DATE 24 NOV 03 | DX | HOSPITAL DAY

VITAL SIGNS																		
TIME	24	01	02	03	04	05	06	07	08	08	09	10	11	12	13	14	15	17
BP Arterial Line																		
BP Cuff	109/66	106/64	110/68	111/63	116/68	119/70	116/73	118/75		110/73	99/64	113/69	114/62	110/64	122/80	115/76	113/70	
Temperature	97.6											75					98.2	
Pulse	77	76	78	76	68	75	78	78		71	69	75	73	71	87	85	87	
Respiratory Rate	19	18	20	18	21	19	20	19		16	19	18	15	18	18	16	21	
SpO2	97	96	97	97	96	95	95	95		96	97	98	97	97	95	96	95	
FiO2	2L	2L	2L	2L	2L	2L	2L	2L		2L	2L	2L	2L	2L	2L	2L	2L	
mode	NC	NC	NC	NC	NC	NC	NC	NC		NC	NC	NC	NC	NC	NC	NC	NC	

INTAKE																		
TIME	24	01	02	03	04	05	06	07	8° T	08	09	10	11	12	13	14	15	8° T
D5½NS 20 KCL	100	100	100	100	100	100	100	100	800	100	100	100	100	100	100	100	100	800
MSO4	4	4	4	4	4	4	4	4	32	4	4	4	4	4	4	4	4	32
Heparin	24	24	24	24	24	24	24	24	192	24	24	24	24	24	24	24	24	192
IVP												100				50		50
TOTALS									1024									

OUTPUT																			
URINE	HOUR	100	60	140	140	200	100	100	175		150	135	110	200	150	120	100	40	
	TOTAL		160	300	440	640	740	840	1015	1015	150	285	395	575	725	845	945	985	1005
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																x1			
CT DRAINS	CT						15			15			10			10			
TOTALS										1030									

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	X
	119/73	111/74	117/67	122	112/76	128/82	123/74	124/75	
			98	82			98		
	85	81	78	89	83	96	81	82	
	18	20	28	17	18	20	20	17	
	98	100	96	95	96	95	96	97	
	2L	2L	2L	2L	2L	2L	2L	2L	
	NC	NC	NC	NC	NC	NC	NC	NC	

INTAKE	16	17	18	19	20	21	22	23	8° T
	100	100	100	100	100	100	100	100	
	4	4	4	4	4	2	2	2	
	24	24	24	24	24	24	24	24	
							50		

OUTPUT	16	17	18	19	20	21	22	23	
	30/20	32/35	Ø	Ø	Ø	25/7	Ø	Ø	327
		pulled							
		70							

ACUITY LEVEL CLASSIFICATION

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

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

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

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE _____

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

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0730	INITIALS [redacted]		INITIALS		INITIALS
NEURO	PUPILS	PERRLA @ 3mm					
	SENSORIUM	Alert & oriented					
		MAE					
RESPIRATORY	RESPIRATORY PATTERN	Even, unlabored					
	BREATH SOUNDS	BS CTA, but					
	SECRETIONS	somewhat diminished					
		@ bases. Coughs up					
		sputum					
SKIN	COLOR	NFR, sutured to					
	INTEGRITY	(L) clavicle area.					
IV SITE	LOCATION	L) jugular catheter					
	CONDITION	(L) jugular site c					
		signs of redness or					
		swelling to either					
		site					
GASTRO	ABDOMEN	Soft, nontender					
	BOWEL SOUNDS	BSX4 quads					
GU	URINE:	voids per urinal					
	COLOR/CLARITY	QS					
CARDIOVASCULAR	CARDIAC RHYTHM	S_1+S_2 Noted					
		NSR w/ ectopy					
		Cap refill brisk					
		+ pulses					

LEGEND

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

(b)(6)-2

(Continue on reverse)

PE[redacted]ature & Title) 9/4/06

DEPARTMENT/SERVICE/CLINIC 7C03

DATE 25 Aug 07

[redacted]NTIFICATION (For typed or written entries give: Name—last, first, [redacted]e; 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 1 MAY 78 4700

Proponent: Dept of Nurs

MEDDAC FBg OP 375, 1 Apr 90 (HSXC-NU)

DATE 2/22/05 DX GSW Chest HOSPITAL DAY

VITAL SIGNS																		
TIME	2400	0100	0200	0300	0400	0500	0600	0700		08	09	10	11	12	13	14	15	8° T
BP Arterial Line																		
BP Cuff	114/78	114/71	101/67	99/59	115/80	116/70	121/74	119/70		118/74	115/71	118/71	114/70	108/63	101/68	119/75		
Temperature	99.1				97.8		99							98.3				
Pulse	87	80	81	70	80	83	80	80		80	67	74	91	69	84	88		
Respiratory Rate	21	20	15	16	18	20	19	20		19	19	20	17	14	21	17		
O_2	95	95	94	97	96	95	95	95		94	96	97	99	97	96	98		
Mode	2L NC	2L NC	2L NC	2L NC	2L NC	2L NC	2L NC	2L NC		2L NC	2L NC	2L NC	2L NC	2L NC	2L NC	2L NC		

INTAKE																		
TIME	2400	0100	0200	0300	0400	0500	0600	0700	8° T	08	09	10	11	12	13	14	15	8° T
IVF	100	100	100	100	100	100	100	100	800	100	100	100	100	100	100	100		
MOV	4	2	2	2	2	2	2	2	18	2								
IVP	24	24	24	24	24	24	24	24	192	24	24	24	24	24	24	24		
IVPB							50		50									
TOTALS									1060									

OUTPUT																		
URINE HOUR	62	Ø	Ø	Ø	200	Ø	Ø	350		300			650			1000		
URINE TOTAL					85			1075	1075	1375			850			1850		
URINE sp gr																		
URINE S/A																		
NG OUTPUT																		
NG pH																		
NG GUIAC																		
EMESIS	X1																	
STOOL	X1																	
DRAINS CT #1							10		10									
TOTALS									1085									

POST-OP DAY

VITAL SIGNS									
INTAKE									8° T
OUTPUT									

ACUITY LEVEL CLASSIFICATION

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

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

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

24° I&O TOTALS	NURSES SIGNATURE	INITIALS
wt Yesterday _____ wt Today _____	[redacted]	[redacted]
INTAKE: IV _____ po _____ _____ TOTAL _____	OUTPUT: Urine: _____ _____ _____ TOTAL _____	
BALANCE _____		

(b)(6)-2

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: _____ Anesthesia Type (Circle)): General Spinal Epidural
Time In: _____ IV Sedation Nerve Block
Allergies: _____ OR Intake: Crystalloid _____ Colloid _____
Pre-op V/S: _____ OR Output: UOP _____ EBL _____
Procedures: _____ Meds/Times: _____

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds 1 2 3 4 History

Time	0220	0320	0330	0400												
SaO2	94	100	100													
FiO2																
Methods																
240																
220																
200																
180																
160																
140	V															
120		V	V	V												
100																
80	•															
	NA		AA													
60																
40																
20																
RR																
T	92.4	92.6														
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			
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea			
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op			
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain			
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic			
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.			

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 | DATE

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

[redacted] (5)(6)-4

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

PACU Bed 4
[redacted] (b)(6)-4

8.0 ETT 22@ lip

28TH COMBAT SUPPORT HOSPITAL VENTILATOR FLOW SHEET

S/p Ex Lap (L) clavicle Fx (GSW)

DATE	TIME	MODE	RATE	VOLUME	FI02	PEEP	PIP	PT RATE	HR	SO2	BP	Ph	Pco2	Po2	BE	HCO3	SaO2	REMARKS
19 NOV 05	0300	SIMV	14	750	60%	+5	22	0	59	100	125/81							[redacted]
	0500	SIMV	14	750	60	5	23	0	77	100	129/81	7.37	36.9	271	-3	22	100	[redacted] ↓FiO2 35% @ 0520
	0820	SIMV	14	750	↓32	5	24	14	80	100	114/75							
	1100	—	—	Pt extubated														
	0300	—	—	3L NC		—	—	26	91	94	108/68	—						[redacted] 66-2

MEDCOM - 25047

Inte. en. ns

Airway / Breathing: intubated ⌀ 8.0 @ 22 @ teeth

Circulation: (R) removed

Other: (L) + (R) saphenous

replaced both chest tubes on left ⌀ 36 French ⌀ minimal returned blood

MEDICATIONS

Time	Drug	Dose	Route	Initials

all other sides

Blood Components

Unit #	Type	Time	Response
1	O+		
2	O+ 2318		

Vital Signs

Time	B/P	Pulse	Resp	Pulse Ox	Temp	GCS
	/					
	/					
	/					
	/					
	/					
	/					

Transfer Instructions:

- intubated
- 2 chest tubes on left
- Foley

NOTES:

Personal Effects:

?

Prepared by: [redacted]

Team Lead [redacted]

Dr [redacted]

(b)(6)-2

Medical Record **Progress Notes**

Wound and Skin Assessment

Date and Time 19 NOV Ø3 Wound number ①
Stage I-IV IV Surgical or Non-Surgical GSW - entrance
Location Ⓛ scapula
Shape sm, round Measurements 5mm
Tissue Color NFR / red
Drains and Type Ø
Drainage (amt and color) min sang
Dressing Type Ø
Dressing Change Frequency Ø Wound Cleansing
Additional Info (turning, elevation of extremeties, etc.)

Date and Time 19 NOV Ø3 Wound number ②
Stage I-IV IV Surgical or Non-Surgical GSW - exit
Location Ⓛ upper chest
Shape jagged, straight Measurements 6in
Tissue Color NFR
Drains and Type Ø
Drainage (amt and color) sm. sang
Dressing Type 4x4's & tape
Dressing Change Frequency BID / PRN Wound Cleansing
Additional Info (turning, elevation of extremeties, etc.)

Date and Time 19 NOV Ø3 Wound number 3 / 4 / 5
Stage I-IV Surgical or Non-Surgical JP / CT1 / CT2
Location Ⓛ upper chest
Shape Measurements
Tissue Color
Drains and Type JP / CT1 / CT2
Drainage (amt and color)
Dressing Type 4x4 & tape
Dressing Change Frequency PRN Wound Cleansing
Additional Info (turning, elevation of extremeties, etc.)

Patient ID: Unit No.
Standard Form 509

[redacted] (b)(6)-4

Medical Record Progress Notes

Braden Scale Evaluation

Date: 11/23/03

Sensory Perception	No Impairment	4	Mobility	No Limitations	4
	Slightly Limited	3		Slightly Limited	3
	Very Limited	2		Very Limited	2
	Completely Impaired	1		Completely Immobile	1
Moisture	Rarely Moist	4	Nutrition	Excellent	4
	Occasionally Moist	3		Adequate (Eats >50%)	3
	Moist	2		Adequate (rarely eats)	2
	Constantly Moist	1		Very Poor	1
Activity	Walks Frequently	4	Friction and Shear	No Apparent Problem	3
	Walks Occasionally	3		Potential Problem	2
	Chairfast	2		Problems	1
	Bedfast	1			

Total Score: 14

Above 20	Low Risk
16-19	Med Risk
11-15	High Risk
Below 10	Very High Risk

Score <15 requires Immediate Ulcer Prevention Program

Date: _____

Sensory Perception	No Impairment	4	Mobility	No Limitations	4
	Slightly Limited	3		Slightly Limited	3
	Very Limited	2		Very Limited	2
	Completely Impaired	1		Completely Immobile	1
Moisture	Rarely Moist	4	Nutrition	Excellent	4
	Occasionally Moist	3		Adequate (Eats >50%)	3
	Moist	2		Adequate (rarely eats)	2
	Constantly Moist	1		Very Poor	1
Activity	Walks Frequently	4	Friction and Shear	No Apparent Problem	3
	Walks Occasionally	3		Potential Problem	2
	Chairfast	2		Problems	1
	Bedfast	1			

Total Score: _____

Above 20	Low Risk
16-19	Med Risk
11-15	High Risk
Below 10	Very High Risk

Score <15 requires Immediate Ulcer Prevention Program

Patient ID:

Unit No. TCU3

Standard Form 509

(b)(6)-7

[redacted]

PLAN OF CARE FOR SKIN BREAKDOWN AND WOUND MANAGEMENT

MEDICAL RECORD **PROGRESS NOTES**

Admission Date: 19 NOV 03 **Diagnosis:** GSW **HD:** 1 **POD:** 0

Date: 19 NOV Time: 0330 RN Signature [redacted] (b)(6)-2

Skin breakdown as evidenced by immobility, friction, shear, moisture, abrasions, surgical wound, skin tear.

Wound type: Surgical wound (s) GSW Location: (L) scap (L) chest Size: 5mm/6 in Drainage: min sang

Diabetic ulcer Tubes: JP x1 CTR2 Pins: Ø Appearance: well approx

Venous stasis ulcer Dressing change: PRN / BID

Other_____ Describe_____

Burn wound (s): % BSA_____ Partial_____ Full_____

Location:_____ Size_____

Appearance:_____

Dressing change:_____

Pressure Ulcer (s): Ø

Stage I, II, III, IV (Circle the one that applies and describe below)

Location:_____ Size:_____

Wound character: Pink____ Moist____ Dry____ Granulation tissue_____ Yellow slough _____

Tunneling_____ Undermining_____ Odor_____ Purulent discharge_____ Eschar_____ Exudates _____

Refer to SOP for Dressing Change Instrucitons.

Please check the appropriate dressing Change:

- ☒ Wet to Dry Dressing
- ☐ Carrasyn-V GelDressing
- ☐ Alginate Dressing
- ☐ Comfeel Dressing
- ☐ Pin Site Care
- ☐ J-Tube Care
- ☐ Colostomy Care
- ☒ Chest Tube Care
- ☐ Burn Care

NOTE: Document daily wound and dressing change on Progress Note or Nursing Note.

Select the appropriate products used:

- ☒ Sterile 4x4 gauze dressing
- ☐ Sterile 2x2 gauze dressing
- ☐ Sterile gloves
- ☐ Kerlix (super sponge)
- ☐ Gauze bandage
- ☐ Sterile Normal Saline
- ☐ Sterile Water
- ☐ 8 x 4 Sponge gauze
- ☐ Op-site
- ☐ Tegaderm clear dressing
- ☐ Alkare skin prep
- ☐ Comfeel clear
- ☐ Comfeel pressure ulcer drsg
- ☐ Carrasyn-V Gel
- ☐ Alginate
- ☐ Bacitracin
- ☐ Silvadene Cream
- ☐ Petrolatum gauze
- ☐ Hibicleanse
- ☐ Non-adhesive dressing
- ☐ Telpha Pad
- ☐ Carra-smart film
- ☐ Sterile Q-tip applicator
- ☐ Xeroform 5 x 9.
- ☐ Moisture barrier cream
- ☐ 0.125% Dakins sol
- ☐ Betadine Swab sticks
- ☐ ½ Hydrogen Peroxide & ½ Sterile Normal Saline

Select the frequency of dressing change:

- ☒ b.i.d. PRN
- ☐ t.i.d

MD Signature and Date:

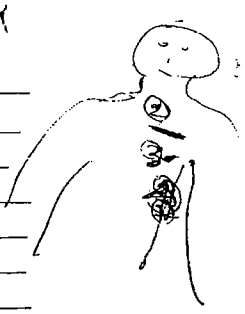
CNS Signature and Date:

Patient's Identification (For typed or written entries give: Name-last, first, middle: Grade; rank; hospital or medical facility) **Medical Record, SF 509**

[redacted] (b)(6)-4

Medical Record — Progress Notes

Wound and Skin Assessment



Date and Time 11/23/03 Wound number 2
Stage I-IV 2 Surgical or Non-Surgical
Location (L) UPPER CHEST
Shape EDGES APPROXIMATED STRAIGHT Measurements 6 IN
Tissue Color
Drains and Type Ø
Drainage (amt and color)
Dressing Type OPEN TO AIR
Dressing Change Frequency Wound Cleansing NS
Additional Info (turning, elevation of extremeties, etc.)
MONITOR FOR SIGN OF INFECTION

Date and Time 11/23/03 Wound number 3
Stage I-IV 2 Surgical or Non-Surgical
Location (R) UPPER CHEST
Shape STRAIGHT Measurements 3 CM
Tissue Color RED
Drains and Type Ø
Drainage (amt and color) Ø
Dressing Type WET TO DRY 4x4
Dressing Change Frequency BID Wound Cleansing NS
Additional Info (turning, elevation of extremeties, etc.)
MONITOR FOR TUNNELING AND FOR SIGN OF INFECTION.

Date and Time 11/23/03 Wound number 4
Stage I-IV IV Surgical or Non-Surgical CHEST TUBE
Location LOWER (L)
Shape STRAIGHT LINE Measurements 4 CM
Tissue Color RED
Drains and Type CHEST TUBE SEROUS
Drainage (amt and color) APPR 5-10 CC/HR
Dressing Type VASELINE GAUZE & 4x4
Dressing Change Frequency BID Wound Cleansing NS
Additional Info (turning, elevation of extremeties, etc.) MONITOR FOR BREAK OF SEAL IN CHEST WALL AND FOR SIGN OF INFECTION.

Patient ID: Unit No. ICU3
Standard Form 509

(b)(6)-4

[redacted]

FSB / FST Trauma Flow Sheet

Name: Iraqi Nedl 82 SSN _____ Unit LOCAL NATIONAL

Date and time of injury: 18NOV03 Time of Arrival 2250

MOI: GSW

HPI:

Blood Type

PMHX: ?

PSHX:

Meds:

Allergies: —

Primary Survey (b)(6)-2

Airway: Patent Mechanically maintained by Intubated by CPT [redacted]

Breathing: Spontaneous Assisted by CPT [redacted]

Circulation:

Pulse: Present Absent CPR

Color: Normal Abnormal

Cap refill: Normal Delayed

arrived c NRB

Secondary Survey

Intial Vital Signs: b/p 100/70 pulse 104 Resp ____ Pulse Ox 99 Temp 95.6

GEN: unresp - #2 100/64 #2 99 #2 97

HEAD: NCAT #3 129/69

NECK: ⊘ lesion

HEART: pulse 100

LUNGS: (L) lung puncture from GS

CHEST: (L) open chest wound → 2 chest tubes on (L) present

ABD: soft

PELVIS: ⊘ lesion ; Foley on arrival

EXT: ? fx (L) forearm

LACT RINGERS

100 KETAMINE 1gram ANCEF

100 succinylcholine

10 mg vecuronium

.4 mg scopolamine

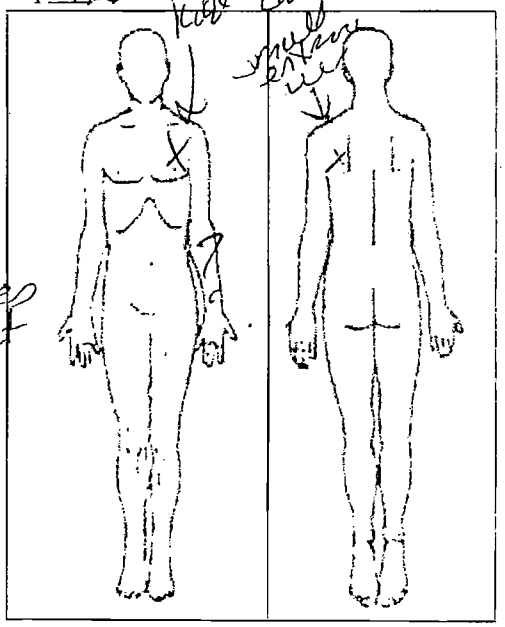
per PT [redacted] (b)(4)-2

#(1) unit of BLOOD started @ 2255

#(2) started @ 2310 done @ 2315

RECTAL: deferred

NEURO: intubated on arrival



GLASCOW COMA		
EYES OPEN	Spontaneously	4
	To Speech	3
	To Pain	2
	None	1
BEST VERBAL RESPONSE	Oriented	5
	Confused	4
	Inappropriate sounds	3
	Incomprehensible sounds	2
	None	1
BEST MOTOR REPONSE	Obeys Commands	6
	Localizes Pain	5
	Withdraws to Pain	4
	Flexes to Pain	3
	Extends to Pain	2
	None	1
	TOTAL	

Revised Trauma Score		
GLASCOW COMA TOTAL	13-15	4
	9-12	3
	6-8	2
	4-5	1
	3	0
SYSTOLIC BLOOD PRESSURE	>89 mmHg	4
	76-89 mmHg	3
	50-75 mmHg	2
	01-49 mmHg	1
	No pulse	0
RESPIRATORY RATE	10-29 / min	4
	>29 / min	3
	6-9 / min	2
	1-5 / min	1
	None	0
	TOTAL	

X-RAY:
1. CT in good placement
2. ETT good placement
3. white out on (L)
4.

LAB
1U
2U

Admission & Coding Information

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

[redacted]	IZ		
3. Register Number [redacted]	Name (Last, First, MI) [redacted]NoFirstNameGiven	4. Pay Grade FGN	5. Sex M
6. DoB (YYYYMMDD)	7. Age at Admission (b)(6)-4	8. Race X	9. Ethnicity 9	Religion
10. Length of Service	ETS	11. FMP 99	12. Social Security Number [redacted]	
Organization (Active Duty Only)		13. Marital Status	Hour of Admission 23:50	Branch / Corps:
14. Flying Status	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES		16. Zip Code of Residence:	
17. Unit Location	18. MOS	19. Trauma BC	Prev. Admission NO	
20. Source of Admission Direct from ER	Ward: ICU3	Name / Relationship of Emergency Addressee Address of Emergency Addressee		
(b)(2)-2 Name and Location of Medical Treatment Facility: [redacted] Install Provided		Telephone Number of Emergency Addressee		
21. Type of Disposition TRF-OTH	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2003-12-02		
24. Clinic Svc - Admitting ABA - GENERAL SURGERY	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-11-18		
27. Location of Occurrence IZ	28. MTF of Initial Admission	29. Date of Initial Admission 2003-11-18		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: GSW SHRAPNAL CHEST

Procedure Narrative(s):

T: 1 Dx: 8760 PR: 8670
8601 8345
Inj: 450 4538 3402
9729
Blood: Y 79900 9904×2
E9912

Cause of Injury Narrative:

(b)(6)-2

Admitting Officer (Signature, as required) [redacted]

Automated Facsimile - DA FORM 2985, MAR 2000

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

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

1. Register Nbr [redacted] 2. Name [redacted] 3. Grade FGN Admission Remarks

4. Sex M 5. Age 45Y 6. Race (b)(6)-4 7. Religion 8. LnthOfSvc 9. ETS 10. PrevAdm NO

11. FMP 99 12. SSN [redacted] 13. Organization 14. Ward ICW1

15. FlyStatus NO 17. Dept / Ben K78-PRISONER OF WAR/INTER 18. BranchCorps ARMY 19. UIC / ZIP 20. Type Case BC

21. Source of Admission Direct from ER 22. Hour Of Adm: 23:45 23. Clinic Service AEA - ORTHOPEDICS

24. Name/Relation of Emergency Addressee 25. Type Disp TRF-OTH 26. Date of Disp 2003-12-27

27a. Address of Emergency Addressee 27b. Telephone No 28. Date This Adm: 2003-11-19 AdmittingOfficer: [redacted] b6-2

29. ReportingMTF [redacted] (b)(2)-2 30. Date Init Adm 2003-11-19 32. Units Blood Components

31. Selected Administrative Data

Marital Status: DoB: 1958-06-01

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

Open L TIB FIB FX

DX: B2310
99859
6826
8911
E9912

Px: 8674
7966
7857
8309
8669
7817

Trauma
9

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	10	10

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	10	10

Injury
569

Si[redacted]ding Medical Officer

Signature of PAD or Medical Records Officer

[redacted]

Automated Facsimile - DA FORM 3647, May 79

(b)(6)-2

MEDCOM - 25055

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

40 yl- Iraqi of truck driver non check point in western Iraq

Gunshot of
RSHR of
MOTS of
Allergic to KCDA

PHYSICAL EXAMINATION

HEENT: wnl
Chest CTA
CVS: SR

Ext: (L) leg ex/fix w splint
3/5 EHL/FHL, sensation intact
2+ DP

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

(R) Open (L) TIB, ankle & GSW & Ex fix
(R) Admit Regent I+D 48

(5)(6)-2

[redacted] | DATE 11/20/03 | IDENTIFICATION NO | ORGANIZATION

[redacted] *(Typed or written entries give Name last, First, middle; grade; date; hospital or medical facility)* | REGISTER NO. | WAPO NO.

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FISMR 141 CFR: 201-45.505
OCTOBER 1975
USAPPC V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	ORTHO
19NOV03	~40 yo iraqi male GSW (L) tibia.
2100	no interpreter available.
	able to plantar flex toes. Appears to have
	sensation plantar/Dorsum foot.
	PMedHx - unknown.
	NKDA (unable to ask)
	AF VSS NAP XRAY - comminuted prox 1/3 tib fx, Fibula intact.
	LLE palp dP/PT pulse
	(+) PF toes. appears to have plantar/dorsal foot sensation,
	but hard to tell (no interpreter)
	exposed bone, GSW prox 1/3 tibia c̄ sig soft tissue
	loss in Ant compartment.
	no other GSW noted. no active bleeding
	toes warm/pink.
	A/P Grade III B (L) tib fx 2° GSW
	to OR for I/D + ex fix.
	Kefzol. tetanus

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

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

EPW [redacted]

(b)(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
20 Nov 03 1445	Pt A & O able to make needs known. VSS. Denies pain. LLE ↑ on pillow. Dsg. to wound site reinforced due to serous drainage. (+) pedal pulse & brisk capillary refil. Moves toes. (D) ft cooler than (R). Heplock patent to RLE. (+) BS x 4 quadrants. Voiding clear yellow urine per pt. (+) N.V. Will continue to monitor & provide emotional support. Continue Abx therapy as ordered. 2 point restraint on ↓ compromise to skin/circulation [redacted]
20 Nov 03 1450	CBC, Chem 7 drawn @ 0715. [redacted]
2050	Assumed care of pt. @ 0000. VSS - A+O. Pt. speaking arabic. LS CTA (B), resp. even unlabored, NSR, Abd. soft non-tender. BS x 4 ↓ IV (R) AC infiltrated new IV started in (L) wrist 18G. Flushes well. (0) S/Sx infiltrate. Reinforced dressing to (L) Leg. Ext. fixator intact. moderate amount serous drainage noted. (+) pedal pulses, Brisk cap. refill. can move toes. Pt. got OOB → toilet. walked to doorway via crutches + turned around to get back in bed. Pt. stated he was too tired to walk and didn't have to use toilet anymore. Two pt. restraints in place ↓ compromise to skin/circulation. Will monitor pt. [redacted]

STANDARD FORM [redacted] V1.

MEDCOM - 25058

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
20 NOV 03 0100	VS T 98.6 - 70 - 18 BP 110/60 O_2 SAT 98% RA. AAO MAE unable to palpate (L) pedal pulses d/t dry. Move toes freely in (L) foot. (L) Toe c capillary refill brisk. IV to (R) AC. D/C (L) IV c cath intact. Saline lock (R) IV AC which is patent & intact. (L) LE c ~~fibrin~~ Tib/fib eff fix & dry eschar c bright red blood. Dry to (L) lower leg reinforced c combine dry. Will monitor for bleeding. Will provide medicate for pain mgmt; IV Antibiotic will monitor closely. [redacted]
20 NOV 03 0030	Pt vomit approx 300cc of undigested meals with thick mucous from substance after being transported to latter from dialysis. Pt denied nausea afterwards. Pt resting c eyes closed. O_2 SAT 98% RA lungs clear Bilaterally. HOB ↑ 30°. (L) LE Tan foldal blankets. Will continue care as planned. [redacted] (5)(6)-2

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

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

REGISTER NO.

WARD NO.

[redacted] (5)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
21 NOV 03 0800	Assumed care of pt. A+O x3. VSS Denies having pain or discomfort @ this time. Lungs CTA HRRR Active BS X4 quads Tolerating PO well. IV ABX TX cont Afebrile (L) LE External fixator applied. Dsg reinforces as needed. Copious amounts of serous drainage to dsg combine dsg and kerlix to reinforce Neurovascular check intact pt. able to wiggle toes slightly cap refill and skin coloration WNL Will cont to monitor — [redacted]
21 NOV 1800	- Pt is NPO c/o for surgery today. Food and water taken from bedside — [redacted]
22 Nov 03 @ 0420	Assumed care @ 1800; VSS, pt Alert, speaking arabic; ⊖ c/o pain/discomfort @ this time; pt Back from OR, Ex-fix in place, dsg CDI, ⊖ drainage; NVV WNL; S/L patent, cont IV abx; Restraints in place, ⊕ circ, ⊖ skin breakdown; will continue to monitor — [redacted]
22 NOV 03 0800	Assumed care of pt. A+O x3. VSS ⊖ c/o pain or discomfort @ this time. Lungs clear HRRR active BS x4 quads. Urinating spontaneously. External fix to (L) LE tibia bulking dressing applied Ace wrapped. Neuro check intact Afebrile Will cont to monitor — [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1995)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

[redacted] (b)(6)-4

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
23Nov03@	Assumed care @ 1900; VSS, pt A&O, Ø c/o pain or discomfort @ this time; Ex-Fix in place, dsg CDI, Ø drainage noted; NV intact to affected extremity; S/L patent easily flushes; Cont c̄ IVabx; Restraints in place, Ø circ, Ø skin breakd Cont to monitor [redacted] 9mm6
23 nov Ø3 1025	Pt a10, VSS, percocet given @ 0800, for (L) leg pain. pin care done to visible pins. drsg reinforced, small amt sero-sang drainage around pin drsgs. Pt can wiggle toes slightly, brisk cap refill, (+) pulses (pedal), (L) leg warm to touch. ex fix intact (L) LE. Will monitor [redacted] LPN
1400	MD @ BS (Dr Oliverio). drsg Δ'd. WTD packed & covered c̄ fluffs, wrapped c̄ Kerlix + ace wrap. Entrance & exit wound connected c̄ bloody drainage. Medicated c̄ 4mg MSO4 prior to Δ. Pt able to lift leg on his own during drsg Δ. Will cont to monitor [redacted] 9MM6.
23NOV.Ø3 1915	Pt A+O x3, VSS, LS CTA (B), (+) BS x4, Ex Fix intact, ace wrap CDI, pain controlled c̄ percs, pedal pulses equal (B), cap ref <3 sec limited movement of toes LLE. voiding (VI) to urinal. [redacted] 9IW

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO. KW #1

PROGRESS NOTES
Medical Record

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

[redacted] (b)(6)-4

MEDCOM - 25061

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
24NOV03	(1725) NSG. VSS. ~~Pt c~~ ⊖c/o pain. (L) Leg ex-fix. DSG CDI intact. Dr. [redacted] A'ed DSG to (L) leg ex-fix. Large openings x2. 4-5" holes. ~~Pt~~ Tissue appeared gray + black c̄ areas of dark red. MD packed WTD c̄ Dakin solution. ~~DSG~~ Wrapped c̄ kerlex + ace bandage. BIL LE +2 pedal pulse, warm to touch, brisk cap refill. Pt able to move toes on command. IV ABX infusing. Pt urinating clear, yellow s̄ difficulty. [redacted]
25NOV03 @0300	assumed care of pt @1800. VSS, c/o pain to LLE, medicated c̄ Percocet ? MSO4 c̄ good relief noted. LSCTA, ⊕BS, void ?S per urinal. LLE ⊕ cms, ex-fix intact, dsg CDI. (L) wrist IV Hep lock, infusing ABX as ordered. 2pt restraints on s̄ s/sx of skin/circulation compromise. Plan: monitor neurovasc status, IV ABX, enc po ? OOB. [redacted]
25NOV03 @1100	Pt a/o, VSS, ⊖ c/o pain, ex fix intact (L) LE, c̄ dsg + ace wrap intact, dsg CDI. Dsg A's done by MD. ⊕ pulses, leg warm + pink, brisk cap refill. Pt ambulated c̄ crutches x2 today to chair. (L) wrist HL patent. IV abx cont, 2 pt restraints on s̄ compromise to skin/circulation. Will monitor— [redacted] PN—
26NOV03 @0300	Assumed care @ 1800. VSS. No c/o pain. (L) LE c̄ ex-fix ? dsg, CDI. ⊕ cms to LLE, cap refill < 2 secs, ⊕ DP pulse, equal BIL. LSCTA tol reg diet, void per urinal QS. 2pt restraints on s̄ s/sx of skin/circulation compromise. Plan: NPO PMN for OR, enc OOB, monitor NV status. [redacted]

[redacted] (b)(6)-4

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
26 Nov 03 0600	Pt. awake + oriented x3, WS, pt went OR after AM care. Pt returned without ex-fix with an IM nailing with a JP drain. Pt post OR WS pt c/o pain from ⊕ lower extremity given 2 pcs 15mg and 4 mg (b)(6)-2 at 1625. Restraints x2 in place, ⊕ circulation. — Sp [redacted] (1335) I concur c above assessment — [redacted]
27 nov 03 @0215	assumed care of pt @1800. VSS. No c/o pain. ⊕ CMS to LLE, brisk capreffill noted. Drsg from toes to above knee CDI. ⊕ thigh drsg c̄ serosang drainage noted. ⊕ wrist IV patent, IV Abx cont. Tol regular diet, void per urinal QS, ⊖ requests for pain medication. Rpt restraints on J s/sx of skin/circulation compromise. Plan: enc IS, enc po, cont IV Abx. will monitor. — [redacted]
27 nov 1200	Pt a/o, VSS, ⊖ c/o pain expressed, ⊕ CMS to ⊕ LE Heplix, drsg, c̄ ace wrap intact, bloody drainage noted to drsg over donor graft site, ⊖ Drsg from toes to top of thigh, unable to palpate pulses. JP intact, output recorded on DD792 Pt tol 50% breakfast this AM. IV Hld. Cont IV abx as ordered. Plan: OOB TC, enc IS, enc PO, pain control monitor — [redacted] LPN

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

[redacted] (b)(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	Assumed care @ 1800; T: ↑ @ 101.5, Tylenol given c̄ good relief, all other VSS, pt A&O, Ø c/o pain; dsg CDI to (L) LE, some bloody drainage noted to donor site, Ø signs active bleeding; ⊕ CMS to (L) LE, pulses audible through doppler, JP intact, OP recorded; S/L D/C'd D/T insufficient flow; New one started in (L) FA pt 2T [redacted] patent, flushing s̄ s/sx infection/infiltration; Rest-aids in place, ⊕ circ, Ø skin break ↓; will cont to monitor. (b)(6)-2 [redacted]
28NOV03	(1650) Assumed care of pt @ 0000 p̄ report from SGT [redacted] Pt alert, speaking Arabic. VSS. Ø c/o pain. Pt amb to chair c̄ crutches c̄ difficulty. Pt c/o dizziness. Tol. well once seated in chair. Dsg to LE c̄ marked drainage. Ø new drainage noted. IV in (L) forearm flushes well s̄ s/sx infection/infiltration. JP to LE to bulb suction draining sm. amount of sero-sang drainage. Tol. reg diet well voiding s̄ difficulty. 2-point restraints in place s̄ s/sx complications. Will cont. to monitor. [redacted] (b)(6)-2
29Nov03 0400-0440	Assumed care @ 1800; pt slightly Febrile, IS used, temp pt, all other VSS, pt Alert + speaking arabic, Ø c/o pain; (L) LE ↑ on 1 blanket, dsg intact Ø New drainage Noted; NV intact; S/L in (L) FA patent, flushes well s̄ s/sx infection/infiltration; JP → LLE intact draining Sero Sanguinous fluid; voiding s̄ difficulty, Restraints in place, Ø circ, Ø skin break ↓, cont to monitor. [redacted]
29NOV03	(1845) Assumed care @ 0000. Pt alert, speaking Arabic. VSS Ø c/o pain. LE elevated in bed. JP to LE d/c'd by MD this pm. Pt tol. well. S/L in (L) forearm flushes well s̄ s/sx infection/infiltration. Tol. reg.

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USAPA V1

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
29NOV03 (1845)	(cont) diet well. Voiding ∅ difficulty. 2 point restraints in place ∅ ~~s/sx infection~~ [redacted] s/sx complications. Will cont. to monitor. [redacted]
	Assumed care @ 1800; VSS, pt alert speaking arabic, ⊖ c/o pain; dsg to L LE CDI; ⊖ active drainage; extremity ↑ on 1 blanket; S/L patent, easily flushes, ∅ s/sx infection/infiltration; voiding ∅ difficulty; Tol Reg diet; Restraints in place, ⊕ circ, ⊖ skin breakdown, cont to monitor [redacted]
30NOV03	(1640) NSG. VSS. ⊖ c/o pain. Lung sounds clear through all lobes. ~~B/L~~ (L) LE splinted. ⊕ popital pulse. (L) ft pt able to move toes, warm to touch. Infusing IV ABX to (L) FA ∅ [redacted] difficulty. (L) elevated c̄ blankets. Tol po well. [redacted]
30NOV03	2200 - VSS - A+O speaking arabic. ⊖ c/o pain @ this time. IV HL (2) FA flushes well. (1) LE splint intact. Elevated (2) leg c̄ blankets ⊕ pulses. Pt. moves toes. Pt. resting in bed @ this time c̄ two pt. restraints in place ⊕ circulation. ⊖ skin breakdown. Will cont. to monitor pt [redacted]
	I circum c̄ also assessed [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. ICW

#[redacted] (5)(6)(4)

PROGRESS NOTES
Medical Record

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

USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
1Dec03	(0800) NSG. VSS. ⊖ c/o pain. (L) Leg elevated ō blankets. Splints to (L) Leg. ⊕ 1 popiteal pulse in (L) Leg. (L) ft warm to touch, able to move toes. ⊖ signs/symptoms of vascular compromise. (L) thigh has DSG. Spoke to Dr. [redacted] (b)(6)-2 about (L) thigh DSG ∆ to ∅ DSG ∆ order + DSG dirty. Dr [redacted] said okay to ∆ DSG. Leave whatever DSG stuck to skin. Do not peel off. Dr [redacted] informed pt will have splint removed today. Lung sounds CTA through all lung fields. (L) dorsal PA IV infusing IV ABX. IV site infuses, slightly sluggish. Will monitor. [redacted] (1350) Pt amb c̄ crutches to outside of room. Pt felt lightheaded + sat in chair. Pt able to amb back to room. Pt sitting in chair c̄ (L) leg elevated. [redacted]
1Dec03	(1700) NSG. Dr [redacted] did DSG ∆ to (L) Leg. D/ced splint. Cleaned wound c̄ NS, applied Bacitrain to wound, placed dry fluffs to fill hole + wrapped c̄ kerlex. Pt tol. DSG ∆ well. Dr [redacted] order QD DSG ∆. No new order written. (b)(6)-2 [redacted]
2000-	Assumed care of pt. @ 1800. VSS- A+O. pt. tolerate Reg diet well. LS CTA (B), Resp. even unlabored, abd. soft. non-tender BSX4. Reinforced dsg to (L) leg. Intact. skin graph intact to (L) UE. Elevated leg. Pt. able to move toes. ⊕ Pop pulse. Stitches intact to (L) knee. Pt. has ⊖ complain. voiding cyclopen urinal. (L) IV FA HL. Patent, flushes well. Two pt. restraints in place 3 skin compromise will cont. to monitor pt. [redacted]

(b)(6)-4 [redacted]

[redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
2DEC2008@1600	Assumed care of pt. @ 0600. VSS. A&O, Ø c/o pain. (L) LE elevated in bed. DRY DSG Δ to (L) lower leg, bacitracin oint. applied to skin graft. sites, mod, sero-sang drainage to old DSG. Pt. OOB, ambulated c crutches. Pt. sat in hallway ẽ becoming light headed. Pt. ambulated back to bed. Pt. given Kerlex roll to manipulate ankle joint & given instruction to exercise (L) LE. Pt. verbalized understanding. IV meds D/C'd. IVSL D/C'd. Pt. in 2-point restraints in bed, Ø S/SX of skin breakdown. Will cont. to monitor. [redacted] CT, AN,
3DEC0360355	Assumed care @ 1800; VSS, pt Alert speaking arabic; Ø c/o pain; IV intact to (L) LE; pt OOB to amb in hall c crutch assistance; Tolwell; pt compliant c P.T. instructions on ankle manipulation exercises; pt voiding c difficulty; TO1 Reg diet; Restraints in place c compromise to circ/skin; dsg to (L) LE CDI @ drainage; cont to monitor. [redacted]
3DEC@1700	Assumed care of pt. @ 0600. V.S.S. A&O, Ø c/o pain. (L) LE elevated on blankets. Pt. dorsiflexing (L) foot c Kerlex roll as per MD instruction. (+) pulses to LE bilat., dry dsg. Δ'd to (L) LE, ⅔ skin graft sites, greyish pink, sanguinous drainage to lateral STSG, serous drainage to proximal site, staples intact, bacitracin oint applied to

(b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

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

PROGRESS NOTES
Medical Record

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

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
3Dec03 0800	VSS Alert & Orient. Peripheral pulses palpable +2. (L) LE c splint / bulky dsg to STSG. Will Δ dsg @1530 hrs c MD. [redacted] D/I @ this time. Pt OOB c crutches to BR NWB to (L) LE. Consumed 50% of Breakfast. Urds clear and/or urine. 2 pt restraints in place without compromising skin integrity or circulation. Will continue care as planned. [redacted]
1935-	Assumed care of pt. @1800. VS - B/P: 111/62, HR: 96, T: 98.6, R: 18, SpO2: 99%, Pt. A+O speaking arabic. Bulky dsg/splint to (L) LE. Pt. able to move toes, brisk cap refill, (+) pulses. Dsg CDT. (5) Pt. ambulated to BR + hallway x 20 mins. NWB to (L) LE. Pt. voiding cyu spontaneously c difficulty. Pt. tol. 100% dinner. Pt. resting in bed @ this time c two pt. restraints in place. (-) skin breakdown. (+) circulation. Will cont. to monitor pt. [redacted]
14Dec 0730	VSS A+O. Peripheral pulses +2. (L) LE c splint / bulky dsg over STSG. Dry & intact. OOB → BR c crutches (I) with MP supervision. Consumed 50% of Breakfast. 2 point restraints in place without compromising circulation or skin integrity. Will continue plan of care. [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
3DEC2003 (cont)	graft. Ø IV access. Pt. in 2-point restraints, Ø S/Sx of skin breakdown or vascular compromise. All other assessments WNL. Will cont. to monitor. — [redacted] LT, AN
4DEC0350030	Assumed care @ 1900; VSS, pt alert + speaking arabic; Ø C/o pain, dsg to L LE intact, sm amt sero-sang drainage, Ø signs active drainage; Pt OOB to amb to BR C crutch assistance; pt C/o dizziness during ambulation, pt ~~then~~ sat in hallway for 10 min then proceeded to BR Ⓟ BM; Pt Tol Reg diet, Voiding Ø difficulty; Restraints in place, Ø skin circulation compromise; Cont to monitor — [redacted]
4DEC03@1100	Assumed care of pt. @ 0600, VSS. A&O, Ø C/O pain. [redacted] DSG Δ to Ⓛ LE, ⅔ STSG sites, staples intact, graft grayish pink, mod sero-sang drainage. Ⓛ LE elevated on blankets, pt does dorsiflexion & plantarflexion exercises (ERROR) [redacted] on own. Pt. in 2-point restraints, Ø S/Sx of skin breakdown. All other assessments WNL. — [redacted] LT, AN
4DEC 03 1900	VSS Alert & Oriented Ⓛ LE = bulky Kerlix dry & intact. Pedal pulses +2 bilateral. Ⓛ LE ↑ on folded blankets. Ø C/O pain or discomfort noted @ this time. Consumed 70% of regular diet for dinner. 2 point restraints implaced without compromising skin integrity or circulation. Will continue plan of care [redacted]
Ø4DEC03	(1350) Assumed care @ Ø600. Pt alert, speaking Arabic. VSS. Ø C/O pain. Pt OOB to amb in hallway C crutches Ø difficulty. ↑ to chair. Tol. well. Dsg to LE Δd. Bacitracin applied to skin grafts.

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
5DEC03	0100 - assumed care of pt. @0800. VSS - A+O. dsg.s completed to abd. WTD. Pt. tol. well. Pt. ambulated to toilet (+) BM. Returned to bed c̄ dsg saturated c̄ blood. Abd dsg, pto packed wounds WTD lightly. dsg crit. Pt. c/o pain. II percs given @ 2030. Pt. voiding cath via urinal s̄ difficulty. Pt. has Ø complaints @ this time. Pt. resting in bed @ this time c̄ two pt. restraints in place. (+) ⅋ circulation (-) skin break-down. Will cont. to monitor pt. [redacted] I concur with above assessment [redacted]
Ø5DEC03	(1230) Assumed care @ 0800. Pt alert, speaking Arabic. VSS. Ø c/o pain. Pt OOB to shower this am. Amb well. Abd wounds packed c̄ WTD dsgs. - NS soaked 2x2s. wounds moist and red s̄ S/Sx infection. Tol. reg diet well. Voiding s̄ difficulty. 2 point restraints in place s̄ S/Sx complications. Will continue to monitor. — [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.

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
04DEC03 (1350)	(cont) staples to skin grafts intact. UE elevated while in bed. Pt doing ROM exercises c̄ UE. Pedal pulse equal bilat +2. Tol. reg diet well. Voiding s̄ difficulty. 2-point restraints in place s̄ s/sx complications. Will cont. to monitor. [redacted]
5DEC03 1400	VSS A+O. Dsg to (L) LE dry & intact. Bulky Kerlix dsg. Consumed 60% of dnr for dinner. Pedal pulses +2 bilaterally. Ø c/o pain or discomfort noted or noted. (L) LE ↑ on folded blankets. Will continue plan of care [redacted]
06DEC03	(1100) Assumed care of pt @ Ø600. Pt alert, speaking Arabic. VSS. Ø c/o pain. Pt OOB to amb in hallway [redacted] c̄ crutches s̄ difficulty. T to chair. Dsg to UE Δd. Bacitracin applied to skin graft sites. Sm. amount sero'sang drainage noted from lateral skin graft site. Staples and sutures removed from UE incisions well healed s̄ s/sx infection. Pt doing ROM exercises c̄ UE. ⊕ pedal pulse equal bilat. Pt able to move all toes. Tol. reg diet well. Voiding

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

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

DATE	NOTES
06DEC03	(cont) ⅁ difficulty. 2 point restraints in place ⅁ SISK complications. Will cont. to monitor. — [redacted]
7Dec03 2015	Assumed care @1800; VSS, pt alert speaking arabic; Ø c/o pain; pt OOB → BR amb ⅁ crutch assistance ⅁ difficulty; dsg to (L) LE CDI, leg ↑ on 1 blanket pt performing ROM exercises as ordered; (+) CMS to (B) LEs; pt TOL Reg diet; voiding ⅁ difficulty; Restraints in place, (+) circ, (−) skin break-down, cont to monitor [redacted]
7DEC03 @1600	Assumed care of pt @ 0600. BP 90/56, other VSS. PO fluids encouraged. A&O, Ø c/o pain. DSG Δ to (L) LE, mod. serosang., staples intact to skin graft sites, bacitracin applied. (L) LE elevated in bed. Pt. OOB → hallway, ambulates well ⅁ crutches. Pt. in 2-point restraints in bed, Ø S/Sx of skin breakdown. All other assessments WNL. — [redacted] 24, AN
7Dec03 2355	Assumed care @1900; VSS; Ø c/o pain, pt alert speaking arabic; dsg to LLE CDI, small amt serosanguinous drainage, (−) s/sgns active drainage; pt OOB → BR ⅁ crutch assistance; (+) CMS to (B) LE; pt performing ROM exercises as instructed; TOL reg diet, voiding ⅁ difficulty; Restraints in place ⅁ compromise to skin/circulation, cont to monitor [redacted]
8DEC03 1000	VSS A&O (L) LE ⅁ skin graft intact to lower leg. Old drsg ⅁ moderate amt of serosanguinous drainage. Staples intact. Bacitracin applied to (L) + high skin graft donor site. (L) LE ↑ on folded blankets. Pedal pulses +2 bilat. Nail bed ⅁ brisk capillary refill. OOB ⅁ crutches to BR. Voiding without difficulty. Denies pain or discomfort @ this time [redacted]

[redacted] (b)(6)-4

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
11DEC03@ 0130	Assumed care of pt @1800. VSS. No c/o pain. Tol reg dinner well, ⊕BS, ⊖n/v. RLQ wound c̄ minimal drainage noted, WTD drsg Δd as ordered. LSCTA, void s̄ difficulty QS, pt ↑AMB to BR s̄ difficulty. 2pt restraints m̄s S/Sx of skin breakdown. Plan: monitor pain, monitor drsg, encpo & encOOB. [redacted]
06DEC03	(1100) Assumed care @ 0600. Pt alert, speaking Arabic. VSS. Ø c/o pain. Pt amb in hallway s̄ difficulty. Abd wounds packed c̄ NS soaked 2x2s. Wounds moist and red s̄ S/Sx infection. Small amount of sero-sang drainage noted. Tol. reg diet well. Voiding s̄ difficulty. 2-point restraints in place s̄ S/Sx complications. Will cont to monitor. [redacted]
7DEC03 @0100	assumed care of pt @1800. VSS. c/o incisional pain to ML abd, percocet given c̄ good relief noted. However, pt requested sleep aid. @ HS, pt sleeping s̄ difficulty. LSCTA ⊕BS, tol reg diet, ⊕BM today per pt report. Voiding s̄ difficulty. ↑AMB in hallway s̄ difficulty. ML & RLQ wounds healing, sm amt of green-tinted sero-sanguinous drainage noted, sutures noted / staples noted, both intact. WTD drsg Δ completed. 2pt restraints m̄s S/Sx of skin/circulation compromise. Plan: encAMB, encpo, pain control, monitor drsg [redacted]
7DEC03 @1100	Assumed care of pt. @0600. VSS. A&O. Ø c/o [illegible] pain. ⊕ Percs for c/o pain to abd. @ 1355. WTD DSG Δ to abd. Ø S/Sx of infx. Pt. OOB → BR, ambulates s̄ difficulty, Ø IV access. Pt. in 2-point restraints. Ø S/Sx of skin breakdown. [redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
9Dec03 0100	Assumed care @1800; VSS, pt alert speaking arabic; splint cast c̄ dsg to LLE intact; ⊕CMS ⊖LE; pt performing AROM exercises; pt OOB c̄ crutch assistance; pt voiding s̄ difficulty; Tol Reg diet; pt anxiously D/c to camp 9Dec; Restraints in place s̄ compromise to skin/circ; Cont to monitor [redacted]
9Dec 03 0700	- Assumed care of pt. A+O x3. VSS Ø c/o pain or discomfort. Lungs clear HRRR Active BS x4 quads Tolerating PO well. Urinating spontaneously s̄ difficulty Ambulates c̄ crutches. ⊖LE soft cast. dsg CDI. Afebrile Ø s/s of infection OK for discharge to epw camp. F/U in one week. Will cont to monitor [redacted]
1230	- Pt off floor to OR I+D of wound ⊖LE [redacted]
1600	- Pt returned from PACU VSS A+Ox3. ⊖LE DSG CDI Afebrile Ø N/V noted food given tolerated well. New orders and resume old. Will cont to monitor [redacted]
10Dec03 0030 0340	Assumed care @1800; VSS, pt alert speaking arabic; Ø c/o pain; dsg/splint/cast to LLE CDI, Ø drainage; pt in NAD; pt amb c̄ crutch assistance s̄ difficulty; Tol Reg diet; voiding spontaneously s̄ difficulty ⊕CMS ⊖LE; Restraints in place s̄ compromise to skin/circulation; cont to monitor [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)

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10 DEC 03 0000	Assumed care of pt. A+O x3. VSS Ø c/o pain or discomfort. Lungs clear HRRR Active BS x4 grade Urinating spontaneously ī difficulty Wound to (2) LE DSG CDI Bulky dsg ace wrapped. PO ABX Given Sterile PIV (2) hand d/c Will cont to monitor [redacted]
2035	Assumed care of pt @1800. VS → B/P: 100/54, HR: 94, R: 16, T: 98.4, SPO2 99%. A+O. Pt. has no c/o pain or discomfort @ this time. LS CTA (B), NSR, Resp. even unlabored, BS x4, voiding clear yellow urine via urinal spontaneously ī difficulty. (2) LE bulky dsg cont. Elevated (L) leg on blanket, brisk cap refill, (+) popliteal pulse, Encouraging IS. Tolerates PO well. good appetite. Pt. in two point restraints ī compromise to skin. (+) circulation (-) skin breakdown. Will cont. to monitor pt. [redacted]
10 DEC 03 @ 700	Assumed care of pt. @ 0600. VSS, A+O, Ø c/o pain. Pt. is (L) LE elevated in bed, splinted & ace-wrapped, CDI; Pt. OOB to chair, ambulates well ī crutches. Pt. tol. reg. diet well. Urinal @ bedside → CTU. MD Δ'd DSG to (L) LE @1530. ~ 11 skin grafts to (L) lower leg, intact ī staples. Bacitracin applied to anterior graft, dry dsg. WTD dsg to lateral skin graft. Splint replaced & ace-wrapped. Pt. in 2-point restraints, Ø S/Sx of skin breakdown. All other assessments WNL, [redacted] pt. HAP
12 Dec 03 @ 0430	Assumed care @ 1800; VSS, Ø c/o pain; pt alert speaking arabic; dsg tol. CDI, Ed/drainage ntd; pt OOB → BR, amb ī crutch assistance ī difficul; Ø BM; pt tol Reg diet; Voiding spontaneously ī difficulty; Restraints in

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
	(cont) place ∃ compromise to skin/circ ~~∃ compromise to~~ [redacted] SPROR ; will cont to monitor [redacted]
12DEC03 0900	VSS A&O. OOB → ⊂ crutches to BR NWB to (L) LE. Consumed 50% of Breakfast. Void clear amber urine. (L) LE ⊂ ~~splint~~ dry & splint dry & intact. Will Δ dry @ 1530 per Dr [redacted] request. Moves toes freely on (L) foot. Capillary refill brisk to nail beds. No c/o pain or discomfort. 2 point restraint in place without compromising circulation or skin integrity. Will continue care as planned. [redacted] LPN
12DEC03 1920	Assumed care of pt. @ 1800. VS: B/P 104/62, HR: 84, R: 16, ~~T: 98~~ SpO2 98%, T: 97.8. Pt has ∅ c/o pain or discomfort @ this time. Pt. ambulated to shower. Placed trash bag to (L) leg. Tolerated very well ⊂ ∅ complaints. ambulated in hallway x15mins. LS CTA(B), Resp. even unlabored, BS x4, voiding cyl via urinal ∃ difficulty. Dsg to (L) LE CDI. Pt. able to move toes, Brisk cap refill, (+) popliteal pulse. Two point restraints in place. will cont. to monitor pt. [redacted]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST [redacted]

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

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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
14DEC03	2130 - assumed care of pt @ 1800. LSS A+O ∅ c/o pain or discomfort @ this time. Tolerates reg diet + PO well. OOB to ambulate in hallway NWB. Tolerated well. left leg elevated. (+) pulses. (L) LE c̄ splint CDI. Pt. able to move toes. Voiding clyr w/o urinal c̄ difficulty - Pt in two pt restraints per UPU protocol. (-) skin breakdown (+) circulation will continue to monitor pt [redacted]
	(0230) Concur ō above assessment. [redacted]
15DEC03 @ 1530	pt. went to OR. taken in a gurney - [redacted]
15DEC03 @ 1740	pt. back from OR c̄ I&D on (L) leg. VSS. A+O, speaking arabic. IV site on (L) forearm patent. splint in place on (L) leg. Dsg c̄ ace wrap around (L) leg CDI. JP drain on I&D site intact - (-) drain at this time. (+) PMS on bilat LE. (-) signs of skin compromise on restraints. - [redacted]
2020 -	assumed care of pt. @ 1800. LSS - A+O ∅ c/o pain or discomfort @ this time.

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

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

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

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

PROGRESS NOTES
Medical Record

STANDARD FORM 51
Prescribed by SGANOVR RPMD (4/1/72)

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
(cont'd)	Dsg to (L) LE CDI c̄ JP drain intact. Pt. able to move toes, brisk cap refill, (+) pulses. Pt. tolerates PO well. voiding cyu ∃ difficulty. IV (L) FA flushes well Ø s/sx inf. Will cont. to monitor pt [redacted]
16	(0315) I concur c̄ above assessment. — [redacted]
0550-	Recieved 3cc via JP drain entire shift [redacted]
16DEC03 @1520	Assumed care @ 0600 VSS. A&O, speaking arabic. Dsg on (L) leg CDI. JP drain intact. (+) PMS on bilat LE. OOB → hallway, toilet. amb well AO c̄ crutches. Reg. diet tol well. Voiding CYU ∃ difficulty. (−) c/o pn. or discomfort at this time. (−) signs of skin compromise on restraints. will continue to monitor. — [redacted] c̄ 9/W/C. —
	remain — [redacted]
16DEC03	(1720) emptied 7.5cc of drainage from [redacted]
1945-	assumed care of pt. @1800. VSS - A&O Ø c/o pain or discomfort @ this time. Pt. ambulated in hallway c̄ crutches. Tol. well. splint to (L) LE CDI. JP drain intact. Pt. able to move toes. brisk cap refill, (+) pulses. Pt. tol. Reg diet well. voids cyu via urinal ∃ difficulty. Pt. resting in bed @ this time c̄ two point restraints. (−) skin breakdown. (+) circulation. Will cont. to monitor pt — [redacted]
17	(0240) I, concur c̄ above assessment. — [redacted]
0600-	Recieved 5cc from JP drain [redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
17DEC03@1610	Assumed care of pt. @ 0600. VSS. A&O, Ø c/o pain. Ⓡ (ERROR) MD Ⓛ LE elevated in bed, splinted, dressed & covered c̄ ace-wrap. DSG to Ⓛ LE intact, sanguinous saturation noted inner aspect of dsg. JP to Ⓛ LE draining sanguinous fluid, MD Δ'd DSG @ 1600, yellow brown drainage from skin graft, now DSG CDI. Incision to inner aspect of lower leg well approx., small amount of sanguinous drainage to inferior portion of incision. Pt. OOB, ambulates well c̄ crutches. Tol. reg diet well. Cont. PO anti-bx. Pt. in 2-point restraints, Ø S/Sx of skin breakdown. All other assessments WNL. Will cont. to monitor pt. [redacted] RN
17DEC03@1915	JP output 8cc sanguinous drainage, [redacted] RN
17Dec03 2025	Assumed care of Pt @ 1800 hrs. VSS A&O ϕ c/o pain. Ⓛ LE elevated. LLE c̄ splint and Ace wrap Dsg. No Drainage noted. JP c̄ bulb suction intact. LS CTA Ⓑ ⊕ BS x 4 quads Pt void qs c/u s̄ difficulty. Will cont to Monitor. [redacted] Sgt 9th MM

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

DEPARTMENT/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)

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WARD NO. KW1

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PROGRESS NOTES
Medical Record

STANDARD FORM 97
Prescribed by SGA/DOMS (PMB 1 AUG 78)

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
18 Dec 0800	VSS A&O OOB c̄ crutches → BR for AM care JP x1 w/ Bulb suction from (L) Leg wound. (L) Leg bulky dry covered c̄ ace wrap D/I. JP c̄ scant output serous. Consumed 30% of Bkf fast. Ø c/o pain voiced. Pedal pulses palpable +2. (L) Leg ↑ while in bed and NWB to (L) LE while ambulating. Ø c/o dizziness while ambulating 2 point restraints in place, while in bed, without compromising circulation or other integrity. Will continue plan of care. [redacted]
18 Dec 03 2000	Assumed care of Pt @ 1800. VSS A&O Tol PO well. LLE in splint c̄ Drsg and Ace Wrap. Drsg CDI. JP to LLE in place & Intact, putting out Sero Sang Fluid. Void qs c̄ x1 c̄ difficulty. LS CTA (R), (+) BS x4 quads. Will cont to monitor. [redacted] 91WM1
19 Dec 03	0550 - Drain 7.5 cc of Bloody Drainage From JP [redacted] 91WM1
19 Dec 03 (@0800)	assumed care of pt @ 0600. VSS, no c/o pain. Alert, speaking arabic. LSCTA, HRR, (+) BS, the leg dressing well, void per urinal QS. LLE in splint & ace wrap dsg, CDI, (+) CMS, +2 edema noted to toes. 2 pt restraints in S/SX of skin/circulation compromise. Plan: AMB today, enc po intake, enc OOB, pain control plan. Addendum: (L) thigh skin graft donor site OTA, healed over, ø S/SX of infection. Will cont to monitor. [redacted]
19 Dec 03 @1800	JP output = 2.5cc of thick bloody drainage. AT / AMB x2 c̄ difficulty. ø pain. Will monitor. [redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
19 DEC '03	Assumed care @ 1800 pt awake + oriented x 3 VSS pt has ∅ c/o pain at this time. pt up with crutches to BR c a little difficulty restraints x2 in place ⊖ skin breakdown, pt self applies lotion to donor site. pt wrists has slight edema. Will Monitor — Spc [redacted]
20 DEC 03 @ 0245	Assumed care of pt @ 0200. VSS. no c/o pain. LLE in splint c dsg CDI, ⊕ CMS, JP c minimal drainage noted. LS CTA, ⊕ BS, tol regular diet, void per urinal QS. pt ↑ Amb c crutches c difficulty. ⊕ Drng c skin graft site healing well, OTA drainage. ⊕ pt restraints on S/Sx of skin/circulation compromise. Plan: cont OOB, cont po intake, monitor neuros, pain control [redacted] Spc
20 DEC '03 JP drain Scc	Assumed care @ 1800 pt AOx3, VSS pt has ∅ c/o pain @ this time, LLE splint dsg Δ'd AM, JP in place intact. Pt self applies lotion ⊖ thigh graft site, restraints x2 in place ⊖ skin breakdown. Will monitor — [redacted]
21	(0835) I concur c above assessment. [redacted]
12/21/03 1400	VSS. AO. ⊕ pulse to LLE & CMS intact. BRB during to JP drain. ∅ c/o pain @ this time. OOB to ambulate

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

DEPARTMENT/SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 97
Prescribed by SGAMCMR 4500.61(C)(3)

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	PRN ∓ difficulty ∓ outcher. Voiding spontaneously light yellow urine ∓ difficulty. ∅ s/s infection to wound and ∅ s/s skin breakdown. [redacted]
21DEC03	Assumed care @ 1800 pt awake oriented x3, VSS pt has ∅ c/o pain at this time, pt up OOB ambulating in hallway without difficulty, pt ⊕ leg elevated receiving meds as ordered, restraints x2 in place ∅ s/s of infection. Will monitor. For [redacted]
22	(⊕A1⊕) I concur ∓ above assessment. [redacted]
22DEC03 1325	VSS. AO. ⊕ pulse to LLE and ⊖ s/s intact. CMS intact to LLE. ∅ c/o pain and up at bed to BR and ambulate. Voiding spontaneously ∓ difficulty. All other systems WNL. ∅ s/s of infection to wound site. ∅ s/s skin breakdown. [redacted]
23Dec03 0605-0540	Assumed care @ 1800; VSS, pt A&O speaking arabic; ∅ c/o pain; pt OOB to amb ∓ crutch assistance ∓ difficulty; splint cast to LLE in place, ⊕ CMS +2 PP, brisk cap Ref; pt tol Reg diet, voiding spontaneously; Restraints in place ∓ compromise to skin/circ; cont to monitor. [redacted]
23DEC03 1620	Assumed care @ 0800. Pt A&O VSS. OOB → ambulated to BR ∓ crutches. Had X-RAY of (L) Tib/fib done. Dr [redacted] reviewed X-Ray results ∅ new ordered. Pedal pulses equal +2. ∅ c/o pain voiced. OOB → chair one hour ∓ ⊕ leg elevated. Consumed 50% of meals. Will continue care as planned. [redacted]
24Dec03	Assumed care @ 1800; VSS, ∅ c/o pain, pt alert speaking arabic; splint/cast in place, dsg CDI; ⊕ CMS, +2 PP, brisk cap Ref to affected extremity

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

pt tol Reg diet, voiding spontaneously ∅ difficulty; Restraints in place ∅ compromise to skin/circ; cont to monitor [redacted]

24DEC03 1250 Assumed care @ 0600. VSS, ~~Pt~~ Pt AO DOB + BR c crutches. Tolerated well ∅ c/o dizziness upon ambulation. ∅ c/o pain voiced or noted. Pt (L) LE cast/splint dry dry & intact. Pt moves toes freely (R) foot. Pedal pulses palpable +2 Bilateral. Consumed 50 % of meals. 2 points restraints in place without compromising circulation or skin integrity. Will continue planned care [redacted]

25Dec03@0245 Assumed care @ 1800; VSS, ∅ c/o pain, pt AO speaking arabic; splint/cast in place, leg wound OTA ∅ 2 Band-Aids, ∅ drainage, (+) CMS to LLE; pt refused to amb; pt voiding ∅ difficulty, Tol Reg diet; Restraints in place ∅ compromise to skin/circ; cont to monitor [redacted]

25 (0400) I concur ∅ above assessment. (11) [redacted]

25DEC03 1600 Assumed care @ 0600. VSS AO. ∅ c/o pain throughout shift. DOB c crutches to BR showered. Consumed 100% of meals. Pedal pulses +2 bilateral. Small amt of active bleeding noted to STSG Rt [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME		SPO
	LAST	FIRST	MI
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PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)

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PROGRESS NOTES
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DATE | NOTES

25DEC03 Assumed care @ 1800 pt AOX3, VSS pt has ∅ c/o pain at this time, LLE elevated dsg removed splint intact, wound OTA sutures intact wound appears dark red with minimal drainage restraints x2 in place will monitor — [redacted]

Concur c above. [redacted]

26DEC03 assumed care @ 0600. AOO VSS. ∅ c/o pain
1600 this shift. OOB c crutches to BR & Amb Care. STSG site (L) LE healed small amt active bleeding upon ambulation. While in bed & chair (L) LE ↑ on pillows. Area clean c sterile NS & dry c sterile gauze. Area left open to air. Splint in place. Pedal pulses palpable c +2 bilateral. Will cont plan of care — [redacted]

27Dec03@0049 Assumed care @ 1800; VSS; pt A&O speaking arabic; ∅ c/o pain; LLE ↑ on one blanket, splint in place, OTA, sutures intact, minimal drainage; s/c to (R) FA patent, easily flushes c̄ s/sx infection; cont IV abx; pt TOI Regular, voiding c̄ difficulty. Restraints in place c̄ compromise to skin/circ; cont to monitor — [redacted]

27Dec03 Pt AtOX3, VSS, LS CTA (B), (+) BSX4, ∅ c/o pain,
1100 LLE on splint c̄ dsg, wound CDI OTA, ∅ s/sx of infex, pending short cast to ext, voiding CYU c̄ difficulties, consumed ∅% of breakfast, awaiting transport to camp, ∅ s/sx of skin breakfast. [redacted]

STANDARD FORM 509 REV 8-72

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
12/27/03	D/C Summary This Iraqi male is post IM nailing c̄ soleus muscle flap for (L) tibia Fx. Wounds are healed. He is to remain on antibiotics for three weeks Augmentin 500 mg po 3x/day. Ambulate c̄ crutches. Follow up 1 week for suture removal & cast change. [redacted] USAF MC (b)(6)-2

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

DEPART., SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1990)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
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)*
19 NOV 03	SEX: M AGE: WGT: HGT:
1945	ALLERGIES: ASA: 1 2 3 4 5 E
	CURRENT MEDICATIONS:
	PROPOSED SURGICAL PROCEDURE: I+D (L) tibia fx, placement ext. fixator
	PAST MEDICAL HISTORY:
	AIRWAY: Mallampati 1 2 3 4 Dentition Status:
	RESPIRATORY:
	CARDIAC:
	RENAL:
	ENDOCRINE:
	PROPOSED ANESTHESIA TECHNIQUE: Spinal
	DISCUSSION OF RISKS AND BENEFITS: accepts
	ANESTHESIA PROVIDER: [redacted] CRNA
	(b)(6)-2

deferred d/t lack of translator

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

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 EPW

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19NOV03	PATIENT ARRIVED AT 1929 ON A LITTER
	WITH AN IV IN L HAND THAT WAS DC'd.
	GSW L LOWER LEG. 556 ROUND. INJURY OCCURRED
	AT 1845. 10 mg MORPHINE GIVEN AT 1845.
1933	WOUND CLEANED AND DRESSED.
	GSW THROUGH AND THROUGH L LOWER LEG
1935	IV STARTED R ARM
1938	IV STARTED L ARM AC
1941	X RAYS L LOWER LEG

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.

IRAQI EPW

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

558-104 7540-01-075-3784

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

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 19 Nov 03 | TIME: 0848

TRANSPORTATION TO FACILITY: Air evac

SEX: M

DUTY/LOCAL PHONE: AREA CODE | NUMBER

AGE: 39

HOME PHONE: AREA CODE | NUMBER

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

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

CURRENT MEDICATIONS: Ø

ALLERGIES: NKDA

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: GSW (L) TIBFIB

Ø med problems
Ø surg

CATEGORY OF TREATMENT

☐ EMERGENT
☒ URGENT
☐ NON-URGENT

TIME: 2340

INITIALS: (b)(6) [redacted]

VITAL SIGNS

TIME	2347				
BP	123/66				
PULSE	72				
RESP	16				
TEMP	94.2				
WT					

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

☒ PULSE OX 97 ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE

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)*

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

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

038

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

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

See Surgery H+P

~~L Frenum vs Central line placement~~

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

(b)(6)-2

PROVIDER SIGNATURE AND STAMP

[redacted]

DIAGNOSIS

OFC6/RS Fx c Fx/Ex

CODES

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

[redacted] (b)(6)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

038

NSN 7540-01-075-3786

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

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

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

CURRENT MEDICATIONS	INJURY OR OCCUPATIONAL ILLNESS				EMERGENCY ROOM VISIT	
	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 GSW (L) lower leg

CATEGORY OF TREATMENT		VITAL SIGNS					
☐ EMERGENT	TIME	TIME	1930	1940			
		BP	137/84	119/80			
☐ URGENT		PULSE	87	85			
	INITIALS	RESP	24	24			
		TEMP					
☐ NON-URGENT		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)*

IRAQI EPW

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

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
19NOV03		2125	BP: 117/42 P: 76 R: 16 Temp 96 SPO2 98% [redacted]
		2130	≈40 yo ♂ admitted to pt hold S/P I&D / ex-fix of (L) leg due to GSW. Pt somnolent due to anesthesia, responsive to verbal stimuli. Pt has (L) leg in (b)(6)-2 compression bandage c̄ ex-fix in place. ∅ soaking of blood. Pt to be evac to Jdth CSH. [redacted]
		2230	Pt to [redacted] priority. [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.

Khamal

EPW

NURSING NOTES

Medical Record

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

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

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA BY	2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY
3. DATE 19 Nov 03 TIME PATIENT ARRIVED IN SUITE	4. PATIENT IN ROOM TIME 0756 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

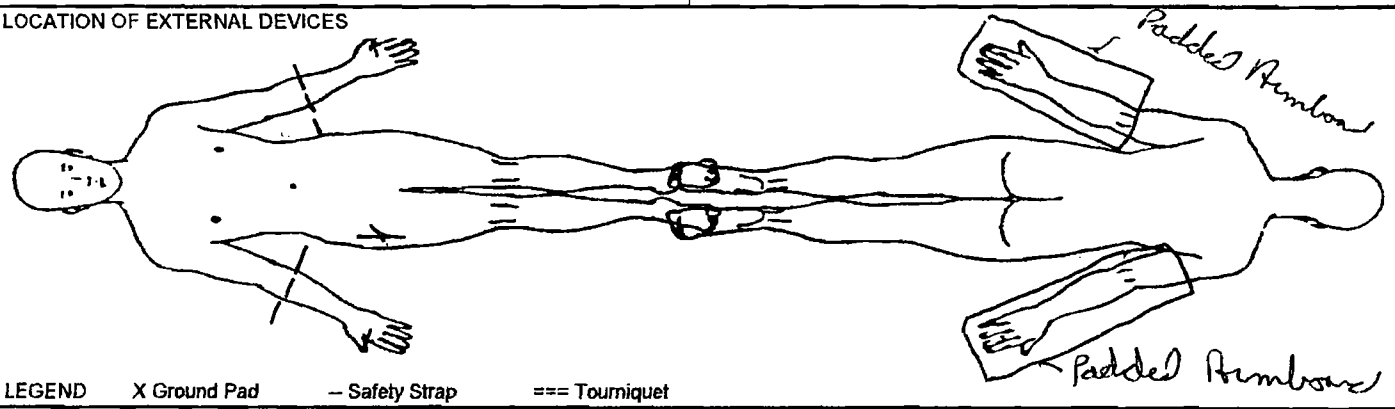
HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☒ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP

COMMENTS:

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

COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap === Tourniquet

C = Correct I = Incorrect

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

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

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

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

☒ ESU NO: 50046
GROUND PAD: BRAND 3M
LOT NO: 2005-07 JN

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

13. PROSTHESIS, IMPLANTS ☐ NO IF YES NAME: ID NUMBI IUFACTURER

External fixator (L) Tibia

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY
[redacted] (b)(6)-2		

PHYSICIAN'S SIGNATU[redacted]

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

YES ☐ NO ☐

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*

2 kapas, Sterile, Ace

19. ADDITIONAL INFORMATION

SP 2025

EP 2117

20. OPERATION(S) PERFORMED

I+D + ex fix (L) Tibia

21. PATIENT TRANSFERRED TO	TIME	METHOD
Pt. hold		litter

22. REGISTERED NURSE SIGNATURE 556 [redacted] (b)(6)-2

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

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 Letter BY anesthesia

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

3. DATE 15 Dec 03 TIME PATIENT ARRIVED IN SUITE —

4. PATIENT IN ROOM TIME 1530 NUMBER 1-1 5

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] 910 (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

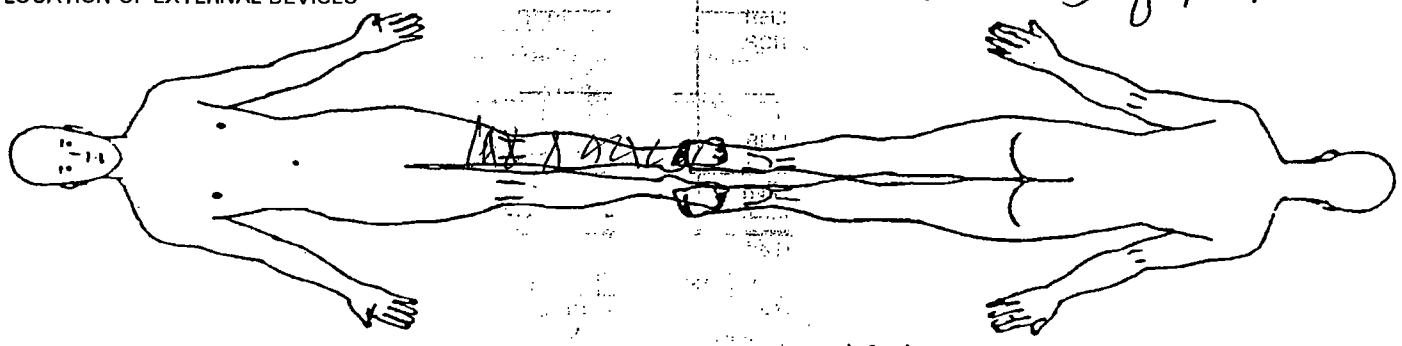
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

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

COMMENTS: no pooling of prep noted

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS — C = Correct I = Incorrect

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

[redacted] (b)(2)-2

13 Dec 03

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

☐ ESU NO: [redacted] CUT COAG 220 watts
GROUND PAD: BRAND Valleylab E7507
LOT NO: 69441 2005-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

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 YES ☐ NO ☐ IF YES, SITE

16. LABORATORY SPECIMENS

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

18. DRESSING/IMMOBILIZATION *(Specify)*
- fluffs
- kerlix

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. JP 10mm	2.	3.
SITE	1. (L) leg.	2.	3.

19. ADDITIONAL INFORMATION

(b)(6)-2

20. OPERATION(S) PERFORMED

DPC (L) leg, I&D (L) leg

21. PATIENT TRANSFERRED TO 1 CUB TIME 1700 METHOD letter

22. REGISTERED NURSE SIGNATURE [redacted] CPT/AN

REVERSE OF [redacted]

MEDCOM - 25095

USAPA V1.00

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

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA stretcher BY anesthesia

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

3. DATE 9 DEC 03 TIME PATIENT ARRIVED IN SUITE →

4. PATIENT IN [redacted] TIME 1343 NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

(b)(6)-2

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Proper body alignment maintained

8. SKIN PREPARATION

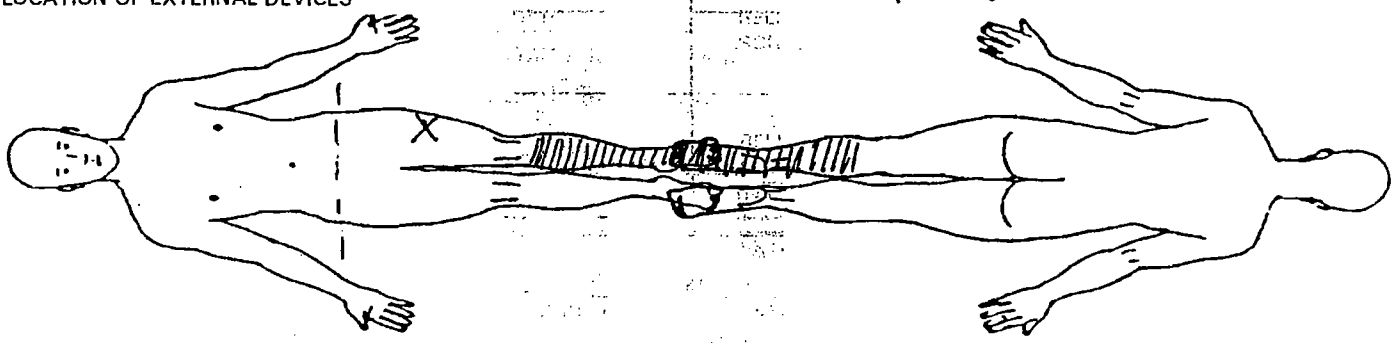
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine scrub/sol'n
SITE: Lt. lower leg BY WHOM [redacted]
SITE: BY WHOM:

COMMENTS: No pooling of fluids

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect Initial C [redacted]

10. COUNTS

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

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

[redacted] (b)(6)-4

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

☐ ESU NO: Force 40 RBB10239S
GROUND PAD: BRAND Valleylab REM
LOT NO: #71516

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

13. PROSTHESIS, IMPLANTS [ ] ☒ NO IF YES NAME: ID NUMBER UFACTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO; TYPE(S):

0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATU[redacted]

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☒ NO ☐	NAME Cx - Aerobic/Anerobic, Gm Stain	NAME - Lt. Leg Wound
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*

Kerlix
Fluffs
Splint
Ace

19. ADDITIONAL INFORMATION

Surg: [redacted] Anesth: [redacted] ENA Type: General

(b)(6)-2

20. OPERATION(S) PERFORMED

1. I&D of Lt. Leg Wound

21. PATIENT TRANSFERRED TO PACU TIME 1450 METHOD Stretcher

22. REGISTERED NURSE SIGNATURE [redacted] CPT/AN

MEDCOM - 25097

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

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 stretcher BY anesthesia

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

3. DATE 26 Nov 03 TIME PATIENT ARRIVED IN SUITE 0755

4. PATIENT IN ROOM [redacted] TIME 0806 NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

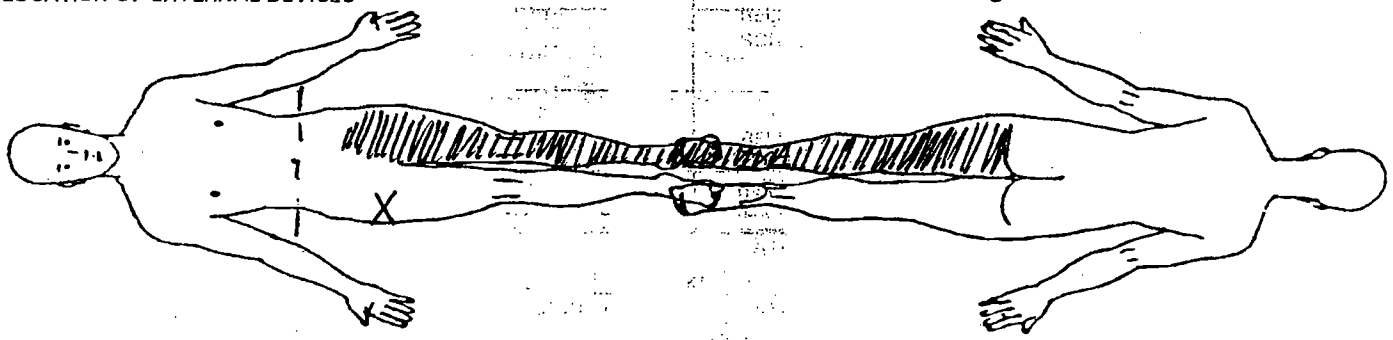
HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP

COMMENTS: No nicks observed

PREP SOLUTION *(Specify)* Betadine scrub/sol'n
SITE: Lt. Leg BY WHOM [redacted]
SITE: BY WHOM:

COMMENTS: No pooling of fluids

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect Initial [redacted]

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

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

[redacted] (b)(6)-7

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

☒ ESU NO: Force 40 R8E105305 50/50
GROUND PAD: BRAND Valleylab REM
LOT NO: 71516

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

Synthes Tib. Set Implants
Load #0232902
Universal Tibial Nail Implants
Load #0232902

90 x 345 IM Nail

Screws:
Proximal 40 x 1
Distal 44 x 1

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Mineral Oil		intraop	topical		Dr [redacted]
Bacitracin oint.		intraop	topical		Dr [redacted]

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY
None		

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

15. X-RAY IN OPERATING ROOM YES ☒ NO ☐ C-Arm IF YES, SITE Lt. Leg

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	16 FR Foley	10mm JP Drain	
SITE	Bladder	4. lower leg	

18. DRESSING/IMMOBILIZATION (Specify)

Xeroform
Kerlix
donor site Lt. thigh

Fluffs Xeroform
Kerlix Cotton
Webril
Plaster splint
Ace wrap
Lt lower leg

19. ADDITIONAL INFORMATION

Surg: [redacted]
Asst: [redacted]

Anesth: [redacted] CRNA

Type: General

(b)(6)-2

20. OPERATION(S) PERFORMED

1. LT. Tibial IM Nailing
2. Soleus Muscle Flap w/ skin graft

21. PATIENT TRANSFERRED TO PACU (ICW-1) TIME 1215 METHOD stretcher

22. REGISTERED NURSE SIGNATURE [redacted] CPT/AN

MEDICAL RECORD — **INTRAOPERATIV DOCUMENT**

For use of this form, see AR 40-407, the propone he office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING M
VIA Litter BY MAJ [redacted]

2. PATIENT IDENTIFIEL ORD REVIEWED AND PROCEDURE VERIFIED BY MAJ [redacted]

3. DATE 21 Nov 03 TIME PATIENT ARRIVED IN SUITE 1805

4. PATIENT IN ROOM TIME 1805 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

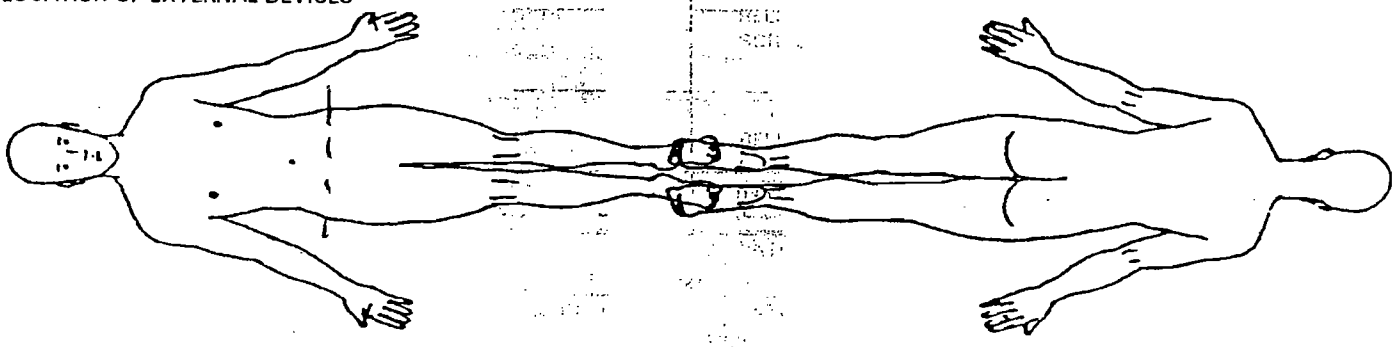
HAIR REMOVAL ☐ YES ☑ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine scrub + solution
SITE: Left Leg to hip BY WHOM: Mr [redacted]
SITE: BY WHOM:

COMMENTS: No pooling of solution

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C = Correct I = Incorrect

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

(b)(6)-2

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

[redacted]
(b)(6)-4

(b)(2)-2

21 Nov 03 [redacted]

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

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

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

☐ BIPOLAR NO: _____

13. PROSTHESIS, IMPLANTS ☐ ☑ 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): Nc 5

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE [redacted]

15. X-RAY IN OPERATING ROOM YES ☐ NO ☑ (b)(6)-2 IF YES, SITE

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☑

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

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs
Kerlix
Ace

19. ADDITIONAL INFORMATION

Surgeon: Du[redacted]
anes: MAJ [redacted]

(b)(6)-2

20. OPERATION(S) PERFORMED

I+D Lt T/16/F16 Fx

21. PATIENT TRANSFERRED TO PACU TIME See SF 517 METHOD OR Litter

22. REGISTERED NURSE SIGNATURE [redacted] MAJ ANC 21 Nov 03

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY 21 22 23 24 25 26-27 27

19 2003 HOUR

PULSE (O) TEMP. F (°) TEMP. C

105° 40.6°

180 104° 40.0°

170 103° 39.4°

160 102° 38.9°

150 101° 38.3°

140 100° 37.8°

130 99° 37.2°

98.6° 37.0°

120 98° 36.7°

110 97° 36.1°

100 96° 35.6°

90 95° 35.0°

80

70

60

50

40

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

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. ICW1

[redacted] (b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR NOV 1963 | DAY | HOUR

PULSE (0) | TEMP. F (°)

DAY	28	29	30	1	2 Dec	3 Dec	4 Dec

TEMP. C (Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT

Record special data only when so ordered

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

REGISTER NO.

WARD NO. 1CW1

#[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: 1

POST- DAY

MONTH-YEAR: Nov 2003 | DAY: 20, 21, 22, 23/24, 25, 26, 26/27 | HOUR: 0, 0, 2, 0800, 0520, 1, 0, 2, 0, 1, 1400, 2, 0, 7

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

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

RESPIRATION RECORD: 18, 18, 20, 16, 18, 18, 18, 115/67, 19, 16, 18, 20

BLOOD PRESSURE: 114/60, 92/50, 100/67, 122/71, 107/66, 104/63, 92/67, 104/67, 114/68, 85, 103, 104/56, 112/61

99.7, 64, 1183, #91, 121/67, 99.1, 89, 197/6, 99.9, 117/76

HEIGHT: | WEIGHT →: 100.6, 98%, 98%, 99%, RA, 98%, 95% RA, 98% (RA) 97% RA, 97% RA, 95%, 98% RA, 95%, 99%, 95% RA, 96% (RA) 97% RA, 101.2

Record special data only when so ordered: 0.25 NT

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

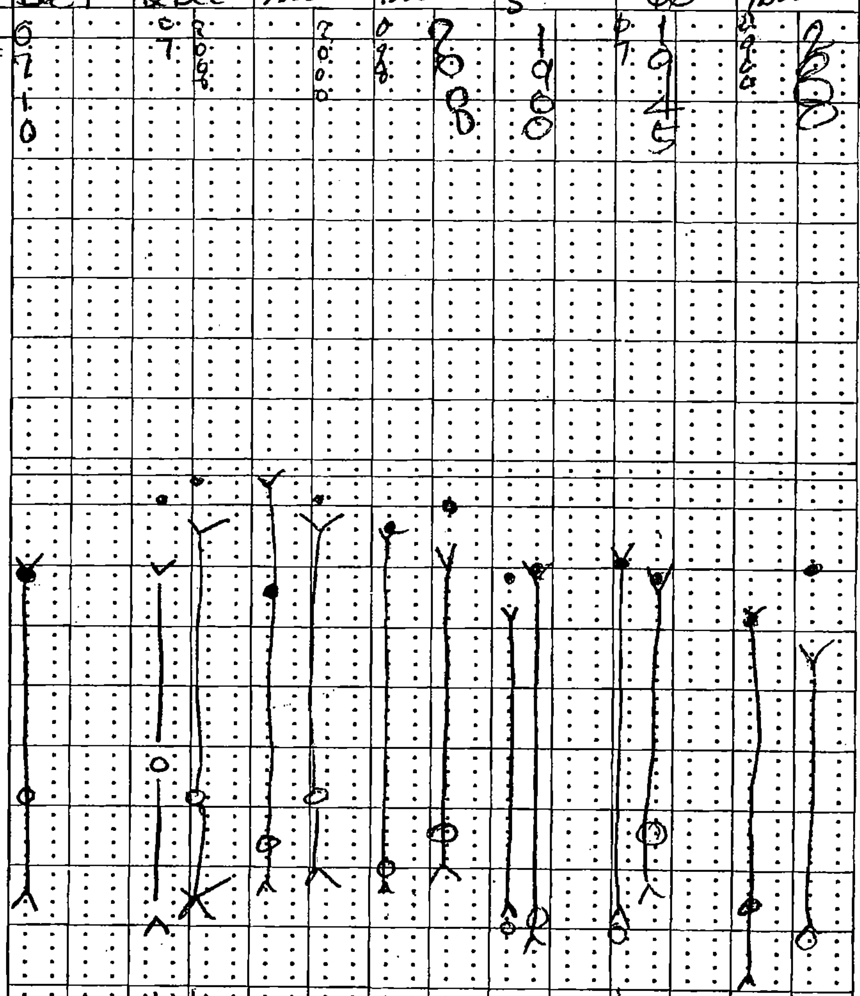
REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7–95) BACK

[redacted] (b)(6)-4

MEDICAL RECORD	VITAL SIGNS RECORD						
HOSPITAL DAY							
POST- DAY							
MONTH-YEAR / DAY	Dec 1	2 Dec	3 DEC	4 DEC	5	6	7 DEC
19 / HOUR	0710	07 / 2000	2000	0800 / 2000	1900	07 / 1945	0800 / 2000



	Dec 1	2 Dec		3 DEC		4 DEC		5	6	7 DEC	
RESPIRATION RECORD		17	18	16	18	16		18 18	16 18	16	18
BLOOD PRESSURE	101/55	101/51	115/55		116/60	94/44	110/60	124/64	111/54		95/52
	72	77						96.8	116/58		
	96.9	98.1						50			
HEIGHT: / WEIGHT →	97.6	97									
			98% RA	98% RA	99% RA	97% RA	98% RA	98%	96% (RA) 98% RA	94% RA	98% RA
								109/49 99% RA			

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7-95) BACK

[redacted] (b)(6)-4

MEDCOM - 25105

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY																		
POST-	DAY	11-25-93		26		26			27		28		29		30			
MONTH-YEAR	DAY																	
19	HOUR	18	1600		0	2				2	0		0	2000	8			
PULSE (0)	TEMP. F (°)				6	8				1	8		8		8			TEMP. C
	105°				5	8					8				8			40.6°
180	104°				5	8				8					8			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			15		18	18			20	16	16		22	20	18			
BLOOD PRESSURE			127/64	113/65	105/60	109/51			116/60	109/54	127/72	110/64	105/68	112/62	114/57	102/49		
			1085	85	97.5				975			85			98.9			
			79	98	64	97.3			63	97.2	107	98			77			
HEIGHT:	WEIGHT →		99%	98%					98%									
			RA		98%	98% RA				98% RA	96% RA	98%		97% RA	97%	98% RA		

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[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	13 Dec		14 Dec		15	16	16	17		18		19		20								
19	HOUR	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1						
PULSE (O)	TEMP. F (°)	3	0	7	2	8	7	8	9	8	9	7	0	8	8	7	3						
	105°	3	3	7	0	8	4	8	0	3	3	0	0	8	8	8	8						
			0	3	0	8	0	0	0	0	0		0				0						
180	104°						5																
170	103°																						
160	102°																						
150	101°																						
140	100°																						
130	99°																						
	98.6°																						
120	98°																						
110	97°																						
100	96°																						
90	95°																						
80																							
70																							
60																							
50																							
40																							
RESPIRATION RECORD		8	8	8		8	6	6	6		4		8	10	8	9							
BLOOD PRESSURE			111/62		108/60	93/54	115/62	101/55				105/58	96/50		106/60								
						97/61						84		99		86							
HEIGHT:	WEIGHT →					97.5	98.1					98.5		98.3		98.0							
						96.8						98.2		5002		5002							
	O2		99%		99%	97%	99%	99%	98%			RA	96%	97%	98%	97%							
	Source		RA		RA	RA	RA	RA	RA				RA		RA								
						99%																	
						RA																	

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)

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

[redacted] (5)(6)-4

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR Dec DAY: 5, 6, 7 Dec, 8 Dec, 9 Dec, 10, 11, 12

19 HOUR

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

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

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

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[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

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

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
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		

======= PICCOLO =======
20/11/03 07:39
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(4)-4
BASIC METABOLIC
DISC LOT #: 3325AA4
OPER #: 172 DR #: 000
SERIAL #: 0000100494

GLU	122*	73-118	MG/DL
BUN	7	7-22	MG/DL
CA++	8.5	8.0-10.3	MG/DL
CRE	0.8	0.6-1.2	MG/DL
NA+	135	128-145	MMOL/L
K+	4.4	3.3-4.7	MMOL/L
CL-	106	98-108	MMOL/L
tCO2	26	18-33	MMOL/L

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
CO_2		18-33 mmol/l

REMARKS:

REPORTED BY:

(b)(6)-2

Ward/Section: ICW 1	REQUESTING PHYSICIAN: Dr. [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
EPW # [redacted] (b)(6)-7	20 NOV03	0720	# [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 10^6	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:	DATE:	LAB ID NO.:

ID [redacted]
WB

20-11-03
00:03

			Patient Limits	
WBC	10.0	x10^3/uL	4.5	10.5
RBC	4.08	x10^6/uL	4.00	6.00
Hgb	12.4	g/dL	11.0	18.0
Hct	37.8	%	35.0	60.0
MCV	92.7	fL	80.0	99.9
MCH	30.5	pg	27.0	31.0
MCHC	32.9 L	g/dL	33.0	37.0
Plt	253.	x10^3/uL	150.	450.
LY%	15.7 *L	%	20.5	51.1
LY#	1.6 *	x10^3/uL	1.2	3.4

(b)(6)-4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/20/03 00:17

Patient ID [redacted]
Test Name :PT
Test Result:= 14.6 sec.
Ratio = 1.2
[redacted]
Sample Type:citrated wh. blood
Test Date :11/20/03
Test Time :00:15
Card Lot :080201
Operator [redacted]

ID [redacted]
WB

20-11-03
07:54

			Patient Limits	
WBC	8.2 *	x10^3/uL	4.5	10.5
RBC	3.94 L	x10^6/uL	4.00	6.00
Hgb	12.1	g/dL	11.0	18.0
Hct	36.7	%	35.0	60.0
MCV	93.2	fL	80.0	99.9
MCH	30.8	pg	27.0	31.0
MCHC	33.0	g/dL	33.0	37.0
Plt	234.	x10^3/uL	150.	450.
LY%	19.1 *L	%	20.5	51.1
LY#	1.6 *	x10^3/uL	1.2	3.4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/20/03 00:23

(b)(6)-2

Patient ID [redacted]
Test Name :APTT
Test Result:= 31.2 sec.
Sample Type:citrated wh. blood
Test Date :11/20/03
Test Time :00:17
Card Lot :110214
Operator [redacted]

(b)(6)-2

Ward Source: EMT	REQUIS[redacted]		LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] (b)(6)-2	DATE: 15nov43	TIME: 2345	SSN/PREFIX-J 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 10³	Color		N/A	RPR		Negative
RBC		4.7-6.1 x 10⁶	App		N/A	Mono		Negative
Hgb		14-15 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 10³ 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		9.3-13.6 secs			
APTT		21-34 secs			
D-Dimer		<500 ng/ml			
FDP		<10 ng/ml			

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

(b)(6)-2

Ward Section: pmt	REMITTING PHYSICIAN: [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted]	DATE: 15NOV TIME: 2345	SSN/PSEUDO SSN: [redacted]

(i-STAT)			(Piccolo) Chemistry			(Piccolo) Metabolic Panel		
TEST	RESULT	REF. RANGE				TEST	RESULT	REF. RANGE
Na		138-146 mmol/L				GLU		73-118 mg/dL
K		3.8-4.9 mmol/L						
Cl		99-109 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 =======
1:/11/03 (b)(6)-00:2: AM
REFERENCE RANGE: MALE
PATIENT #: [redacted]
LIVER PANEL PLUS
DISC LOT #: 3154AA7
OPER #: 013 DR #: 000
SERIAL #: 0000100684

ALB	3.6	3.3-5.5	G/DL
ALP	61	26-84	U/L
ALT	23	10-47	U/L
AMY	38	14-97	U/L
AST	27	11-38	U/L
TBIL	0.6	0.2-1.6	MG/DL
GGT	8	5-65	U/L
TP	5.9*	6.4-8.1	G/DL

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

======= PICCOLO =======
20/11/03 00:24
REFERENCE RANGE: MALE
PATIENT #: [redacted]
BASIC METABOLIC
DISC LOT #: 3325AA4
OPER #: 013 DR #: 000
SERIAL #: 0000100494

GLU	144*	73-118	MG/DL
BUN	9	7-22	MG/DL
CA++	8.2	8.0-10.3	MG/DL
CRE	0.8	0.6-1.2	MG/DL
NA+	135	128-145	MMOL
K+	4.2	3.3-4.7	MMOL
CL-	107	98-108	MMOL
tCO2	23	18-33	MMOL

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

516-108

NSN 7540-00-634-4156

MEDICAL RECORD

OPERATION REPORT

PREOPERATIVE DIAGNOSIS

(b)(6)-2

SURGEON	FIRST ASSISTANT	SECOND ASSISTANT	
CPT [redacted]	LTC [redacted]		
ANESTHETIST [redacted]	ANESTHETIC [redacted]		TIME BEGAN:
Capt			TIME ENDED:
CIRCULATING [redacted]	SCRUB NURSE [redacted]	TIME OPERATION BEGAN 2025	TIME OPERATION COMPLETED 2117
556			

OPERATIVE DIAGNOSES

GSW (L) tibia. Grade IIIA open (L) tibia fx.

DRAINS *(Kind and number)*	SPONGE COUNT VERIFIED
none	1 Lap pad soaked c̄ Kefzol left in wound.

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION

None

OPERATION PERFORMED

I/D + ex fix above injury.

DESCRIPTION OF OPERATION *(Type(s) of suture used, gross findings, etc.)*	PROSTHETIC DEVICES *(Lot no.)*	DATE OF OPERATION

Kefzol soaked lap pad left in wound.
probably IIIB (will need gastroc flap) for coverage + STSG.
moderate contamination in wound.
no sig vasc/nerve injury encountered.

(b)(6)-2

SIGNATURE [redacted] LPT	DATE 19 NOV 03
PATIENT'S [redacted] *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*	REGISTER/I.D. NO. / WARD NO. 2100

EDW [redacted]

(b)(6)-4

OPERATION REPORT
Medical Record

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

USAPPC V1.00

(b)(2)-2

[redacted]SPITAL

[redacted]tal

Baghdad, Iraq

Microbiology Request Form

Req: Cx - Aerobic/Anerobic
Gm St.

(b)(6)-4

Last Name: [redacted]

First Name:

Patient # or SSN:

Collected by: [redacted] (b)(6)-2

Date: 9 Dec 03

Time: 1430

Received by: [redacted]

Date: 9 Dec 03

Time: 1500

Ward:

Room:

Bed:

Physician: [redacted]

Source: Wound

Site: Lt. lower leg

[redacted]

Specimen #: W173

Laboratory Results

No Bacteria - Seen q 2ee

Acinetobacter baumannii/haemolyticus
towreamc

Reported

Date: 12 Dec 03

Time: 1000

Tech: [redacted]

Reviewer: [redacted]

Number of attached sheets:

Microbiology Report

[redacted] boratory

Name: (b)(6)-7
Patient ID: [redacted]
Ward/Rm: /

Specimen: W173 (b)(2)-2
Source: Wound/Sterile site
Ward of Iso:

Status: Final
Collected:
Attd Phys:

1 Acinetobacter baumannii/haemolyticus Status Final

1 Ac baumann/haem

Drug	MIC	Interps	Drug	MIC	Interps
Amikacin	<=16	S			
Amox/K Clav (c)	16/8				
Amp/Sulbactam (c)	<=8/4	S			
Ampicillin	>16				
Aztreonam	>16	R			
Cefazolin	>16				
Cefepime	>16	R			
Cefotaxime (c)	>32	R			
Cefotetan	>32				
Cefoxitin	>16				
Ceftazidime (a)	>16	R			
Ceftriaxone (c)	>32	R			
Cefuroxime (b)	>16				
Cephalothin	>16				
Chloramphenicol	>16	R			
Ciprofloxacin	>2	R			
ESBL-a Scrn	>4				
ESBL-b Scrn	>1				
Gatifloxacin	>4				
Gentamicin	>8	R			
Imipenem (c)	<=4	S			
Levofloxacin	>4	R			
Meropenem (c)	<=4	S			
Moxifloxacin	>4				
Nitrofurantoin	>64				
Norfloxacin	>8				
Piperacillin (a)	>64	R			
Tetracycline	>8	R			
Ticar/K Clav (a)	<=16	S			
Tobramycin	>8	R			
Trimeth/Sulfa	>2/38	R			

S = Susceptible
I = Intermediate
R = Resistance
MIC = mcgml mg/L

N-R = Not Reported
--- = Not Tested
TFG = Tetracycline-dependent strain

Bla+ = Beta-lactamase in Staphylococcus aureus tested
ESBL = Extended spectrum beta-lactamase
Bla- = Beta-lactamase negative

R* = Resistant due to extended spectrum beta-lactamases (ESBL)
ESBL? = Suspected ESBL. Confirmatory tests needed to differentiate ESBL from other beta-lactamases
IB = Inducible Beta-lactamase. Appears in place of Sensitive with species known to possess inducible beta-lactamases. potentially they may become resistant to all beta-lactam drugs. Monitoring of patients during/after therapy is recommended. Avoid other/combined beta-lactam drugs

For blood and CSF isolates, a beta-lactamase test is recommended for Enterococcus species

(a) Use maximum doses of drug with an aminoglycoside for P. aeruginosa in patients with granulocytopenia or serious infections
(b) Breakpoints based on parenteral dose. For cefuroxime axetil (PO) use: S=S, I=I, R=R. Fosfomycin: applies to this drug
(c) For streptococci refer to penicillin interpretations. For amoxicillin/clavulanate or amoxicillin/sulbactam with enterococci, refer to the penicillin interpretations
(d) For non-beta-lactamase producing enterococci, refer to the penicillin interpretations. Fosfomycin: applies to this drug

Interpretive breakpoints are based on NCCLS M100-S12 Jan 2002. Sparfloxacin (for Gram Negative isolates) and moxifloxacin are based on FDA approved breakpoints.
For S. pneumoniae, cefotaxime and ceftriaxone breakpoints are based on isolates from patients with meningitis. For non-meningitis infections use I=S, R=R

Name:
Patient ID: [redacted]
Ward/Rm: / (b)(6)-7

Specimen: W173
Source: Wound/Sterile site
Ward of Iso:

Status: Final
Collected:
Req. Phys: [redacted]

Printed 12/12/2003 2:30:33 PM

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

[redacted] SPITAL (b)(2)-2
[redacted]
Baghdad, Iraq

Microbiology Request Form

CULTURE:

Last Name [redacted] (b)(4)-7 Ward: OR
First Name: Room:
Patient # or SSN: Bed:
Physician:
Collected by: DR [redacted] (b)(6)-2
Date: 15 DEC 03 Source: (L) log
Time: 1620 Site:

[redacted]

Received by: [redacted] Specimen #: W186
Date: 16Dec03
Time: 0530

Laboratory Results

Acinetobacter baumannii/haemolyticus

Reported
Date: 18Dec03
Time: 1440
Tech: rgc
Reviewer: [redacted] Number of attached sheets:

MEDCOM - 25117

(b)(2)-2

Microbiology Report

[redacted] Laboratory

Name:		Specimen:	W186	Status:	Final
Patient ID:	[redacted]	Source:	Wound/Sterile site	Collected:	
Ward/Rm:	/ (b)(6)-4	Ward of Iso:		Attd. Phys:	

1 Acinetobacter baumannii/haemolyticus Status: Final

1 Ac baumann/haem

Drug	MIC	Interps	Drug	MIC	Interps
Amikacin	<=16	S			
Amox/K Clav (c)	16/8				
Amp/Sulbactam (c)	<=8/4	S			
Ampicillin	>16				
Aztreonam	>16	R			
Cefazolin	>16				
Cefepime	>16	R			
Cefotaxime (c)	>32	R			
Cefotetan	>32				
Cefoxitin	>16				
Ceftazidime (a)	>16	R			
Ceftriaxone (c)	>32	R			
Cefuroxime (b)	>16				
Cephalothin	>16				
Chloramphenicol	>16	R			
Ciprofloxacin	>2	R			
ESBL-a Scrn	>4				
ESBL-b Scrn	>1				
Gatifloxacin	>4				
Gentamicin	>8	R			
Imipenem (c)	<=4	S			
Levofloxacin	>4	R			
Meropenem (c)	<=4	S			
Moxifloxacin	>4				
Nitrofurantoin	>64				
Norfloxacin	>8				
Piperacillin (a)	>64	R			
Tetracycline	>8	R			
Ticar/K Clav (a)	<=16	S			
Tobramycin	>8	R			
Trimeth/Sulfa	>2/38	R			

S = Susceptible
I = Intermediate
R = Resistance
MIC = mcg/ml (mg/L)

N/R = Not Reported
--- = Not Tested
TFG = Thymidine-dependent strain

Blank = Data not available, or drug not advisable or tested
ESBL = Extended spectrum beta-lactamase
Blac = Beta-lactamase positive

R* = Resistant due to extended spectrum beta-lactamases (ESBL)
ESBL? = Suspected ESBL Confirmatory tests needed to differentiate ESBL from other beta-lactamases
IB = Inducible Beta-lactamase Appears in place of Sensitive with species known to possess inducible beta-lactamases potentially they may become resistant to all beta-lactam drugs Monitoring of patients during/after therapy is recommended Avoid other/combined beta-lactam drugs

For blood and CSF isolates a beta-lactamase test is recommended for Enterococcus species

(a) Use maximum doses of drug with an aminoglycoside for P aeruginosa in patients with granulocytopenia or serious infections
(b) Breakpoints based on parenteral dose. For cefuroxime axetil (PO) use (8=S, 8-16=I, >16=R). Footnote (c) applies to this drug
(c) For streptococci refer to penicillin interpretations. For amoxicillin/K clavulanate or ampicillin/sulbactam with enterococci, refer to the penicillin interpretation
(d) For non beta-lactamase producing enterococci, refer to the penicillin interpretation. Footnote (a) also applies to this drug.

Interpretive breakpoints are based on NCCLS M100-S12 Jan 2002. Sparfloxacin (for Gram Negative isolates) and moxifloxacin are based on FDA approved breakpoints
For S pneumoniae, cefotaxime and ceftriaxone breakpoints are based on isolates from patients with meningitis For non-meningitis infections, use <2=S 2=I, >2=R

Name:		Specimen:	W186	Status:	Final
Patient ID:	[redacted] (b)(6)-4	Source:	Wound/Sterile site	Collected:	
Ward/Rm:		Ward of Iso:		Req. Phys:	[redacted] (b)(6)-2

Printed 12/18/2003 1:53:52 PM

Tech: [redacted]

[redacted] (b)(2)-2
Baghdad, Iraq

Microbiology Request Form

CULTURE!

Last Name [redacted] (b)(6)-7
First Name:
Patient # or SSN:

Ward: OR
Room:
Bed:
Physician:

Collected by: Dr. [redacted] (b)(6)-2
Date: 15 Dec 03
Time: 1620

Source: (L) log
Site:

[redacted]

Received by: [redacted]
Date: 16Dec03
Time: 0530

Specimen #: W186

Laboratory Results

Acinetobacter baumannii/haemolyticus

Reported
Date: 18Dec03
Time: 1440
Tech: [redacted]
Reviewer: [redacted]

Number of attached sheets:

(b)(2)-2

Microbiology Report

[redacted] Laboratory

Name:		Specimen:	W186	Status:	Final
Patient ID:	[redacted]	Source:	Wound/Sterile site	Collected:	
Ward/Rm:	(b)(6)-4	Ward of Iso:		Attd. Phys:	

1 Acinetobacter baumannii/haemolyticus Status: Final

1 Ac baumann/haem

Drug	MIC	Interps	Drug	MIC	Interps
Amikacin	<=16	S			
Amox/K Clav (c)	16/8				
Amp/Sulbactam (c)	<=8/4	S			
Ampicillin	>16				
Aztreonam	>16	R			
Cefazolin	>16				
Cefepime	>16	R			
Cefotaxime (c)	>32	R			
Cefotetan	>32				
Cefoxitin	>16				
Ceftazidime (a)	>16	R			
Ceftriaxone (c)	>32	R			
Cefuroxime (b)	>16				
Cephalothin	>16				
Chloramphenicol	>16	R			
Ciprofloxacin	>2	R			
ESBL-a Scrn	>4				
ESBL-b Scrn	>1				
Gatifloxacin	>4				
Gentamicin	>8	R			
Imipenem (c)	<=4	S			
Levofloxacin	>4	R			
Meropenem (c)	<=4	S			
Moxifloxacin	>4				
Nitrofurantoin	>64				
Norfloxacin	>8				
Piperacillin (a)	>64	R			
Tetracycline	>8	R			
Ticar/K Clav (a)	<=16	S			
Tobramycin	>8	R			
Trimeth/Sulfa	>2/38	R			

S = Susceptible
I = Intermediate
R = Resistance
MIC = mcg/ml (mg/L)

N/R = Not Reported
--- = Not Tested
TFG = Thymidine-dependent strain

Blank = Data not available, or drug not advisable or tested
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Blac = Beta-lactamase positive

R* = Resistant due to extended spectrum beta-lactamases (ESBL)
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For blood and CSF isolates a beta-lactamase test is recommended for Enterococcus species

(a) Use maximum doses of drug with an aminoglycoside for P aeruginosa in patients with granulocytopenia or serious infections
(b) Breakpoints based on parenteral dose For cefuroxime axetil (PO) use (8=S 8-16=I >16=R) Footnote (c) applies to this drug
(c) For streptococci refer to penicillin interpretations For amoxicillin/K clavulanate or ampicillin/sulbactam with enterococci refer to the penicillin interpretation
(d) For non beta-lactamase producing enterococci refer to the penicillin interpretation Footnote (a) also applies to this drug

Interpretive breakpoints are based on NCCLS M100-S12 Jan 2002 Sparfloxacin (for Gram Negative isolates) and moxifloxacin are based on FDA approved breakpoints
For S pneumoniae cefotaxime and ceftriaxone breakpoints are based on isolates from patients with meningitis For non-meningitis infections use <2=S 2=I >2=R

Name:		Specimen:	W186	Status:	Final
Patient ID:	[redacted]	Source:	Wound/Sterile site	Collected:	(b)(6)-2
Ward/Rm:	(b)(6)-4	Ward of Iso:		Req. Phys	[redacted]

Printed 12/18/2003 1:53:52 PM

Tech: [redacted]

MEDICAL RECORD - ANESTHESIA

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

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "1" = CONSTANT INFUSION

DRUG (Units)															TOTALS	TOTAL EBL
Fentanyl (mcg)		<150>	100												250	100ml
Propofol (mg)		250														TOTAL URINE
Succinylcholine (mg)		100													3 / 7	Ø
Morphine (mg)						3										
( )																
( )																
VOLAT AGENT	Forane % del	—	1.0	.50	.50	.80									FLUIDS - SUMMARY	
	% e.t.														CRYSTALLOID- 1800ml	
AIR	L/Min															
N2O	L/Min														COLLOID- Ø	
O2	L/Min	10 –	1.5 –	1.0 –	1.0 –	6										
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS →															BLOOD- Ø	

FLUIDS

LINE site (L) FA 18G ☑ Warmed		(1)												
☐ Warmed														
☐ Warmed														
☐ Warmed														

LOSSES — EST BLOOD LOSS; URINE -

REMARKS

Code drugs with numbers, events with letters

1515 ID'd pt on ICW, (Chart review) TO DR via nursing. 1525 In Rm. O2 + monitors applied. IV started.

1652 Extubated, O2 applied. To PACU stable. Report given.

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 70 (KG) LB

HEMATOCRIT:

INITIAL DATA:

BP- 120/70

HR- 82

EQUIP CHECK

OK?- (Y) N

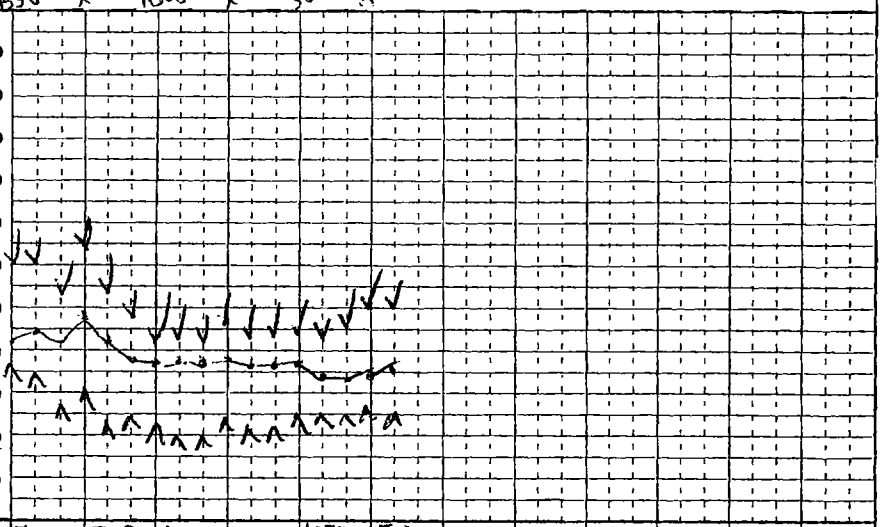
PATIENT RECHECK

OK for PROCEDURE? Y

TIME- 1520

TIME → 1530 X 1600 X 30 X

SYMBOLS: BP by cuff V (2) ^ Arm; Heart rate ●; Resp rate; BR (transduced); TOURNIQUET T–T; ANES- X-X; PROC- ⊙-Ø



VENTIL

VT - ml	500	700	650	500	450	500
f - breaths/min	12	10	8	6	10	10
Peak inf pres / PEEP	—	11	15	—		
MODE - S(pon), A(ssist), C(on)	A	C	C	A	S	S

MONITORS/ACCESSORIES

BP/Auto Cuff / ET CO2 (torr)	4	31	30	42	45	45
BP/oth / FIO2 (Frac or %)	.90	.90	.90	.90	.90	.90
ART line / SpO2 (%)	100	100	100	100	100	100
Steth- PC/ES / ECG	SR	SR	SR	SR	SR	SR
Gas analyzer / TEMP-site Axil						
N-M Block (T/4)		4/4	—			
Warming blkt						
Conv warmer						

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

RECOVERY AT: (PACU) ICU ____ (Specify) OTHER ____

CONDITION: Stable

RESP-12 SpO2-96-97% RA BP-106/63 HR-88

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1515	1525	1700
	Ready	Begin	End
PROC	1540	1600	1648

PROCEDURES and CPT Codes: I+D (L) Lower Leg

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

[redacted] (b)(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GETA

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

DL E MAC 4 grade I view. 8.0 cuffed ETT placed. ⊕ Chest Tube ⊕ ETCO2 sustained, ⊕ BILEBS. Secured 24cm at lip. Atraumatic.

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

ANESTHETIST: [redacted]

PROCEDURE LOCATION: OR1

DATE: 15DEC03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 — [redacted] 2 - ANESTHESIA PROVIDER — USAPA V1.00

MEDCOM - 25121

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)	1400 x 30 x 1500
Propofol	(mg)	150
Fentanyl	(mcg)	100 100
LHL	(mg)	80
Anrine Vec	(mg)	8 2
Reglan Basic	(mg)	10 10
	( )	
VOLAT AGENT Forane	% del / % e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	6 1.0 1.0

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

FLUIDS

LINE site		
Bag Rhart	☐ Warmed	500
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES

EST BLOOD LOSS	Ø
URINE -	Ø

PHYS STATUS (1) 2 3 4 5 E

BODY WEIGHT: 80 (KG) LB

HEMATOCRIT: Ø

INITIAL DATA:

BP- 123/68

HR- 94 99

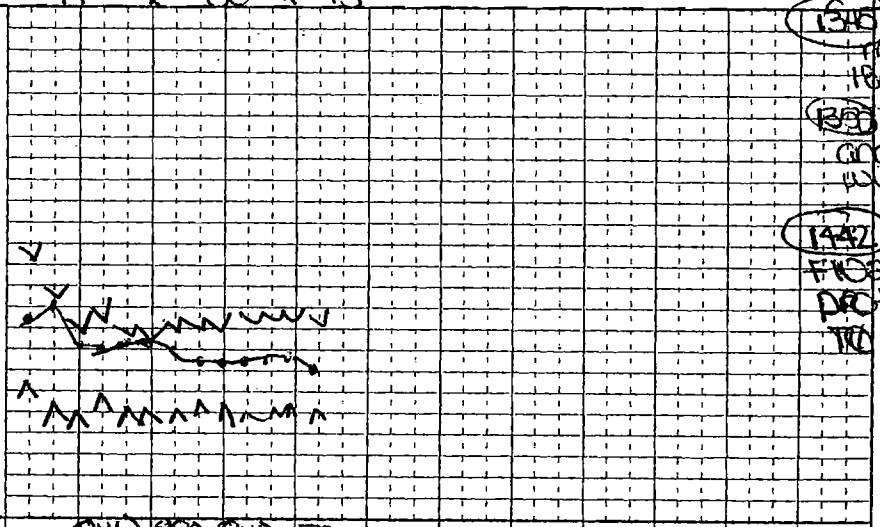
EQUIP CHECK OK? (Y) N

PATIENT RECHECK OK for PROCEDURE? (Y)

TIME- 1350

TIME → 14 x 30 x 15

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



VENTIL

VT - ml	+	340	380	340	500
f - breaths/min		12	11	10	16
Peak inf pres / PEEP		14	14	14	
MODE - S(pon), A(ssist), C(on)	SV	CV	CV	CV	SV

MONITORS/ACCESSORIES

X BP/Auto Cuff	X ET CO2 (torr)	+	34	35	33	35
BP/oth	X FIO2 (Frac or %)	100%	40%	52%	50%	100%
ART line	X SpO2 (%)	99	100	100	100	100
Steth- PC/ES	X ECG	SR	SR	SR	SR	SR
Gas analyzer	X TEMP-site skin		36°C	36°	36°	
	N-M Block (T/4)	4/4	4/4	4/4 without train of four x 5 seconds		
Warming blkt	Room warmed →					
Conv warmer						

Mark with letters & symbols, explain under REMARKS — EVENTS Position → supine (A) safety strap (B) arms 90° abducted.

TOTALS | **TOTAL EBL**

TOTAL URINE Ø

FLUIDS - SUMMARY

CRYSTALLOID- LR 400

COLLOID- Ø

BLOOD- Ø

REMARKS

Code drugs with numbers, events with letters

1330 Chart Dt v H & MD states difficult to ascertain.

1345 OR #2, pleasy monitors 18ga IV started.

1350 Induction and intubation without incid.

1442 extubated FIO2 100% (+) protective reflexes TO PACU

RECOVERY AT 1450

PACU ICU ____ (Specify)

OT [redacted]

CONDITION: 967

RESP- 20 SpO2- 96%

BP- 116/62 HR- 87

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1330	1345	1500
PROC	Ready 1355	Begin 1405	End 1442 1450

PROCEDURES and CPT Codes:

I + D of (D) leg

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

[redacted] (5)(61-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GEA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* Rapid sequence induction. DL x 1 Miller 3. Ø Atraumatic 8.0 ETT - secure 22cm @ lips eyes taped closed. No blood remained. ETCO2 x 3 BBS clear

SURGEONS: [redacted] (5)(61-2

ANESTHETISTS: [redacted] RDA, MAJ, MSC

PROCEDURE LOCATION: OR #2

DATE: 9 Dec 03

PAGE I OF I

DA FORM 7389, FEB 1998

COPY 3 - ANESTHESIA DEPARTMENT

USAPA V1.00

19y Caucasian ♂ SP LT Rad Fx GSW including DROPS

MEDCOM - 25122

MEDICAL RECORD - ANESTHESIA

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

used/wasted

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

DRUG (Units)													
Fent (14) (cc)						1							
MSO4 (mg)													
( )													
( )													
( )													
( )													
VOLAT AGENT	Iso % del	1.5	1.0	0.8	X								
	% e.t.												
AIR	L/Min												
N2O	L/Min												
O2	L/Min	1	1	1	2	8							

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

FLUIDS

LINE site													
18g ⊕ H	☐ Warmed	PD cont	PD 1610007										
	☐ Warmed												
	☐ Warmed												
	☐ Warmed												

LOSSES

EST BLOOD LOSS				300									
URINE - (500)				50/550									

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: KG / LB

HEMATOCRIT:

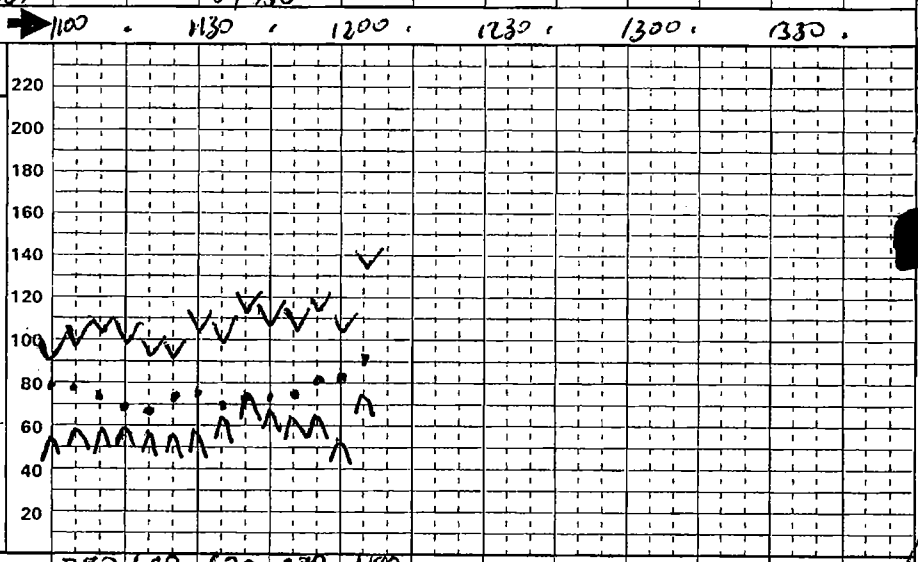
INITIAL DATA: BP- See page 1 HR-

EQUIP CHECK OK? - Y N

PATIENT RECHECK OK for PROCEDURE? TIME-

TIME → 1100 · 1130 · 1200 · 1230 · 1300 · 1330 ·

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



VENTIL

VT - ml		780	680	670	380	480
f - breaths/min		8	5	5	9	9
Peak Inf pres / PEEP		17	17	17		
MODE - S(pon), A(ssist), C(on)		C	C	C	S	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	32	40	44	49	48
BP/oth	FIO2 (Frac or %)	.66	.67	.67	.83	.88
ART line	SpO2 (%)	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site	35.6	35.5	35.4	35.4	
	N-M Block (T/4)					
Warming blkt						
Conv warmer						

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

TOTALS	TOTAL EBL
15	0
	TOTAL URINE
	See

FLUIDS - SUMMARY

CRYSTALLOID- page 1

COLLOID-

BLOOD-

REMARKS

Code drugs with numbers, events with letters

Cont from pg 1
Intubated @
SV + OP Foley.
SV cont to PACU
Report to PACU
Nurse.

[redacted]

CONT

RECOVERY AT

PACU ICU _____ (Specify)

OTHER _____

CONDITION:

RESP- SpO2-

BP- HR-

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES			
	Ready	Begin	End
PROC			

PROCEDURES and CPT Codes:

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

See

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

[redacted]

(5)(6)-4

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

page 1

SURGEONS:

[redacted] (6)(6)-2

[redacted]

PROCEDURE LOCATION: 1

DATE: 26 NOV 03

PAGE 2 OF 2

DA FORM 7389, FEB 1998 — COPY 2 - ANESTHESIA PROVIDER — USAPA V1.00

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)											
Fentanyl	(cc)	(3)		2/3		2			2		2	
Propofol	(mg)	150										
Sux	(mg)	80										
Versed	(mg)		10									
	( )											
	( )											
VOLAT AGENT	Forz % del	X1 —	1 —	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5
	% e.t.												
AIR	L/Min												
N2O	L/Min												
O2	L/Min	X6 —	2 —	2	2	1	1	1	1	1	1	1	1

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS → (1) (2) (3) X

FLUIDS

LINE site	
18ga (L) H	☐ Warmed
	☐ Warmed
	☐ Warmed
	☐ Warmed

RL 1000 — RL 1000

LOSSES

EST BLOOD LOSS	
URINE -	800

PHYS STATUS (1) 2 3 4 5 E

BODY WEIGHT: 70 KG/LB

HEMATOCRIT: 36.7

INITIAL DATA:

BP- 115 / 67

HR- 85

EQUIP CHECK

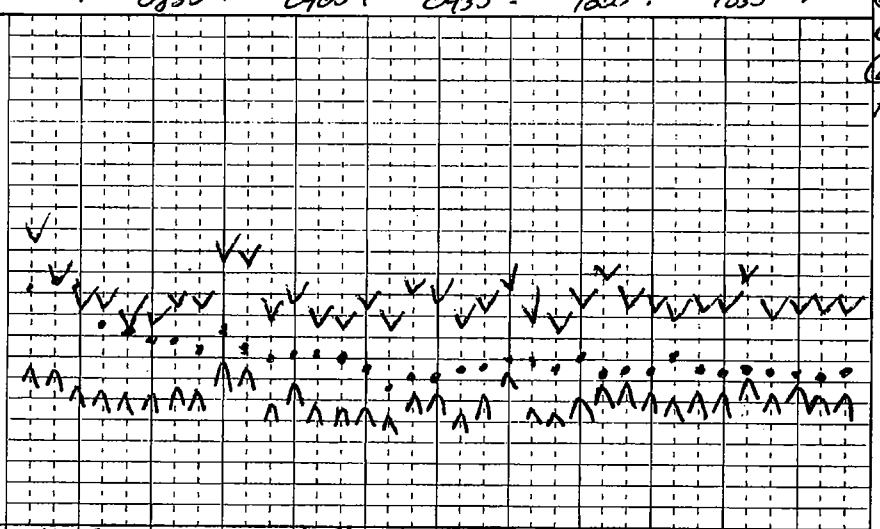
OK?- (Y) N

PATIENT RECHECK

OK for PROCEDURE? (✓)

TIME- 0800

TIME → 0800 · 0830 · 0900 · 0930 · 1000 · 1030 ·



VENTIL

VT - ml	810	800	940	940	750	760	730	800	790	760	740	760
f - breaths/min	8	8	8	8	8	8	8	8	8	8	8	8
Peak inf pres / PEEP	19	18	18	19	16	17	16	16	16	17	17	17
MODE - S(pon), A(ssist), C(on)	S AC		C	C	C	C	C	C	C	C	C	C

MONITORS/ACCESSORIES

BP/Auto Cuff — ET CO2 (torr)	33	32	32	30	30	31	32	31	32	32	32	32
BP/oth — FIO2 (Frac or %)	.67	.68	.84	.89	.89	.67	.59	.54	.55	.56	.59	.63
ART line — SpO2 (%)	100	99	100	100	100	100	100	99	99	100	100	100
Steth- PC/ES — ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer — TEMP-site	36.6	36.7	36.4	36.3	36.2	36.0	35.9	35.8	35.7	35.7	35.6	35.6
N-M Block (T/4)												
Warming blkt												
Conv warmer												

Mark with letters & symbols, explain under REMARKS — EVENTS *Position* → O1

TOTALS	TOTAL EBL
	300
	TOTAL URINE
	550

FLUIDS - SUMMARY

CRYSTALLOID- 2300

COLLOID- Ø

BLOOD- Ø

REMARKS

Code drugs with numbers, events with letters

Pt IDd on ICU
Qstart/Exit room
(1) Induction
(2) Start/Stop
(3) Decrease 800 mg IV
per schedule
Cont on page 2

[redacted]

RECOVERY AT 1215

PACU (✓) ICU ____ (Specify)

OTHER ____

CONDITION: Pt to ward

RESP- 14 SpO2- 96

BP- 135/75 HR- 144

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0730	0805	1220
	Ready	Begin	End
PROC	0808	0845	1210

PROCEDURES and CPT Codes: 5756
I&D (L)LE / IM Nail / Soleus Muscle Flap

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

[redacted]

(b)(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
DLX1, 3mg Ancef, BS=B, + RTCA
8.0 ETT @ 24 cm GBD, eyes taped [redacted]

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

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

[redacted]

PROCEDURE LOCATION: 1

DATE: 26 Nov 03

PAGE 1 OF 2

DA FORM 7389, FEB 1998 — GSW (L)LE NKDA — COPY 2 - ANESTHESIA PROVIDER — USAPA V1.00

MEDCOM - 25124

MEDICAL RECORD - ANESTHESIA

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

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

DRUG (Units)														
phenergan (mg)	25													
MSO4 (mg)	10													
propofol (mg)	200													
toradol mg		30												
( )														
VOLAT AGENT ISO % del / % e.t.	2.0	2.0	2.5	2.0										
AIR L/Min														
N2O L/Min														
O2 L/Min	6	2	2	2										
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS	1 2													

FLUIDS

LINE site														
HL RG LW	☐ Warmed	500 NS 1	/ #2											
	☐ Warmed													
	☐ Warmed													
	☐ Warmed													

LOSSES — EST BLOOD LOSS / URINE -

TOTALS: TOTAL EBL: min; TOTAL URINE: N/A

FLUIDS - SUMMARY: CRYSTALLOID- 750 LR 6 NS; COLLOID- 0; BLOOD- 0

REMARKS

Code drugs with numbers, events with letters

No Δ in status since prior anesthetic. Plan GETA.
(1) To room via litter, 50C mrs, pre O2.
(2) IV indx LMA placed. 1850 ETC Gas CRNA Rely drug in IV opens mouth & pull out to gummy

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 70 KG / LB

HEMATOCRIT: —

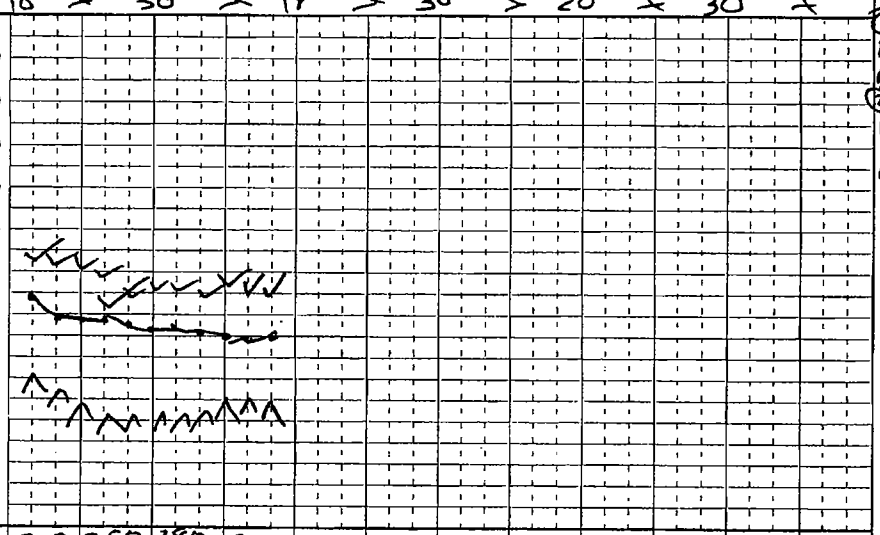
INITIAL DATA: BP- 120/76; HR- 108

EQUIP CHECK: OK? Y N

PATIENT RECHECK: OK for PROCEDURE? ✓; TIME- 1755

TIME → 18 > 30 > 19 > 30 > 20 > 30 >

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



VENTIL

	18:00	18:30	19:00	19:30
VT - ml	300	250	280	320
f - breaths/min	14	14	16	18
Peak inf pres / PEEP	—	—	—	—
MODE - S(pon), A(selst), C(on)	S	S	S	S

MONITORS/ACCESSORIES

		18:00	18:30	19:00	19:30
✓ BP/Auto Cuff	✓ ET CO2 (torr)	46	50	50	44
BP/oth	✓ FIO2 (Frac or %)	0.7	0.7	0.7	0.7
ART line	✓ SpO2 (%)	100	100	100	100
Steth- PC/ES	✓ ECG	SR	SR	SR	SR
Gas analyzer	TEMP-site				
	N-M Block (T/4)				
Warming blkt					
Conv warmer					

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

RECOVERY AT 1900

PACU ICU ____ (Specify)

OTHER ____

CONDITION: T-97 RESP- 16 SpO2- 97% BP- 119/69 HR- 104

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1800	1805	1905
	Ready	Begin	End
PROC	1810	1838	1857

PROCEDURES and CPT Codes: I&D Lt tibia GSW

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GLMA

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

39 yo Iraqi ♂
[redacted] NKDA
Smoker (b)(6)-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* Eyes taped. LMA #4 in E diff or trauma. ⊕ ETCO2, B/EB. Soft bite block.

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

[redacted] CRNA

[redacted] ESIA PROVIDER

PROCEDURE LOCATION: 1

DATE: 11/21/03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 USAPA V1.00

MEDCOM - 25125

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)												
VERSED	(mg)	3	2										
	( )												
	( )												
	( )												
	( )												
	( )												
VOLAT AGENT	% del												
	% e.t.												
AIR	L/Min												
N2O	L/Min												
NC O2 4	L/Min	→	→	→	→	→	→						

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

FLUIDS

LINE site												
(L) A	☐ Warmed	→	→	#2	→	→						
(R) A	☐ Warmed	→	#2	→	→	→						
	☐ Warmed											
	☐ Warmed											

LOSSES: EST BLOOD LOSS; URINE -

TOTALS: TOTAL EBL 150 cc; TOTAL URINE ~~0~~

FLUIDS SUMMARY: CRYSTALLOID- 3000 cc; COLLOID- ~~0~~; BLOOD- ~~0~~

REMARKS — Code drugs with numbers, events with letters

2010 Ancef 1gm IV

PHYS STATUS: 1 2 3 4 5 (E)

BODY WEIGHT: KG / LB

HEMATOCRIT:

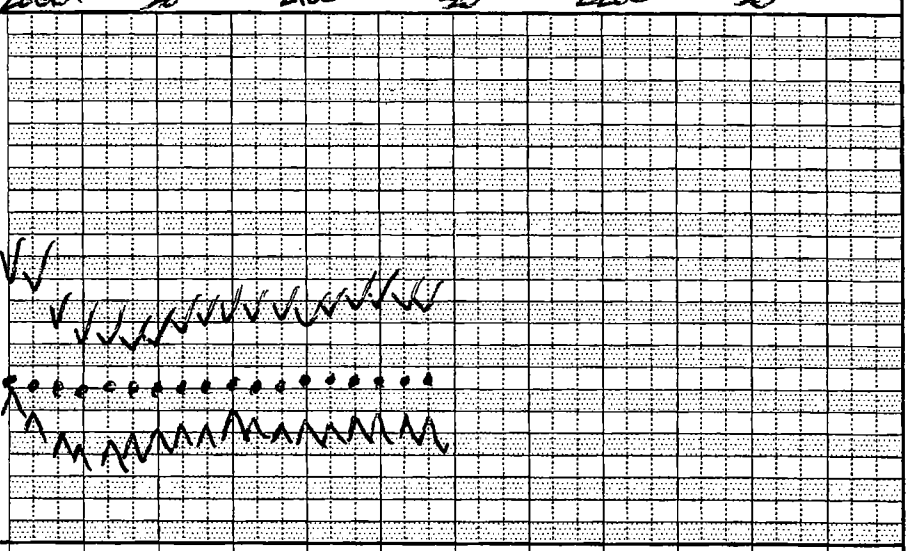
INITIAL DATA: BP- 138/65; HR-

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? TIME- 1950

TIME → 2000 – 30 – 2100 – 30 – 2200 – 30 –

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



VENTIL

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

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	ET CO2 (torr)						
BP/oth	FIO2 (Frac or %)						
ART line	✓ SpO2 (%)	99	100	100	100	100	100
Steth- PC/ES	✓ ECG	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site						
	N-M Block (T/4)						
Warming blkt							
Conv warmer							

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

RECOVERY AT: (PACU) ICU _____ (Specify); OTHER _____

CONDITION: STABLE

RESP- 18 SpO2- 97 BP- 117/42 HR- 102

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1945	2000	2130
	Ready	Begin	End
PROC	2015	2020	2100

PROCEDURES and CPT Codes: I+D (L) tibia GSW, placement of ext. fixator

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

IRAQI EPW

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

Spinal, 25 ga, 100 mg Lidocaine in 3-4, level T10

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

betadine prep

SURGEONS: CPT [redacted] LTR [redacted]

ANESTHETISTS: CPT [redacted] (b)(6)-2

PROCEDURE LOCATION: OR

DATE: 19 NOV 03

PAGE 1 OF 1

MEDCOM - 25126

NSN 7540-01-196-7294

519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
AP + LAT		M		ICU #3	
(L) tibia	FILM NO.				PREGNANT ☐ YES ☐ NO
	REQUESTED BY: [redacted]				TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR: (b)(6)-2				DATE REQUESTED: 26 Nov 03

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*

S/P

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

RADIOLOGIC REPORT

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*	LOCATION OF MEDICAL RECORDS
# (b)(6)-4 [redacted]	LOCATION OF RADIOLOGIC FACILITY
	SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
1 — MEDICAL RECORD

STANDARD FORM 519-B (8-83)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.806-8

NSN 7540-01-165-7284

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Spe[redacted]	WARD/CLINIC	REGISTER NO.
(L) T.b/F.b	24	m	[redacted] (b)(6)-4	EMT	
	FILM NO. (b)(6)-2				PREGNANT ☐ YES ☐ NO
	REQUESTED BY (Print) [redacted]				TELEPHONE/PAGE NO.
	SIGN[redacted] REQUESTOR				DATE REQUESTED 15 Nov 43

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*

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

RADIOLOGIC REPORT

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*	LOCATION OF MEDICAL RECORDS
[redacted] (b)(6)-4	LOCATION OF RADIOLOGIC FACILITY
	SIGNATURE

MEDICAL RECORD			DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
19NOV'03			Admit to pt hold [redacted]		
			Stabl		
2100			s/p I/D + ext fix (L) tibia fx		
			LR@100cc/°		
			NPO ~~y~~ meds.		
			MSO4 1-4 mg IV q 30 min pm		
			percocet 1-2 po q4° pm		
			Tylenol 650 mg po PR q6° pm		
			phenergan 25 mg IV/PR q6° pm N/V		
			Keflex 1g IV q8 - next dose @ 3AM.		
			elec priority when available.		
			Tetanus immunization please.	(b)(6)-2	
			[redacted]		
[redacted]			(b)(6)-7		
EPW					

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	Ortho evac note
19NOV03	~40yo Iraqi male GSW (M-16) to (L) tibia
2100	(+) plantar flexion toes. appears to have plantar
—	and dorsal foot sensation. palpable dP/pT
	on presentation. XRAYS - comminuted prox 1/3 tibia
	Fx (no fibula fx). Med Hx unavailable (no interpreter).
	— To OR on 19NOV for I/D + ex fix.
	~Grade IIIB Fx - will need Gastroc flap
	+ STSG for eventual closure. wound c̄
	moderate contamination. left kefzol
	soaked lap pad in wound (no cement
	available).
	— Admitted on kefzol. rec'd tetanus immunization.
	Postop course uneventful
	Evac to CSH for IM nail + Gastroc flap + STSG.
	Evac Meds: Kefzol 1g IV q8°
	MSO4 1-4mg IV q30min prn [redacted]
	[redacted] CPT
	(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		

EPW

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

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]

39 y/o ♂

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 20 NOV 03 TIME OF ORDER: 0012 HOURS

LIST TIME ORDER NOTED AND SIGN

Admit FCW # 1 - Dr [redacted]
Dx: T.4/F.4 Fx (L) c External Fixator
condition: Stable
VS/ANS: per Routine
AMINKDA
Meds: ~~Ign Ancef IV Q6°~~
2-4 mg MSO4 IV Q2° prn pain.

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

650 mg tylenol p.o. Q.D prn Fever.
Diet: Regular
Activity: ~~Bedrest~~ as tolerated
~~Plan Recovered in A.M by Dr~~ [redacted]
CBC, chem 7 @0700, 20 NOV 03

NURSING UNIT | ROOM NO. | BED NO.

[redacted]

PATIENT IDENTIFICATION

[redacted]

(5)(6)-2

DATE OF ORDER | TIME OF ORD[redacted] | HOURS

- Percocet II po q4° PRN pain
- Ancef 1gm IVPB q8
- Levoquin 500mg IVP q D
- Ambien 10mg po q HS prn
- Phenergan 25mg IV q6° prn nausea
- [redacted]

NURSING UNIT | ROOM NO. | BED NO.

24/0110 | 20NOV03 | [redacted]

PATIENT IDENTIFICATION

[redacted]

DATE OF ORDER | TIME OF [redacted]ER | HOURS

21 NOV 03 12:30 [redacted]
- NPO now
[redacted]

21 NOV 03 1900
- Resume PreOp orders [redacted]
- GOS ambulate c crutches [redacted]

NURSING UNIT | ROOM NO. | BED NO.

(5)(6)-2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
21NOV03	OpNote
1900	PreOpDx: III B open (2) TIB-AFX
	Postop Dx: Same
	Procedure: Replant IFD (2) TIB-AFX
	Surgeon: [redacted]
	Anesthesia: GEDA
	Esc of
	fluids: 750cc
	Findings: medial soft tissue defect.
	will need secondary closure. (b)(6)-2
	[redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

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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] (b)(6)-4				11/25/03 NPO pm	1630 HOURS	
				[redacted] (b)(6)-2		11/25/03 1630
NURSING UNIT	ROOM NO.	BED NO.				
ICU						
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER _____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER _____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER _____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

NURSING UNIT | ROOM NO. [redacted]

DATE OF ORDER: 11/26/03 | TIME OF ORDER: 1230 HOURS | LIST TIME ORDER NOTED AND SIGN

- Resume preop meds, activities, & diet.
- D/C sterile D's
- Elevate @ LE
- Record output of JP drain q. Shift
- AP + LAT @ TIBIA under R.
- Incentive Spirometry [redacted]

PATIENT IDENTIFICATION: [redacted]

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

DATE OF ORDER | TIME OF ORDER

- D/C Foley [redacted]

12/2/03 10:45

- Daily dry dressing D to left leg. Apply Bacitracin ointment to graft sites & cover dressing D. [redacted]

(b)(6)-2

PATIENT IDENTIFICATION: [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

12/2/03 1045 HOURS

- D/C IV ABX, D/C IV
- Begin levaquin 500 mg po QD
- OOB, ambulate NWB @ LE [redacted]

(b)(6)-2

NURSING UNIT: ICW | ROOM NO.: 248 | BED NO.: 30-03 0035 [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

HOURS

NURSING UNIT | ROOM NO. | BED NO.

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
11/26/03	OpNote
	PreOpDx: Open III B (L) tibia fx
	PostOpDx: same
	Procedure: IM nailing (L) TIBIA & local soleus flap, split thickness skin grafting
	Surgeons: [redacted]
	EBL: 300
	Fluids: 2300 cc
	Findings: Mid shaft tibia fx c̄ anterior cortical bone loss a soft tissue loss.
	Implants: Synthes 9 x 345 mm femoral nail.
	PostOpPlan: Wound 5 days
	(b)(6)-2 [redacted]

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

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

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
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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				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] (b)(6)-4				12-26-03	1830 HOURS	
				- D/C to EPW CAMP in AM		
				- F/u 1 week		
				[redacted]		
NURSING UNIT	[redacted]	BED NO.				
27° [redacted]				(b)(6)-2		
[redacted]				09DEC03 0040		
PATIENT IDENTIFICATION				DATE OF ORDER		
Ø Neworder 12 Dec03@0100				[redacted]	HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

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

[redacted] (b)(6)-4

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
2/8/03	S/C Note This Iraqi male is post open (2) TIB/AFx from GSW. He has had I.M. nailing & local soleus flap and split thickness skin grafting. His wounds are clean. He is to remain in a short leg cast and non weight bearing. He should follow up in 1 week for wound check. Continue oral antibiotics x 3 weeks. [redacted] (b)(6)-7

(b)(6)-4

[redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
12/9/03	Op Note PreopDx: Sub Abscess / Hematoma PostOpDx: same Procedure: I&D (L) leg Surgeon: [redacted] Anes: MAC (b)(6)-2 Fluids: 300cc Findings: Sub Q haematoma / abscess between med + lateral wounds. Cultures obtained. Began WET Dry packing [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

STANDARD FORM 509 (REV. 5/1999)
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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			DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6) [redacted]			12-9-03	1450 HOURS	
[redacted]			— Resume preop orders meds, activities + diet.		
[redacted]			— Daily wet to dry dressing Δ Q 6h @ 1530 ĉ Dr. O present.		
NURSING UNIT	ROOM NO.	BED NO.			
16W	24	2223	[redacted]		[redacted]
PATIENT IDENTIFICATION					
Ø New Orders 15Dec 0200			[redacted]	HOURS	
			12-15-03	1630	
			NPO now		
			[redacted]		
			12-16-03	0124	
			Augmentin 500mg po TID		
NURSING UNIT	ROOM NO.		[redacted]		
PATIENT IDENTIFICATION			[redacted]	TIME OF ORDER 16Dec 0200	
				HOURS	
NURSING UNIT	ROOM NO.	BED NO.			
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
				HOURS	
NURSING UNIT	ROOM NO.	BED NO.			

(b)(6)-2

(b)(6)-2

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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
12/15/03	pNote
	Pre Dx: sub-q abscess/hematoma
	Post Dx: same
	Procedure: I&D, SPC + V-Y advancement
	Surgeon [redacted] (b)(6)-2
	Anesthesia: Gen
	EBL: 50 cc
	Fluids: 1800 cc
	Findings: sub Q hematoma
	Drains: JP
	Cx: +
	Spec: Cx's obtained

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

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

NURSING UNIT: KCN #1 | ROOM NO.: [redacted]

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
12/15/03	HOURS	
- Resume preop activities diet & meds		
- D/C Levaquin		
- Start Augmentin 875 mg po QD first dose tonight		
- S/L every 4's		
- Record output, IP clear QD shift		

PATIENT IDENTIFICATION: 24°V 16Dec@0130 [redacted]

~~No new orders~~

1358

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

DATE OF ORDER	TIME OF ORDER
No new orders [redacted] 17DEC	
No new orders [redacted] 18DEC03 0250	
12-18-03 1500	
Amikacin 975 mg IVPB qD, first dose tonight	
(b)(6)-2 [redacted]	

PATIENT IDENTIFICATION: 24°V 19Dec@0230 [redacted]

~~No new orders~~ 24DEC03 0235 ~~No new orders~~

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

DATE OF ORDER	TIME OF ORDER
23 Dec	1015 HOURS
X-RAY AP/LAT (L) Tib/fib	
V.O Dr [redacted]	
(b)(6)-2	

NCW1 24°V 24Dec03@0235

PATIENT IDENTIFICATION: [redacted]

DATE OF ORDER	TIME OF ORDER
24 Dec 03	1530 HOURS
(1) Leave (L) Lower Leg wound open to air. Leave splint in place also.	
V.O Dr [redacted]	
(b)(6)-2	

NURSING UNIT: ICW1 | ROOM NO.: 24°V | BED NO.: 25Dec03@023[redacted]

DA FORM 1 APR 79 4256 REPLACES EDITION [redacted] WHICH MAY BE USED. 24°V 26 DEC03 @ 0400 /LT, AN

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] (b)(6)-4				12/27/03	1030 HOURS	
				D/C to EPW	[redacted]	
					(b)(6)-2	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER _____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER _____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER _____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

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

MEDICAL RECORD - DOCTOR'S ORDERS

For use of this form, see MEDCOM Circular 40-5

DIRECTIONS: The provider will DATE, TIME, and SIGN each order or set of orders recorded. Only one order is allowed per line. Nursing will list the time the new order(s) are noted and initial in the column provided. Orders completed during the shift in which they were written do not require recopying. They may be signed off, as completed, in the far right column.

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
	POST ANESTHESIA ORDERS (circled Items)		
1	VS q 5 min X 15 min, then q 15 min until discharge.		
2	Supplemental oxygen.		
3	Morphine / Meperidine 2 mg IV now and 1-2 mg q 3-5 min prn pain for a		
	max dose of 15 mg.		
4	Zofran____mg IV prn N/V q 15 min, may repeat x ____.		
5	Metoclopramide____mg IV prn N/V x 1.		
6	Droperidol 0.625 mg IV prn N/V x 1. or		
7	Phenergan 12.5 mg 25 IV prn N/V x 1.		
8	Benadryl 25-50mg IVP q1 hr prn, itching while in PACU.		
9	IVF: Ln @ KVO cc/hr.		
10	Discharge from recovery status when PACU discharge criteria met.		
	[redacted]		
	(b)(6)-2		

PATIENT IDENTIFICATION

[redacted]

(b)(6)-7

Complete the following information on page 1 only. Note any changes on subsequent pages.

Diagnosis: _____

Height: _____ Weight: _____ Diet: _____

Allergies: _____

Nursing Unit	Room No.	Bed No.	Page No.
PACU, 28th CSH			1 of 1

MEDCOM FORM 688-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE MC V1.00

Rewritten 2 Dec 03

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. 12 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 2	3	4	05	06	07	08	09	10	11	12	13	14
20	[redacted]	VS routine	D	[redacted]												
			N													
20	[redacted]	DIET: Regular	D													
			N													
20	[redacted]	ACT as tolerated	D													
			N													
20	[redacted]	Elevate (L) leg	D													
			N													
20	[redacted]	Incentive spirometry	D													
			N													
2 Dec 03	[redacted]	Daily dry dsg Δ to	D	[redacted]												
		left leg. Apply bacitra-														
		ointment to graft site														
		c each dsg Δ														
2 Dec 03	[redacted]	OOB, ambulate NWB	D	[redacted]												
		(L) LE	N													
4 Dec	[redacted]	NIO: BRADEN SCALE Q7	06	/		X	/						[redacted]			
		DAYS	18	/		DONE	/						X	/		
5 Dec	[redacted]	Daily wet to dry dsg	06								[redacted]		SEE			
		Δ (L) leg @ 1530 & PRN	18										BELOW			
		present														
09 Dec	[redacted]	Daily WTD dsg Δ @ leg	1530										[redacted]			
		@ 1530 c Dr. O present														

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS: TIB/FIB FX (L) c IM nailing

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

(b)(6)-2

(b)(6)-2

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 11 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
20	[redacted]	admit ICW#1 [redacted] stable	20	—	—	[redacted]
20	[redacted]	CBC, Chem 7 @ 0700 20 NOV 03	11/20		0715	[redacted]
21	[redacted]	NPO o/c to surgery	21 NOV	—	—	[redacted]
11/25	[redacted]	NPO ~~p~~ MN	11/26	0001	not done	[redacted]
26 NOV	[redacted]	Resume preop meds, activities, diet	26	—	—	[redacted]
26	[redacted]	PIC dsg Δs	26	—	—	[redacted]
26	[redacted]	AP/LAT @ TIBIA	26	done in [redacted]		[redacted]
26	[redacted]	PIC foley	26	done in PACU		

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

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
20	[redacted]	reinforce drsg prn	D 20 NOV T 1700	20 NOV 0630	PRN 1080											
----	----		[redacted]													
----	----															
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CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 12 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 24	25	26	27									
24 DEC 03	[redacted]	Leave lower leg wound	06	/	[redacted]											
		OTA. Leave splint in	18													
		place also	06													
20 NOV	[redacted]	V S: Routine	06	/	[redacted]											
			18	/												
20 NOV	[redacted]	Diet Regular	06	/	[redacted]											
			18	/												
20 NOV	[redacted]	ACT. As Tolerated	06	/	[redacted]											
			18	/												
20 NOV	[redacted]	Elevate (L) Leg	06	/	[redacted]											
			18	/												
20 NOV	[redacted]	Incentive Spiron	06	/	[redacted]											
			18	/												
20 DEC	[redacted]	OOB, Ambulate	06	/	[redacted]											
		NWB (L) LE	18	/												
4 DEC	[redacted]	N I O: Braden scale	D	/	/	/	/	/	/	/	/	/				
4 DEC	[redacted]	Q 7 DAYS	N	/												

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO	PRIMARY DIAGNOSIS: CTB. RIB FX C IM NAILING	ADDITIONAL PAGES IN USE: ☒ YES ☐ NO PAGE NO: 2

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

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. 11 Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 19	20	21	22	23	24	25	26	27	28	29	30	1
20	[redacted]	VS: routine	06	/	[redacted]											
			18	✓												
20	[redacted]	DIET: regular	6	/												
			18	✓												
20	[redacted]	ACT: as tolerated	6	/												
			18	✓												
20/26	[redacted]	Elevate (L) leg	6	/												
			18	[redacted]												
26	[redacted]	Record output of JP	06													
			18													
		drain q shift	18													
26	[redacted]		06													
		incentive spirometry	06													
			18													
			18													
			06													

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: TIB/FIB FX (L) c EX FIX

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 12 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
9 Dec	[redacted]	DC to EPW camp in am	9 Dec			
9 Dec	[redacted]	F/U 1 week	16	—	—	[redacted]
9 Dec	[redacted]	resume preop orders meds	9 Dec	—	—	—
	----	activity + diet	—	—	—	[redacted]

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

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 (MEDI[illegible]NS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon Gene.	Mo. 12 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
16 Dec 03	[redacted]	Augmentin 500mg po	[redacted]														
	-----	TID	14														
	-----		26														
18 Dec	[redacted]	Amikacin 975mg	20	/	/												
	-----	IVPB QD first	X														
	-----	dose tonight	X														

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

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: OTB FIB Fx c IM Nailing

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 1 FEB 79 4678 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. MEDCOM-25149

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 12 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
20 NOV	[redacted]	MSO4 2.4mg IV q2° pm pain	D/T													
			D/I													
20	[redacted]	Tylenol 650mg po QID pm	D/T													
			D/I													
20	[redacted]	Percocet TT po q4° pm pain	D/T	2/08 1520												
			D/I	[redacted]												
20	[redacted]	Ambien 10mg po qHS pm	D/T													
			D/I													
20	[redacted]	Phenergan 25mg IV q6° pm nausea	D/T													
			D/I													

(6)(6)-2

*U.S. GPO: 1998-454-110/95216

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. 12 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 2	3	4	5	6	7	8	9	10	11	12	13	14	15
2DEC03	[redacted]	LEVOQUIN 500mg PO QD	08	/	[redacted]												
	-----			16	17	18	19	20	21	22	23	24	25	26	27	28	29
3Dec 03	[redacted]	Levoquin 500mg PO QD	08			D	D										
	-----			15	16	17	18	19	20								
15Dec	[redacted]	Augmentin 875mg	08			Order	Mod	16Dec	[redacted]								
	-----	PO QD (1st tonight)	20														
16Dec	[redacted]	Augmentin 500mg PO	06														
	-----	TID	14														
	-----		22														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (L) Tib/fib fx c̄ IM Nailing

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

(b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 12 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
02 DEC	[redacted]	PIC IV ABX, PIC IV	02	—	—	[redacted]
15 DEC	[redacted]	PIC Levoquin	15	—	—	[redacted]

2-(b)(5)

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
20 NOV	[redacted]	MSO4 2-4mg IV Q2° PRN PAIN	D/T													
			D/I													
20 NOV	[redacted]	TYLENOL 650mg PO QID PRN	D/T													
			D/I													
20 NOV	[redacted]	PERCOCET # PO Q4° PRN PAIN	D/T													
			D/I													
20 NOV	[redacted]	AMBIEN 10mg PO QHS PRN	D/T													
			D/I													
20 NOV	[redacted]	PHENERGAN 25mg IV Q6° PRN NAUSEA	D/T													
		~~PHENERGAN 25mg IV Q6° PRN NAUSEA~~ (ERROR) WD	D/I													

*U.S. GPO: 1998-454-110/95216

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. 11 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED														
				~~19~~	~~20~~	21	22	23	24	25	26	27	28	29	30	1	2	
20	[redacted]	Ancef 1 gm IVPB	6	/	[redacted]													
	-----	Q8°	14	/														D'cd 2Dec @ 110
	-----		22	/														
20	[redacted]	Levaquin 500mg	08	/														
	-----	IVP QD	~~00~~	~~2~~	3	4	5	6	7	8	9	10						
2Dec03	[redacted]	Levaquin 500 mg PO	06															
	-----	QID	12															
	-----		18															
	-----		~~24~~															
	-----	(b)(6)-2																

ERROR M.D.

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
(L) TIB/FIBPX c̄ EX-FIX

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 1 FEB 79 4678 EDITION OF 1 DEC 1978 WILL BE USED UNTIL EXHAUSTED.

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 11 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
2 Dec 03	[redacted]	D/C IV Abx, DC IV	2 Dec 03	Now		

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
20	[redacted]	MSO4 2-4mg IV q2° prn pain	D/T	23 Nov 1400	24 Nov 2215	26 Nov 1625										
			D/I	4mg	4mg	4mg										
20	[redacted]	Tylenol 650mg po q4D prn	D/T	[redacted]												
			D/I													
20	[redacted]	Percocet 1tp° q4° prn pain	D/T	22 Nov 1500	23 Nov 0800	24 Nov 1200	25 Nov 0000	26 Nov 1500								
			D/I	1T	2	2	1tab	1T								
20	[redacted]	Ambien 10mg po QHS prn	D/T	[redacted]												
			D/I													
20	[redacted]	Phenergan 25mg IV q6° prn nausea	D/T	[redacted]												
			D/I	25mg												
				[redacted]												

*U.S. GPO: 1998-454-110/95216

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. 11 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED													
				~~20~~	~~20~~	21	22	23	24	25	26	27	28	29	30	1	2
20	[redacted]	Ancef 1gm IVPB	6	/	[redacted]												
	-----	Q8°	14	/	[redacted]												
	-----		22	/	[redacted]												
20	[redacted]	Levaquin 500mg	08	[redacted]													
	-----	IVP QD	~~Dec~~	2	3	4	5	6	7	8	9	10					
2Dec03	[redacted]	Levaquin 500mg PO	06														
	-----	Q 1D	12			ERROR											
	-----		18														
	-----	(b)(6)-2	24														

Dcd 2Dec @ 11Z

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
(L) TIB/FIBPX c̄ EX-FIX

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 1 FEB 79 4678 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. 11 Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
2 Dec 03	[redacted]	D/C IV Abx, DC IV	2 Dec 03	Now		

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
20	[redacted]	MSO4 2-4mg IV Q2° prn pain	D/T	23 Nov 1400	23 Nov 2215	26 Nov 1025										
			D/I	4mg	4mg	4mg	[redacted]									
20	[redacted]	Tylenol 650mg po QID prn	D/T													
			D/I													
20	[redacted]	Percocet II po Q4° prn pain	D/T	22 Nov 1500	23 Nov 0800	24 Nov 1200	24 Nov 2000	26 Nov 1300								
			D/I	II	2	2	2	II	[redacted]							
20	[redacted]	Ambien 10mg po QHS prn	D/T	24 Nov 2215												
			D/I	10mg po	[redacted]											
20	[redacted]	Phenergan 25mg IV Q6° prn nausea	D/T	26 Nov 1755												
			D/I	25mg	[redacted]											

*U.S. GPO: 1998-454-110/95216

MEDCOM - 25156

Green Sheet Green Sheet Green Sheet

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. 12 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 15	16	17	18	19	20	21	22	23	24	25	26	27	28
20Nov	[redacted]	VS: Routine	D	[redacted]													
20Nov	[redacted]	Diet: Regular	D	[redacted]													
			N														
20Nov	[redacted]	Act. as tolerated	D	[redacted]													
			N														
20Nov	[redacted]	Elevate (L) leg	D	[redacted]													
			N														
20Nov	[redacted]	Incentive spirometer	D	[redacted]													
			N														
2Dec	[redacted]	Daily dry dsg Δ	D	[redacted]													
		to (L) leg. Apply															
		bacitracin ointment						D/C'D									
		to graph sites C															
		each dsg Δ															
2Dec	[redacted]	OOB, ambulate	D	[redacted]													
		NWB (L) LE	N	[redacted]													
4Dec	[redacted]	NIO: Braden Scale	D														
		Q7 Days	N														
9Dec	[redacted]	Daily WTD dsg Δ	1530														
		(L) leg @ 1530 C						D/C'D									
		Dr [redacted] present															
12Dec	[redacted]	Record JP output	6	[redacted]													
		Q shift	18	[redacted]				D/C'd									
15Dec	[redacted]	Record JP output	D	[redacted]													
		Q shift	N	[redacted]													

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (L) 4/6 F.6 Fx + Int Malleolus

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO. 1

PATIENT IDENTIFICATION:

EPW # [redacted]
ICW # 1(5)61-4

Rewritten: 15Dec03

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 4679 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED

MEDCOM - 25157

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
8DEC	[redacted]	~~DC~~ ERROR DC to EPW camp				
15DEC	[redacted]	NPO now for Sx	15DEC	1130	1130	[redacted]
15 DEC	[redacted]	DC dsg Δs	15	—	—	[redacted]
15	[redacted]	Resume pre op activities, diet, meds	15	—	—	[redacted]
23DEC	[redacted]	X-RAY APP/LAT (L) Tib/fib	23DEC	Today	1130	[redacted]
24DEC	[redacted]	Leave (L) Lower Leg wound open to air	24DEC		15[redacted]	[redacted]
		(b)(6)-2				

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

*U.S. GPO: 1998-454-110/95216

OUTPUT

URINE						NASOGASTRIC			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST						EMESIS			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL

(b)(6)-2

STOOLS				
TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL
				28 NOV

OTHER OUTPUT [redacted]			
TIME	AMOUNT	TYPE	ACCUM TOTAL
0600 1800	20cc	Sero-Sang	20cc
1800-0600	10cc	Sero-Sanginous	30cc
GRAND TOTAL OUTPUT			

REMARKS

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

[redacted] (b)(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS (1 oz)	30	HALF PINT MILK	240
	120	LARGE SOUP BOWL	240
SMALL FRUIT CUP	160	LARGE WATER GLASS	240
COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

DD FORM 792, JAN 74

OUTPUT

URINE						NASOGASTRIC			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST						(27 nov Ø3) ~~EMESIS~~ JP drain			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL
						1800	40cc	bloody	40cc
						0600	12 cc	Sero-Sanguinous	52cc

STOOLS					(26 NOV Ø3) OTHER ~~OUTPUT~~ JP			
TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL
					(26) 1810	40cc	Sero-Sang	40
					(27) 0500	65		(105)
					GRAND TOTAL OUTPUT			

26 NOV 24 TOTAL

REMARKS

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

[redacted] (b)(6)-7

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS *(1 oz)*	30	HALF PINT MILK	240
SMALL FRUIT CUP	120	LARGE SOUP BOWL	240
COFFEE CUP	180	LARGE WATER GLASS	240
LARGE COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

DD FORM 792, JAN 74 EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 72 WHICH MAY BE USED. USAPPC 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: _____ Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block

Time In: 1900

Allergies: NKA OR Intake: Crystalloid _____ Colloid _____

Pre-op V/S: 108/60, 105 OR Output: UOP _____ EBL _____

Procedures: TKR (R) tibia (CSW) Meds/Times: _____

750 NS
3400
ASA 2
25 Phen
10 MSO4
1c Toradol

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

Pre Op Meds _____ History _____

Time	1800	1805	1810	1815	1820
SaO2	98	95	99	98	98
FiO2	RA	2L	2L	2L	2L
Methods		W	W	W	W
240					
220					
200					
180					
160					
140					
120	V	V	V	V	V
100	•	•			
80	∧	∧	•	•	•
60			∧	∧	∧
40					
20					
RR	16	15	14	14	14
T	97				

Time	
Pain (0-10)	
LOS	

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

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: _____ Labs: _____

Post-Anesthesia Recovery score

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

Codes

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

V/S
X = A-line BP
˙ = Cuff BP
= Pulse

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

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

PREPARED BY (Signature & Title) SGT [redacted] (b)(6)-4 9/6 30

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 21 NOV 03

PATIENT'S IDENTIF[redacted] 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

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
1900 Adm	⊕LE	Limited	+	P	B	W	WNL
15'	⊕LE	Limited	+	P	R	W	WNL
30'	⊕LE	Limited	+	P	R	W	WNL
45'							
60'							
90'							
D/C	⊕LE	Limited	+	P	R	W	WNL

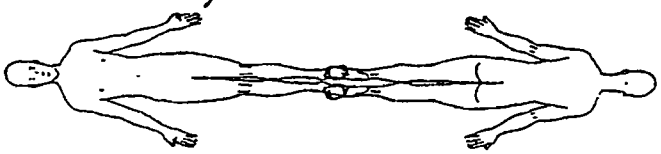
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 1900	⊕ Leg Lower	Gauze Ace	Ø
30' 1930	⊕ Leg Lower	Gauze Ace	Ø
60'			
D/C 2015	⊕ Leg Lower	Gauze Ace	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1900	NSR	Ø	Ø

WAMC OP 173-E

NURSING NOTES

Admitted from OR via gurney Alert - arouseable c stimuli USS IV cg NS to ⊕ hand is patent x- fix to ⊕ LE wrapped c Ace and gauze Ø drainage Ø c/o pain c present. Perrla 3mm - HR - NSR S1S2 - Lungs CTA - Resp even reg. Bs⊕ x4 quads. Pedal pulses - ⊕ +2 ⊕ cms intact cap refill > 3secs Radial +2, color WNL skin warm dry. - Sgt [redacted] -2

(b)(6)-2

Discharge Criteria:
Date: 21 NOV 02 **Time:** **PARS:**
BP: 105/51 **T:** 98.1 **HR:** 73 **RR:** 7 **Sa02:** 99
Pain Level at D/C (0-10): Ø
Intake: Ø **Output:**
Additional Data: Ø
Transferred To: ICW #1
Report Given To:
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: [redacted] LCO
Cleared IAW Recovery [redacted]
Charge Nurse Signature [redacted] RN

(b)(6)-2

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 26 Nov 03
Time In: 1215
Allergies: NKDA
Pre-op V/S: 115/67 85
Procedures: M Nailing Skin graft + HD

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 2300 Colloid
OR Output: UOP 550 EBL 300
Meds/Times: Fentanyl 150 mcg, Levaquin

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

Pre Op Meds History

Time	1215	1220	1225	1235	1240	1250	1315
SaO2	95	96	95	97	94	99	98
FiO2							
Methods	RA	RA	RA	RA	RA	RA	RA
240							
220							
200							
180							
160							
140	✓	✓	✓				
120	•	•	•	✓	✓	✓	✓
100				•	•	•	•
80	^	^	^	^	^	^	^
60							
40							
20							
RR	14	15	15	10	18	24	19
T	97.4						

Time	
Pain (0-10)	
LOS	

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1215	LR	700	(D) ARM	DL	2300

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			
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

(b)(6)-2

PREPARED BY (Signature) [redacted] RN

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 26 Nov 03

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

[redacted] (b)(6)-4

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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1240		MSO4 3mg				[redacted]

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	D/leg	Rom	+	+	B-S	W	Pk
15'							
30'							
45'							
60'							
90'							
D/C							

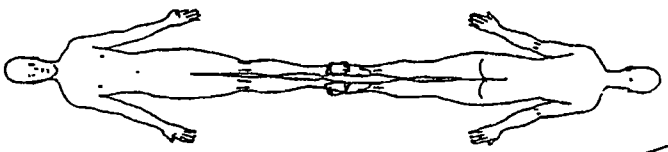
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	D/leg	Splint &	—
30'		Kerlex	min-mod
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1215	ST	—	—

WAMC OP 173-E

NURSING NOTES

Pt to recovery room from OR s/p IM nailing, I&D & skin graft to (L) leg. Bulky dressing & splint & SP drain to lower extremity. Kerlex to upper portion of (L) leg. IV of LR infusing into (L) wrist. + s/s. Medicated OK overall. Foley cath D/C'D. KSS will continue to infusion. [redacted] up 1240 - Pt c/o pain. Medicated c 3mg MSO4. X-ray also done. [redacted]

(b)(6)-2

Discharge Criteria:
Date: 26 Nov **Time:** 1320 **PARS:** 9
BP: 119/75 **T:** 96.5 **HR:** 107 **RR:** 26 **Sa02:** 97
Pain Level at D/C (0-10):
Intake: 300 **Output:** 0
Additional Data:
Transferred To: [redacted]
Report Given To: [redacted]
Transferred Via: [redacted] Ambulance
Transferred By: [redacted]
Cleared IAW Recovery Room [redacted]
Charge Nurse Signature: [redacted]

(b)(6)-2

130/60 98 15

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 09 DEC 03
Time In: 1450
Allergies: NKDA
Pre-op V/S: 105/53 85 98.2 97%RA
Procedures: I&D (L) Leg

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 400cc LR Colloid Ø
OR Output: UOP Ø EBL MIN
Meds/Times: Reglan Zantac 250cc Fentanyl

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

Pre Op Meds

History 40 yo

Time	1450	1455	1500	1505	1510												
SaO2	97	96	97	96	98												
FiO2	RA	RA	RA	RA	RA												
Methods	RA	RA	RA	RA	RA												
240																	
220																	
200																	
180																	
160																	
140																	
120																	
100	✓	✓	✓	✓	✓												
80	•	•	•	•	•												
60	^	^	^	^	^												
40																	
20																	
RR	20	11	10	11	9												
T	98.7																
Time																	
Pain (0-10)																	
LOS																	

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1520	Ø LR	200cc	(R) hand	IV	—

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	/	/	/
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	8	10	10

Codes

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

V/S
X = A-line BP
˙ = Cuff BP
= Pulse

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

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

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

(Continue on reverse)

(b)(6)-2

PREPARED BY (Signature & Title): [redacted] RN

DEPARTMENT/SERVICE/CLINIC: ICU 3

DATE: 09 DEC 03

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

40 yo

[redacted] (b)(6)-4

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(L)LE	+	+	BP	<3sec	W	Pk
15'	(L)LE	+	+	P	B	W	Pk
30'	(L)LE	+	+	P	B	W	Pk
45'							
60'							
90'							
D/C	LLE	+	+	P	B	W	Pk

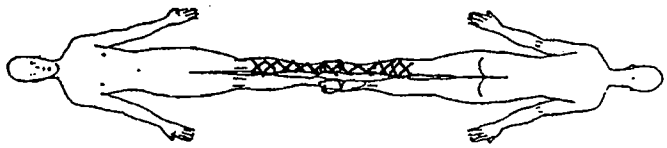
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L)LE	Splint	CDI
30'	(L)LE	Splint	CDI
60'			
D/C	(L)LE	Splint	CDI



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1500	NSR	No	No

WAMC OP 173-E

NURSING NOTES

1505 pt recieved from OR @ 1450 VSS pt IAD (L)LE No problems @ present will continue to monitor — [redacted] PACS/WMC

(b)(6)-7

Discharge Criteria:
Date: 09 Dec 03 Time: 0525 PARS: 10
BP: 102/60 T: 96.7 HR: 77 RR: 11 Sa02: 99 on RA
Pain Level at D/C (0-10):
Intake: 200cc Output: Ø
Additional Data: None
Transferred To: ICW 1
Report Given To:
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: PFC SGT [redacted] (b)(6)-7
Cleared IAW Recovery Room [redacted]
Charge Nurse Signature: [redacted]

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 15 Dec 03
Time In: 1700
Allergies: NKDA
Pre-op V/S: 120/70 82
Procedures: I&D (L) leg

Anesthesia Type (Circle)): (General) Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1800 Colloid Ø
OR Output: UOP Ø EBL 100
Meds/Times: 250 Fentanyl 3 mg Versed

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

Pre Op Meds History ASA 2

Time	1700	1705	1710	1715	1730											
SaO2	98	96	99	100	96											
FIO2	RA	RA	RA	RA	RA											
Methods	RA	RA	RA	RA	RA											
240																
220																
200																
180																
160																
140																
120		✓	✓	✓												
100	✓				✓											
80	•	•	•	•	•											
60	^	^	^	^	^											
40																
20																
RR	20	11	10	17	24											
T	96.4															
Time																
Pain (0-10)																
LOS																

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1700	LR	TKO	(L) Forearm	IV	TKO

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

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

(Continue on reverse)

PREPARED BY (Signature & Title) (b)(6)-2 [redacted] FC 91WM6

DEPARTMENT/SERVICE/CLINIC: ICU 3

DATE: 15 DEC 03

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

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

☐ 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

NURSING NOTES

pt recieved From OR @ 1700 pt VSS pt able to wiggle toe of (L) LE warm ⊕ pulses will continue to monitor for any Δ's – [redacted] PFC 9/WRK

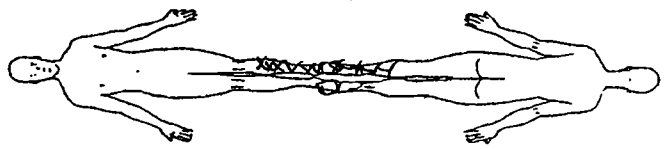
(b)(6)-2

NEUROVASCULAR							
Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(L) LE	⊕	⊕	P	B	W	PK
15'	(L) LE	⊕	⊕	P	B	W	PK
30'	(L) LE	⊕	⊕	P	B	W	PK
45'							
60'							
90'							
D/C	(L) LE	⊕	⊕	P	B	W	PK

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

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

DRESSINGS			
Time	Location	Type	Drainage
Adm	(L) LE	Ace wrap splint Kerlex	CDI, J-P drain
30'	(L) LE	Ace wrap splint Kerlex	CDI, J-P drain
60'			
D/C	(L) LE	Ace wrap splint Kerlex	CDI, J-P drain



PACU OUTPUT			
Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1705	NSR	No	No

Discharge Criteria:
Date: 15 DEC 03 **Time:** 1735 **PARS:** 10
BP: 105/60 **T:** **HR:** 70 **RR:** 18 **SaO2:** 99% RA
Pain Level at D/C (0-10):
Intake: 50cc **Output:** Ø
Additional Data: None
Transferred To: ICW2
Report Given To: PFC [redacted] (b)(6)-2
Transferred Via: W/C Litter ~~Gurney~~ Ambulance
Transferred By: PFC [redacted]
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:

WAMC OP 173-E

ROVISIONAL AUTHORITY FORCES APPREHENSION FORM

LDS MUST BE FILLED IN, IF APPLICABL UPON APPREHENSION

Offense agai s) [check one] If "Other" then describe

- [ ] on (I.P.C 34
- [ ] n of Form ion (I.P.C
- [ ] t/Sexu cts (I.P.C 98, 402)
- [ ] ssault With Intent To Ki P.C. 410)
- [ ] Burglary ousebreaking (I.P.C. 428)
- [ ] Extortion unicating Threats (I.P.C. 430)
- [ ] Theft (I.P
- [ ] Destructio roperty (I.P.C. 477)
- [ ] Obstructi ublic Highway/Place (I.P.C. 487)
- [ ] Dischargi earm/ Explosive in City/Town/Village (I.P.C. 495)
- [ ] Riot or Br of Peace (I.P.C. 495(3))
- [x] Other

Coalition Forces [check one] If "Other" then describe: RAN TCP

- [ ] Curfew
- [ ] Illegal Possession
- [ ] Assault/A s
- [ ] Theft o
- [ ] Trespass on Military Installation or Facility
- [ ] Photographing/Surveilling Military Installation o
- [ ] Obstructing Performance of Military Mission
- [ ] Other

(b)(2)-2

Apprehend [redacted]		Location Grid 502752	
Date of Inc 19 11 03	Time of Incident: 18 30 hrs to 1835 hrs	Date of Report: (D/M/Y) 19 11 03	Time 20

(b)(6)-4

Detainee # ALPHA		Key Connecti Person: [ ] Victim [ ] W	
Last Name		Last Name.	
First Name [redacted]	Given Name	First Name:	Given Name:
Color: K	ttoos/Deformities:	Hair Color:	Scars/Tattoos/Deformities:
Brown	150lb Height: 66 in	Eye Color:	Weight: lb Height:
		Address.	
		Place of Birth	
Phone#: DOB D/M/Y:	[ ] Mobile [ ] Regular	Ethn/Tribe/ Sect	[ ] M [ ] F
Phone#: DOB D/M/Y:	[ ] Mo [ ] Re		
[ ] Dr license	[ ] Other (specify)	[ ] Passport	[ ] Dr. license [ ] Other (s
Document #:		Document #:	

Total Number of Per lved 1 (list names/identifying info on reverse under "Additional Help

[ ] Vehicle	Vehicle Number ____ of ____ Vehicle(s)	Owner:	
Make: Tra	r: BLUE	VIN:	
Model: Mer	Fuel Tank	Plate No.:	Number of People in Veh
Year:	es of People in Vehicle:		
Contraband	e: None		

[ ] Proper	[ ] Weapon	Photo Taken of Suspe with Weapon/Contraband: Yes/ No	
pe:	Model:	Color/Caliber:	
No.:	ntity: Make:	Receipt Provided to Owner: Yes/ N	
ils:	Where Found:	Owner:	

n Inte Em Phone, or Contact Info:

(b)(6)-2

[redacted] MI SGT/E-5	Supervising Offi s Name (Prin Last, First MI
	Signature:
Date: 19 / 11 / 03	Email: Unit Phone: Date:

ON PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

TRIED to DRIVE vehicle Through COALITION TR
Control Point

Who witnes... g detained or the reason for detention? Give names, contact number

(b)(6)-2 [redacted]

(b)(6)-2 [redacted]

APO AE [redacted]

person ... car, bus, on foot)? semi TRACTOR TRAILER (fuel tanke

NO one

...s this person carrying? None

What contra... on carrying? None

What other ... ed?

...ormatio... get from the person?

Suspect tried to drive Through COALI
...ck point, 2 soldiers FIRED WARNING shots
...s of ...ck, one into grill. soldier (SPC [redacted] (b)(6)-2
into ...r's side door, striking suspect in left
...stop until Driver (suspect) was scre

SWORN STATEMENT

For use of this form, see AR 190-45; the proponent agency is ODCSOPS

PRIVACY ACT STATEMENT

C Section 301; Title 5 USC Section 2951; E.O. 9397 dated November 22, 1943 (SSN).
commanders and law enforcement officials with means by which information may be accu
al security number is used as an additional/alternate means of identification to facilitate fil
Disclosure of your social security number is voluntary.

	2. DATE (YYYYMMDD)	3. TIME	4. FILE
FOB ES	20031119	2030	

5. LAST NAME, FIRST N DLE NAME	6. SS	7.
[redacted]	[redacted]	

8. ORGANIZATION OR A (b)(6)-2 [redacted] (b)(6)-2 APO AE 09

9. I, SGT [redacted] (b)(2)-2, WANT TO MAKE THE FOLLOWING STATEMENT UN

On , At Approximately 1830, while conducting A
esence pa ute clearance of Route Bronze, the killer
atrol A Hasty Traffic Control Point At vicinity GR
After searching Approximate five cars with no
ue, Fuel Semi Truck Approached from The sou
lagged the truck over and signaled for the
, which it did not. Advancing uphill Through our T
The truck ued. I fired A warning shot with
9mm pisto The truck's cab, and PFC (b)(6)-2 [redacted]
warning into the truck's radiator grill. The truc
up the emingly Gaining speed. instructed Sp
to the est) of The vehicle to fire Low into The Dr
side doo fired 3 rounds, And The truck finally came
We ed The single occupant from The vehicle And an
medic issued first aid. We were Then instructed to
spect/casualty to FOB RIFLES / AL ASAD, which we di
contraband or weapons were found in The vehicle

NOTHING FOLLOWS

EXHIBIT	11. INITIALS OF PERSON MAKING STATEMENT	PAGE
	[redacted] (b)(6)-2	

ADDITIONAL PAGES MU IN THE HEADING "STATEMENT ____ TAKEN AT ____ DATED ____

THE BOTTOM OF EACH AL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEME
MUST BE BE INDICATED

DA FORM 2823, DE

DA FORM 2823, JUL 72, IS OBSOLETE

USE THIS PAGE IF NEEDED. IF THIS PAGE IS NOT NEEDED, PLEASE PROCEED TO FINAL PAGE OF THIS FORM

STATEMENT OF [redacted] TAKEN AT FOB RIFLES DATED

(b)(6)-2

9. STATEMENT (Continued)

[redacted]

(b)(6)-2

[redacted]

[redacted]

[redacted]

OF PERSON MAKING STATEMENT

[redacted]

PAGE 2 OF 3

7823, DEC 1948

STATEMENT OF [redacted] TAKEN AT FOB [illegible] DATED 19 No

STATEMENT (Contin

[redacted]

(b)(6)-2

AFFIDAVIT

[redacted], HAVE READ OR HAVE HAD READ TO ME THIS ST

BEGINS ON PAGE 1 AND ENDS ON PAGE 1. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIR

BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND HAVE INITIALED THE BOTTO

CONTAINING THE STATEM I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR

THREAT OF PUNISHMEN WITHOUT COERCION, UNLAWFUL INFLUENC

[redacted]

WITNESSES:

Subscribed and sworn to before me, a person

administer oaths, this 19 day of Nov

at

(b)(6)-2

[redacted]

ZATION OR AD istering Oath)

[redacted]

(Ty ering Oath)

(Authority To Administer Oaths)

EMENT

PAGE 3 OF 3

DEC 1998

SWORN STATEMENT

For use of this form, see AR 190-45; the proponent agency is ODCSOPS

PRIVACY ACT STATEMENT

USC Section 301; Title 5 USC Section 2951; E.O. 9397 dated November 22, 1943 (SSN).
commanders and law enforcement officials with means by which information may be accu
security number is used as an additional/alternate means of identification to facilitate filing
disclosure of your social security number is voluntary.

	2. DATE (YYYYMMDD)	3. TIME	4. FILE NUM
03 Rifles	19 Nov 03	2006	

5. LAST NAME, FIRST NAME, MIDDLE NAME	6. SSN	7. RA
[redacted] (b)(6)-2	[redacted]	

8. ORGANIZATION OR ADDRESS
[redacted]

9.
I, SPC [redacted], WANT TO MAKE THE FOLLOWING STATEMENT U

While on [illegible] sence patrol From FOB Miller to FOB Rifles [illegible] stopped and [redacted] AT Grid 50[illegible]75[illegible] During that [illegible] fuel [illegible] failed to stop and SGT [redacted] (b)(6)-2 fired a wa[illegible] The Truck continued PFC [redacted] (b)(6)-2 also fired a warn[illegible] At that time SGT [redacted] told me to fire lo[illegible] I fired, I put three shots into the lo[illegible] side door, After I fired the truck th[illegible] The man was screaming and we rend[illegible] the truck. [illegible] had a wound on his left calve and S[illegible] did first-a[illegible] We were then instructed to Bring t[illegible] Iraqi to F[illegible] fles. When we arrived, we dropped t[illegible] of at the [illegible] Aid-Station at FOB Rifles.

Nothing Follows

Nothing Follows

	11. INITIALS OF PERSON MAKING STATEMENT	PAGE
	[redacted] (b)(6)-2	

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT _____ TAKEN AT _____ DATED _____"

THE BOTTOM OF EACH ADDITIONAL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEMENT MUST BE BE INDICATED.

DA FORM 2823, DEC [illegible] DA FORM 2823, JUL 72, IS OBSOLETE

[redacted] TAKEN AT FOB Rifles DATED 19

9. STATEMENT (Continued) (b)(6)-2

[redacted]

(b)(6)-2

[redacted]

(b)(6)-2

AFFIDAVIT

[redacted], HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT [redacted] PAGE 1, AND ENDS ON PAGE 2. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT [redacted] IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND HAVE INITIALED THE BOTTOM OF EACH PAGE [redacted] I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT [redacted] WITHOUT COERCION, UNLAWFUL INFLUENCE, OR [redacted]

[redacted] (Signature of Person Making Statement)

Subscribed and sworn to before me, a person [redacted] administer oaths, this 19 day of [redacted] at [redacted]

(b)(6)-2

ORGANIZATION OR ADDRESS [redacted] (Signature of Person Administering Oath)

[redacted] (Typed Name of [redacted] Administering Oath)

ORGANIZATION OR ADDRESS (Authority To Administer Oaths)

[redacted] OF PERSON MAKING STATEMENT [redacted]

PAGE 2 OF 2

[redacted] 2823, DEC 1998

Admission a. Coding Information

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

1. Reporting MTF	2. MTF Lo.			
[redacted]	IZ			
3. Register Number	Name (Last, First, MI)		4. Pay Grade	5. Sex
[redacted]	[redacted]		FGN	M
6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
1958-06-01 (b)(6)-4	45Y	X	9	
10. Length of Service	ETS	11. FMP	12. Social Security Number	
		99	[redacted]	
Organization (Active Duty Only)		13. Marital Status	Hour of Admission	Branch / Corps.
			23:45	ARMY
14. Flying Status	15. Beneficiary Category		16. Zip Code of Residence:	
NO	K78-PRISONER OF WAR/INTERNEES			
17. Unit Location	18. MOS		19. Trauma	Prev. Admission
			BC	NO
20. Source of Admission	Ward:		Name / Relationship of Emergency Addressee	
Direct from ER	ICW1		Address of Emergency Addressee	
(b)(2)-2 Name and Location of Medical Treatment Facility: [redacted] No Install Provided			Telephone Number of Emergency Addressee	
21. Type of Disposition	22. MTF Transferred To		23. Date of Disposition (YYYYMMDD)	
TRF-OTH			2003-12-27	
24. Clinic Svc - Admitting	25. MTF Transferred From		26. Date this Admission (YYYYMMDD)	
AEA - ORTHOPEDICS			2003-11-19	
27. Location of Occurrence	28. MTF of Initial Admission		29. Date of Initial Admission	
IZ			2003-11-19	

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: L TIB FIB FX

Procedure Narrative(s):

Cause of Injury Narrative:

Admitting Officer (Signature, as required)

[redacted] (b)(6)-2

Signature of Admitting Clerk

for [redacted]

Automated Facsimile - DA FORM 2985, MAR 2000

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

1. Register Nbr	2. Name					3. Grade	Admission Remarks
[redacted]						FGN	
4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm	
M	30Y	(b)(6)X-4				NO	
11. FMP	12. SSN	13. Organization				14. Ward	
99	[redacted]					ICW1	

15. FlyStatus	17. Dept / Ben	18. BranchCorps	19. UIC / ZIP	20. Type Case
	K78-PRISONER OF WAR/INTER			DIS

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	15:55	AEA - ORTHOPEDICS

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	TRF-OTH	2003-11-25

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-11-21	[redacted] (b)(6)-2

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
[redacted] (b)(2)-2	2003-11-21	

31. Selected Administrative Data

Marital Status: Z DoB: 1973-06-01

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

GSW R FOOT RENAL FAILURE

Dx: 8720
Dx: 7760

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	5	5

Signature of Attending Medical Officer	Signature of [redacted] Records Officer
[redacted] (b)(6)-2	[redacted]

Automated Facsimile - DA FORM 3647, May 79

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

2 hrs ago Iraqi [illegible] shot in foot by Iraqi police
15 days ago. No complaints of pain
Self treated at home by patient

Penicillin: [illegible]
Psych: [illegible]
Meds: [illegible]
Allergies: [illegible]
Society: [illegible]

PHYSICAL EXAMINATION

HEENT: [illegible]
Chest: Clear
Card: S.R.
Abd: Heavy [illegible] / tender + [illegible] on [illegible]
Ext: 2x3 cm plantar wound + granulation tissue
2+DP/PT

RR: Shrapnel
1st 2nd [illegible] space
3rd [illegible]
no [illegible]

12.3 / 8.8 / 88.3 / 476
130 / 103 / 14 / 116
4.6 / 20 / 21

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

(A) GSW (R) foot renal failure
(P) Admit overnight

(b)(6)-2

SIG[redacted]	DATE 4/21/03	IDENTIFICATION NO.	ORGANIZATION

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

REGISTER NO.	WARD NO.

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
1/21/03	Operative
	PreOpDx: GSW (R) foot
	PostOpDx: same
	Procedure: I&D (R) foot
	Surgeon: [redacted]
	Anesthesia:
	Fluids: 500cc
	Findings: open granulating wound plantar aspect of foot
	(b)(6)-2 [redacted]
1/24/03	PreOpDx: GSW (R) foot
	PostOpDx: same
	Procedure: Repeat I&D irrig (R) leg
	Surgeon [redacted] (b)(6)-2
	Fluids: 400cc
	Anesthesia: general
	Findings: clean wound
	[redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/19)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)
USAPA V

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
21 Nov 03 2000	Pt received from ICU 3 via Litter. Pt A&O VSS, Denies pain @ this time. (R) Foot Drsg c̄ Ace Wrap. CDF. Pt c̄ multiple open wounds, Superficial to Back. Wounds OTA, Scabbed over. Pt has 18 G to (L) FA. 150 cc/h of NS. No s/sx of infection Noted. Lung Sounds clear to Ascultation bilat. HRRR, S1 S2 present (+) BS x4 quads. Will cont to monitor (b)(6)-2 [redacted] Spc 911N/M6
22 Nov 03	(1530) Assumed care @ 0600. Pt alert, speaking Arabic. VSS. 0 c/o pain. IVFs infusing into IV in (R) forearm s̄ s/sx infection/infiltration. Splint/dsg on RLE CDI. Pt OOB to amb c̄ crutches. Tol well. Wounds on back cleaned c̄ ~~Silvadene~~ Hibiclens and NS. Loose scabs cut off. Burn pad placed behind back. Tol reg diet well. Voiding s̄ difficulty. Pt OOB to chair for 2°. 3 point restraints in place. s̄ s/sx complications. Dsgs applied to wrists d/t old lacerations on wrists. Will cont to monitor. [redacted] (b)(6)-2
~~22 Nov 03~~	

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

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
22 NOV 03 1900	VSS. (L) FA IV patent & intact infusing NS @ 152 (R) LE c [redacted] ~~cast~~ splint/ace wrap in place. Pt move toes freely to (R) foot. (R) dorsalis pedis pulse palpable +2. Capillary ~~refill~~ will ~~be~~ brisk. Consumed 70% of regular diet for dinner. Urinary clear yellow urine. Ø c/o pain @ this time. 2+ ~~restraints~~ restraints in place without [redacted] compromising circulation or skin integri [redacted]
23 NOV 03	(1500) Assumed care @ 0000. Pt alert, speaking Arabic. VSS. Ø c/o pain. Pt OOB to amb c crutches. Splint/Ace wrap to RLE CDI. Pt able to move toes. Wounds on back open to air. Min. amount of drainage on burn pad. Pt MRSA (+). Placed in own room. MD notified. Precautions started. IVFs infusing into (L) forearm ∃ SISX infection/infiltration. 3-point restraints in place ∃ SISX complications. Will cont. to monitor. [redacted]
23 Nov 03 2100	Assumed care of Pt @ 1800. Pt Alert & Oriented. Speaking small amount of english. VSS. Denies pain @ this time. LR infusing @ 150 c/hr via [redacted] 18g to (L) FA. Wounds on back OTA. Wound to (R) Foot Dressed ∃ kerlix roll. small "Dime size" showing on bottom of foot. Pt MRSA (+) and precautions in place. Will [redacted] continue To monitor. [redacted]

(REV. 5/1999) BAC

USAPA V1.

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
24NOV03@1400	Assumed care of pt. @ 0900. VSS. A&O. Mod. amount serosang. drainage to (R) foot dressing, no order for DRSNG Δ. feedbed over wounds to back. Pt. ambulated c crutches to BR this AM. Pt. on MRSA precautions. Pt. NPO, O/C to OR. Will cont. to monitor. [redacted] RN, BSN
24NOV03	Pt return From OR @ 1930 hours. LS CTA (B), HRRR (+) BS x4 quads. VSS. Pt consumed 80% of Dinner. Cast to (R) Foot e Ankle. Toes Warm e Dry to palpation. Able to move toes. Cap refill ≤ 3 Sec. NS @ 150cc/h via 18g to (L) [redacted]. [redacted] Pt Denies Pain @ this time. Will [redacted] to Monitor. [redacted] 9/WM
2100	Pt DC to camp tomorro[redacted] prescriptions in Med Folder [redacted] 9/WM
25NOV'03	Assumed care 0600 pt awake + oriented x3, VSS, pt has no c/o pain at this time. IV initiated left forearm, IV initiated (R) forearm patent and intact. (L) foot (+) circulation, good cap-refill. NS @ 150cc. Pt awaiting DC to EPW camp. Restraints x2 in place (O) skin breakdown, will monitor [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

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

(b)(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
11/25/03	Discharge Note
	Imp: 5th = GSW to right foot, open 3rd MT fx a 1w from injury > 2 weeks old. wound clean & healing well. Full contact cast applied. Weight bearing as tolerated. Follow 2 weeks for cast change. Continue oral antibiotics, levaquin 500mg po QD for four weeks.
	[redacted]
	(b)(6)-2

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

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

REGISTER NO.

WARD NO.

(b)(6)-4

[redacted]

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 7540-01-075-3766

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

PATIENT'S HOME ADDRESS OR DUTY STATION			ARRIVAL	
STREET ADDRESS			DATE *(Day, Month, Year)* 20 Nov 03	TIME 1627
CITY	STATE	ZIP CODE	TRANSPORTATION TO FACILITY HMMWV	

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		
21	AREA CODE	NUMBER	MEDICAL HISTORY OBTAINED FROM				NAME OF INSURANCE COMPANY		

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

CHIEF COMPLAINT Foot

CATEGORY OF TREATMENT		VITAL SIGNS					
☐ EMERGENT	TIME 1627	TIME 1627					
☐ URGENT		BP 112/50					
	INITIALS	PULSE 116					
☑ NON-URGENT		RESP 16					
		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: Met 8			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
1640	TD & IM		[redacted]		
1640	3G Unasyn			(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				
☐ DETERIORATED	TIME OF RELEASE	I have received and understand these instructions.		
		PATIENT'S SIGNATURE		

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

(b)(6)-2

[redacted]

(b)(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

NSN 7540-01-075-3786

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

TEST RESULTS

WBC 12	SMAC	130	103	4 / 116	ABG/PULSE OX			RADIOLOGY — Check if read by radiologist ☐
H/H 8.8/28					SUP 02	PH	PO2	RESULTS
PLT 476		4.6	20	2.1	PCO2	SAT	OTHER	
					U/A	DIP		EKG INTERPRETATION
TT	BHCG	ETOH	GLU			MICRO		

OVIDER HISTORY/PHYSICAL

: 21yo EPW c̄ wounds on face/back/(R) foot x 3 + weeks old.

PMHx
⊖

: A&O, NAD
· Back - multiple large scabbed plaques on back
Face (+) depigmented patches on face
(R) foot - (+) swelling c̄ lg. defect plantar aspect; (+) foul smell.

All
NKA
Meds
⊖

X-ray (R) foot
(+) 3rd mc fx
(+) 1st mc fx
(+) gas soft tissue (from wound tracking)
(+) shrapnel

: Unasyn 3.0 gm IV
Tetanus
Surg/ortho consult.
Aerobic/anaerobic cx sent.

(b)(6)-2

CONSULT WITH	TIME	ACTION

RESIDENT [redacted] STUDENT SIGNATURE AND STAMP

[redacted]

AND STAMP
MAJOR
FM/Sports
28th

DIAGNOSIS
A: (1) chronic open foot fx c̄ infection (R)
(2) Back - healing wounds/? infection
(3) anemia
(4) ↑ react... dehydration likely.

CODES

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

[redacted]

(b)(6)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

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: 21 HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): NKDA 3. PREVIOUS SURGERY [ ] NO [ ] YES (type): unknown

4. PROPOSED SURGICAL PROCEDURE:
(R) Foot I&D

5. ADDITIONAL INFORMATION: Last PO: ? Medical Hx: ∅ Implants: ∅ Medications: None
Jewelry removed: yes/no Family waiting: yes/no

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL 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	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; position; fluid shift	o PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	o Utilize pressure preventing devices on OR table and accessories. o Check for proper positioning and support to maintain good body alignment. o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling.

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

[redacted] (b)(6)-4

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; shock; previous surgery	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. 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. X Disminished visual perception due to being injury; sedation; F.2. X Potential for decreased communictaion due to language barrier; sedation F.3. Potential injury due to dentures.	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from _____ 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] 21 NOV 03 DATE

11. POSTOPERATIVE EVALUATION:

(b)(6)-2

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

DATE: 21 NOV 03 TIME: 1905

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

DATE: 21 NOV 03 TIME: 1956

VIA Litter BY [redacted] VERIFIED BY [redacted]

3. DATE 21 Nov 13 TIME PATIENT ARRIVED IN SUITE 1912

4. PATIENT IN ROOM TIME 1912 NUMBER 2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt in supine body w/ mech DVT prophylaxis

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

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

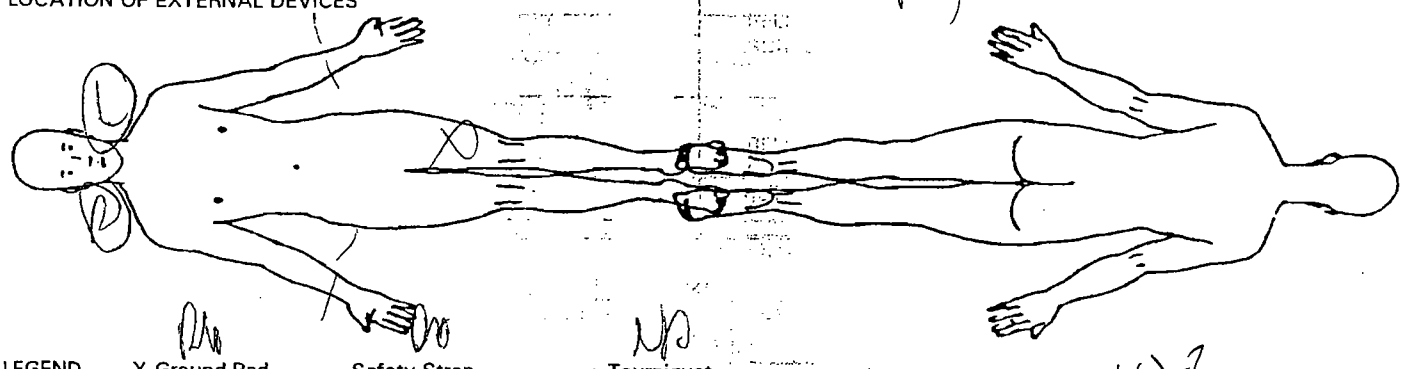
PREP SOLUTION *(Specify)* [redacted]

SITE: (1) Foot & lower leg [redacted] BY WHOM [redacted]

SITE: BY WHOM:

COMMENTS: No foley intal

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap = = = Tourniquet

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No		2	2		
Needle Sharp	☒ Yes	☐ No		2	2		
Instrument	☐ Yes	☒ No				[redacted]	[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: RBB 107398

GROUND PAD: BRAND

LOT NO: 69741

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)*

Flips, Kelly, webril, splints, webril, ace

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

19. ADDITIONAL INFORMATION

Surgeon [redacted]

Ass [redacted] CRNA

(b)(6)-2

20. OPERATION(S) PERFORMED

I&D (D) foot

21. PATIENT TRANSFERRED TO [redacted] TIME 1950 METHOD Gurney

22. REGISTERED NURSE SIGNATURE [redacted]

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.00

MEDICAL RECORD	INTRAOPERATIVE DOCUMENT For use of this form, see AR 40-4[illegible] [illegible]one[illegible] [illegible]cy is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPE[illegible]G ROOM
VIA stretcher BY anesthesia

2. PATIENT [illegible]IFIED, RECORD REVIEWED AND PROCEDURE
VERIFIED BY [redacted] CPT/AN

3. DATE 24 NOV 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM
TIME 1720 NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Proper body alignment maintained

8. SKIN PREPARATION

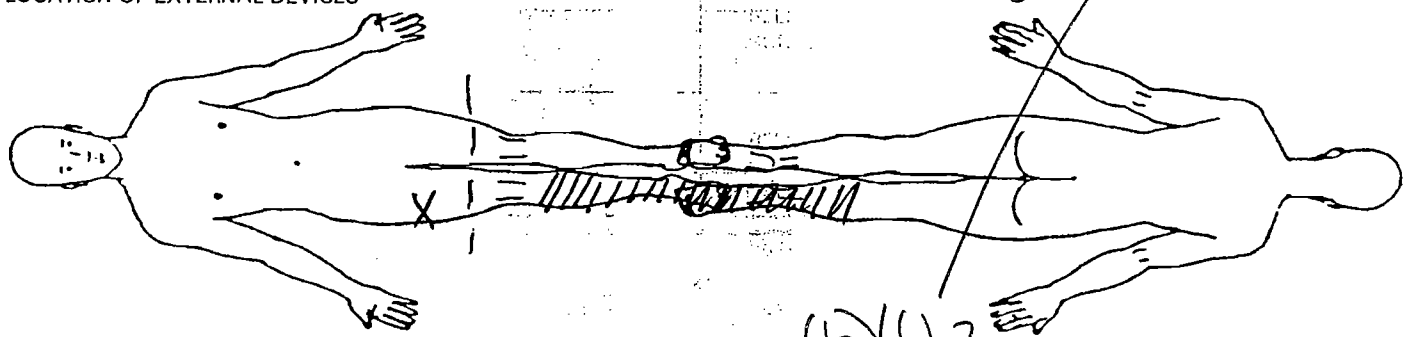
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine scrub/sol'n
SITE: Rt lower leg BY WHOM [redacted]
SITE: BY WHOM [redacted]

COMMENTS: No pooling of fluids

9. LOCATION OF EXTERNAL DEVICES



(b)(6)-2

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

C = Correct I = Incorrect INITIAL C [redacted]

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes	☐ No			C	[redacted]	[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: Force 40 R8E10530S 50/50
GROUND PAD: BRAND
LOT NO: 69441

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

13. PROSTHESIS, IMPLANTS ☐ YE ☒ IF YES NAME: ID NUMBER; .. .N RER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY
None		

PHYSICIAN'S SIGNATU [redacted]

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs Kerlix
Webril Fiberglass cast

19. ADDITIONAL INFORMATION

Surg: [redacted] Anesth: [redacted] RNA Type: General

(b)(6)-2

20. OPERATION(S) PERFORMED

1. I & D RT Leg Wound (foot) w/ fiberglass cast

21. PATIENT TRANSFERRED TO PACU (ICW1) TIME 1815 METHOD stretcher

22. [redacted] NATURE CPT/AN

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																							
POST- DAY																							
MONTH-YEAR NOVEMBER	DAY	21			22			23/24			24			25									
19 2003	HOUR	2			8	1		8	1	1				0720									
PULSE (O)	TEMP. F (•)	2 1 5			8	9 0 0		8	9 0 0	9 0 0													TEMP. C
	105°					0			0	0													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		4			8	6		8	6	8				114/62									
Record special data only when so ordered	BLOOD PRESSURE ①	152/82				138/84		127/68		122/68				144									
	②							124/66						98.1									
	① TEMP	98.1 F				99.3		99.9		98.0				98.0									
HEIGHT:	WEIGHT TEMP																						
	① O2Sat	99%				98%		97% (RA)		97%													
	SOURCE	RA				RA				RA													
	② O2Sat							98%		98%													
	SOURCE							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.

[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

(Centigrade Equivalents, for Reference only)

MEDICAL RECORD | VITAL SIGNS RECORD

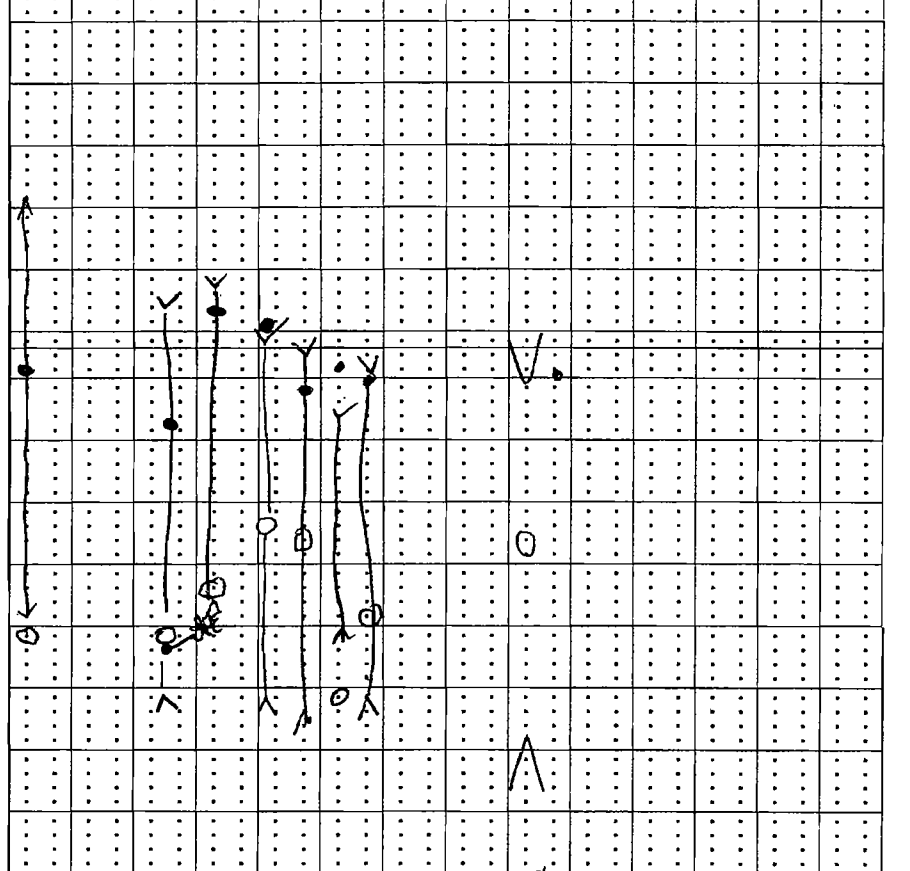
HOSPITAL DAY

POST- DAY

MONTH-YEAR NOVEMBER DAY 21 22 23/24 24 25

19 2003 HOUR 2 8 1 9 1 6 1 9 0720

PULSE (O) / TEMP. F (°) / TEMP. C



(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD: 14 18 16 16 18 119/62

BLOOD PRESSURE ① 157/82 138/84 127/68 127/68 144/94
② 124/66 148/81

① TEMP 98.1 F 99.3 97.9 98.0 98.0

HEIGHT: WEIGHT ② TEMP

① O2Sat 99% 98% 97% (98) 97%
SOURCE RA RA RA

② O2Sat 98% 98%
SOURCE RA RA

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[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

(b)(6)-2

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST: [redacted]	DATE: 21 NOV	TIME: 1627	SSN/PSEUDO SSN: [redacted]

(b)(6)-7

ID: [redacted]

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

(b)(6)-4

Misc. Serology

------ PICCOLO ------

21/11/03 16:55

REFERENCE RANGE: MALE

PATIENT #: [redacted]

METLYTE 8

DISC LOT #: 3152AA4

OPER #: 777 DR #: 000

SERIAL #: 0000100494

GLU	116	73-118	MG/DL
BUN	14	7-22	MG/DL
CRE	2.1*	0.6-1.2	MG/DL
CK	96	39-380	U/L
NA+	130	128-145	MMOL/L
K+	4.6	3.3-4.7	MMOL/L
CL-	103	98-108	MMOL/L
tCO2	20	18-33	MMOL/L

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 0

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

CSF		
Cell Count		
Directigen		Negative

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

Blood Bank Un
(MUST SUBMIT SF 518 WIT
REQUE

UNIT	TYP

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

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

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:

(i-STAT)

TEST	*RESULT*	*REF. RANGE*
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
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:	**DATE:**	**LAB ID NO.:**

Ward/Section: ICU 1	REQUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI.	DATE 22Nov	TIME 2520	SSN/PSEUDO SSN: [redacted]

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (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 8

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

(b)(6)-4

==== == PICCOLO ========
22/11/03 06:02
REFERENCE RANGE: MALE
PATIENT #: [redacted]
BASIC METABOLIC
DISC LOT #: 3325AA4
OPER #: 013 DR #: 000
SERIAL #: 0000100494
.....

GLU	97	73-118	MG/DL
BUN	11	7-22	MG/DL
CA++	8.5	8.0-10.3	MG/DL
CRE	1.5*	0.6-1.2	MG/DL
NA+	140	128-145	MMOL/L
K+	4.5	3.3-4.7	MMOL/L
CL-	111*	98-108	MMOL/L
tCO2	23	18-33	MMOL/L

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

[redacted] (b)(2)-2

Baghdad, Iraq

Microbiology Request Form

Last Name: [redacted] (b)(6)-4

First Name:

Patient # or SSN:

Collected by: Maj [redacted]

Date: 21 Nov 03

Time: 1651

Ward: EMT

Room:

Bed:

Physician: [redacted]

Source: Wound

Site: Right Foot

(b)(6)-2

[redacted]

Received by: [redacted]

Date: 21 Nov 03

Time: ~~1655~~ 1728

Specimen #: W141

Laboratory Results

Staphylococcus aureus MRSA

Reported

Date: 23 Nov 03

Time: 1000

Tech: Zu

Reviewer: [redacted]

Number of attached sheets:

MEDCOM - 25197

Name:
Patient ID: [redacted] (b)(6)-4
Ward/Rm: EMT/

Specimen: **W141**
Source: Wound/Sterile site
Ward of Iso:

Status: **Final**
Collected:
Attd. Phys:

1 Staphylococcus aureus Status: Final

1· S. aureus

Drug	MIC	Interps	Drug	MIC	Interps
Amox/K Clav (c)	<=4/2	R			
Amp/Sulbactam (c)	<=8/4	R			
Ampicillin	>8	BLAC			
Azithromycin	<=2	S			
Cefazolin	<=8	R			
Cefepime	<=8	R			
Cefotaxime (c)	<=8	R			
Ceftriaxone (c)	<=8	R			
Cephalothin	<=8	R			
Chloramphenicol	>16	R			
Ciprofloxacin	<=1	S			
Clindamycin	<=0.5	S			
Erythromycin	<=0.5	S			
Gatifloxacin	<=2	S			
Gentamicin	<=4	S			
Imipenem (c)	<=4	R			
Levofloxacin	<=2	S			
Linezolid	4	S			
Moxifloxacin	<=2	S			
Nitrofurantoin	<=32				
Norfloxacin	<=4				
Ofloxacin	<=2	S			
Oxacillin	>2	R			
Penicillin	>8	BLAC			
Rifampin	<=1	S			
Synercid	<=1	S			
Tetracycline	>8	R			
Trimeth/Sulfa	<=2/38	S			
Vancomycin	<=2	S			

S = Susceptible
I = Intermediate
R = Resistance
MIC = mcg/ml (mg/L)

N/R = Not Reported
--- = Not Tested
TFG = Thymidine-dependent strain

Blank = Data not available or drug not advisable or tested
ESBL = Extended spectrum beta-lactamase
Blac = Beta-lactamase positive

R* = Resistant due to extended spectrum beta-lactamases (ESBL)
EBL? = Suspected ESBL Confirmatory tests needed to differentiate ESBL from other beta-lactamases
IB = Inducible Beta-lactamase Appears in place of Sensitive with species known to possess inducible beta-lactamases, potentially they may become resistant to all beta-lactam drugs Monitoring of patients during/after therapy is recommended Avoid other/combined beta-lactam drugs

For blood and CSF Isolates, a beta-lactamase test is recommended for Enterococcus species

(a) Use maximum doses of drug with an aminoglycoside for P aeruginosa in patients with granulocytopenia or serious infections
(b) Breakpoints based on parenteral dose For cefuroxime axetil (PO) use (8=S, 8-16=I, >16=R) Footnote (c) applies to this drug
(c) For streptococci refer to penicillin interpretations For amoxicillin/K clavulanate or ampicillin/sulbactam with enterococci, refer to the penicillin interpretation
(d) For non beta-lactamase producing enterococci, refer to the penicillin interpretation Footnote (a) also applies to this drug

Interpretive breakpoints are based on NCCLS M100-S12 Jan 2002 Sparfloxacin (for Gram Negative isolates) and moxifloxacin are based on FDA approved breakpoints
For S pneumoniae cefotaxime and ceftriaxone breakpoints are based on isolates from patients with meningitis For non-meningitis infections, use <2=S 2=I >2=R

Name:
Patient ID: [redacted] (b)(6)-4
Ward/Rm: EMT/

Specimen: **W141**
Source: Wound/Sterile site
Ward of Iso:

Status: **Final**
Collected: (b)(6)-7
Req. Phys [redacted]

Printed 11/23/2003 9:48:36 AM

Tech: [redacted]

[redacted] (b)(2)-2

Baghdad, Iraq

Microbiology Request Form

Last Name: [redacted] (b)(6)-4

First Name:

Patient # or SSN:

Collected by: Maj [redacted] (b)(6)-2

Date: 21 Nov 03

Time: 1651

Received by: [redacted]

Date: 21 Nov 03

Time: ~~1655~~ 1728

Ward: EMT

Room:

Bed:

Physician [redacted]

Source: Wound

Site: Right Foot

Specimen #: W 1411

Laboratory Results

S Taphylococcus aureus MRSA

Reported

Date: 23 NOV 03

Time: 1000

Tech: [illegible]

Reviewer: [redacted]

Number of attached sheets:

MEDCOM - 25199

Name:
Patient ID: [redacted] (b)(6)-4
Ward/Rm: EMT/

Specimen: W141
Source: Wound/Sterile site
Ward of Iso:

Status: Final
Collected:
Attd. Phys:

1 Staphylococcus aureus Status: Final

1 S. aureus

Drug	MIC	Interps	Drug	MIC	Interps
Amox/K Clav (c)	<=4/2	R			
Amp/Sulbactam (c)	<=8/4	R			
Ampicillin	>8	BLAC			
Azithromycin	<=2	S			
Cefazolin	<=8	R			
Cefepime	<=8	R			
Cefotaxime (c)	<=8	R			
Ceftriaxone (c)	<=8	R			
Cephalothin	<=8	R			
Chloramphenicol	>16	R			
Ciprofloxacin	<=1	S			
Clindamycin	<=0.5	S			
Erythromycin	<=0.5	S			
Gatifloxacin	<=2	S			
Gentamicin	<=4	S			
Imipenem (c)	<=4	R			
Levofloxacin	<=2	S			
Linezolid	4	S			
Moxifloxacin	<=2	S			
Nitrofurantoin	<=32				
Norfloxacin	<=4				
Ofloxacin	<=2	S			
Oxacillin	>2	R			
Penicillin	>8	BLAC			
Rifampin	<=1	S			
Synercid	<=1	S			
Tetracycline	>8	R			
Trimeth/Sulfa	<=2/38	S			
Vancomycin	<=2	S			

S = Susceptible
I = Intermediate
R = Resistance
MIC = mcg/ml (mg/L)

N/R = Not Reported
--- = Not Tested
TFG = Thymidine-dependent strain

Blank = Data not available or drug not advisable or tested
ESBL = Extended spectrum beta-lactamase
Blac = Beta-lactamase positive

R* = Resistant due to extended spectrum beta-lactamases (ESBL)
ESBL? = Suspected ESBL. Confirmatory tests needed to differentiate ESBL from other beta-lactamases
IB = Inducible Beta-lactamase. Appears in place of Sensitive with species known to possess inducible beta-lactamases. Potentially they may, if induced, develop resistance to all beta-lactam drugs. Monitoring of patients during/after therapy is recommended. Avoid other/combined beta-lactam drugs.

For blood and CSF isolates, a beta-lactamase test is recommended for Enterococcus species.

(a) Use maximum doses of drug with an aminoglycoside for P. aeruginosa in patients with granulocytopenia or serious infections.
(b) Breakpoints based on parenteral dose. For cefuroxime axetil (PO) use (8=S, 8-16=I, >16=R). Footnote (c) applies to this drug.
(c) For streptococci refer to penicillin interpretations. For amoxicillin/K clavulanate or ampicillin/sulbactam with enterococci refer to the penicillin interpretation.
(d) For non beta-lactamase producing enterococci refer to the penicillin interpretation. Footnote (a) also applies to this drug.

Interpretive breakpoints are based on NCCLS M100-S12 Jan 2002. Sparfloxacin (for Gram Negative isolates), and moxifloxacin are based on FDA approved breakpoints.
For S. pneumoniae, cefotaxime and ceftriaxone breakpoints are based on isolates from patients with meningitis. For non-meningitis infections use (S, I, R).

Name:
Patient ID: [redacted] (b)(6)-4
Ward/Rm: EMT/

Specimen: W141
Source: Wound/Sterile site
Ward of Iso:

Status: Final (b)(6)-2
Collected
Req. Phys: [redacted]

Tech: [redacted]

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)													
Propofol	(mg)	120/30												
Sux	(mg)	80												
Fent	(mcg)	150	100											
	( )													
	( )													
	( )													
VOLAT AGENT	Sevo % del	2.5	3.0%											
	% e.t.													
AIR	L/Min													
N2O	L/Min													
O2	L/Min	8	2	2	8									

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

FLUIDS

LINE site														
18ga L AC	☐ Warmed	NS 1000												
	☐ Warmed													
	☐ Warmed													
	☐ Warmed													

LOSSES: EST BLOOD LOSS; URINE -

TOTALS	TOTAL EBL
	nil
250	TOTAL URINE
	0
	nasogastric

FLUIDS - SUMMARY

CRYSTALLOID- 500

COLLOID 0

BLOOD 0

REMARKS

Code drugs with numbers, events with letters

Pt I D on table
Oxygen/Exit on
Airway tip
Start/Stop
Dexamethasone 500mg
IV PB PSR
Intubated
SV & OP Supine
SV cont to PACU
Report to PACU RN
[redacted]

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 95 KG LB

HEMATOCRIT: 28

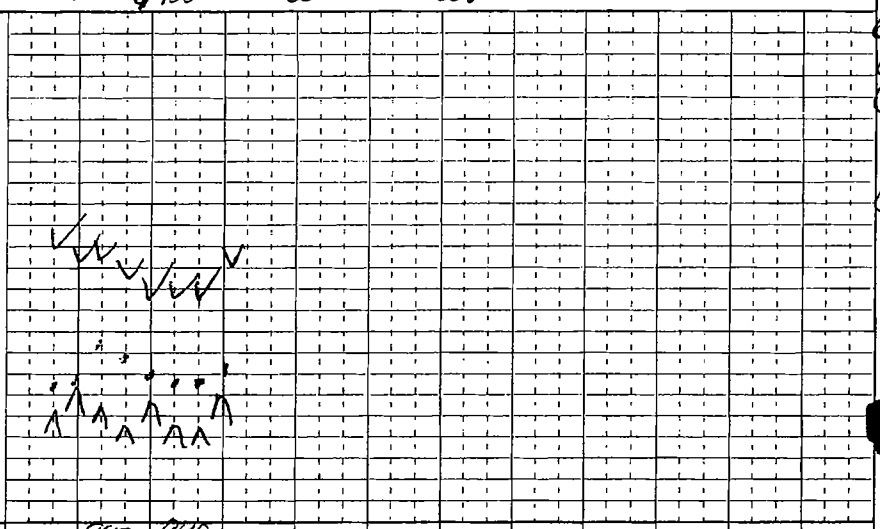
INITIAL DATA: BP- / HR-

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? Y TIME- 1905

TIME → 1930, 2000, 2030

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



VENTIL

VT - ml		980	940
f - breaths/min		8	10
Peak inf pres / PEEP		18	21
MODE - S(pon), A(ssist), C(on)	S A C		C

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	39	39	
BP/oth	FIO2 (Frac or %)	81	81	
ART line	SpO2 (%)	100	100	100
Steth- PC/ES	ECG	SR	SR	SR
Gas analyzer	TEMP-site			
	N-M Block (T/4)			
Warming blkt				
Conv warmer				

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

RECOVERY AT 1949

(PACU) ICU _____ (Specify)

OTHER _____

CONDITION: Pt is awake
T 98.9
RESP- 20 SpO2- 98
BP- 100/69 HR- 103

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1900	1912	1950
	Ready	Begin	End
PROC	1920	1930	1942

PROCEDURES and CPT Codes: EXD (R) Pt

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*: GETA

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

[redacted]

(b)(6)-7

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*: Pt X7 Nil 2 Grade I view ETT for O2 & BEBS. Taped @ 22cm @ lip. Eyes taped. Time Bandaid B 1900

SURGEONS: [redacted]

ANESTHETIST: [redacted]

(b)(6)-7

PROCEDURE LOCATION: 2

DATE: 21 NOV 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 — COPY 2 - ANESTHESIA PROVIDER — USAPA V1.00

MEDICAL RECORD - ANESTHESIA

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

Used wasted

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

DRUG	(Units)														TOTALS	TOTAL EBL
Fent	(mcg)	150	100												250	0
Prop	(mg)	180														
	( )															TOTAL URINE
	( )															
	( )															Ø measured
	( )															
VOLAT AGENT	Sevo % del	2.0	2.5	2.5												FLUIDS - SUMMARY
	% e.t.															CRYSTALLOID- 400
AIR	L/Min															COLLOID- Ø
N2O	L/Min															
O2	L/Min	8	2	2												BLOOD- Ø

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

FLUIDS

LINE site														
18ga @ AC	☐ Warmed	RL 1000												
	☐ Warmed													
	☐ Warmed													
	☐ Warmed													

LOSSES — EST BLOOD LOSS / URINE -

REMARKS

Code drugs with numbers, events with letters

Pt I+D @ foot w/ LW.
Qtn/Exit [illegible]
Induction [illegible]
Qnt removed
SW cont to
RACU, Report
to RACU [redacted]
cpnt
(b)(6)-2

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 90 KG LB

HEMATOCRIT:

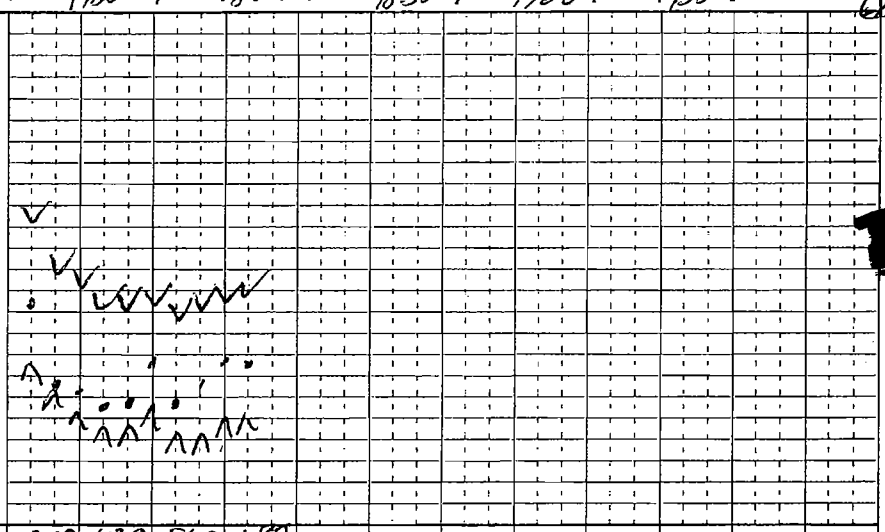
INITIAL DATA: BP- / HR-

EQUIP CHECK: OK? Y N

PATIENT RECHECK: OK for PROCEDURE? Y TIME- 1710

TIME → 1730, 1800, 1830, 1900, 1930, 2000

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



VENTIL

VT - ml	600	420	560	680
f - breaths/min	14	9	12	8
Peak inf pres / PEEP				
MODE - S(pon), A(ssist), C(on)	SA	S	S	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	49	48	43	47
BP/oth	FIO2 (Frac or %)	.80	.80	.79	.80
ART line	SpO2 (%)	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR
Gas analyzer	TEMP-site	37.1	37.1	37.0	37.0
	N-M Block (T/4)				
Warming blkt					
Conv warmer					

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

RECOVERY AT 1808

PACU ICU _____ (Specify)

OTHER _____

CONDITION: Pt in NAD

RESP RA SpO2- 98

BP 120/62 HR- 93

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1705	1720	1814
	Ready	Begin	End
PROC	1730	1735	1805

PROCEDURES and CPT Codes: I+D @ Foot

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

[redacted]

(b)(6)-1

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GA

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

LMA #4 placed 3 difficulty. leak [illegible] @ 20 cm H_2O pressure

SURGEONS: [redacted]

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

PROCEDURE LOCATION: 1

DATE: 24 Nov 03

PAGE 1 OF 1

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

Noted [redacted] 23 NOV 03 1525

NURSING UNIT [redacted] BED NO.

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
11-21-03	HOURS	
- Admit 1 CAV-1		
- IV LR C 125 c/hr		
- NPO		
- On call to or		
[redacted]		

PATIENT IDENTIFICATION

Noted 21 NOV 03 2100hrs [redacted] 21 NOV 03 1525

NURSING UNIT [redacted] BED NO.

DATE OF ORDER	TIME OF ORDER	
11/21/03	1945 HOURS	
- Stable		
- Routine vitals		
- ~~Levaquin~~ Ambulate c crutches WBAT		
- ~~1 heparin IV~~		
- IVF NS @ 150 c/hr		
- Regular diet		
- Percocet 1 tab q 4° PRN		

PATIENT IDENTIFICATION [redacted]

DATE OF ORDER	TIME OF ORDER	
- Tylenol 650 mg PO q 4° PRN fever > 100.5	HOURS	
- Ambien 10 mg PO QHS PRN		
- Levaquin 500 mg IV qd in AM		
- Phenergan 25 mg IVP q 6° PRN nausea		
- CHEM 8 in AM.		
[redacted]		

NURSING UNIT ROOM NO. BED NO.

PATIENT IDENTIFICATION

Noted 23 NOV 03 1150 [redacted]

DATE OF ORDER	TIME OF ORDER	
11/23/03	2130 HOURS	
- NPO p MN		
[redacted]		
- 11/24/03	1830	
- Resume Pre op orders.		
- B/c in AM to EPW CAMP		
[redacted]		

NURSING UNIT ROOM NO. BED NO.

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

(b)(6)-2

(b)(6)-2

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 21	22	23	24	25								
21Nov	[redacted]	Routine Vitals	06	[redacted]												
			18													
21Nov	[redacted]	Ambulate c crutches	06													
		WB AT	18													
21Nov	[redacted]	Regular Diet	06													
			18													
21	[redacted]	NPO	06													
			18													
		(b)(6)-2														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW (R) Foot

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION: [redacted]

(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 11 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
21 Nov	[redacted]	Stable Admit ICW	21 Nov	2000		[redacted]
21 Nov	[redacted]	Chem 8 in Am	22 Nov	0500	—	[redacted]
21 NOV	[redacted]	On call to OR	21 NOV	—	—	[redacted]
22 Nov	[redacted]	NPO Tp MN	24 NO	0001		

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

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
----	----															
----	----															
----	----															
----	----															
----	----															
----	----															
----	----															
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----	----															
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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. Nov Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 21	22	23	24	25	26
21 Nov	[redacted]	IVF NS @ 150cc/h	06	[redacted]					
	-----		18						
21 Nov	[redacted]	Levaquin 500mg IV	08	[redacted]					
	-----	QD in AM							
21	[redacted]	LR @ 125cc/hr	08						
	-----		18						

(b)(6)-2

SPRC-OP

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW (R) Foot

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 1 FEB 79 4678

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 11 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
21 Nov	[redacted]	Ambien 10 mg po	D/T													
		qhs PRN	D/I													
21 Nov.	[redacted]	Phenergan														
21 Nov	[redacted]	Percocet II q 4°	D/T													
		PRN	D/I													
21 Nov	[redacted]	Tylenol 650 mg q	D/T													
		4° PRN Fever > 100.5	D/I													
21	[redacted]	Phenergan 25 mg IV	D/T	21 Nov 1600 [redacted]												
		q 6° prn nausea	D/I	25 mg [redacted]												
		(b)(6)-2														

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

OTSG APPROVED *(Date)*

Date: 1955 21 WOU
Time In: 1955
Allergies: NKDA
Pre-op V/S:
Procedures: ICD & f.n.

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

500 flur
500 w/s
500 Levaquin

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds History

Time	1955	2000
SaO2	99%	99%
FiO2	RA	RA
Methods		
240		
220		
200		
180		
160		
140		
120	V	
	•	
100		
80		
	∧	•
60		
40		
20		
RR	15	20
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	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	/	/	/
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	10	10	10

Codes

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

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

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

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

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

(Continue on reverse)

PREPARED BY *(Signature)* [redacted] (b)(6)-2 9/1/00

DEPARTMENT/SERVICE/CLINIC PACU

DATE 21WOU03

PATIENT'S ID [redacted] *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

Allergies:

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(R) LE	Limited	+	P	R	W	WNL
15'	(R) LE	Limited	+	P	R	W	WNL
30'	(R) LE	Limited	+	P	R	W	WNL
45'							
60'							
90'							
D/C	(R) LE	Limited	+	P	R	W	WNL

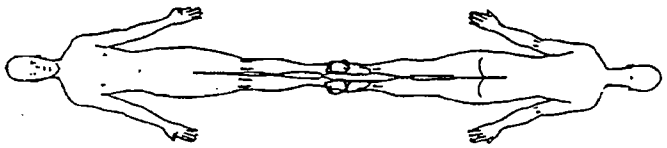
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 1955	(R) LE cast	cast	Ø
30' 2030	(R) LE	CAST	Ø
60'			
D/C 2030	(R) LE	Cast	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1955	NSR	Ø	

WAMC OP 173-E

NURSING NOTES

Received from OR via Gurney Admitted to PAC U. VSS - Awake, ~~[illegible]~~ IV of NS to (L) Arm patent cast to (R) LE c/o/s - Pearl La 3m HR - NSR S1 S2 - Lungs CTA BIL Resp Reg even. BS (+) x 4 quads. Pedal pulses (L) +2 (R) cms intact - cap refill <3 sec. Radial +2. Color WNL warm to touch. Ø c/o pain. — Sa[redacted]

(b)(6)-2

Discharge Criteria:
Date: 21 NOV 03 Time: 2030 PARS:
BP: 139/78 T: 98.1 HR: 67 RR: 21 Sa02: 98
Pain Level at D/C (0-10): Ø
Intake: Ø Output: Ø
Additional Data: Ø
Transferred To: 1CW #1
Report Given To:
Transferred Via: W/C [redacted] Ambulance
Transferred By: [redacted]
Cleared IAW Recovery [redacted]
Charge Nurse Signatu[redacted]

(b)(6)-2

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

OTSG APPROVED *(Date)*

Date: 24 NOV 03 Anesthesia Type (Circle)): General Spinal Epidural
Time In: 1815 IV Sedation Nerve Block
Allergies: OR Intake: Crystalloid 400 Colloid
Pre-op V/S: 142/73 103 OR Output: UOP Ø EBL min
Procedures: Meds/Times:
1 & D @ foot

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds History

Time	1815	1820	1825	1830	1835											
SaO2	97	97	97	96	97											
FiO2	RA	RA	RA	RA	RA											
Methods																
240																
220																
200																
180																
160																
140																
					V											
120	V	V	V	V												
100																
80	•	•														
			•	•	•											
60	^	^	^	^	^											
40																
20																
RR				10												
T	99															

Time									
Pain (0-10)									
LOS									

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1715	RL & LOR	600	L AC	OR	50cc

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

V/S
X = A-line BP
˙ = Cuff BP
= Pulse

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

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

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

DEPARTMENT/SERVICE/CLINIC PACU

DATE 24 NOV 03

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

[redacted] MRSA

(b)(6)-4

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

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

Allergies:

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

NURSING NOTES

1815- pt arrived via gurney
Stable, alert/oriented X3
Ø C/O pain - C[redacted]TAN
PT Transferred to ICW, by litter.
Report given to SPC [redacted]
Transferred by SPC [redacted]

(b)(6)-2

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(R) foot	+	+	UA	BR	W	Pk
15'							
30'	(R) foot	+	+	UTA	BR	W	Pk
45'							
60'							
90'							
D/C	(R) foot	+	+	UTA	BR	W	Pk

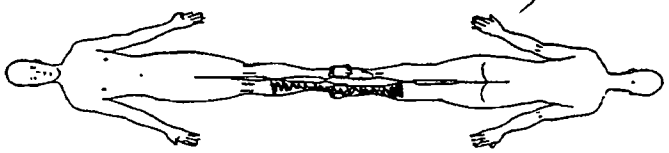
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(R) foot	cast	Ø
30'	(R) foot	cast	Ø
60'			
D/C	R foot	cast	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1820	NSR	Ø	Ø
1845	NSR	Ø	Ø

WAMC OP 173-E

Discharge Criteria:
Date: 2/10/03 Time: 1845 PARS: 10
BP: 132/59 T: 97.7 HR: 65 RR: 10 Sa02: 98
Pain Level at D/C (0-10):
Intake: 500 cc Output: Ø
Additional Data: Ø
Transferred To: ICW
Report Given To: SPC [redacted]
Transferred Via: W/C [redacted] Gurney Ambulance
Transferred By: SPC [redacted]
Cleared IAW Recovery Room [redacted]
Charge Nurse Signature [redacted]TAN

(b)(6)-2

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

YELLOW FIELDS MUST BE FILLED IN, IF APPLICABLE, UPON APPREHENSION

[X] Offense against Civilian(s) [check one] If "Other" then describe: IED Murder

- [ ] Arson (I.P.C. 342)
- [ ] Solicitation of Fornication/Prostitution (I.P.C. 399)
- [ ] Rape/Indecent/Sexual Assaults/Acts (I.P.C. 393-96, 402)
- [X] Murder (I.P.C. 405) 401
- [ ] Aggravated Assault/Assault With Intent To Kill (I.P.C. 410)
- [ ] Maiming (I.P.C. 412)
- [ ] Simple Assault (I.P.C. 415)
- [ ] Kidnapping (I.P.C. 421)
- [ ] Burglary or Housebreaking (I.P.C. 428)
- [ ] Extortion/Communicating Threats (I.P.C. 430)
- [ ] Theft (I.P.C. 439)
- [ ] Destruction of Property (I.P.C. 477)
- [ ] Obstructing a Public Highway/Place (I.P.C. 487)
- [ ] Discharging Firearm/ Explosive in City/Town/Village (I.P.C. 495)
- [ ] Riot or Breach of Peace (I.P.C. 495(3))
- [ ] Other

[ ] Offense against Coalition Forces [check one] If "Other" then describe:

- [ ] Violation of Curfew
- [ ] Illegal Possession of Weapon
- [ ] Assault/Attack on Coalition Forces
- [ ] Theft of Coalition Force Property
- [ ] Trespass on Military Installation or Facility
- [ ] Photographing/Surveilling Military Installation or Facility
- [ ] Obstructing Performance of Military Mission
- [ ] Other

Apprehending Unit: IP / 1165 M MP		Location Grid:	
Date of Incident: (D/M/Y) / / to / /	Time of Incident: hrs to hrs	Date of Report: (D/M/Y) 21 / 11 / 03	Time of Report: 1645 hrs

(b)(6)-1

Detainee #:		Key Connected Person: [ ] Victim [ ] Witness	
Last Name: [redacted]		Last Name:	
First Name: [redacted] Given Name [redacted]		First Name: Given Name:	
Hair Color: BLACK	Scars/Tattoos/Deformities: MANY	Hair Color:	Scars/Tattoos/Deformities:
Eye-Color: BLACK	Weight: 65 kg / Height: 170 cm	Eye-Color:	Weight: lb / Height: in
Address: AL DWARA POLICE		Address:	
Place of Birth:		Place of Birth:	
Ethn/Tribe/ Sect:	Sex: [X] M [ ] F / Phone#: / DOB D/M/Y: / [ ] Mobile [ ] Regular	Ethn/Tribe/ Sect:	Sex: [ ] M [ ] F / Phone#: / DOB D/M/Y: / [ ] Mobile [ ] Regular
[ ] Passport [ ] Dr. license [ ] Other (specify) Document #:		[ ] Passport [ ] Dr. license [ ] Other (specify) Document #:	

Total Number of Persons Involved _____ (list names/identifying info on reverse under "Additional Helpful information")

[ ] Vehicle Information	Vehicle Number ____ of ____ Vehicle(s)		Owner:
Make:	Color:	VIN:	
Model:	Type:	Plate No.:	Number of People in Vehicle:
Year:	Names of People in Vehicle:		
Contraband/Weapons in Vehicle:			

[ ] Property/Contraband	[ ] Weapon	Photo Taken of Suspect with Weapon/Contraband Yes/ No	
Type:	Model:	Color/Caliber	
Serial No.:	Quantity:	Make:	Receipt Provided to Owner Yes/ No
Other Details	Where Found	Owner	

Name of Assisting Interpreter: Email, Phone, or Contact Info.

Detaining Soldier's Name (Print): SSG [redacted]	Supervising Officer's Name (Print): [redacted]
Signature: [redacted]	Signature: 1st LT Last: [redacted]
Email: [redacted] Unit Phone: [redacted] Date: 21 NOV 03	Email: Unit Phone: 582 [redacted] Date:

(b)(6)-2

(b)(6)-2

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

(b)(6)-4

Why was this person detained? [redacted] is awaiting multiple murder charges in AC-Mahmudia for confirmed killing of two IP police officers. He is being investigated by several police units and the 82nd Airborne and [redacted] AC case files held in AC-Mahmudia

Who witnessed this person being detained or the reason for detention? Give names, contact numbers, addresses. (b)(7)-2

Case is still under investigation

How was this person traveling (car, bus, on foot)? N/A

Who was with this person? N/A

What weapons was this person carrying? N/A

What contraband was this person carrying? N/A

What other weapons were seized? N/A

What other information did you get from this person? N/A

Additional Helpful Information: N/A

3. Register Number	Name (Last, First, MI)	4. Pay Grade	5. Sex
[redacted]	[redacted]	FGN	M

6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
1973-06-01	30Y (b)(6)-4	X	9	

10. Length of Service	ETS	11. FMP	12. Social Security Number
		99	[redacted]

Organization (Active Duty Only)	13. Marital Status	Hour of Admission	Branch / Corps:
	Z	15:55	

14. Flying Status	15. Beneficiary Category	16. Zip Code of Residence:
	K78-PRISONER OF WAR/INTERNEES	

17. Unit Location	18. MOS	19. Trauma	Prev. Admission
		DIS	NO

20. Source of Admission	Ward:	Name / Relationship of Emergency Addressee
Direct from ER	ICW1	Address of Emergency Addressee

Name and Location of Medical Treatment Facility:	Telephone Number of Emergency Addressee
[redacted] (b)(2)-2	

21. Type of Disposition	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD)
TRF-OTH		2003-11-25

24. Clinic Svc - Admitting	25. MTF Transferred From	26. Date this Admission (YYYYMMDD)
AEA - ORTHOPEDICS		2003-11-21

27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission
		2003-11-21

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: GSW R FOOT RENAL FAILURE

Procedure Narrative(s):

Cause of Injury Narrative:

Dx: 8920
5586
Px: 7760

Admitting Officer (Signature, as required)	Signature of Admitting Clerk
[redacted] (b)(6)-2	[redacted]

Automated Facsimile - DA FORM 2985, MAR 2000

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

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

1. Register Nbr	2. Name					3. Grade	Admission Remarks
[redacted]						FGN	
4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm	
M	45Y (b)(6)-4	X				NO	
11. FMP	12. SSN	13. Organization				14. Ward	
99	[redacted]					ICW2	
15. FlyStatus	17. Dept / Ben	18. BranchCorps	19. UIC / ZIP	20. Type Case			
NO	K78-PRISONER OF WAR/INTER			BC			
21. Source of Admission	22. Hour Of Adm:	23. Clinic Service					
Direct from ER	05:40	AEA - ORTHOPEDICS					
24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp					
	TRF-OTH	2003-11-25					
27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:				
		2003-11-22	[redacted]				
29. ReportingMTF		30. Date Init Adm	32. Units Blood Components				
[redacted] (b)(2)-2		2003-11-22					

31. Selected Administrative Data

Marital Status: DoB: 1958-01-01

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

GSW R LEG S/P IM NAILING

Open (R) Tib/A Fx Gd I

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	4	4

Sig[redacted] Attending Medical Officer [redacted] (b)(6)-2 [redacted]

Automated Facsimile - DA FORM 3647, May 79

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

45 y/o Iraqi ♂ sustained GSW @ leg thru-thru.

PMHx: ∅
PSHx: ∅
MEDS: ∅
Allergies NKDA
Smoke (+) tob

PHYSICAL EXAMINATION

HEENT: WNL
Chest: CTA
CVS: S. Sr
Ext:

XR: midshaft fibula fx

GSW anterior fibula, swollen anterior / lat cmp.
Non tense. 2+DP/PT

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

(A) Open (R) TIB/FIB fx
(A) Admit, IVF nutrition

(b)(6)-2

SIGNATURE [redacted]	DATE 11/22/03	IDENTIFICATION NO.	ORGANIZATION

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

REGISTER NO.	WARD NO.

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

SKIN AND WOUND ASSESSMENT

MEDICAL RECORD — PROGRESS NOTES

Admission Date: 22 NOV 03 Diagnosis: GSW (R) leg POD: 3 POD: 3

Skin assessment must be done initially and every 7 days.

Braden Scale Evaluation (See Braden Evaluation Table for Details)

Sensory Perception	No impairment	(4)	4	Mobility	No limitations	4	3
	Slightly limited	3			Slightly limited	(3)	
	Very limited	2			Very limited	2	
	Completed	1			Completely immobile	1	
Moisture	Rarely moist	(4)	4	Nutrition	Excellent	4	3
	Occasionally moist	3			Adequate (Eats >50%)	(3)	
	Moist	2			Adequate (Rarely eats)	2	
	Constantly moist	1			Very poor	1	
Activity	Walks frequently	(4)	4	Friction and Shear	No apparent problem	(3)	3
	Walks occasionally	3			Potential problems	2	
	Chairfast	2			Problems	1	
	Bedfast	1					

Add the total score — *Total Score:* 21

Above 20	Low Risk
Between 16 and 20	Medium Risk
Between 11 and 15	High Risk
Below 10	Very High Risk

Note: A Braden Scale Score of less than 15 indicates HIGH RISK-requires immediate Ulcer Prevention program.

Surgical wound (s): Yes X No__ Location: (R) leg Size: several small incisions Drainage: ∅

Tubes: ∅ Pins: ∅ Appearance: staples intact

Dressing change: ∅ kerlix dressing sutures intact

Burn wound (s): Yes__ No X % BSA_____ Partial_____ Full_____

Location:_____ Size_____

Appearance:_____

Dressing change:_____

Pressure Ulcer (s): Yes___ No X

Stage I, II, III, IV (Circle the one that applies and describe below)

Location:_____ Size:_____

Wound character: Pink____ Moist____ Dry____ Granulation tissue____ Yellow slough _____ Tunneling____

Undermining____ Odor____ Purulent discharge_____ Eschar_____ Exudates _____

Type of dressing change: Wet-to-dry____ Comfeel dressing_____ Carrasyn-V Gel_____ Alginate_____

Physician notified/consulted for wound debridement: Yes___ No X Date/time MD notified _____

CNS notified/consulted for Stage II and greater: Yes____ No X

Nutrition Referral: Yes_____ No X

Physical Therapy Referral: Yes_____ No X

Action taken:_____ Date & Time 22 NOV 03

REGISTER NO. WARD NO. TCW2

Patient's Identification (For typed or written entries give: Name-last, first, middle; Grade; rank; hospital or medical facility)

PROGRESS NOTES
Medical Record
STANDARD FORM 509

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
11/22/03	Op Note
1	Pre Op Dx: Gal I open (R) Tibia fx
	Post Op Dx: Same
	Procedure: I&D Int nailing (R) Tibia
	Surgeon [redacted]
	EBL: 100cc
	Fluids: 1400
	Tourq: mid shaft fibular fx (b)(6)-2
	Cx: C
	Implant: Synthes 8mm x 330 mm titanium nail
	Cx: C
	[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

STANDARD FORM 509 (REV. 6/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
(cont) 24nov @ 1300.	Monitor [redacted] LPN (b)(6)-2

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

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

REGISTER NO.

WARD NO. ICW #1

[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

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
22NOV03	S 45y/o ♂ c̄ gsw to (R) lower leg/tibia, possible fracture.
P 107	
R	IV started @ 0334 18g 500cc NS
B/P 120/80	Rt fracture
T	(A) Pms
SpO2 98	resplinted leg
4mg Toradol	0334 45y/o Detainee c̄ GSW to (R) leg, pt has A
4gm Ansef	0337 Fx mid shaft tibia fibula intact per xray.
	no other injuries.
	exam ADVANCED xray show Fx to (R) tibia comminuted
	two bones one entrance and exit ∅ loss of length
Foley cath	Distal pulses intact, ∅ deformity noted
	A/∅ GSW to (R) leg Fx to (R) tibia comminuted
	- Medevac to MEK to be evaluated by ortho
	- pt in a L+U splint now
	- pt will need further lavage + debridement + casting.
	(b)(6)-2 [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.)* (b)(6)-4 | REGISTER NO. | WARD NO.

[redacted]

Civilian D

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)*
	Flight Medic notes
	LOC - Alert
	ABC - Patent / stable SpO2 98 room air
	(R) lower leg - TX + splinted PTA (+) Distal PMS
	V/S - 110/71 R 86 R WNL 0505
	IV Access PTA patent NS
	0503 - 500 cc NS on board, switched to 1L bag WO
	0515 - 118/54 P - 88 c̄ 1000 mL NS onboard

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

NSN 7540-01-075-3766

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Patient)* Bed 7	LOG NUMBER / TREATMENT FACILITY [redacted] / RECORDS MAINTAINED AT (b)(6)-2

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS: # [redacted]

CITY: (b)(6)-4 | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 22 Nov 03 | TIME: 0530

TRANSPORTATION TO FACILITY: A/E

SEX: M

AGE: 45

DUTY/LOCAL PHONE		HOME PHONE	
AREA CODE	NUMBER	AREA CODE	NUMBER

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

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

CURRENT MEDICATIONS: Zantac

ALLERGIES: NKDA's

INJURY OR OCCUPATIONAL ILLNESS			
ITEM	YES	NO	WHEN *(Date)*
IS THIS AN INJURY?			WHERE
INJURY/SAFETY FORMS			
HOW Safety 1st & RTA WS			

EMERGENCY ROOM VISIT	
DATE LAST VISIT	24 HOUR RETURN ☐ YES ☐ NO
TETANUS	
DATE LAST SHOT	COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: GSW (R) tib/fib

Smoke - 1/2 yr x 25 yrs PSHx - (L) hand GSW ~~Hand~~ Ring finger PMHx - Gastritis

CATEGORY OF TREATMENT

☐ EMERGENT
☐ URGENT
☒ NON-URGENT

TIME / INITIALS

VITAL SIGNS

TIME	0530			
BP	115/74			
PULSE	112			
RESP	18			
TEMP Oral	96.8			
WT				

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

☐ PULSE OX 98 % ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
	Td 5 mL cc IM		[redacted]	(b)(6)-2	
	Penicillin 5 Meg IM				
	GSW R L WS				

DISPOSITION: ☐ HOME ☐ FULL DUTY

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

MODIFIED DUTY UNTIL

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

EPW # [redacted]

(b)(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

NSN 7540-01-075-3786

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

TEST RESULTS

WBC	SMAC			ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
H/H				SUP 02	PH	PO2	RESULTS	(R) open Comminuted fx
PLT				PCO2	SAT	OTHER		
				U/A	DIP		EKG INTERPRETATION	
TT	BHCG	ETOH	GLU		MICRO			

PROVIDER HISTORY/PHYSICAL

41 y/o ♂ s/p GSW to (R) leg @ 0245. Arrived by airwave. Seen @ (BAS?) given Anef PTA. ⊖ other injuries. AOS neg stenose c/o (R) leg pain

Sx: Ao x/ – mod distress.

HEENT: OPLWP clear pat mucosa neck: supple NT Abd: atraumatic

Cvs: CTA (R) LS: nrm pu l/f Abd: bsx

Ext: (R) leg ⊕ T-T GSW (R) and fib ⊕2 dors pedis pulses (R)

Pmh: GERD
PSH: (L) heel fx
Meds: Zantac

A/P: Stable

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE [redacted] (b)(6)-2

PROVIDER SIGNATURE AND STAMP [redacted]

DIAGNOSIS: open (R) fib comminuted fx 2° GSW

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] (b)(6)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

NURSING NOTES
(Sign all Notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
22Nov03			Pt admitted to floor. IVF patent (R)
0710			arm. Foley to gravity (R) leg bandaged
			c̄ bright red blood. Pt o/c to OR. 2-point
			restraints applied ⊖ skin breakdown
			under restraint - [redacted] 10MG
0850			Pt transported to OR via litter - [redacted]
22Nov03		1500	Pt returned from sx via gurney in
			stable cond. Pt alert, speaking Arabic.
			VSS. ⊖ C/O pain. Drsg to RLE CDI. Pt
			able to move toes. Cap refill <3secs.
			SL in (R) arm flushes well ⊖ S/Sx
			infiltration/infection. Foley draining
			quantity sufficient clear yellow urine.
			Tol reg diet well. 2-point restraints in
			place ⊖ S/Sx complications. Will cont
			to monitor. [redacted]
23Nov03	0745		assumed care of pt @1800. VSS. C/O some
			pain to RLE. Drsg CDI, ⊕ CMS, elevated
			on blankets. (R) FA IV flushes well, IV
			Abx cont. Foley draining clear yellow
			urine. 2pt restraints ⊖ S/Sx of skin
			circulation compromise. Plan: monitor
			NV status, pain control, IV Abx.
			[redacted]

[redacted] (b)(6)-4

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
23NOV03		1855	Assumed care @ 1900. Pt alert, speaking Arabic VSS. Pain controlled c̄ Percs. Pt amb in hallway c̄ crutches s̄ difficulty. Dsg/splint to RLE intact c̄ sm. amount sero-sang drainage noted. Elevated while in bed. Pt OOB to chair. Tol. well. Foley dlcd @ 1710. Pt amb to BR - ⊕ void. Tol. reg diet well. 2 point restraints in place s̄ s̄/sx complications. Will continue to monitor. — [redacted]
23 Nov 03		2112	Assumed care of Pt @ 1800 hrs. Pt A&O [redacted] VSS Denies pain @ this time. Dsg to (R) LE c̄ Ace Wrap CDI. LS CTA (B). HRRR. ⊕ BS x4 quads. RLE elevated while in Bed. Pt consumed 40% of meal this PM. Will cont to monitor. — [redacted]
24 nov 03	@ 1300		Pt A/O, VSS, ∅ c/o pain @ this time. Pt amb x1 c̄ crutches s̄ difficulty. Splint c dsg to RLE c̄ small amt sero-sang drainage. Elevated while in chair or bed. Pt moves toes, brisk cap refill. Tol. Reg diet well. 2 pt restraints on while in bed. Will

(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

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: 45
HEIGHT: 165 cm
WEIGHT: 63 Kg

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): NKDA

3. PREVIOUS SURGERY [ ] NO [X] YES (type): (L) Hand surgery

4. PROPOSED SURGICAL PROCEDURE: IM Nailing (R) LE

5. ADDITIONAL INFORMATION: Last PO: NPO 5 2000 Medical Hx: + gerd Implants: (R) TOB Medications: Zantac
Jewelry removed: yes/no Family waiting: yes/no
missing 1 front bottom tooth

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

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

[redacted] (b)(6)-4

[redacted]

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; shock; previous surgery	ϕ 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. ϕ Check that safety straps are correctly applied. ϕ Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. ϕ 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	ϕ Pt. will be transferred to OR table without difficulty. ϕ Pt. will not experience unnecessary physical discomfort.	ϕ Have sufficient people available for transfer. ϕ Insure proper body alignment. ϕ Allow patient to lie in position of comfort while waiting for surgery. ϕ Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. X Disminished visual perception due to being injury; sedation; F.2. X Potential for decreased communictaion due to language barrier; sedation F.3. Potential injury due to dentures.	ϕ Pt. will be made aware of surroundings prior to anesthesia induction. ϕ Pt. will be transferred safely to OR table. ϕ Pt. will be able to understand instructions. ϕ Minimize danger of injury during intraop period.	ϕ Introduce self. Keep pt. informed as to where he/she is and what is happening. ϕ Inform pt. in which direction to move and assist if necessary. ϕ Speak clearly and slowly. ϕ Address pt. from either side. Very little English ϕ 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/AN 22 NOV 03 DATE

11. POSTOPERATIVE EVALUATION:

Bovie site: intact
Dsg: C+D
Resp: unassist
LOC: Drowsy

(b)(6)-2

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)	13. ~~PRE~~ Post OPERTIVE EVALUATION PREPARED BY (Signature and Title)
[redacted] RMN DATE: 22 NOV 03 TIME: 0700	[redacted] CPT, AN DATE: 22 NOV 03 TIME: 1052

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

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

PATIENT TRANSPORTED TO OPERATING ROOM: stretcher BY anesthesia

2. PATIENT IDENTIFICATION RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted]

DATE: 2NOV03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME: 0821 NUMBER: 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

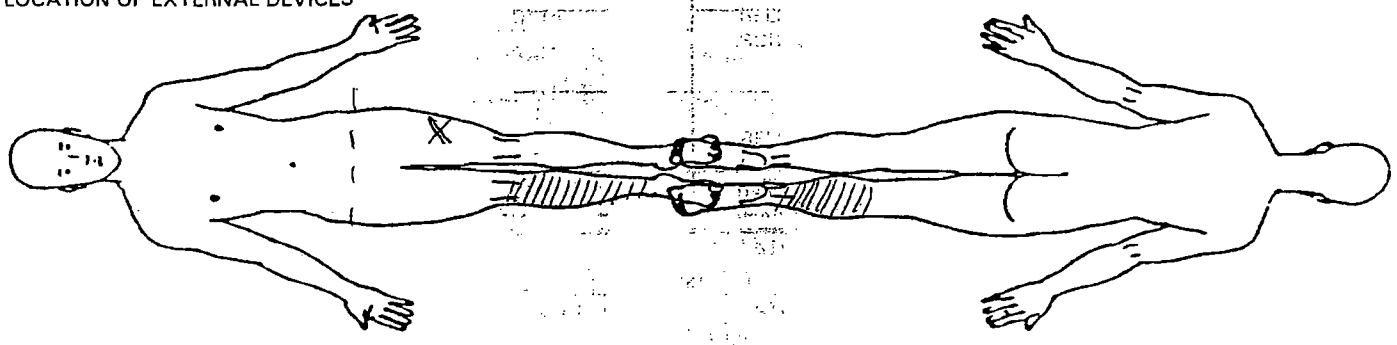
COMMENTS: on fx trable. Arms tucked @ sides

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP
COMMENTS: 5m. skin nick on knee

PREP SOLUTION *(Specify)* Betadine scrub/sol'n
SITE: Rt. Lower leg BY WHOM: Meyer
SITE: BY WHOM:
COMMENTS: No pooling of fluids

9. LOCATION OF EXTERNAL DEVICES



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

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

10. COUNTS

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

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

[redacted] (b)(6)-2

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

☒ ESU NO: Force 40 R8E 105303 50/50
GROUND PAD: BRAND
LOT NO: 69441

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

IM Nail Tray Load # 0332601 | IM Nail X1 8 X 330 | Screws 38 X 58.800 X1, 42 X1 | Cap screw 5 X 58.100 X1

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY
None		

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☒ NO ☐ C-Arm IF YES, SITE Rt. Lower Leg

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

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

19. ADDITIONAL INFORMATION

Surg: [redacted]
Asst: [redacted]
Anesth: [redacted] CRNA Type: General

(b)(6)-2

Foley in place PTA.

20. OPERATION(S) PERFORMED
1. Rt. Tibial Nailing

21. PATIENT TRANSFERRED TO PACU TIME 1049 METHOD stretcher

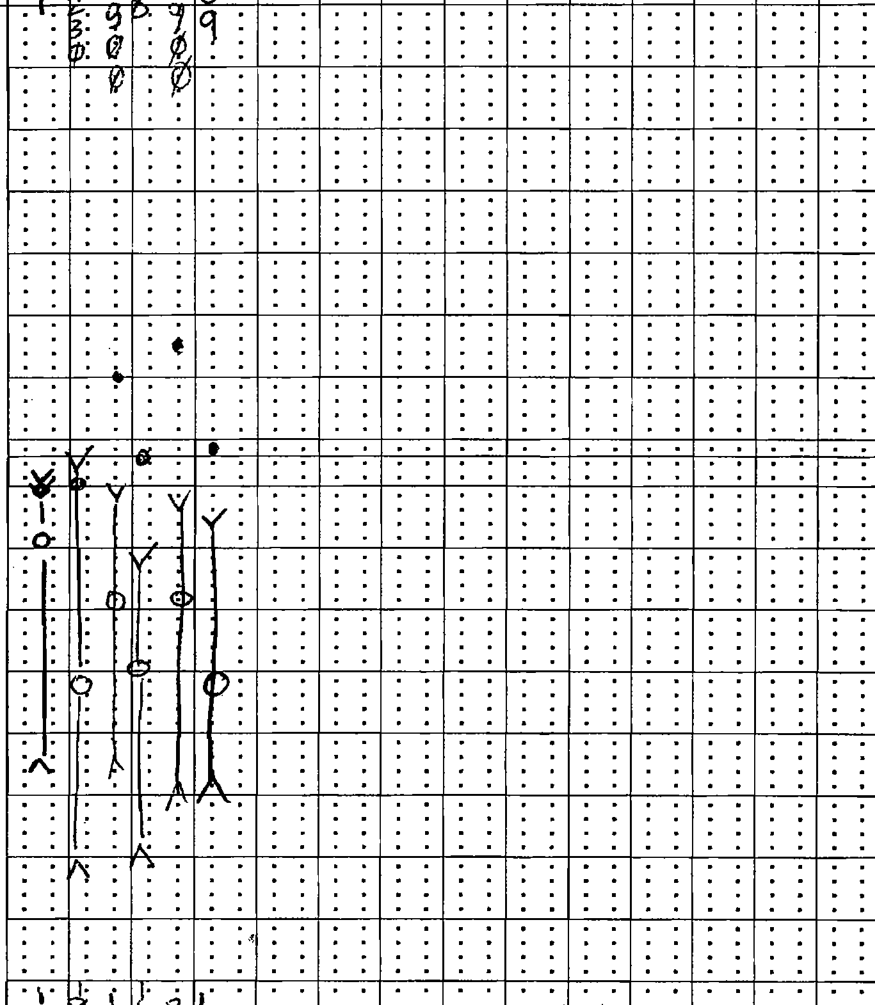
22. [redacted] SIGNATURE CPT/AN

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY		
POST-	DAY	
MONTH-YEAR	DAY	22 / 23/24
Nov 2003	HOUR	[illegible]

PULSE (O) — TEMP. F (•) — TEMP. C



PULSE	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)

Record special data only when so ordered					
RESPIRATION RECORD	18	18 / 16	16 / 20	18	
BLOOD PRESSURE ①	124/75	123/59	106/62	114/73	
②	111	115/77	117/79		
① TEMP	T97.9	100.1	100.6		
HEIGHT: / WEIGHT ② TEMP		98.C			
① O_2 sat		(91/(R)	96 (RA)	97%	
SOURCE		RA	9	(RA)	
② O_2 sat		100%	97%		
SOURCE		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.

[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	25																
19	HOUR	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

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.

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

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/22/03 06:16

Patient ID:
Test Name
Test Result:= 14.8 sec.
Ratio
Calculated INR = 1.07
Sample Type:citrated wh. blood
Test Date :11/22/03
Test Time :06:15
Card Lot :080201
Operator [redacted]

(b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/22/03 06:22

Patient ID [redacted]
Test Name
Test Result:= 33.6 sec.
Sample Type:citrated wh. blood
Test Date :11/22/03
Test Time :06:19
Card Lot :100208
Operator [redacted]

(b)(6)-4

[redacted]

22-11-03
06:12

			Patient Limits	
WBC	14.5 H	x10^3/uL	4.5	10.5
RBC	4.78	x10^6/uL	4.00	6.00
Hgb	12.7	g/dL	11.0	18.0
Hct	40.1	%	35.0	60.0
MCV	83.9	fL	80.0	99.9
MCH	26.6 L	pg	27.0	31.0
MCHC	31.7 L	g/dL	33.0	37.0
Plt	299.	x10^3/uL	150.	450.
LYM%	11.2 *L	%	20.5	51.1
LYM#	1.6 *	x10^3/uL	1.2	3.4

(b)(6)-2

Ward/Section: ER	REQUESTING PHYSICIAN: [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. EPW # [redacted]	DATE 22NOV03 / TIME	SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na	143	138-146 mmol/L
K		3.5-4.9 mmol/L
Cl	109	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

(b)(6)-4

(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

```
======= PICCOLO =======
22/11/03            06:17
REFERENCE RANGE:      MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #:        3152AA4
OPER #: 013      DR #: 000
SERIAL #:       0000100494
.......................
GLU   102   73-118   MG/DL
BUN     9   7-22     MG/DL
CRE   1.2   0.6-1.2  MG/DL
CK   4165*  39-380   U/L
NA+   126*  128-145  MMOL
K+    4.5   3.3-4.7  MMOL
CL    ***   98-108   MMOL
tCO2   18   18-33    MMOL

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

GSW (R) ch/Fil 3mo n Nailing Fent 50 PC BAS ≈ 0100

MA II E

MEDICAL RECORD - ANESTHESIA

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

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

DRUG (Units)	0810	30	0840	910	x	30	x	1000		30		1100
Fentanyl MCG	100		100	50			50	50			25	25
Lidocaine 1% mg	100											
Propofol MG	150										20/20	
Neostigmine (MG)	10							2				
( )												
( )												

VOLAT AGENT	Forane % del / % e.t.	1.5	1.0	1.0	1.0	1.0	.9	1.3	1.0	1.0	.6	.6	.6	.1%
AIR L/Min														
N2O L/Min														
O2 L/Min		2.6	2.5	1.8	1.8	1.8	1.6	1.6	1.6	1.6	1.6	1.6	2.4	1.6

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS → 1030 #1 Granisetron

FLUIDS

LINE site												
18GA (R) FA	☐ Warmed	LR		1000					300			1700
	☐ Warmed											
	☐ Warmed											
	☐ Warmed											

LOSSES

EST BLOOD LOSS												
URINE - Foley			500						300		750	

PHYS STATUS 1 2 3 4 5 (E)

BODY WEIGHT: ≈ 75 (KG) LB

HEMATOCRIT: 40

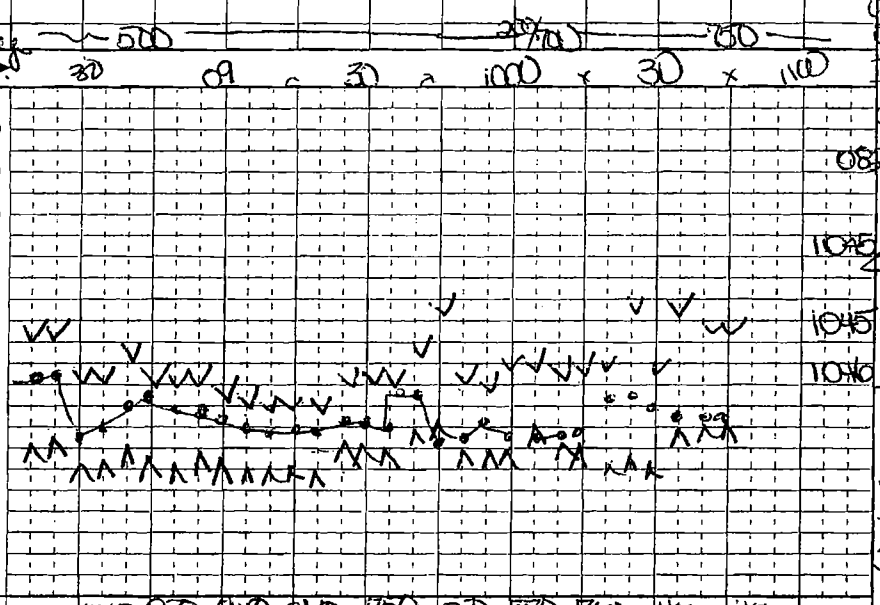
INITIAL DATA: BP- 126 / 75 HR- 106 100%

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? YES TIME- 0820

TIME 30 0900 30 1000 x 30 x 1100

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



VENTIL

VT - ml		700	630	810	840	750	730	770	760	400	400
f - breaths/min	+	9	10	9	7	8	8	8	7	9	16
Peak inf pres / PEEP		16	15	20	20	21	21	21	21	20	
MODE - S(pon), A(ssist), C(on)	SV	A/CV	CV	CV	CV	CV	CV	CV	CV	AV	SV

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	+	35	39	29	29	31	29	29	28	45	45
BP/oth	FIO2 (Frac or %)	.88	.88	.85	.85	.80	.82	.82	.80	.80	.80	.80
ART line	SpO2 (%)	100	100	100	100	100	100%	100%	100%	100%	100%	100%
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site Nasal		36.0	35.9	36.0	36	35.9	35.9	35.9	35.9	35.9	
	N-M Block (T/4)	4/4	0/4	0/4	0/4	0/4	0/4	3/4	0/4	1/4	4/4	decon
Warming blkt	Warmed room											X 1045
Conv warmer												

Mark with letters & symbols, explain under REMARKS — EVENTS Position → Supine fracture table arms tucked

TOTALS

TOTAL EBL	TOTAL URINE
<50 ml	750 ml

FLUIDS - SUMMARY

CRYSTALLOID- 1700 ml

COLLOID- Ø

BLOOD- Ø

REMARKS

Code drugs with numbers, events with letters

0755 Propofol as below IV 1

0810 IV OR #1

transfer to fx table prone

0825 Induction

0845 Neostigmine 3.0 mg Robinul 0.4 mg

0845 oral suction

0840 Extubated FiO2 1.0

1040 T4/4 c twitch 0

1045 Head lift x 5 seconds

SWE RR 16 (+) pressure

Transferred

TO PACU Report to [redacted]

RECOVERY AT 1050

PACU ICU _____ (Specify)

OTHER _____

CONDITION: SpO2 100% RESP 22 SpO2 98 S/4 BP 132/75 HR 98 65 (T)

ANESTHESIA / PROCEDURE TIMES

ANES	Start	Room	End
	0755	0810	1100
PROC	Ready	Begin	End
	0825	0850	1045

PROCEDURES and CPT Codes: IM Nailing R tib / fib

ANESTHETIC TECHNIQUES: Describe block technique under Remarks GETA

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

#[redacted] EPW

(b)(6)-4

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments 90 mm OPA Easy Mask Vaporizing DL x 1 Grade 1 View with CP ETT x 3 BBS=CTA Secured 23 cm @ teeth 8.0 ETT Miller 2.0

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

PROCEDURE LOCATION: OR #1

DATE: 22 Nov 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 — COPY 4 - ANESTHESIA PROVIDER — USAPA V1.00

MEDCOM - 25234

0100 11/22/03 PT 14.8 INR 1.2 PH 33.6 143 109/9 4.7 92.7 102 299 NKDA NPO 10 hours

NSN 7540-01-165-7294 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE / SEX	SSN *(Sponsor)*	WARD/CLINIC	REGISTER NO.
AP | LAT (R) TIBIA	M		ICW#	
	FILM NO.			PREGNANT ☐ YES ☐ NO
	REQUESTED BY *(Print)* [redacted]			TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR (b)(6)-2			DATE REQUESTED 22NOV03 ASAP

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*

POST-OP FILMS

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

RADIOLOGIC REPORT

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*

[redacted] (b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

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
(b)(6)-4 [redacted]	(b)(6)-2 [redacted]			22 Nov 03	0600 HOURS	
				① Admit to ICW 1		
				NPO		
				IVF 100 cc/hr LR		
				on call to OR		
				MSO4 2-8mg IV q 2° PRN pain		
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER _____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER _____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER _____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 11/27/03 TIME OF ORDER: 1800 HOURS

LIST TIME ORDER NOTED AND SIGN

- Stable
- Routine vitals
- Heplock IV
- Elevate (R) leg @ heart level
- Reinforce dressing PRN
- Bedrest today. OOB & ambulate tomorrow WBAT

PATIENT IDENTIFICATION: [redacted] Noted 22NOV03 1200

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

- Regular Diet
- Percocet 1 po q4° p
- Demerol 50-75 mg IM q4° PRN breakthrough
- Phenergan 25 mg IVq6° PRN nausea
- Amoxicillin 10 mg po q4hs PRN
- Ancef 1gm IV/IS q8°
- Levoquin 500mg IVqD

PATIENT IDENTIFICATION: (b)(6)-2 24° a100 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

- XR: AP+LAT (R) TIBIA

[redacted]

23NOV03 1630

DIC Foley

V.O. Dr [redacted]

PATIENT IDENTIFICATION: [redacted] Noted 24 Nov

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 24 Nov TIME OF ORDER: 1730 HOURS

V.O. from Dr [redacted]

Transfer to 1CW

[redacted]

(b)(6)-2

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

.EDICAL RECORD - DOCTOR'S ORDE.

For use of this form, see MEDCOM Circular 40-5

DIRECTIONS: The provider will DATE, TIME, and SIGN each order or set of orders recorded. Only one order is allowed per line. Nursing will list the time the new order(s) are noted and initial in the column provided. Orders completed during the shift in which they were written do not require recopying. They may be signed off, as completed, in the far right column.

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
	POST ANESTHESIA ORDERS (circled Items)		
1	VS q 5 min X 15 min, then q 15 min until discharge.		
2	Supplemental oxygen.		
3	Morphine / Meperidine 2 mg IV now and 2 mg q 3-5 min prn pain for a max dose of 10 mg.		
4	~~Zofran ____ mg IV prn N/V q 15 min, may repeat x ____.~~ [redacted]		
5	Metoclopramide 10 mg IV prn N/V x 1.		
6	Droperidol .625 mg IV prn N/V x 1.		
7	Phenergan 25 mg IV prn N/V x 1.		
8	~~Benadryl 25-50mg IVP q1 hr prn, itching while in PACU.~~ [redacted]		
9	IVF: LR @ 100 cc/hr.		
10	Discharge from recovery status when PACU discharge criteria met.		
11.	Demerol 12.5mg IV prn for shivering, may repeat x1 in 15 minutes for continued shivering. [redacted] Wa/Major, MD (b)(6)-2	[redacted] (b)(6)-2 22 Nov 03	

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

Complete the following information on page 1 only. Note any changes on subsequent pages.

Diagnosis: _____

Height: _____ Weight: _____ Diet: _____

Allergies: _____

Nursing Unit	Room No.	Bed No.	Page No.
PACU, 28th CSH			1 of 1

MEDCOM FORM 688-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE MC V1.00

.CORD - DOCTOR'S ORDERS

For us . 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
(b)(6)-7 [redacted]				11/24/03	1045 HOURS	
				- D/C IV ABX		
				- Start Levoquin 500m po QD		
				- D/C to Exp w Ampicillin		
				(b)(6)-2 [redacted]		
NURSING UNIT	ROOM NO.	BED NO.				
24° / done [redacted] /AN						
PATIENT IDENTIFICATION					TIME OF ORDER	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

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

CLINICAL RECORD	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 10 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 22	23	24									
22 Nov	[redacted]	NPO	06 12 18	[redacted]											
			06 12 18												
22	[redacted]	routine vitals	06 12 18	[redacted]											
			06 12 18												
22	[redacted]	elevate (R) leg above heart level	06 12 18	[redacted]											
			06 12 18												
22	[redacted]	~~ice~~ (R) leg PRN	06 12 18	[redacted]											
			06 12 18												
22	[redacted]	PBC crutches tm. WBAT	06 12 18	[redacted]											
			06 12 18												
22	[redacted]	regular diet	06 12 18	[redacted]											
			06 12 18												

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW (R) leg s/p IM nailing.

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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