINE - 50 / 80/100

REMARKS — Code drugs with numbers, events with lettters

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 86 KG LB

HEMATOCRIT:

INITIAL DATA: BP- / HR-

EQUIP CHECK: OK?- Y N

PATIENT RECHECK: OK for PROCEDURE? Yes TIME- 2355

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

TIME 1945 2000 2015 2030 2045 2100 2115 2130 2145 2200 2215 2230 2245 2300 2315 2330

2145 PRBC II [redacted]
2130 PRBC [redacted]
2205 PRBC [redacted]
2210 Ca++ 100mg IV.
2220 Anesef 20mg
2230 PRBC II [redacted]

VENTIL

VT - ml			760	700	710	690	710	700	700	730	730	710	700
f - breaths/min			12	8	10	10	10	16	11	11	11	11	12
Peak inf pres / PEEP			18	18	18	17	18	18	18	19	18	18	19
MODE - S(pon), A(ssist), C(on)		S/A/C	C	C	C	C	C	C	C	C	C	C	C
BP/Auto Cuff	ET CO2 (torr)		32	39	35	39	39	34	34	34	36	36	34
BP/oth	FIO2 (Frac or %)	72	.75	.63	.62	.62	.61	.61	.62	0.62	.66	.66	.66
ART line	SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	OR	ST	ST	ST	ST	ST	ST	ST	ST	ST	ST	ST
Gas analyzer	TEMP-site		Axill										
	N-M Block (T/4)		4/4	4/4	4/4	0/4		0/4	0/4	0/4	—	0/4	—
Warming blkt													
Conv warmer													

MONITORS/ACCESSORIES

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

RECOVERY AT 0320
PACU ICU 3 (Specify)
OTHER
CONDITION: Vital 96.8
RESP- 17 SpO2- 99
BP- 140/88 HR- 126

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	2020	2050	0330
	Ready	Begin	End
PROC	2100	2110	0260

PROCEDURES and CPT Codes: FACIAL
(L) ARM ABDOMINAL

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GATA

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

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
PRA-O2 5min 100% FIO2, RSI E Cricoid. OLT mic 2 Grade II View 8.0 ETT Placed ETCO2 @ lips (+) BBS (+) PRC

SURGEONS: [redacted]

ANESTH... [redacted] b(6)-7
STA... [redacted]

PROCEDURE LOCATION: ORC
DATE: 19AUG05
PAGE 1 OF 3

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

MEDCOM - 17788

MEDICAL RECORD - ANESTHESI

...f this form, see AR 40-66; the proponent ager... ...HE OTSG

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

DRUG (Units)													TOTALS
Versed (mg)	1										1	1	3
Fentanyl (mcg)		50											50
Nimbex (mg)		10			20					10			
( )													
( )													
Neostigmine (mg)		100				100							
VOLAT AGENT ISO % del	.8	.4	.6	.6	.6	.4	.6	.6	.8	.6	.6	.4	
% e.t.													
AIR L/Min													
N2O L/Min													
O2 L/Min	1	1	2	3	3	3	3	3	4	4	4	4	

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

TOTAL EBL

TOTAL URINE

FLUIDS SUMMARY

CRYSTALLOID-

COLLOID-

BLOOD-

FLUIDS

LINE site												
LRM	☐ Warmed											
LRM	☒ Warmed	320					4000					4800
LRB	☒ Warmed	1500					1700					1500
	☐ Warmed											

LOSSES

EST BLOOD LOSS	350											
URINE -	400/700											

REMARKS

Code drugs with numbers, events with lettters

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT 86 KG LB

HEMATOCRIT

INITIAL DATA

BP-

HR-

EQUIP CHECK OK?- Y N

PATIENT RECHECK OK for PROCEDURE? yes TIME- 2355

TIME → 2345 2400 30 0100 30 0200 30

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

VT - ml	750	760	780	810	800	800	740	750	750	800	740	760
f - breaths/min	12	12	12	12	12	12	12	12	12	12	12	12
Peak inf pres / PEEP	19	18	18	19	18	18	18	18	18	20	19	19
MODE - S(pon), A(ssist), C(on)	C	C	C	C	C	C	C	C	C	C	C	C

MONITORS/ACCESSORIES

BP/Auto Cuff — ET CO2 (torr)	35	36	34	33	34	34	35	35	35	36	36	36
BP/oth — FIO2 (Frac or %)	68	69	65	65	65	65	69	70	70	65	65	65
ART line — SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES — ECG	ST	ST	ST	ST	ST	ST	ST	ST	ST	ST	ST	ST
Gas analyzer — TEMP-site	AVAILABLE											
N-M Block (T/4)	0/4	2/4	0/4	0/4	1/4	0/4	0/4	0/4	0/4	0/4	0/4	0/4
Warming blkt												
Conv warmer												

RECOVERY AT

PACU ICU ____ (Specify)

OTHER ____

CONDITION:

RESP- SpO2-

BP- HR-

ANESTHESIA/PROCEDURE TIMES

ANES	Start	Room	End
PROC	Ready	Begin	End

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

PROCEDURES and CPT Codes: (D) ARM (L) Fed / Facial trauma / OPMX Glass

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

th [redacted] b(6) -4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* See pb #1

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

SURGEONS: [redacted]

ANESTHETIST: [redacted] b(6) -2

PROCEDURE LOCATION: ORR

DATE: 19 AUG 03

PAGE 2 OF 3

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

MEDCOM - 17789

MEDICAL RECORD - ANESTHESI

... of this form, see AR 40-66; the proponent agen... the OTSG

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

DRUG	(Units)	
Vecuronio	(mg)	10
	( )	
	( )	
	( )	
	( )	
	( )	
VOLAT AGENT 1.80	% del	.6
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	

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

FLUIDS

LINE site		
UR 14g	☐ Warmed	5000
UR 18g	☐ Warmed	1800
	☐ Warmed	
	☐ Warmed	

LOSSES: EST BLOOD LOSS; URINE -

TOTALS: TOTAL EBL; TOTAL URINE

FLUID SUMMARY: CRYSTALLOID-; COLLOID-; BLOOD-

REMARKS

Code drugs with numbers, events with lettters

0528 To ICU #3 intubated

VGS. @ 1635

@ 1800 CO2.

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 80 KG / LB

HEMATOCRIT:

INITIAL DATA: BP- / HR-

EQUIP CHECK: OK?- Y N

PATIENT RECHECK: OK for PROCEDURE? yes TIME-

TIME → 0245 0500 · 30 · 0400 · 30 · 0500 · 30

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

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

VENTIL

VT - ml	690
f - breaths/min	12
Peak inf pres / PEEP	19
MODE - S(pon), A(ssist), C(on)	C

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	36
BP/oth	FIO2 (Frac or %)	66
ART line	SpO2 (%)	100
Steth- PC/ES	ECG	ST
Gas analyzer	TEMP-site	Axillary
	N-M Block (T/4)	0/4
Warming blkt		
Conv warmer		

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

RECOVERY AT: PACU ICU ____ (specify) OTHER ____

CONDITION:

RESP- SpO2

BP- HR

ANESTHESIA/PROCEDURE TIMES

	Start	Room	End
ANES			
PROC	Ready	Begin	End

PROCEDURES and CPT Codes: See PG #2

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

#[redacted] b(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* See PG #

SURGEONS:

[redacted] b(6)-2

PROCEDURE LOCATION: OR

DATE: 19 AUG 03

PAGE 3 OF 3

DA FORM 7389, FEB 1998

MEDCOM - 17790 [redacted] PATIENT'S MEDICAL RECORD

USAPA V1.00

NKA

MEDICAL RECORD - ANESTHESI

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. "1" = CONSTANT INFUSION

DRUG (Units)		05	X	30	X	10	X	30	X	11	X
Versed (mg)	2										
Propofol (mg)	100										
Fentanyl (mcg)	50										
Ketamine (cc.)	2			1	1 1				1	1 1	
Robinul (mg)				MORPHINE mg				3	3 4		
Neostigmine (mcg)		50/50									
VOLAT AGENT — Sevo % del	X2-5-1	—	1.5 —	1.5 —	1.5 —	1.6 —	1.6 —	1.6 —	1.5 —	1.5 —	1.2 X
% e.t.											
AIR L/Min											
N2O L/Min											
O2 L/Min	6 —	2 —	2 —	2 —	2 —	2 —	2 —	2 —	2 —	2 —	4
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS →											

TOTALS	TOTAL EBL
2	100
	TOTAL URINE
8	
10	500

FLUIDS - SUMMARY

CRYSTALLOID- LR 1700

COLLOID- Ø

BLOOD- Ø

FLUIDS

LINE site RA											
☐ Warmed	4/90 —	5000 —	1000 —		1100 —			1200 —		1400	
☐ Warmed											
☐ Warmed											
☐ Warmed											

LOSSES

EST BLOOD LOSS											
URINE -											

PHYS STATUS 1 (2) 3 4 5 E

BODY WEIGHT: 86 (KG) LB

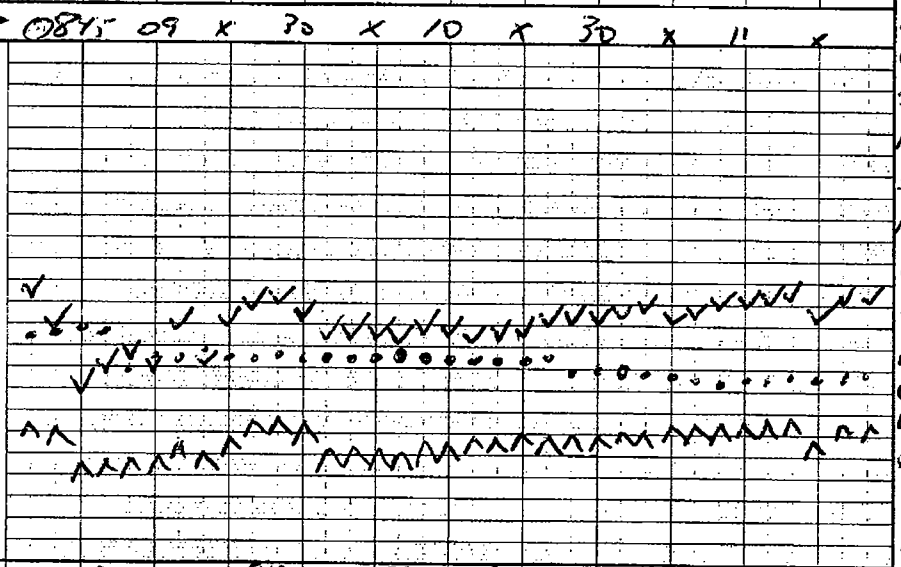
HEMATOCRIT:

INITIAL DATA: BP- 120/3 122 169 HR- 104

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? Y/N TIME- 0820

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



VENTIL

VT - ml		890	830	880	870	890	950	780	760		470
f - breaths/min		8	8	8	8	8	8	8	6	22	19	17
Peak inf pres / PEEP		23	23	23	23	23	27	23	22			
MODE - S(pon), A(ssist), C(on)	SA	C	C	C	C	C	C	C	C	S	S	S

MONITORS/ACCESSORIES

X BP/Auto Cuff	X ET CO2 (torr)	7	34	33	32	31	30	28	29	32	41	47	49
BP/oth	X FIO2 (Frac or %)	.7	.7	.7	.7	.7	0.7	.7	.7	.7	.7	.7	.7
ART line	X SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES	X ECG	ST	ST	ST	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site												
	X N-M Block (T/4)	4/0	0	0	4	+ TRS ∅ FADE							
Warming blkt													
Conv warmer													

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

REMARKS

Code drugs with numbers, events with lettters

Prep PIV NPO
Emergency Airway
Set-up OR
O2, monitors
5min deN2
Propofol, Sevo
SV, OPA, shell
Rocu, Zem, Sux
DLX1 gel lmi
Intic sense
prep/drape
okay/split on
OP section SV
epidural under
OHA
LUE Tron @ 250
↑ @ 0916
↓ @ 1112
116 min TT.

RECOVERY AT 1130

PACU (ICU) #3 (Specify)

OTHER

CONDITION:

RESP- 14 SpO2- 100% RA
BP- 111/63 HR- 107

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0820	0835	1145
	Ready	Begin	End
PROC	0850	0910	1125

PROCEDURES and CPT Codes: Washout, Flex Tendon, OR

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

[redacted] b(6)-2

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
DLX 1, gel I mid, 3mA. 7.0 & TT + ETC2

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
BS - B.

SURGEONS: [redacted] b(6)-2

AN[redacted]

PROCEDURE LOCATION: OR2

DATE: 21 APR 07

PAGE 1 OF

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 27 DAYS MOS (YRS) Sex (✓) MALE ( ) FEMALE

PROPOSED PROCEDURE: I:D (L) Humerus Repair RAT Tech
SURGICAL SERVICE: ORTHO
NPO SINCE: 7. MN

hoji civil.

ASA Physical State 1 (2) 3 4 5 (E)
WT: 86 (KG/LB) HT: ____ IN
ALLERGIES: Ø

HABITS:
TOBACCO: ____
ETOH: ____
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) Fentanyl
( )
( ) Tylenol
( )
( ) Ancef
( )

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

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

86
24

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT
PAST SURGICAL/ANESTHETIC
15 Aug Forearm bone Repair of Ruptured Artery
extub. 20 Aug on RA O_2

PHYSICAL EXAMINATION
BP 107/67 HR 92 R 14 T ____
Pain Scale 0-10 ____ SO_2 99% on RA
HEENT - Teeth ____
Trachea ____
TMJ/Neck ____
Oropharnyx ____
Nares ____
CHEST: ____
CARDIAC: ____
EXTREMITIES: ____
IV Access: ____
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since ____

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

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

pt Speaks english

The patient/legal guardian seems to understand and agrees. Questions answered.
Signed: [redacted] Date: 21 Aug 03 Time: 0800 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) Icu #3

#[redacted] b(u) -4

[redacted]

SEDATION KEY:

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

MEDICAL RECORD	BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

- [x] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of ____ units)*
- [ ] CRYOPRECIPITATE *(Pool of ____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* ____

VOLUME REQUESTED *(If applicable)* ____ ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED: 19 Aug 03

DATE AND HOUR REQUIRED: ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: ____

HEMOLYTIC DISEASE OF NEWBORN? ____

REQUESTING PHYSICIAN *(Print)*: b(6)-2 [redacted]

DIAGNOSIS OR OPERATION [redacted]

Shrapnel

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER

DATE VERIFIED: Sept 01 1993

TIME VERIFIED: 518

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. b(6)-2 [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR — ABO: A — Rh: pos

RECIPIENT — ABO: A — Rh: pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	Comp

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [x] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: [redacted]

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE: 19 Aug 03

REMARKS: Exp 26 Aug 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*: [redacted] b(6)-2

AT *(Hour)*: 2112 ON *(Date)*: 19 Aug 03

IDENTIFICATION:

I have [redacted] Blood Component container label and this form and I find a[redacted] identifying the container with the intended recipient ma[redacted] the recipient is the same person named on this Blood [redacted]sion Form and on the patient identification tag.

[redacted] *(Signature)*: [redacted] b(6)-2

[redacted] *(Signature)*: [redacted]

PRE-TRANSFUSION

TEMP. ____ PULSE 109 BP 101/56

DATE OF TRANSFUSION: 19 Aug

TIME STARTED: 2115

POST-TRANSFUSION DATA

AMOUNT GIVEN: 1 unit ML

TIME COMPLETED: 2130 DATE COMPLETED: 8/19/03 INTERRUPTED

REACTION

- [x] NONE
- [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER ____

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

- [ ] NO
- [ ] YES *(Specify)* ____

[redacted] PERSON NOTING ABOVE: b(6)-2

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written e[redacted] NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

[redacted]

b(6)-4

SEX: M

WARD: OR

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDICAL RECORD COPY

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

- [x] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)* _____ ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [x] TYPE AND SCREEN
- [ ] CROSSMATCH

DATE REQUESTED: 19 Aug 03

DATE AND HOUR REQUIRED:

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* b(6)-2 [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE: Shrapnel

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct. [signature]

SIGNATURE OF VERIFIER [redacted]

DATE VERIFIED: 19 Aug 03 b(6)-2

TIME VERIFIED: 2000

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. b(6)-2 [redacted]

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION	
ANTIBODY SCREEN	CROSSMATCH
N/A	Comp

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [x] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST b(6)-2 [redacted]

DONOR ABO: A Rh: pos

RECIPIENT ABO: A Rh: pos

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 19 Aug 03

REMARKS: Exp 26 Aug 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* [redacted] b(6)-2

AT *(Hour)* 2112 ON *(Date)* 19 Aug 03

IDENTIFICATION

I have [redacted] nent container label and this form and I find all info[redacted]er with the intended recipient matches item by item. [redacted]ned on this Blood Component Transfusion Form and [redacted] b(6)-2 [redacted] CRNA

2[redacted] CRNA

PRE-TRANSFUSION

TEMP. PULSE 109 BP 101/56

DATE OF TRANSFUSION 19 AUG 03 TIME STARTED 2150

POST-TRANSFUSION DATA

AMOUNT GIVEN 1 unit ML

TIME/DATE COMPLETED/INTERRUPTED 2145

REACTION

- [x] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
	124	95/55

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER [redacted]ES *(Equipment, clots, etc.)*

[redacted] YES *(Specify)*

[redacted] ABOVE b(6)-2

[redacted] 4PT, AN, CRNA

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—[redacted]; grade; rank; rate; hospital or medical facility)

SEX M WARD SMT

[redacted]

b(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 17794

Medical Record Copy

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

b(6)-2

COMPONENT REQUESTED *(Check one)*

- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of ____ units)*
- [ ] CRYOPRECIPITATE *(Pool of ____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* ____

VOLUME REQUESTED *(If applicable)* ____ ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [X] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED: 19 Aug 03

DATE AND HOUR REQUIRED: 19 Aug 03 2110 STAT

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: ____

HEMOLYTIC DISEASE OF NEWBORN? ____

REQUESTING PHYSICIAN *(Print)* [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE: trauma / facial-arm Lac.

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. b(6)-2 [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR ABO: A Rh: POS

RECIPIENT ABO: A Rh: POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	Comp

PREVIOUS RECORD CHECK: [ ] RECORD [X] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: b(6)-2 [redacted]

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED | DATE 19 Aug 03

REMARKS: Exp 26 Aug 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION

INSPECTED AND [redacted] b(6)-2

AT *(Hour)* 2201 ON *(Date)* 19 Aug 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)* [redacted] LPN CNA

2nd [redacted] b(6)-2

[redacted] TRANSFUSION

TEMP. PULSE 129 BP 83/45

DATE OF TRANSFUSION 19 AUG 03 TIME STARTED 2205

POST-TRANSFUSION DATA

AMOUNT GIVEN 1 unit ML TIME DATE COMPLETED 2224 19 AUG 03 INTERRUPTED

REACTION [X] NONE [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION

[ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN

[ ] OTHER ____

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

[X] NO [redacted] [ ] YES *(Specify)* ____

SIGN[redacted] PERSON NOTING ABOVE b(6)-2 LPN, CRNA

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

[redacted] b(6)-4

SEX M WARD OR

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDICAL RECORD COPY

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

- [x] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of ____ units)*
- [ ] CRYOPRECIPITATE *(Pool of ____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* ____

VOLUME REQUESTED *(If applicable)* ____ ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [x] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED: 19 Aug 03

DATE AND HOUR REQUIRED: 19 Aug 03 2110 STAT

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: ____

HEMOLYTIC DISEASE OF NEWBORN? ____

REQUESTING PHYSICIAN *(Print)* b(6)-2 [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE: trauma / facial-arm Lac

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER: [redacted]

DATE VERIFIED: 19 Aug 2003

TIME VERIFIED: [redacted]

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO. b(6)-2

PATIENT NO. [redacted]

DONOR: ABO A; Rh POS

RECIPIENT: ABO A; Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
MA	Comp

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [x] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: [redacted] b(6)-2

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE: 19 Aug 03

REMARKS: Exp 26 Aug 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AN[redacted]A

[redacted] b(6)-2

AT *(Hour)* [redacted] ON *(Date)* 19 Aug 03

IDENTIFICATI[redacted]

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)* [redacted] LTC CRNA b(6)-2

[redacted] *(Signature)*

[redacted] CPT, AN, CRNA

TEMP. ____ PULSE 111 BP 111/71

DATE OF TRANSFUSION: 19 AUG 03

TIME STARTED: 2230

POST-TRANSFUSION DATA

AMOUNT GIVEN: 1 unit ML

TIME: 2240 DATE: 19 AUG 03 COMPLETED ____ INTERRUPTED ____

REACTION

- [ ] NONE
- [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER ____

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

- [x] NO
- [ ] YES *(Specify)* ____

[redacted] PERSON NOTING ABOVE b(6)-2

[redacted] CPT, AN, CRNA

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

[redacted] b(6)-4

SEX: M. WARD: OR

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDICAL RECORD COPY

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 | HOURS | LIST TIME ORDER NOTED AND SIGN

Admit ICU 3
Dx: Repair facial lacs
Repair ruptured globe
Condition fair
Vitals: q1
Activ. Bed Rest
Nursing: foley in place

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

Diet Adv as tolerated
All NPO
IV SQ/LR
Meds: Ancef 1gm q12°
Pred Acetate 1% 1 gtts OS q2°
Ocuflox 1 gtts OS qid
Eryth ophth oint to eyelid wounds bid

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

Bacitracin to other wounds bid

Meds: ~~Morphine~~
Fentanyl 1-5 µ/kg/hr prn
paid titrate for pain

Vent - to be modified by anesth/nursing

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER

[redacted] continue

Versed 1-5 mg/hr
titrate for sedation

[redacted]

Vent: 700, 5 imv 15, [redacted] continue
Peep 5, Wean FIO2 for Sat > 95.

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

[redacted] b(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

II [redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 20AUG03 TIME OF ORDER: 0711 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Hold sedation / Fentanyl @ 0800.
2. Extubate his [redacted]

[redacted] b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 8/20/03 TIME OF ORDER: 2300 HOURS

- NPO now
- on call to OR in AM

[redacted] b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 8/20/03 TIME OF ORDER: 2330 HOURS

tylenol 625 mg po q4h°
5 tsp of Hz0 [redacted] b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 21 AUG03 TIME OF ORDER: HOURS

- Resume preop orders, meds, activities
- Regular Diet
- Percocet 1 po q4° prn [redacted]
- MSO4 2mg IV q1° prn [redacted]
- phenergan 25mg IVQ6° prn nausea
- Ancef 2gm IVPB q8°

[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: 1986—409-924

"USE BALL POINT PE[illegible] 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: [redacted] b(6)-4

DATE OF ORDER: 8/24/03 TIME OF ORDER: 2045 HOURS

LIST TIME ORDER NOTED AND SIGN

(6) Remove dressing & leave tomorrow evening & leave wounds open to air b(6)-2 [redacted]

Noted 24Aug03 2045 [redacted]

NURSING UNIT: b(6) ROOM: [redacted]

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

DATE OF ORDER: 25 AUG 03 TIME OF ORDER: 1309 HOURS

1. LUE - splint to stay on. No dressing Δ.
2. Remove staples (R) shoulder/hand
3. Bactrim (R) shoulder/hand/antecubital skin x 5 days. [redacted]

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

b(6)-2 [redacted]

PATIENT IDENTIFICATION:

DATE OF ORDER: 25 AUG 03 TIME OF ORDER: 1320 HOURS [redacted]

AMBIEN 10mg PO qhs PRN insomnia [redacted]

b(6)-2 [redacted] HC, MC, US Army [redacted]

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

24° chart ✓ [redacted] 91W MC 26Aug03 0720 [redacted]

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

DATE OF ORDER: 26Aug03 TIME OF ORDER: 0643 HOURS

(1) Discharge to Jordan. [redacted]

Noted 26Aug03 [redacted]

NURSING UNIT: ROOM NO.: BED NO.: b(6)-2 [redacted]

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

b(a) - 2 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 20	21	22	23
20 Aug 03	[redacted]	Vitals q 2°	06	[redacted]			
			18	[redacted]			
			X	[redacted]			
20 Aug	[redacted]	Activity: Bed rest	06	[redacted]			
			18	[redacted]			
			X				
		Nursing:					
20 Aug	[redacted]	Foley in Place	06	[redacted]			
			18	[redacted]			
			X	[redacted]			
20 Aug	[redacted]	Diet as tolerated	06	[redacted]			
		(Regular)	18	[redacted]			
21 Aug	[redacted]	Ancef 1g IVPB Q8°	08	[redacted]			
			16	[redacted]			
			24	[redacted]			

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS: Eye Condition
Repair Facial Laceration,
Repair Ruptured Globe

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 77 MAY BE USED. — USAPA V1.00

b(6)-2 All

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
20 Aug	[redacted]	Admit to ICU 3	20 Aug			
20Aug03	[redacted]	NPO NOW	20 Aug03	2300	2300	[redacted]
20Aug03	[redacted]	ON CALL to OR in AM	20Aug03	2330	2300	[redacted]
21 Aug	[redacted]	Resume pre-op orders, meds,	21 Aug	1200	1200	[redacted]
	[redacted]	activities, regular diet				
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					

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

USAPA V1.00

Queen Street Non-Medical Sheet 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. ____ Yr. ____

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 22	23	24	25	26
22Aug03	[redacted]	VS routine	08	[redacted]				
23Aug03	[redacted]		19					
22Aug03	[redacted]	Bedrest	05					
			19					
22Aug	[redacted]	Foley to gravity	05					
			19					
22Aug	[redacted]	Clear diet Advance	05					
8/23	[redacted]	as tol. Regular.	19					
8/23	[redacted]	Act. Bed-libc assist.	06	X	X			
			14	X				
			22	X				
8/23	[redacted]	Cleanse/Bacitracin + facial closures q shift	06	X	X			
			14	X				
8/24	[redacted]	Include abrasions	22	X				
25	[redacted]	Include (R) shoulder/hand and AC area						
23	[redacted]	Δ drsgs LUE/LLE q shift	06	X	X			
			14	X				
			22	X				
24Aug	[redacted]	Elevate LUE on pillow or sling	06					
			14					
			22					
			06					
		Error [redacted]						
24Aug	[redacted]	Remove dressi						

Changed 25Aug03 [redacted]

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: Blast wounds / Facial lacs, LUE, LLE inj

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

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

b(6)-2 A-11

(Green sheet)

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
22Aug	[redacted]	To ICU2	22Aug03	1030	1030	[redacted]
22Aug	[redacted]	Condition Stable	22Aug03	1030	1030	[redacted]
8/23	[redacted]	TX to ICW # 2 ; cond good	8-23	1618	1618	[redacted]
24Aug	[redacted]	Remove dressing (L) Knee tomorrow evening	25Aug	2000		
	-----	& leave wounds open to air				
25	[redacted]	LUE - splint to stay ON - NO DSG Δ	25Aug	1309	muted	[redacted]
25	[redacted]	Remove staples (R) hand / shoulder	25Aug	1309	1330	[redacted]

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

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) 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 ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 20	21	22	23
20 Aug 03	[redacted]	IV LR 50cc/hr	00	[redacted]			
	.....	b(6)-2	18				
	.....		X				
20 Aug.	[redacted]	Ancef 1 gm q12°	0	[redacted]	DC'ed		
	.....		10				
	.....		X				
	.....	Pred Acetate 1%	00	[redacted]			
	.....	1 gtts OS q2	08				
	.....		10				
	.....		1				
	.....		14				
	.....		10				
	.....		18				
	.....		20				
	.....		22				
	.....		24				
	.....		02				
	.....		04				
	.....		X				
20 Aug	[redacted]	Acuflex 1 gtts OS	0	[redacted]			
	.....	QID	12				
	.....		18				
	.....	b(6)-2	2				
	.....		X				
20 Aug	[redacted]	Erythromycin opth	0	[redacted]			
	.....	ointment to eyelid	16				
	.....	wounds BID	X				

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: b(6)-2

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

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. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 20	21	22	23	24
20 Aug 03	[redacted]	Bacitracin to other	04	[redacted]				
	.....	wounds BID	16	[redacted]				
	.....		X	[redacted]				
	[redacted]	Fentanyl 1-5 u/kg/hr	06	[redacted]				
	.....	prn pain titrate	18	[redacted]				
	.....	for pain	X					
	.....		X					
20 Aug	[redacted]	Versed 1-5 mg/hr	06					
	.....	titrate for sedation	18					
	.....		X					
20 Aug 03	[redacted]	Vent: 700, SIMV 13,						
	.....	Peep 5, Wean FIO2						
	.....	for sat > 95						

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Repair Facial Laceration
Repair Ruptured Globe.

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

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

Verify by Initialing	...RAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo._____ Yr. 2003

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
21 Aug	[redacted]	Percoat 2 tabs	D												
.....	[redacted]	po q4° prn	T												
.....	.....		I												
21 Aug	[redacted]	MSO4 2mg IV q1°	D												
.....	.....	prn Breakthrough	T												
.....	.....		I												
21 Aug	[redacted]	Phenergan 25mg	D												
.....	[redacted]	IV q6° prn nausea	T												
.....	.....		I												
21 Aug	[redacted]	Tylenol 625mg	D												
.....	.....	po q4-6° ō sip f	T												
.....	.....	Ad	I												
.....	.....														

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. ___ Yr. ___

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 22	23	24	25	26									
22Aug03	[redacted]	Bactrach to wounds	10	10:24 AM													
		BID	22	22 ME													
22Aug03	[redacted]	IV LR @ 125 cc/hr	07	[redacted]													
			19														
22Aug03	[redacted]	Ancef 1gm IVPB	06														
		q8°	14														
			22														
22Aug03	[redacted]	Erythromycin opth	10														
		ointment to suture	22														
		lashes around (L)															
		eye lid BID															
22Aug	[redacted]	Bacitracin topical ointment	10														
		to facial sutures BID	22														
8-23	[redacted]	Erythromycin Opth.	06	X	X	[redacted]											
		Oint. (L) eye closure	14	X	X												
		shift.	22														
8-23	[redacted]	Keflex 500mg PO TID	08	X	X	[redacted]			X		X						
		X5days	16	X	X												
			24	X	U	U	U	X									
8-24	[redacted]	Afrin Nasal spray ii	10	/	/	[redacted]		3	4	5	/						
		each nostril BID x	22	/	/						/						
		5days															

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: Blast Wounds / Facial laco. LLE/LUE inj.

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

b(6)-2

[redacted]

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

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED														
22Aug 8:25	[redacted]	Tylenol 650 mg po	22 Aug 1630	23 Aug 0800			23 Aug 1720	24 Aug 0710	24 Aug 1440	24 Aug 1930	25 Aug 0320	25 Aug 1500	25 Aug 2000	26 Aug 0500			
		q 4° prn	[redacted]				[redacted]					[redacted]					
22Aug	[redacted]	Percocet 1-2 tabs	[redacted]	23 Aug 0800	23 Aug 2200	23 Aug 0500	23 Aug 0900	23 Aug 1330									
	[redacted]	po q 4-6° prn	[redacted]				[redacted]										
22Aug	[redacted]	MS04 2-6 mg															
		IVPq 2° prn															
24Aug 27Aug	[redacted]	Percocet 1-2 po q 4°															
		prn															
24Aug	[redacted]	Ambien 10mg PO															
		qhs PRN insomnia															

D/C'd.

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
INTENSIVE CARE NURSING FLOW SHEET

b(6)-2

OTSG APPROVED *(Date)*
QA APPR 08MAR8

INITIAL SHIFT ASSESSMENT

		Time: 0700 Initals: [redacted]	Time: Initals:
NEURO	Pupils	(R) reactive sluggish ? m[redacted]	
	Sensorium	(D) shut UTA	
	LOC / GCS	follows commands, moves all ext,	
		Versed 4mg fent 50 mcg	
CARDIAC	Cardiac Rhythm	S1 S2 / ST / Ø ectopy	
	PRI: / QRS:	↑2 pulses all ext ~~x~~ LUE (UTA	
	Pulse Strength	2° bulky dressing, cap refill <3sec	
	Cap Refil / JVD	all ext ~~x~~ LUE >4 sec	
	Edema	facial edema,	
	Chest Pain		
RESP	Respiratory Pattern	OTA bilat SIMV-13, TV-700,	
	Breath Sounds	P-5, 30%, PIP-21 22cm@	
	Secretions	Ett #8.0, small amt bloody	
	Cough	secretion from ETT, small amt bloody	
		from suctioner.	
SKIN	Color	warm for rec. multiple sutured	
	Integrity	lacerations (D) face, (R) shoulder	
	Backside	(D) arm fracture, (D) leg lacerations	
		(D) hand lacerations	
IV	Access Devices	(D) (R) hand, (R) AC PW	
	Location	Ø S/S of infiltration	
	Condition		
GI	Abdomen	+ BS x4 quad	
	Bowel Sounds	flat, NT, ND	
	Stoma/Ostomy		
GU	Device	foley, clear, light yellow	
	Color / Clarity		

(Continue on reverse)

b(6)-2

PREPAR[redacted] *Title)* CPT / [redacted]

DEPARTMENT/SERVICE/CLINIC (b)(2)-2 ICU3, [redacted]

DATE 20 Dec 03

PATIEN[redacted]IFICATION *(For typed or written entries give: Name – last, first, mi[redacted]e; date; hospital or medical facility)*

[redacted]

b(6)-4

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

DA FORM 4700, MAY 78

USAPPC V2.00

ICU3

Patients Name: [redacted] Date: 20 Aug 03

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	83	101	105	90	111	97	99	102	90	102	105	101		98		117/		105/		131/		123/		114/		
NBP	80	54	60	39	66	60	55	60	51	59	55	63		55		82		58		57		61		58		
TEMP		100.4		100		100.4					100.1					100.3		100.1		100.5		100.0		100.5		
HR	114	114	122	106	107	109	101	100	103	100	91	104		95		97		94		92		95		93		
RR	13	14	21	21	32	29	30	30	28	28	26	24		10		15		14		10		12		14		
SaO2	100	100	100	100	100	100	100	100	100	99	100	100		98		100		100		100		100		98		
FiO2	30	30	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA		RA												
Source	✓	✓																								
MAP				84																						

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	50	50	50	50	50	80	50	50	50	50	80	50		50	50	50	50	50	50	50						
IVPB		50														5	5	5								
NGT																										
PO																										
Total																										

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	200	50			100				250	80	50	100		100	150	200	80	200	220	150	150	100	150	200		
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 17810

ICU1

Patients Name: #[redacted] bed-2 Date: 23 Aug 03

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																										
NBP	79/53	74/55	96/61	104/59	90/60	109/61	102/51	100/60	104/57	103/50	100/59	103/57		93/56			100/65									
TEMP						99.6		98.8				99.4														
HR	94	85	92	89	81	93	86	92	104	89	99	86		109			94									
RR	12	16	14	17	14	12	15	14	18	14	17	11		24			12									
SaO2	99	97	98	98	97	99	97	99	98	96	100	97		99			96									
FiO2	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA		RA			RA									
Source																										
MAP	71	70	100	75	77	79	74	81	75	69	69	74		70												

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	125	125	125	125	125	125	125	125	125	125	125	125		125	125	125	125									
IVPB							50																			
NGT																										
PO	240								240																	
Total	365	490	615	740	865	990	1165	1290																		

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		275		350			300			350		400					1000									
NGT																										
STOOL																										
DRAIN																										
Total		275		1025			925			1275																

MEDCOM - 17811

MI[illegible] RECORD-SUPPLEMENTAL MEDIC[illegible]

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA APPR 08MAR8

INITIAL SHIFT ASSESSMENT

		Time: 0700 Initals: [redacted] b(6)-2	Time: 1900 Initals [redacted] b(6)-2
NEURO	Pupils	(L) shut VTA, (R) [redacted] sluggish	(L) Eye closed c̄ edema, (R) eye
	Sensorium	expresses needs appropriately	3 mm, responds to verbal
	LOC / GCS	asleep but awakens easily	stimuli, follows simple
			commands.
CARDIAC	Cardiac Rhythm	NSR/ST	NSR, S1 S2 normal
	PRI: / QRS:	+2 X3 ext	no ectopy/murmurs
	Pulse Strength	(L) VB: warm, pale, <3sec cap refill	noted.
	Cap Refil / JVD	(+) Color, motion, ↑ sensation	
	Edema	edema on injured area	
	Chest Pain	focal edema	
RESP	Respiratory Pattern	even and unlabored	RRR, non labored, 100%
	Breath Sounds	98% on RA	O2 sat on RA.
	Secretions		
	Cough		
SKIN	Color	multiple facial lacerations, (R)	NTR, c̄ abrasions & abrasions
	Integrity	shoulder, (R) hand, (R) leg	to face and body.
	Backside	(L) leg are wrapped	
		(L) arm are wrapped	
IV	Access Devices	(R) (R) AC PIV	CR, AC & NO S/S of
	Location	⊘ S/S of infxn	infection/infiltration.
	Condition		
GI	Abdomen	↑ BS X ↑ flat	(=) TRO, (+) BS x 4
	Bowel Sounds	flat, ND, NT	quadrants
	Stoma/Ostomy		
GU	Device	foley clear yellow	foley to gravity, QS
	Color / Clarity		Clear / yellow

(Continue on reverse)

PREP[redacted] & Title) b(6)-2 CPT/BN

DEPARTMENT/SERVICE/CLINIC ICU3[redacted] b(6)-2

DATE 21 Aug 03

PAT[redacted]N *(For typed or written entries give: Name – last, first [redacted] date; hospital or medical facility)*

[redacted]

b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

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

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

USAPPC V2.00

ICU3

Patients Name: [redacted]

Date: 21 Aug 03

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	102						122	114	113	108	110	114		122/				118/		119/53		119/	123/			
NBP	57						66	60	60	59	59	55		54				57				52	55			
TEMP	100.5						98.7											98.5		98.0		98.3				
HR	97						106	101	96	102	102	104		105				101		98		110	92			
RR	18						12	10	14	12	11	14		10				15		21		16	20			
SaO2	95						100	100	100	98	99	99		100				99		97		99	99			
FiO2																										
Source	PA						PA	PA	PA	PA	PA	PA														
MAP																										

NTAKE	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
F	50						50	50	50	50	50	50		50	50	50	50	50	50	50	50	50	50	50	50	
PB		100									NO															
GT																										
PO																										
Total																										

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
URINE							25	125	125	125	200	200		200	150	100	200	200	100	100	200	180	100	150	100
NGT																									
STOOL																									
DRAIN																									
Total																									

MEDCOM - 17813

L RECORD-SUPPLEMENTAL MED TA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT			
		Time: 1030 Initals: [redacted] b(6)	Time: Initals:
NEURO	Pupils	(L) eye = sutures No orbital. eye	
	Sensorium	sutured closed. (R) eye PERRL @ 2	
	LOC / GCS	mm. Pt Alert & oriented x3.	
CARDIAC	Cardiac Rhythm	NSR = ectopy noted. (L) radial	
	PRI: / QRS:	pulse unable to assess due to	
	Pulse Strength	cast (L) Arm & hand. CDI. Pt	
	Cap Refil / JVD	able to move (L) hand fingers	
	Edema	& able to feel sensations =	
	Chest Pain	fingers. (R) radial pulse (+)	
		Pedal pulses present bil.	
RESP	Respiratory Pattern	= rise & fall of chest bil. R 16	
	Breath Sounds	Clear bil.	
	Secretions	None @ present time.	
	Cough	No cough noted.	
			(cont. 1030)
SKIN	Color	W&D to touch. appropriate for race.	(R) ↑ Arm = staples CDI (R)
	Integrity	good	hand = staples CDI. open
	Backside	Sutures covering (L) face to scalp to	lesion on chin approx 2cm. Wound
		chin (L) ear to chin (L) neck CDI.	pinkered in center. [redacted]
IV	Access Devices	IV (R) AC = S/S of infiltration	(L) Knee DSG CDI. Mid Back area
	Location	or infiltration noted. IV LR @	pt has sore area approx @ 5cm
	Condition	125 cc/hr	long by 2cm wide. (R) lateral inner
			calf has sore area = scab forming
GI	Abdomen	Soft Non-distended	approx @ 3cm wide x 5cm long.
	Bowel Sounds	BS (+) in all 4 quads	edema noted to (L) Knee area
	Stoma/Ostomy		[redacted]
GU	Device	Foley to gravity = clear yellow	
	Color / Clarity	urine to foley bag.	

(Continue on reverse)

PR[redacted] b(6)-2 DEPARTMENT/SERVICE/CLINIC ICU #1, [redacted] b(2)-2 DATE 22 Apr 03

(Typed or written entries give: Name – last, first, [illegible] hospital or medical facility)

NAME [redacted] RANK: AGE: 29

UNIT: [redacted] b(6)-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

ICU Flowsheet Patient Name: [redacted] 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												99.7 A					100.5 A	100.5 A	100.5 A	100 A	99.8		98.7			
Pulse											92	88		91	91	101	[illegible]	98	94	94	90	85	83	85	81	
B/P A-Line																					76			73		
MAP											75	82		72	79	74	73	73	71	80	[illegible]	71	74	85	73	
B/P Cuff											103/59	109/65		108/65	105/55	106/62	103/51	108/54	99/54	101/62	100/57	104/52	108/54	102/54	99/55	
Respirations											17	15		16	18	16	12	23	20	25	18	14	17	16	14	
Sa02											99	99		99	98	98	[illegible]	99	98	99	98	99	98	99	99	
											RA	RA		RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	

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	125	125	
NPB																								50		
PO intake											60				60		60			500				240		
O.R. IN																										
Totals											185	310		435	1020	745	930	1055	1180	1805	1930	2055	2180	2595	2720	2720

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												550		350/900	125/125		350/1375			800/2175	500/2675		800/3000		350/350	3350
NG Tube																										
Drains #1																										
#2																										
#3																										
Emesis/Stool																										
O.R. OUT																										
Totals																										

24 hour input	
24 hour output	
24 hour balance	

MEDCOM - 17815

ADMISSION AND CODING INFORMATION

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

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

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

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
N/A	U	1950	N/A b(6)-4

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0	ICU3	Unk

[redacted] LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
[redacted]	Unk

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
Unk

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
21 b(6)-2		030826

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
A B A A		030819

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

FOR LOCAL USE

Dx: Repair Facial Lacerations
Repair Globe Rupture
Open (L) Humerous Fx
Open (L) Radius Fx

ADMITTING [redacted] as [redacted]ired) [redacted] b(6)-2

SIGNATURE OF ADMITTING CLERK [redacted] SPC 91B10

DA FORM [redacted]

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) [redacted] b(6)-2			3. GRADE N/A	ADMISSION REMARKS
4. SEX M	5. AGE 37	6. RACE UNK	7. RELIGION UNK	8. LENGTH OF STAY N/A	9. ETS N/A	10. PREVIOUS ADMISSION ND
11. FMP 9990	12. SSN [redacted]	13. ORGANIZATION N/A				14. WARD ICW3
15. FLYING STATUS N/A	16. RATING/DSG	17. DEPT./BEN ~~K76~~ K70	18. BRANCH/CORPS N/A	19. UIC/ZIP		20. TYPE CASE WIA
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION DIRECT FROM EMT				22. HOURS OF ADMISSION 1339	23. CLINIC SERVICE ABDA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK			25. TYPE DISPOSITION 05		26. DATE OF DISPOSITION 26AUG03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK			27b. TELEPHONE NO. UNK		28. DATE OF THIS ADMISSION 24AUG03	ADMITTING OFFICER b(6)-2 DR [redacted]
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b(2)-2					30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: MULTIPLE FACIAL AND LEFT UPPER EXTREMITY LACERATIONS.

DX: 8509
2765
3102
9190
924B
E993

Trauma
9

Injury
599

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	3	3

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	3	3

SIGNATURE OF ATT[redacted] 4797 PR. [redacted]

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER FOUR [redacted]

DA FORM 3[redacted] EDITION OF 1 AUG 78 IS OBSOLETE USAPPC V1.10

[redacted] b(6)-2

MEDICAL RECORD | 1330 | **ABBREVIATED MEDICAL RECORD**

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

37 y/o male UN employee injured in explosion 19AUG03, treated at Italian hospital, then discharged shortly thereafter. Pt returns today with unsteadiness, headache, photophobia, and anorexia.

PmH None.

ALL None.

Meds None.

PHYSICAL EXAMINATION

Face/Scalp - repaired lacerations.
Neck/back - nontender.
Chest/Abdomen - benign.
Extremities - multiple abrasions / no crepitance suggesting fracture.
Neuro - intact
Skin - ↑ turgor / dry mucosae suggesting dehydration.

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

Impression: (1) Mild-moderate concussion / Post-concussive syndrome
(2) Multiple abrasions + contusions.

Plan: (1) IVF / Pain Control.
(2) CXR / (L) humerus X-ray.
(3) CT Scan when suite available.

b(6)-2

PHYS[redacted]	4797	DATE 24AUG03	IDENTIFICATION NO.	ORGANIZATION
[redacted]ON (For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)			REGISTER NO.	WARD NO.

[redacted]

b(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
539-106

[redacted]

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
24 1400 Aug 03	NURSING NOTE: Pt arrived to ward via litter c difficulty. A AAOx3. Airway patent
T=96.8 P=71	breathing even and unlabored, LS CTA(B). Abd soft, nontender, c distention. BS(+)x4. Voids
RR=18 BP=120/61	spontaneously. EFAST and neurovascularly intact to all extremities. Abrasions and incisions to
SaO2=100RA	face w/ CDE. Bacitracin applied. Pt c/o sporadic photosensitivity, headache and dizziness. b(6)-2 [redacted]
	Physician notified.
24 1800 Aug 03	NURSING NOTE: Neurocheck: Pupils equal and reactive to light. (+) photosensitivity. (+) HA. [redacted]
	(+) Dizziness while lying in bed. Grips equal (B). Push-pull (+) and strong to (B)LE. [redacted]
24 2200 Aug 03	NURSING NEURO NOTE: AAOx3. Pupils equal and reactive to light. (+) photosensitivity. (+) HA. [redacted]
	(+) Dizziness while lying in bed. Grips equal (B)UE. Push-pull (+) and strong to (B)LE. [redacted]
2200 24 Aug	25 Aug 03 2330 Pt sleeping, easily b(6)-2
BP 111/61	arousable. PERRLA. Brisk pupillary
P 64	response to light. Pt c/o pain to (L) leg. c/o
T 98.2	slight photophobia. Scattered ecchymotic
R 18	areas to face healing. Lungs CTA bilat, ∅
SpO2 99%	resp distress. NSR. Abd soft, non-tender, bowel
25 Aug 0400	sounds active x4 quads. ∅ c/o dizziness
9/10 68	+3 strength & coordination to upper and
9/10 68	lower extremities. Given percocet 1 tab for
R 16 T 96.4	n/a b(6)-2 [redacted] UT/PT
	25 Aug 03 0345 Neurovascular check
	grossly intact. PERRLA. Pupils reacting

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

Civ [redacted]
b(6)-4

PROGRESS NOTES
Medical Record

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

038

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	briskly to light. Bilaterally equal strong upper and lower extremities. Strong pulses and brisk cap refill x4 extremities. Ø Complaint of pain at this time — [redacted] b(6)-2
25 Aug 03	1030 - Pt A-O x 3, VSS, afebrile, lungs CTA, HR reg, BS ⊕ x4, pulses ⊕ + strong to ↑ & lower extremities, PERRLA, skin warm, cap refill < 3 sec. Neurovascular intact. OOB x 2 ambulating to door. Pt states he is slightly dizzy when getting out of bed. Pt slept well throughout night. Stitches intact to face & ⊕ arm. Bacitracin applied. Voiding adequately. Tolerated breakfast. Voiding Ø complaints. Will call to master — b(6)-2 [redacted]
	1300 - Pt spiked temp 104.5. MD notified. Motrin given 400 mg. Will have pt to ambulate b(6)-2 Will call to master — [redacted]
25 1400 Aug 03	NURSING NOTE: Assumed care of pt. AAOx3. Airway intact, breathing even and unlabored, BS, CTA ⊕, Abd soft, nontender, ≠ distention. BS ⊕ x4. Voids spontaneously. FROM all extremities, intact to all extremities. Abrasions to face are open to air. MD [illegible] Well approximated. b(6)-2 [redacted]
2200 25 Aug 03	PT VS SpO2 - 98, BP 122/74, T - 98.3, R - 20, P - 86 — [redacted] 9W
2300	Pt awake and alert, visiting with another pt. Sutures removed today, wounds to face CDI. Bacitracin applied. Ø C/O pain. PERRLA. Pupils bilat brisk response. Lungs CTA bilat, Ø resp distress. VSR and Cont, non-tender, bowel sound

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

038

PROGRESS NOTES

DATE	
25Aug03 2300 Cont	@ active x 4 quads. Ambulating steadily in hallway. Strong pulses and brisk capr refill x 4 extremities. Possible D/c to home in am. — [redacted] /AN
25Aug 2400	4/5 B/P 100/70 R 14 P88 R 97.1 NW 9/W
26Aug03 0900	Pt. VSS. — [redacted] /AN
8-26-03 0850	Pt D/C to air mac. Meds given. — [redacted] /AN
	b(6)-2 A11

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

PROGRESS NOTES

DATE

26AUG03 Discharge Summary

[redacted]

b(6)-4 History – 37 y/o right handed male who suffered multiple facial and left upper extremity lacerations in the UN explosion 19AUG03. X-rays of the face, skull, chest, and left arm showed only a left nondisplaced zygoma fracture and a distal humerus soft tissue foreign body consistent with glass fragment. He was initially treated at an Italian hospital and released. He returned 23 AUG03 with dizziness and dehydration.

Hospital Course – Pt was rehydrated with IV fluids and his activities advanced. Despite 36 hours observation, he remained dizzy with upright activities. The UN coordinated transfer to Jordan, so he was released on this date.

Disposition – He will require a CT scan to look at his brain. Sutures are removed. He will need supervised advancement of his activities. He is expected to make a complete recovery.

Medications – Percocet 1-2 po q 3-4 hrs prn.

[redacted]

Neurosurgery

b(6)-2

[redacted]

b(6)-4

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

IDENTIFICATION

[redacted]

b(6)-4

G UNIT | ROOM NO. | BED NO.

DATE OF ORDER 24AUG03 TIME OF ORDER 1537 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit ICW 2 - Neuro - [redacted]
2. Diagnosis Concussion
3. Condition Good
4. Vitals q 4° c̄ neuro ✓
5. Activity Walk c̄ assist q shift.
6. Nursing May elevate HOB ad-lib.

IDENTIFICATION

G UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

Cleanse / bacitracin abrasions q shift.

7. Diet Regular.
8. IV NS @ 150 cc/hr.
9. Meds Tylenol 650 mg PO q 4° pm [redacted] b(6)-2
   Percocet 1-2 PO q 4° pm.
   Zofran 4 mg IV q 6° pm.

Noted 24Aug03 1400 [redacted]

IDENTIFICATION

G UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

10. Lab none.
11. X-rays: CXR / (L) humerus on call.

[redacted]

IDENTIFICATION

Aug03 0315 [redacted]

G UNIT | ROOM NO. | BED NO.

DATE OF ORDER 25AUG03 TIME OF ORDER 1307 HOURS

1. D/C IV [redacted]
2. Δ VS [redacted]
3. D/C Neuro ✓ [redacted]
4. May shower ad-lib.

b(6)-2

25Aug 1320 [redacted]

[redacted]

G UNIT | ROOM NO. | BED NO.

[redacted] 24° chart ✓

FORM 4256 APR 79 REPLACES EDITION OF 1 JUL 79. [redacted] b(6)-2

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994-3

Doctors Orders

26AUG03 Discharge to Fridn.
0801

[redacted] 4797
b(a)-2

noted
26AUG03
[redacted]
b(a)-2

b(a)-4

#[redacted]

Air Evacuation Checklist

Initial when complete

Completed By Physician

✓ Evac Form 3899 completed and sent to PAD.

✓ Category: (R) P U (circle one)

✓ Ambulatory or (Litter) (circle one)

✓ Air Evac Order written in doctor's orders

✓ Prescriptions written for evac.

✓ Narrative Summary Completed

Completed By Nursing

✓ Prescriptions sent to Pharmacy

✓ Medications given to Patient

✓ Nursing Discharge Note written

CROCE ROSSA ITALIANA - ITALIAN RED CROSS
OSPEDALE ATTENDATO BAGHDAD

ITALIAN RED CROSS
Hospital - Baghdad (Iraq)

The patient [redacted] is admitted to Italian Red Cross Hospital in 19.08.03 complainig of multiple injury in the head and in the face. At admission he was drowsy, the pupils were equal and reactive to light, the abdomen was soft. He complained also vomiting.

We have done the sutures of the multiple lesions, we have given him IV fluids and after the stabilization we have transfer the patient to Shamed Adnan Hospital for CT scan of skull and for further evaluation.

22 AGOSTO '03

Medico
Dr. [redacted]

Il Direttore Sanitario
Dr. [redacted]

Il Direttore del Campo
[redacted]

b(a)-2

ITALIAN RED CROSS - HOSPITAL - BAGHDAD - IRAQ

Emergenza Umanitaria IRAQ
CROCE ROSSA ITALIANA
Ospedale attendato - BAGHDAD

(b)(6)-4

[redacted] / [redacted]

[redacted]

Dear Dr.

Brain CT

would you please do CT Scan for this patient with history of explosion 3 days ago...

Fer

He was well, for the last 6 hours he is drowsy, vertigo, nausea & vomiting with hypotension.

He needs Brain CT & your kind Mx please. Thank you...

b(6)-2

[redacted]

22.8.03

ADMISSION AND CODING INFORMATION

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

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

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
	37 Y	U	9	UNK

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
	N/A	~~9 9~~ 20	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	ADMISSION	
N/A	U	1339	N/A b(6)-2

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
O b(2)-2	ICW 2	UNK
NAME AND LOC[redacted]TY		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)
05		030826

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
ABOA		030824

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYMMDD)
		2

FOR LOCAL USE

DX- MULTIPLE FACIAL AND LEFT UPPER EXTREMITY LACERATIONS.

DX: 8529
2765
3102
9120
9248
8958

TRAUMA
9
INJURY
599

ADMIT[redacted]ignature, as required)

[redacted] DR[redacted]

b(6)-2

SIGNATURE OF ADMITTING CLERK

[redacted]

b(6)-2

DA[redacted] MAR 89

USAPPCV1.0

[redacted]

b(6)-2

IN. ENT TREATMENT RECORD COVER S

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 UNK	5. AGE UNK	6. RACE UNK	7. RELIGION UNK	8. LENGTH OF SVC —	9. ETS —	10. PREVIOUS ADMISSION N
11. FMP 99	12. SSN [redacted]		13. ORGANIZATION b(6)-4			14. WARD ICW
15. FLYING STATUS —	16. DSG —	17. DEPT./BEN K78	18. BRANCH/CORPS —	19. UIC/ZIP —		20. TYPE CASE NBI
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION direct from ER			22. HOURS OF ADMISSION 1820	23. CLINIC SERVICE AJAA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK			25. TYPE DISPOSITION d/c to Amp	26. DATE OF DISPOSITION 28 Aug 03		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK			27b. TELEPHONE NO. UNK	28. DATE OF THIS ADMISSION 27 Aug 03		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b(2)-2				30. DATE OF INTIAL ADMISSION		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

(L) distal comminuted humerous fx 812.40

E928.9

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF A[redacted] OFFICER [redacted] RECORDS OFFICER

DA FO[redacted] EDITION OF 1 [redacted] USAPPC V1.10

b(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
27 Aug 03	PT Note
Hx	here for x-ray, s/p prior surgery;
Exm:	present ē ex fix. distal (L) humerus
	wasting (L) forearm /
	apparent Rpa Hand (L)
	ROM: unable make fist (L), unable full flex/
	extend
	MMT: unable hold wr ext / flex, (L)
	X-rays: unhealed (L) distal comminuted
	humerus fx
	D/w ortho
Diag:	Probable Radial / Median / Ulnar n. palsy
	Unhealed (L) distal comminuted humerus fx
Intv:	Ø A @ this time
	F/u looks for new films
c:	Deferred
	[redacted] b(6)-2
	CPT, SP [redacted] b(2)-2
28Aug03	assumed care @2200 - no c/o pain - slept throughout
0330	Shift - to bed'd to EPW camp @ 1800
	today b(6)-7 [redacted] CRA

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART. [redacted]	AINED 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

28 Aug Rt calop 130/70 P65 Rg R16 T97.1 [redacted] b(ce)-2
0400

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

EPW [redacted]

Noted

NURSING UNIT: ICWZ 27 Aug 03 | ROOM NO. | BED NO. [redacted] AN

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
27 Aug	1830 HOURS	
1) Admit: Border Status		
DX: (R) distal comminuted humerus fx		
2) V.S. per routine		
3) General diet		
4) Activity: Bedrest		

PATIENT IDENTIFICATION [redacted] b(6)-2

DATE OF ORDER	TIME OF ORDER	
5) Tylenol #3 PO HOURS		b(6)-2
q4hrs prn pain		
6) Return to EPW		[redacted]
camp in AM		

NURSING UNIT: ICWZ | ROOM NO.: 5 | BED NO.: B 34 V033028Aug03 [redacted] CR+AN

b(6)-7

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
	HOURS	

SING UNIT | ROOM NO. | BED NO.

T IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
	HOURS	

ROOM NO. | BED NO.

b(6)-2 A

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 27	28	29
27Aug	[redacted]	V.S. per routine	06	[redacted]		
			14			
			22			
27Aug	[redacted]	General diet	07	[redacted]		
			11			
			17			
27Aug	[redacted]	Activity: Bedrest	06	[redacted]		
			14			
			22			

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (L) Distal comminuted humerous fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

EPW [redacted]

b(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

b(6) 2 A11

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
27Aug	[redacted]	Admit i Boarder Status	27Aug	Done		[redacted]
27Aug	[redacted]	Return to EPW camp in AM	28Aug			

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
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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														
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ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (L) Distal comminuted humerous fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION: bl(e) - 4

EPW [redacted]

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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
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Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED													
27Aug	[redacted]	Tylenol tabs PO														
- - - -	- - - - -	q 4h Prn pain														
- - - -	- - - - -	b(a)-2														
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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	F Z	[redacted]	EPW [redacted] b(4)-4	EPW	Z

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

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—	Z	1820	b(4)-4

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

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

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

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

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
A J A A		0 3 0 8 2 7

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

FOR LOCAL USE

(L) distal comminuted humerous fx DX V5411
3543 [redacted]
9052
E9299
b(4)-2 [redacted] Trauma 9 Inj 989

ADMITTIN[redacted] (Signature, as required) [redacted] CLERK [redacted]

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)-2			3. GRADE NA
4. SEX M	5. AGE 27	6. RACE Unk	7. RELIGION Unk	8. LENGTH OF SVC NA	9. ETS NA	10. PREVIOUS ADMISSION NO
11. FMP 99		12. SSN [redacted]		13. ORGANIZATION NA		14. WARD Tan3
15. FLYING STATUS NA		16. RATING/DSG b(6)-2	17. DEPT/BEN NA	18. BRANCH/CORPS NA	19. UIC/ZIP	20. TYPE CASE NBI

ADMISSION REMARKS

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from Emt	22. HOURS OF ADMISSION: 0900	23. CLINIC SERVICE: ABAA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: Unk	25. TYPE DISPOSITION: SO	26. DATE OF DISPOSITION: 22SEPT03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): Unk	27b. TELEPHONE NO.: Unk	28. DATE OF THIS ADMISSION: 28AUG03
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted]		30. DATE OF INITIAL ADMISSION

ADMITTING OFFICER: b(6)-2 Dr [redacted]

32. [redacted] COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA [redacted]

b(2)-2

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW TO POSTERIOR NECK

805.18
802.39
872.11
E991.2

06.09
96.6

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	26	26

36. Total [redacted] Facilities

a. [redacted]	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
[redacted]	0	0	0	26	26

b(6)-2

Dr. [redacted]

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER: [redacted]

DA FORM 3[redacted], MAY 79 EDITION OF 1 AUG 78 IS OBSOLETE USAPPC V1.10

ABBREVIATED MEDICAL RECORD

1. ADMISSION DATE *(YYYYMMDD)*

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

27yo EPW s/p GSW neck. GCS upon arrival to medics 15. Neck wound
XLC [illegible] for each. It c/o pain neck wound. dribbling swallowing.
No pain elsewhere
Pupils [illegible] ALL [illegible] motor [illegible] sensory [illegible]

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

HR/RR 92 97% RA
NAD.
Neck: (1) [illegible] T/T wound. (2) neck zone II wound patient expect
Chest [illegible] CV [illegible]
Abd [illegible]
Ext [illegible] wounds. Neuro strength 5/5 (1) all ext [illegible]

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

(1) GSW neck zone II, x midline.

(2) neck exploration

[redacted]

[redacted] b(6)-2

b. DATE SIGNED *(YYYYMMDD)*
9/20/07

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

7. DISCHARGE DATE *(YYYYMMDD)*

8. DISCHARGING OFFICER

a. NAME *(Last, First, Middle Initial)*	b. GRADE	c. TITLE	d. SIGNATURE

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

10. OUTPATIENT/HEALTH RECORD MAINTAINED AT:

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

DD FORM 2770, APR 1998 (EG)

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8/28/03	Op Note
	Procedure: (1) Neck exploration, left
	(2) Wound debridement
	(3) (L) ear wound debridement
	Surgeon: [redacted] b(6)-2
	Anes GETA
	Fluids EBL 600
	Urine 3L
	Findings: (1) (L) ear - TM exposed cartilage
	(2) (L) carotid intact, jugular intact
	(3) (L) mandible fx c̄ submandibular involvement. no mucosal penetration
	(4) (L) spinous process/vertebral body fx c2, 3 region
	(5) Anterior tracheal wall from posterior neck.
	To ICU, intubated
	[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

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