BATES PAGES MEDCOM 25241-26178 ARE NONRESPONSIVE AND HAVE NOT BEEN PROVIDED

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

20yo EPW S/P Blunt trauma to face.
Pt seen @ 21st CSH (mosul) and transferred here for tx. 5min LOC per report.
Pt c̄ Bilateral mandible fx's per plain film.

PMH: Ø
PSH: Ø
meds: Ø
allergies: NKDA.

136 | 15.9 | 278 / 46.9

132 | 101 | 18 / 3.9 | 0.8 | 90

PHYSICAL EXAMINATION

nc c̄ facial swelling
Perrl EOMI Ø Battle's sign/Raccoon eyes
Ø palpable facial steps (mid face)
nares patent
mouth stable
mand mobile
CV RRR
lungs CTA (B)
abd [redacted]
ext Ø C/C/E
neuro (D) V3 paresthesia

Plain film show [redacted] b6-2 Right parasymphysis fx and left angle + ramus fx

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

A/P Bilateral mandible fx's
(D) Plan for OR c̄ reduction of fx's
Open vs closed

b(4)-2

SIGNATURE OF PHYSICIAN	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted]	11 Dec 03		

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

REGISTER NO.	WARD NO.

#[redacted] b(4)-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
12 Dec 03	(1250) VSS. Ø c/o pain. Pt arrived to floor ~ 2330. Pt amb into cot ī difficulty. (L) side of face swelling noted. Pt spitting into cup bt bright, red blood. Yankeur suction at ~~BS~~ bedside. HOB @ 45°. Ø signs/symptoms of Respiratory distress. BS CTA, BS (+) x 4 quads. IV in (R) AC. ī difficulty. NS 125cc/hr. 2 pt Restraints placed. Will monitor. b(6)-2 [redacted] RN/III
12 Dec 03 0700	- Assumed care of pt. A+O x 3. VSS Ø c/o pain or discomfort Lungs clear No evidence of respiratory distress noted HRRR Active BS x 4 quads tolerating clear liquid diet ī difficulty suction machine ī yankeur at bedside. Clear yellow urine spontaneously QS. Dx mandible fx. HOB elevated. (L) side of face swollen spitting dark blood Ø active bleeding noted. Will cont to monitor [redacted] Kwan
13 DEC 03	(0001) Assumed care @ 1800. Pt alert, speaking Arabic. b(6)-2 VSS. Ø c/o pain. Swelling noted on (L) side of face. Ø c/o N/V. HOB elevated. IV in (R) ac dlcd d/t infiltration, catheter intact. IV 18g started in (R) forearm. IVFs infusing ī sisx infiltration. Pt aware he is NPO @ this time. voiding ī difficulty. 2-point restraints in place ī sisx complications. Will continue to monitor. 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. 6/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

[redacted] b(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
	b(6)-2 Ant
22DEC03 (0005)	Wired shut. Tol. BTS diet well. Voiding ō difficulty. 2 point restraints in place ō s/sx complications. Will cont. to monitor. [redacted]
22DEC03 @ 1605	Assumed care @ 0600. VSS. A&O, speaking arabic c Jaws still wired shut. BTS diet tol well. Voiding clear, yellow urine ō difficulty. OGB → hallway x 1hr, toilet. ⊖ signs of skin compromise on restraints, will monitor. [redacted]
23Dec03	(0115) VSS. ⊘ c/o pain. Jaw wired shut. Wire cutters at nurse's station. Tol po well. Voids clear, yellow ō difficulty. Amb c steady gait. ⊘ BS CTA, BS+ x 4 quad. ⊕ side of face slightly swollen. Will continue to monitor. [redacted]
23Dec03 1610	Assumed care of pt @ 0600. Pt resting comfortable in bed ⊖ s/s of resp distress, pain or discomfort. Pt ambulates in hallway. Voiding clear urine. Jaws remain wired. Wire cutters @ nurses station. Will continue to monitor. [redacted]
24Dec03	(0000) VSS. ⊘ c/o pain. ⊕ side of jaw ↓ swelling. ⊘ signs/symptoms resp distress. Wire cutters at nurse's station. Voids clear, yellow ō difficulty. Amb c steady gait. Tol po well. Will monitor. [redacted]

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

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

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

PROGRESS NOTES
Medical Record

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

[redacted] b(6)-1

b(6)-2 A11

NAME | FIRST NAME | M.I. | S. NUMBER

DATE	NOTES
24DEC03 @ 1145	Assumed care @ 0600. VSS. A&O, jaws still wired shut. Scissors @ nurse's station. Tol BTS diet c̄ milk and ensure well. Voiding clear, yellow urine s̄ difficulty. OOB → toilet, hallway. Ø signs of skin compromise on restraints. will monitor — [redacted] PFC9/1
24DEC03 @ 2300	Assumed care of pt. @ 1800. VSS. A&O, Ø c/o pain. LS CTA. ⊕ BS all 4 quads. Pt. reported watery stool p̄ OOB → BR. Voids CYU s̄ difficulty. Ø IV access. Jaws wired shut, tol. BTS diet well. Pt. in 2-point restraints Ø s/sx of skin breakdown. All other assessments WNL. [redacted] 2LT, AN
0915 25Dec03	Pt A&Ox3 VSS, LS CTA ⊕, ⊕ BS x4, OOB → BR, performed ~~ADLs~~ personal hygiene, c/o loose stool, new order for Immodium 20cc liquid, voiding CYU s̄ difficulties, Ø s/sx of skin breakdown, jaws remain wired shut [redacted] MW consumed 100% of diet. —
1150	Adm 4mg Immodium diluted in water [redacted] for loose stools. — [redacted]
26DEC03 0400	Assumed care of pt. @ 1800. VSS, Ø c/o pain. [redacted] sleeping @ this time. Jaws wired shut, wire cutters @ nurses station. Mild edema to mandible. Tol. BTS diet well. Ø IV access. Pt. in 2-point restraints, Ø signs of skin breakdown. All other assessments WNL. Will cont. to monitor. — [redacted] T, AN
1200	Pt a&o, VSS, Ø complaints, sleeping often, wire cutters @ Nurses station. Tol. BTS diet this am. amb. s̄ difficulty. voiding cyu. 2 pt restraints on Ø complication — [redacted] PN —

STANDARD FORM 509 (REV. 9/1999) BY USAFS

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
26DEC03	(2236) Assumed care of pt @ 1800. Pt alert, speaking Arabic. VSS. Ø c/o pain. Jaw remains wired shut. Tol. BTS diet well. Amb well. Voiding ~~s~~ difficulty. 2 point restraints in place ~~s~~ S/Sx complications. Will cont. to monitor. [redacted] b(6)-2
27DEC03 @1045	Assumed care of pt @ 0600. VSS. No c/o pain. Jaws wired shut, all intact, Ø c/o from pt. Tol liquid diet ~~s~~ difficulty. LSCTA, Ø BS, void ~~s~~ difficulty, AMB in hallway ~~s~~ problems. 2pt restraints in place in bed, Ø S/Sx of Sym/circulation compromise. Plan: enc po, enc OOB, monitor jaws/mouth, pain control. [redacted] b(6)-2
28DEC03	(0045) Assumed care @ 1800. Pt alert, speaking Arabic. VSS Ø c/o pain. Amb well. Jaw remains wired shut. Tol. BTS diet well. Oral hygiene done this pm. Voiding ~~s~~ difficulty. 2 point restraints in place ~~s~~ S/Sx complications. Will cont. to monitor. b(6)-2 [redacted]
28DEC03 @0915	Assumed care of pt @ 0600. VSS. Ø c/o pain. Alert, speaks some English. LSCTA Ø BS, tol ~~diet~~ eng blended/liq diet well. Oral care completed. Wires to mouth intact Ø difficulty c̄ voiding, AMB often. (CONT) [illegible]

RELATIONSHIP TO PATIENT | PROVIDER NAME LAST FIRST MI | PROVIDER ID NUMBER

PATIENT NAME | HOSPITAL ASSIGNED FACILITY | RECORD MAINTAINED AT

PATIENT IDENTIFICATION: For inpatient without, place patient mailing label here. Or for SSN, Sex, Date of Birth, Race, Marital

REGISTER NO | WARD NO

PROGRESS NOTES
Medical Records
STANDARD FORM 509 REV. [illegible]

[redacted] b(6)-4

b(6)-2 A11

0915 2 pt restraints on ∃ S/Sx of skin/circulation
(CONT) compromise. Plan: monitor airway, enc OOB,
enc po. [redacted]

29DEC03 (0110) Assumed care @ 1800. Pt alert, speaking Arabic. VSS. ∅ c/o
pain. Pt amb well. Jaw remains wired shut. Tol. BTS diet
well. Voiding ∃ difficulty. 2 point restraints in place ∃
S/Sx complications. Will cont. to monitor. [redacted]

29Dec03 Rec'd report and assumed care. ⊖ s/s of resp distress
1100 pain or discomfort @ present time. Pt ambulates to
BR. Jaw remains wired, wired cutter @ nurses'
station. ⊖ skin breakdown under restraints. Will
continue to monitor - [redacted] 91WM6

1630 Pt evaluated by Dr [redacted] ⊖ 4 in condition
wires intact - [redacted] 91WM6

30DEC03 (0140) VSS. ∅ c/o pain. HOB 30°. BS CTA. ∅ signs/symptoms
of resp distress. Jaw wired shut. Tol PO well. Amb c̄ steady
gait. Voids ∃ difficulty. Wire ~~cutters~~ cutters at NS. Will
continue to monitor. [redacted] 24/F

30DEC03 @ 1600. Assumed care @ 0600 VSS. A&O. Pt c/o
being hungry after meals. Dr [redacted] informed
Pt diet changed to Double Portion to BTS diet. Pt
also informed of NPO status p̄ MN for in Tomorrow
∅ c/o pain voiced or noted. OOB to BR and ambulate
in hallway. Jaws remain ~~tots~~ wired. Wire cutters
@ nurses station. HOB ↑ 30°. Will continue plan of
care. 2 point restraints in place without compromise
circulation or skin integrity. [redacted] 21M

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

OMFS Transfer Summary

02 JAN 04 @ 1117 ~2040Im S/P Blunt Trauma to face. Pt sustained a right mandibular body + left mandibular angle fx. Pt was originally seen @ 21ST CSH mosul and transferred to [redacted] 622 Baghdad for Tx. Pt taken to OR on 13 DEC 03 for closed reduction of mandible fracture with arch bars + wire c̄ maxillo-mandibular fixation. S/P tx Pt c̄ c/o movement @ (L) mandibular angle. Panorex xray taken and left mandibular angle - Proximal segment more displaced. Pt was taken back to the OR on 31 Dec 03 for open reduction of left mandibula angle fx with wire osteosynthesis @ superior border. Post OP panorex

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 [redacted]		

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1998)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

TRANSFER SUMMARY

NSN 7540-01-075-3786

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

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

20 year old Iraqi male, pt states he was "punched" in left side of Jaw, pt states difficulty swallowing saliva, no difficulty breathing, ⊖ LOC, Pt. states ⊕ dizziness, pt. incident that lasted 5-10 mins, pain radiated to mandible [redacted] DCTA

b(4)-2

20yo EPW s/p Jaw injury on Dec 8th c̄ fx to Mandible
C/o Pain @ Jaw + upperarm.

PE: WSS gen NAD
CV: RRR ⊖ Ⓜ
Lungs: CTA Ⓑ Good air exchange
abd: ⊕ Contusion c̄ ecchymosis over Ⓛ inf Rib, ⊕ TTP @ Rib, ⊖ crepitus, ⊖ flailing. Abd soft, ND, ⊕ BS, NTTP, ⊖ HSM.
Neuro: AAOx3, CN intact.

Xray: ⊕ fx Mandible - L to R.
CT:

CONSULT WITH	TIME	ACTION
OMF	2130	Admit

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP b(4)-2 [redacted]

DIAGNOSIS

Mandible fx

CODE [redacted]

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

[redacted]

[redacted] b(4)-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

b(6)-4 [redacted]

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

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp): 21CSH, B Co, Mosul Iraq

LOG NUMBER

ARRIVAL — DATE: DAY 11, MONTH Dec, YR. 03 — TIME: 1450

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

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

HISTORY OBTAINED FROM: ☒ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code): Mosul Iraq

HOME TEL. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration)

SEX: M AGE: 20

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: on arrival

VITAL SIGNS			
TIME	1500	1605	1801
BP	130/71	120/69	116/72
PULSE	118	110	105
RESP.	18	18	18
TEMP.	98.8	98.6	99.4
WT. (Child)	98%	97%	98

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

ORDERS | INITS. | TIME
- MANDIBLE SERIES

ASSESSMENT/DIAGNOSIS: MANDIBLE FRACTURE

DISPOSITION (Check all that apply)
- ☐ HOME ☐ FULL DUTY
- QUARTERS: ☐ 24 Hrs. ☐ 48 Hrs. ☐ 72 Hrs.
- MODIFIED DUTY UNTIL: DAY ___ MONTH ___ YEAR ___
- REFERRED TO (Indicate clinic): 21st (S) OMFS 1600
- ☐ EMERGENCY ☐ TODAY
- ☐ 72 HOURS ☐ ROUTINE
- ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
- ☐ IMPROVED ☐ UNCHANGED
- ☐ DETERIORATED

TIME OF RELEASE:

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

20 y/o ~~AIR~~ ♂ c/o

PFC HIETT, 2/44 FA accompanied patient from 2nd BDE HOLDING AREA.

20y IRAQI ♂ DETAINEE brought to CSH for evaluation ⁊ sustaining blunt trauma to face. Reportedly evaluated by PA or physician at AID STATION w FSB and x-ray shows mandible fracture. History obtained through translator. Individual reports that he sustained injuries in beating. Reports 5min ago. Injury sustained within past 24 o

PMHx: Ø Meds: None

PSxHx: Ø Allergies: NKDA

13.6 | 15.9 / 46.9 | 278

GENERAL: Thin Iraqi ♂ young adult/NAD/alert
monitoring/answers questions through interpreter

INTEG: Warm + dry Ø rashes

MUSCULOSKELETAL: ↑ jaw swelling as noted
RERL/conj sclera clear
Nares patent Ø septal hematoma
Obvious malocclusion lower incisors
Midface stable
Upper incisors, maxilla stable
Ø Battles or Raccoon's
C-spine without tenderness or step-off

132 | 101 / 39 | 90 / 18 / 0.8

LUNGS: CTAB ⁊ W/R/R
CV: NRR ⁊ (m) w S1/S2
CHEST: Scattered minor contusions, no TTP
BACK: Ø penetrating trauma, ØTTP, Ø CVAT
ABDO: Soft/NT/ND/Ø mass
EXTREM: Normal
NEURO: Nonfocal
PELVIS: Stable

(CONTINUE ON SF 507, IF NEEDED)

PATIENT'S IDENTIFICATION (Mechanical imprint)
FOR WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).

POTUS- [redacted] b(6)-4

SIGNATURE OF PROVIDER: [redacted] MC, USA

INSTRUCTIONS TO PA[redacted] medications ordered, any limitations and follow-up plans):
X-ray - (+) Mandible fracture
/b6-2
ACCEPTED / IN TRANSFER 3X b2-2
DR [redacted] CSH
OMFS @ 1800

EMERGENCY CARE AND TREATMENT — STANDARD FORM 558 (Rev. 5-82)

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
13 Dec 03 0700	- Assumed care of pt. AOX3. VSS Ø c/o pain or discomfort. Lungs clear HRRR Active BS x4 quads. Urinating QS CXU ī difficulty ambulates ward. FX to mandible swelling to (D) side of face suction @ bedside a shift check Ø difficulty swallowing spitting up dark red blood Ø active bleeding noted remains NPO ī MN on call for surgery this morning. Will cont to monitor b(6)-2 [redacted] Grames.
14 Dec 03	(PX/AS) ~~Assumed care @ 1800. Pt [redacted]~~ Pt returned from PACU via gurney in stable cond following surgery. VSS. medicated ī MSO4 for pain ī good relief. (D) side of face swollen. Ø c/o nausea. Wire cutters @ BS and @ nurses station. Pt tol water and juice. (D) post op void. Pt OOB to chair and amb in hallway ī difficulty. SL in (D) ac dlcd d/t infiltration IVFs infusing into IV in (R) forearm ī SISX infection/infiltration. 2-point restraints in place ī SISX complications. Will cont. to monitor [redacted] b(6)-2
14 Dec 03 0800	- Assumed care of pt. AOX3. VSS Ø c/o pain or discomfort @ this time lungs CTA HRRR Active BS x4 quads. Full liquid diet tolerating well. Mandible FX mouth wired shut wire cutter @ bedside and nursing station. Suction machine and yanker at bedside. (L) side of face ī swelling noted. Urinating CXU QS PIV (R) FA 18g HC IV ABX TX Afebrile Will cont to monitor [redacted] Grames. b(6)-2 [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
12 DEC 03	UNFS HD# 2
@ 0531	
	Pt injury unbed 3 c/o Thu Am.
	unm. cont of pain controlled c meds.
	pt tolerating a liquid diet.
	Step off vessels extremities area
	CVR RR
	lungs CTA B
	abd SOFT NT ND (+) BS
	ext. 4 c/c/c
A/P S/P [illegible]	
	(1) Recent Dl. teg and screws
	(2) Plan for OR tomorrow. b(6) 2
	[redacted]

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

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

REGISTER NO.

WARD NO.

#[redacted] b(6) 4

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE

OMFS Brief OP NOTE

13 Dec 03 @ 1844

Pre op dx: Right mandibular Body
Left angle fracture

Post op dx: Same

Procedure: Closed reduction of mandible fracture

Surg: [redacted] b(6)-2

Assist: [redacted]

E.Bl.: [redacted]

fluids: 1300 LR

Comp: Ø

findings: Mobile tooth # 26

Cond: Stable extubated and breathing spontaneously and transferred to recovery Ward

b(6)-2

[redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

b(6) 2

15 DEC '03 Assumed care @ 1815 pt AOX3, VSS pt has Ø c/o pain at this time. pt jaw wired shut pt exhibits some swelling to ⓡ side of face. pt tol fluids well, wire cutter located in unit green, suction at bedside. pt restrained x2, IV @ forearm infiltrated new IV started further up @ forearm. Will monitor [redacted] (0330) ⓘ 10mg/Dx of respiratory distress. Concur c̄ above ~~asso~~ assessment. [redacted]

15 Dec 03 0715 - Assumed care of pt. AOx3. VSS Ø c/o pain or discomfort. Lungs clear HRRR Active BS x4 quads tolerating full liquid diet. c̄ difficulty mandible to ⓛ side of face swollen mouth wired shut. Wire cutters @ bs suction c̄ yankauer at bedside. PIV patent HL urinating c̄ difficulty QS. Ø s/s of infection Will cont to monitor - [redacted]

15 DEC 03 Assumed care @ 1815, AOX3 VSS pt has Ø c/o of pain at this time, pt jaws is still wired shut, pt exhibits swelling on ⓡ side of face, pt tol liquid diet well, wire cutter located in unit green suction @ BS. pt restraint x2, IV @ forearm flushes easily. Will monitor [redacted]

(0125) I concur c̄ above assessment. [redacted]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | ISSN or Social Security Number

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. KW1

[redacted]

b(6) 2

PROGRESS NOTES
Medical Record

STANDARD FORM 56
Prescribed by SGANGMR 4 FMR (4 HOSP)

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
16 Dec 03 0700	- Assumed care of pt. A&O x3. Sleep yet easily arousable lungs clear HRRR Active BS x4 quads tolerating Liquid BTS diet. Urinating ∓ difficulty CVU QS. (L) side of face c̄ swelling Mouth wired shut. Wire cutters @ bs and nursing station. Ø c/o pain or discomfort. Will cont to monitor b(6)-2 [redacted]
16 Dec 03	Assumed care 1800 hrs. Temp 103.8 @ 2000 hrs. Tylenol 650mg Suppository administered. 2200 hrs Temp 100.8 0200 Temp 100.8 IV (R) FA D/C'd IV (L) FA HL. Wire cutters @ BS. Suction c̄ yankar @ bedside. Pt A&O ~~[illegible]~~ BP 183/93 Pulse 105. LS CTA (B), HRRR. (+) BS x4 quads. cont IV Antibiotics. Pt void CVU QS ∓ difficulty. (L) side of face c̄ swelling Will cont. To monitor. b(6)-2 [redacted] 9/WM6
6/17/03 1200	USS. A&O. T @ 97° @ 0745. HRR & SCLAB. PERRLA. Suction c̄ yankauer @ bedside. Wire cutters @ nurses station. Up and tbr. c/o diarrhea x2 and provided 4mg Loperamide per V.O. Dr. [redacted] d/c skin breakdown. b(6)-2 [redacted] cont to monitor.
17 DEC 03	ASSUMED care @ 1815 Pt Awake oriented x3, USS pt HAD Ø c/o pain at this time, swelling on (L) side jaw reduced, IV (L) forearm flushes easily, suction at BS wire cutters ready at nursing station, restraints x2 in place @ skin breakdown, will monitor, pt tol. clear diet. [redacted] 2130 HCA, Place from OI came to visit and all questions requested if possible copies of X-rays [redacted]
18	(0230) I concur c̄ above assessment. [redacted] b(6)-2

STANDARD FORM 509 (REV. 5/1999) BP USAPA

[redacted] b(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
12/18/03 1247	VSS. AO. ∅ s/s infection to jaw. Wire cutters placed @ nurses station. Favored take for ongoing investigation. Up ad lib to BR. Voiding spontaneously, light amber urine. Performed oral care ∑ difficulty. ∅ s/s skin breakdown. b(6)-2 [redacted] Amy N
2045-	Assumed care of pt @1800 VSS - AAO. Pt. has ∅ c/o pain or discomfort @ this time. Ambulated to BR ∑ complaints. ⊕ edema to ⓒ side of jaw. HOB ↑ 30°. Yankauer suction @ BS, wire cutters readily available @ nurses station. Tolerates BTS diet well. Voiding dark yellow urine via urinal ∑ difficulty. Pt. in bed @ this time in two point restraints per DPW protocol. Will cont. to monitor pt. b(6)-2 [redacted]
	Concern ℮ observe. [redacted] SPN
12/19/03 1130	VSS, AO. Up ad lib. Jaw remains wired shut. Tolerating BTS diet well. ∅ c/o pain or discomfort @ this time. Voiding spontaneously. ∅ s/s infection or ∑ skin breakdown. [redacted] Amy N b(6)-2

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

PATIENT'S IDENTIFICATION: (not typed or written entries, print: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)

REGISTER NO. | WARD NO. KW1

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 51
Prescribed by DEPARTMENT OF DEFENSE

b(6) 2 A11

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES b(6) 2 A11
19DEC03	(2235) Assumed care of pt @ 1800. Pt alert, speaking Arabic VSS. Ø c/o pain. swelling to (L) side of face ↓. Pt tol. BTS diet well. Voiding ~~s~~ difficulty. SL in (L) forearm flushes well ~~s~~ S/Sx infection/infiltration. Pt OOB to amb in hallway ~~s~~ difficulty. 2-point restraints in place ~~s~~ S/Sx complications. Will cont. to monitor. [redacted]
20DEC03 @1625	Assumed care @ Ø1600. Pt alert and oriented. jaws still wired shut. VSS. Θ c/o pn. OOB → hallway, toilet. tol BTS diet well. Voiding clear, yellow urine ~~s~~ difficulty. Decreased swelling on (L) cheek. IV site on (L) forearm patent. Θ signs of skin compromise on restraints. will monitor. [redacted] PFC GIW/10
21DEC03	(0105) Assumed care @ 1800. Pt alert, speaking Arabic. VSS Ø c/o pain. Jaw remains wired shut. swelling ↓. Pt OOB to amb in hallway ~~s~~ difficulty. Tol. BTS diet. Voiding ~~s~~ difficulty. SL in (L) forearm flushes well ~~s~~ S/Sx infection/infiltration. Will cont. to monitor. [redacted]
21DEC03 @ 1510	Assumed care @ Ø1600. VSS. A&O. jaws wired shut. Θ c/o pn. BTS diet tol well. Voiding clear yellow urine ~~s~~ difficulty. OOB → toilet, hallway. Minor swelling on (L) side of face. IV site on (L) forearm patent. Θ signs of skin compromise on restraints. Will cont. to monitor. [redacted] PFC GIW/10
21 DEC	(1730) IV site on (L) forearm D/C'd per order [redacted] GIW/10
22DEC03	(0005) Assumed care @ 1800. Pt alert, speaking Arabic. VSS. Ø c/o pain. Amb ~~s~~ difficulty. Jaw remains

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

AUTHORIZED FOR LOCAL REPRODUCTIO

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

OMFS POD #16

29 Dec 03 @ 0811 Pt doing very well S/P closed reduction of mandible fx. Pt tolerating PO intake well. IMF stable and oral hygiene good.

CV RRR
Lungs CTA (B)
Abd Soft NT ND (+) BS
ext: (-) C/C/E

A/P S/P closed reduction of mandible fx. (R) body (L) ✗ doing well.

1. Plan for IMF removal 23 Jan 03
2. Continue current care

b(6)-2 [redacted]

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

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

AUTHORIZED FOR LOCAL REPRODUCTIO

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
30 Dec 03	(2250) VSS. ø c/o pain. Pt aware O.R. on ~~0.7~~ 31 Dec + NPO p̄ MN. IV placed in (R) FA 20G. Flushes well. (L) side of face slightly swollen. Tol PO well. BTS diet through straw. Wire cutters at NS. Amb c̄ steady gait to BR. Voids clear yellow s̄ difficulty. Will continue to monitor. b(6)-2 [redacted] /xxx
31 DEC 03 1005	AO. To OR @ 0830. HRR. (+) pulses. LSCTAB. Voiding spontaneously. ø s/s skin breakdown @ this time b(6)-2 [redacted]
01 JAN04 @ 0140	Assumed care of pt. @ 1800. VSS, AAO, Tramadol 60mg IV for c/o mild pain to (L) mandible, Edema noted to (L) mandible, Pt. tol BTS diet well. Jaws wired shut, wire cutters @ nurses station. Ambulates well to BR, voids CYU s̄ difficulty. HRRR, LS CTA bilat., (+) BS all 4 quads. Pt. in 2-point restraints, Ø signs of skin breakdown. Will cont to monitor pt. — b(6)-2 [redacted] 1LT, AN
1/1/04 1140	VSS. AO. OOB Ad lib this AM. Provided ice pack to place on (R) side of face. Marked (+) 2 swelling to that area. LSCTAB. HRR. BS (+) x4. ø c/o pain @ this time. Resting comfortably. Voiding spontaneously CYU s̄ difficulty b(6)-2 [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR 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)-2

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

OMFS Brief OP NOTE

31 Dec 03 @ 1018

Pre OP dx: Left mandibular angle fracture
Post OP dx: Same
Procedure: ORIF left mandibular angle fx c Wire Osteosynthesis
Surg: [redacted]
Assist: [redacted]
Anesth: [redacted] b(4)-2
EBL: min
fluids: 600cc LR
Comp: Ø
findings: displaced medial segment
Cond: stable and extubated and transferred to recovery S ward.

b(4)-2 [redacted]
MAJ/DC

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(4)-2

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
1/1/04 1755	@ or around 1720 Pt. c/o feeling very cold and shaking extremely. Notified MD. Given 25 mg Benadryl IV push, covered c blanket which subsequently removed to cool off patient. Lab drawn. VS – HR 125 O_2 – 96% BP – 112/59. MD ordered 30cc Tylenol elixir for 103.7 temp. axillary.
1800	BP – 112/59 HR – 119 T – 102° O_2 – 96% Cont to monitor closely and notify MD of abnormalities. b(6)-2 [redacted] ew
2JAN04@0120	Assumed care of pt. @ 1800. T – 99.1. Other VSS. Ø C/O pain. Mod. edema noted to © mandible. Jaw wired shut, wire cutters @ nurses station. Pt. tol. BTS diet well. Ø BS all 4 quads. Voids C/O difficulty. Pt. asleep @ this time. Pt. in 2-point restraints. Ø Signs of skin breakdown. All other assessments WNC. Will cont. to monitor. b(6)-2 [redacted] ILT, AN
2JAN03 1900	VSS. AO. Jaw intact. IV ABx given. Ice pack provided & ↓ nearly RTC. Ø c/o pain. Tolerated PO well. CORT BR served. Tues. b(6)-2 [redacted] AN
02JAN04	(0350) Assumed care @ 1800. Pt alert, speaking Arabic. VSS. Ø C/O pain. Swelling to © side of face ↓. Tol. BTS diet well. Amb well. Voiding c̄ difficulty.

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.
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203
USAPA

[redacted] b(6)-2

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
03JAN04	(cont) SL in @ forearm flushes well ~~5~~ S/Sx complications 2 point restraints in place ~~5~~ S/Sx infection/ infiltration. Will cont. to monitor. [redacted]
30Jan04 1000	Rt alg, temp now 99.5 ~~p~~ 20cc Tylenol elixir. slight swelling to (L) cheek. Wire cutters @ ns. IV fluids and meds now d/c'd, tol BTS diet well. amb ~~5~~ difficulty, voiding sys. 2 pt restraints on ~~5~~ complication. Will monitor [redacted] LPN.
04JAN04	(0400) Assumed care @ 1800. Pt alert, speaking Arabic. VSS. Ø c/o pain. Amb well. tol BTS diet well. Swelling to @ side of face cont. to ↓. voiding ~~5~~ difficulty. 2 point restraints in place ~~5~~ S/Sx complications. Will cont. to monitor. [redacted]
4 JAN04	@ 0800 - Assumed care of pt. A+O x3. VSS. Denies having pain or discomfort @ this time. Lungs CTA. Heart Actin BS x 4 quads. Tolerating BTS diet well. Mouth wired shut. swelling to (L) side of face. Afebrile. Ø s/s of infection. Will cont to monitor. [redacted]
4Jan04 @0930	Falls risk assessmt: Pt ambulates & transfers ~~5~~ difficulty. Will cont. to monitor/assess. [redacted]

b(6)-2 A1

STANDARD FORM 509 (REV. 5/1999) BACK

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	Shows both pt sides to be in good alignment T wire on left superior border (superimposed on #17 on panorex). *Please refer to Panorex film dated 31 Dec 03.
	Procedures
	① CR mand ® body + (L) ⅋ fx on 13 DEC 03
	② OR mand (L) ⅋ fx on 31 DEC 03
*	D/C Diet: BTS diet (Blended/thinned/Strained
	D/C cond: Stable
	D/C meds: Percocet (crushed) 1-2 tab pog 4-6° prn pain
	D/C Films: Panorex (x3) & CT Scan
	Follow UP Plan
	① Pt will need wires + arbars removed on 23 JAN 04.
	② Pt will need to remain on a soft diet for 2 weeks after archbars and wires removed.
	[redacted] MAJ/DC
	OMFS
	b(2) [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

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

NSN 7540-01-075-3786

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

PATIENT'S HOME ADDRESS OR DUTY STATION			ARRIVAL	
STREET ADDRESS # [redacted] b(4)-1			DATE *(Day, Month, Year)* 11 Dec 03	TIME 2112
CITY	STATE	ZIP CODE	TRANSPORTATION TO FACILITY	

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

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

CHIEF COMPLAINT Jaw Deformity

CATEGORY OF TREATMENT	TIME	VITAL SIGNS					
☐ EMERGENT	2112	TIME	2112	2212			
☐ URGENT		BP	114/64	108/65			
		PULSE	107	91			
		RESP	15	15			
☒ NON-URGENT	[redacted]	TEMP	97.6				
		WT	99				

LAB ORDERS					X-RAY ORDERS		
✓ CBC/DIFF	[redacted] PT/PTT		BHCG/URINE/BLOOD/QUANT		CXR PA & LAT/PORTABLE		C-SPINE
URINE C&S	UA MSCC/CATH		CHEM: Na 81		ACUTE ABDOMEN		LS SPINE
BLOOD C&S X			LFTS		SINUS	✓	HEAD CT Cuts through mandible
					ANKLE R/L		

ORDERS

☐ PULSE OX 100% ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
2212	bolus ÷ L NS	[redacted]	[redacted]		[redacted] b(4)-2
2238	Tel 5cc DM				
	ing MSO4 1cc				

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

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

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

[redacted]

DOB 1983

[redacted] b(4)-1

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
			OMFS POD #8
21 Dec 03 @1637			Pt sitting in bed 5 c/o this PM. Tolerating BTS diet very well. (+) (L) V3 paresthesia. xlMF wires stable and oral hygiene good.
			VSS, AF CV RRR lungs CTA (B) abd soft NT/ND BS ext ⊖ c/c/c
			A/P S/P CR of mand fx's doing well (1) Plan for xlMF removal 23 Jan 03. (2) continue current care [redacted] MMFS
			OMFS POD #10
23 Dec 03 @0823			Pt doing well S/P C/R of mand fx. xlMF stable, oral hygiene fair continue current care [redacted] b(6)-2

(Continue on reverse side)

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

NURSING NOTES

Medical Record

[redacted] b(6)-4

438

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

MEDCOM - 26202

MEDICAL RECORD [redacted]

INTRAOPERAT[redacted]D[redacted]ENT

For use of this form, see AR 40-407, the proponent age[redacted]e office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY Anesthesia

2. PATIENT IDENTIF[redacted]VED AND PROCEDURE
VERIFIED BY ILT [redacted] b(6)-2

3. DATE 13 DEC 03
TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM
TIME 1600 NUMBER 2 #6

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SGT [redacted] 91D b(6)-2	RELIEF SCRUB	b(6)-2
ASSIGNED CIRCULATOR	1LT [redacted] 66E	RELIEF CIRCULATOR	[redacted] (1830-1925)

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt. supine on padded OR table. LUE on padded armboard <90°. RUE tucked at side. Safety strap across mid-thigh.

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

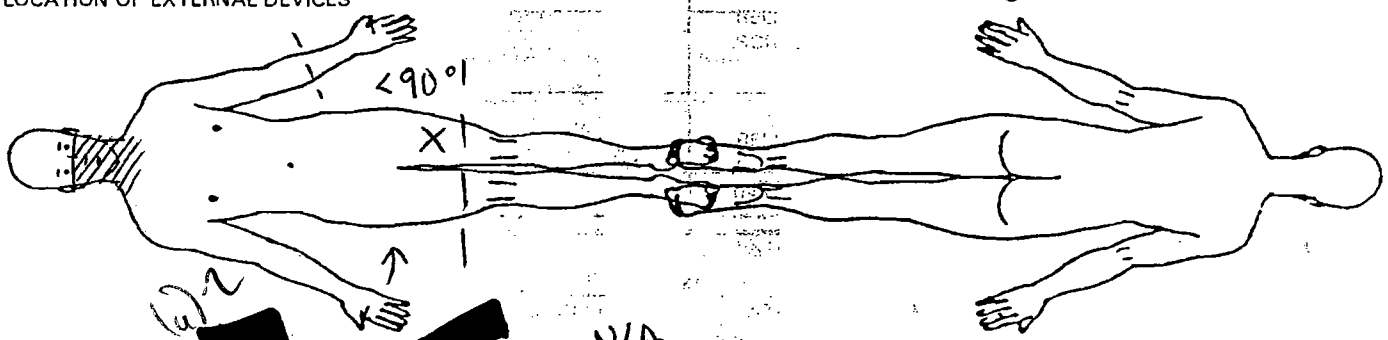
COMMENTS: Normal anatomic body alignment maintained

8. SKIN PREPARATION

HAIR REMOVAL [ ] YES [X] NO
DONE BY: [ ] OR [ ] NURSING UNIT
METHOD: [ ] DEPILATORY [ ] RAZOR [ ] CLIP
COMMENTS: N/A

PREP SOLUTION *(Specify)* [redacted] ~~Betadine~~
SITE: Face & neck BY WHOM: IC[redacted]
SITE: BY WHOM:
COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



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

INITIAL: SGT [redacted] ILT [redacted]

C = Correct I = Incorrect

10. COUNTS

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

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

[redacted]
b(6)-4

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

[ ] ESU NO: VL Force 40 CUT: 30 COAG: 30
GROUND PAD: BRAND VL Rem PolyHesive II
LOT NO: 69441 Exp 2005-03

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

[ ] BIPOLAR NO:

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

b(6)-2

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
1% Xylocaine c̄ Epi Lot 208137 Exp 8-04	8cc	intra-op	Local Injection	MFR: [redacted]	Dr. [redacted]

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

OTHER ORDERS	TIME	CARRIED OUT BY
None		
[redacted]		

b(6)-2

15. X-[redacted]ROOM IF YES, SITE
YES ☐ NO ☒

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
None

19. ADDITIONAL INFORMATION
Surgeon: Dr. [redacted]
Anesthesia: CPT [redacted]

b(6)-2

20. OPERATION(S) PERFORMED
1. Closed Reduction Mandible Fx: Lt. Angle & Right Body

b(6)-2

21. PATIENT TRANSFERRED TO PACU TIME See DA2389 METHOD LITTER

22. REGISTERED NURSE SIGNATURE [redacted] T/AN [redacted] CPT/AN

MEDICAL RECORD [redacted] **INTRAOPERAT[redacted]D[redacted]ENT**

For use of this form, see AR 40-407, the proponent age[redacted]e office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING R[redacted]M
VIA ambulatory BY anesthesia

2. PATIENT IDENTIFIED, R[redacted]D AND PROCEDURE
VERIFIED BY Karen [redacted] CPT/AN

3. DATE 31 DEC 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 0817 [redacted] NUMBER b(6)-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SGT [redacted] b(6)-2	RELIEF SCRUB	PFC [redacted] (005-EOC) b(6)-2
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Rt. arm tucked @ side. Proper body alignment maintained

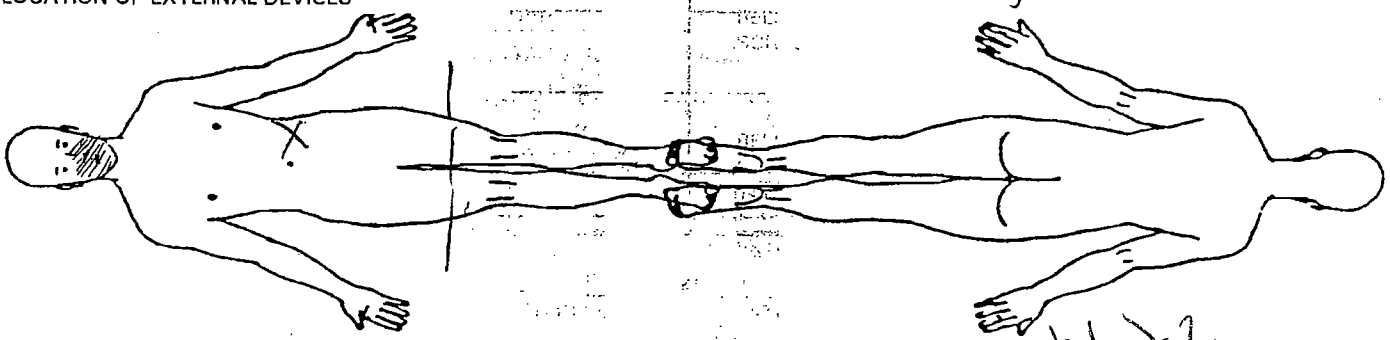
8. SKIN PREPARATION

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

COMMENTS:

PREP SOLUTION *(Specify)* [redacted]
SITE: lower face BY WHOM [redacted] 2
SITE: BY WHOM
COMMENTS: No pooling of fluids b(6)

9. LOCATION OF EXTERNAL DEVICES



b(6)-2

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

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

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No				[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 2 FOE000366 30/30
GROUND PAD: BRAND Valleylab REM
LOT NO: 69441

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
2% Lidocaine w/ 1:100,000	5cc	intraop	inj		[redacted] b(6)-2

WOUND IRRIGATION ☒ YES ☐ NO; TYPE(S):

0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY
None		

[redacted] b(6)-2

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)*

19. ADDITIONAL INFORMATION

Sur[redacted]s Anesth[redacted] Type: General

b(6)-2

20. OPERATION(S) PERFORMED

ORIF Mandible Fx Lt. Angle

21. PATIENT TRANSFERRED TO PACU b(6)-2 TIME 1027 METHOD stretcher

22. REGISTERED NURSE SIGNATURE [redacted] CPT/AN

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY														
POST-	DAY													
MONTH-YEAR	DAY	12		12/13		13/14	DEC 14			15 Dec		16		
19	HOUR	0	0630	2	0645	2	0700			0800		0800	2	20

PULSE (0) — 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°

RESPIRATION RECORD

16		8	16	28	16	120/69		16	112/72	16				

Record special data only when so ordered

BLOOD PRESSURE	119/70	124/53	108/56	103/63	137/82	115/77	P100		122/69	P101	110/69	108/63		
	99	H101		H87		H81	148.7		107 R	147.9	A91	105		
	992	T992		T984		T98°	99.6		985 T	S002	T982	638		
HEIGHT: WEIGHT →	98%	97%		98%		95%	99%		98%	98%	97%			
	RA	RA		RA	99% (RA)	RA			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 DEC DAY — 17 DEC, 18, 19, 20, 21, 22, 23

19 2003 HOUR

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

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

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

[redacted] b(4)-4

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

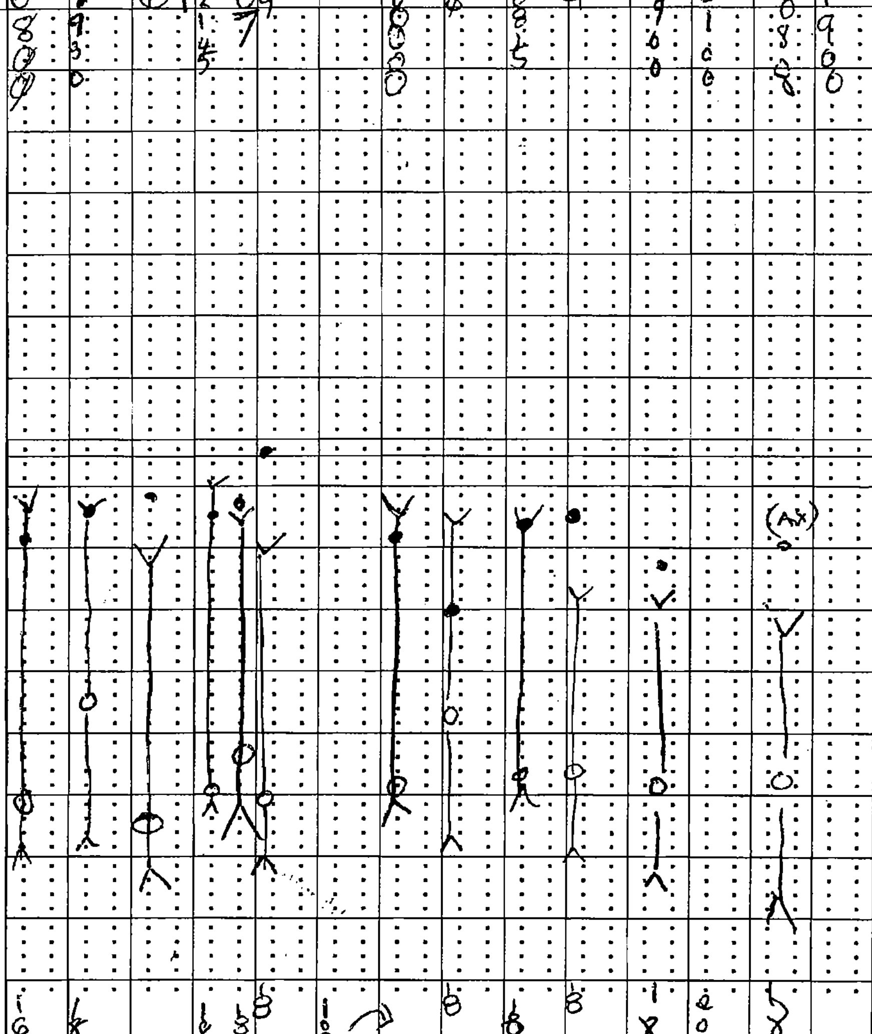
POST- DAY

MONTH-YEAR DEC 19 2003 — DAY: 24, 25/26, 26, 27, 28, 29, 30

HOUR: 0800, 1930, 0900, 2145, 0700, 0800, 2030, 0800, 1900, 0900, 2100, 0800, 1900

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

(Centigrade Equivalents, for Reference only)



RESPIRATION RECORD: 16, 18, 18, 18, 18, 18, 18, 18, 18, 20, 18

Record special data only when so ordered

BLOOD PRESSURE: 116/63, 101/58, 115/68, 109/64, 115/70, 114/63, 113/71, 102/62, 108/57, 98/60

65, 67, 74

97.4, 97.8, 97.5, 97.4

HEIGHT: WEIGHT →

99% RA, 99% RA, 98% 98% RA, 98% RA, 98% RA, 98% RA, 99% 98% RA, 98% 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

MEDCOM - 26209

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR: JAN 2024

DAY: 31 | 1 | 2 | 3 | 4

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° / 98.6°	37.2° / 37.0°
98°	36.7°
97°	36.1°
96°	35.6°
95°	35.0°

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

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

[redacted]

b(6)-4

bdw-2

Ward/Section: EM7	REQUESTING [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, M [redacted] bdw-4	DATE 11 Dec 03 / TIME 2112	SSN/PSEU [redacted] bdw-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

b(6)-4

EMT

Ward/Section: EMT	[redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. b(6)-4 # [redacted] b(6)-2	DATE 11DEC03	TIME 2112	SSN/P[redacted] # [redacted] b(6)-4

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC		4.7-6.1 x 10^6	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] 11-12-03
WT 21:42

			Patient %	Limits	
WBC	13.4 H	x10^3/uL	4.5	10.5	
RBC	5.03	x10^6/uL	4.00	6.00	
Hgb	15.0	g/dL	11.0	18.0	
Hct	48.3	%	35.0	60.0	
MCV	96.1	fL	80.0	99.9	
MCH	29.7	pg	27.0	31.0	
MCHC	31.0 L	g/dL	33.0	37.0	
Plt	320.	x10^3/uL	150.	450.	
LYM	11.4	%	20.5	51.1	
LYM	1.5 *	x10^3/uL	1.2	3.4	

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

11/12/03 21:43

REFERENCE RANGE: MALE

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

BASIC METABOLIC

DISC LOT #: 3325AA4

OPER #: [redacted] DR #: 000

SERIAL #: 0000100697

GLU	98	73-118	MG/DL
BUN	14	7-22	MG/DL
CA++	9.1	8.0-10.3	MG/DL
CRE	0.7	0.6-1.2	MG/DL
NA+	139	128-145	MMOL/L
K+	4.7	3.3-4.7	MMOL/L
CL-	95*	98-108	MMOL/L
tCO2	23	18-33	MMOL/L

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 0

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

0?/12/03 15:01

REFERENCE RANGE: MALE

PATIENT #: [redacted]

LIVER PANEL PLUS

DISC LOT #: 3154AA7

OPER #: [redacted] DR #: 000

SERIAL #: 0000100684

ALB	5.0	3.3-5.5	G/DL
ALP	62	26-84	U/L
ALT	48*	10-47	U/L
AMY	56	14-97	U/L
AST	131*	11-38	U/L
TBIL	1.9*	0.2-1.6	MG/DL
GGT	11	5-65	U/L
TP	8.1	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 0

.nt ID: [redacted] b(6)-4
t Name :PT
.t Result:= 14.8 sec.
io = 1.2
.culated INR = 1.37
ple Type:citrated wh. blood
t Date :12/11/03
t Time :21:43
d Lot :080201
rator : [redacted] b(6)-2

DPOINT COAG ANALYZER V4.54
AL #005485 12/11/03 21:47

Patient ID: [redacted] b(6)-4
Test Name :APTT
Test Result:= 32.6 sec.
Sample Type:citrated wh. blood
Test Date :12/11/03
Test Time :21:45
Card Lot :110210

4

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI.	UNIT	DOB	RANK	SSN
NM-US 426				

Physician:	Ward:	STAT / Routine	Specimen Date and Time:	R	Date and Time:
[redacted]	EMT			[redacted]	DEC03

Chemistry (i-STAT) — 6+ 7+ 8+ Glu Crea

X	TEST	RESULT	REF. RANGE
	Na	132	128-145 mmol/L
	K	3.9	3.3-4.7 mmol/L
	Cl	101	98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN	18	7-22 mg/dL
	Glu	90	73-118 mg/dL
	Creat	0.8	0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		Negative
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC		Epi	
RBC		Mucus	
Bacteria		Yeast	
Casts:		Spermatozoa	
Crystals:		Amorph Sed	
Other:			
Other:			

Chemistry (Piccolo Analyzer) — Chem 12 MetLyte8 BMP Liver

X	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
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative
DOA		Negative
CK-MB		< 4.3 ng/mL
Troponin I		< 0.19 ng/mL
Myoglobin		< 107 ng/mL

Microbiology

Source:		
FecLeuk		Negative
Gram Stain		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

HCG

Urine		Negative
Serum		Negative

Hematology @ 1800

CBC Malaria H/H

X	TEST	RESULT	REF. RANGE
	WBC	13.6	4.8-10.8 x10(3)/uL
	RBC	4.92	4.2-6.1 x10(6)/uL
	Hgb	15.9	12.0-18.0 g/dL
	Hct	46.9	35.0-60.0%
	MCV	95.2	80.0-99.0 fl
	MCH	32.3	27.0-31.0 pg
	MCHC	33.9	33.0-37.0 g/dL
	Plt	278	130-400 x10(3)/uL
	LY%	10.8	15.0-55.0%
	LY#	1.5	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Immature cells

RBC Morph:		
Plt verify:		
Spun Crit		35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative
D-Dimer		Negative
Fibrinogen		200-400 mg/dL

Blood Bank

ABO/Rh		
T&C		
T&S		

Ward/Section: ICW-1	ORDERING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. b(6)-2 [redacted]	DATE 1/1/04 TIME 1740	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

(Piccolo) Metabolic Panel

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

======= PICCOLO =======
01/01/04 17:47
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-2
METLYTE 8
DISC LOT #: 3474AA5
OPER [redacted] DR #: 000
SERIAL #: b(6)-2 0000100494

GLU	95	73-118	MG/DL
BUN	7	7-22	MG/DL
CRE	1.0	0.6-1.2	MG/DL
CK	154	39-380	U/L
NA+	142	128-145	MMOL/L
K+	4.2	3.3-4.7	MMOL/L
CL-	104	98-108	MMOL/L
tCO2	25	18-33	MMOL/L

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

======= PICCOLO =======
01/01/04 17:47
REFERENCE RANGE: MALE
PATIENT #: [redacted]
LIVER PANEL PLUS
DISC LOT #: 3352AA4
OPER #: [redacted] DR #: 000
SERIAL #: 0000100676

ALB	4.6	3.3-5.5	G/DL
ALP	60	26-84	U/L
ALT	24	10-47	U/L
AMY	86	14-97	U/L
AST	31	11-38	U/L
TBIL	1.4	0.2-1.6	MG/DL
GGT	17	5-65	U/L
TP	7.9	6.4-8.1	G/DL

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

REMARKS: [redacted]
-Thanks-

REPORTED BY:	DATE:	LAB ID NO.:

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

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

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

b6-4

ID: [redacted] 01-01-04
10:54

				Patient Limits	
WBC	10.8 H	x10^3/uL		4.5	10.5
RBC	4.91	x10^6/uL		4.00	6.00
Hgb	14.4	g/dL		11.0	18.0
HCT	46.1	%		35.0	60.0
MCV	94.0	fL		80.0	99.9
MCH	29.4	pg		27.0	31.0
MCHC	31.3 L	g/dL		33.0	37.0
PLT	302.	x10^3/uL		150.	450.
LYM%	5.3	%L %		20.5	51.1
LYM#	0.6	%L x10^3/uL		1.2	3.4

[redacted] 01-01-04
23:05

				Patient Limits	
WBC	8.0	x10^3/uL		4.5	10.5
RBC	4.42	x10^6/uL		4.00	6.00
Hgb	12.8	g/dL		11.0	18.0
HCT	42.5	%		35.0	60.0
MCV	96.5	fL		80.0	99.9
MCH	29.0	pg		27.0	31.0
MCHC	30.1 L	g/dL		33.0	37.0
PLT	289.	x10^3/uL		150.	450.
LYM%	9.3	%L %		20.5	51.1
LYM#	0.8	%L x10^3/uL		1.2	3.4

4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 01/01/04 17:49

Patient ID: [redacted] b(6)-4
Test Name :PT
Test Result:= 13.4 sec.
Ratio = 1.1
Calculated INR = 1.16
Sample Type:citrated wh. blood
Test Date :01/01/04
Test Time :17:48
Card Lot :010302
Operator [redacted] b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 01/01/04 17:53

Patient ID: [redacted]
Test Name :APTT
Test Result:= 40.2 sec.
Sample Type:citrated wh. blood
Test Date :01/01/04
Test Time :17:49
Card Lot :100208
Operator [redacted]

Ward/Section: ICW 1	REQUESTING PHYSICIAN: [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: b(6)-4 # [redacted]	DATE: 25JAN04 TIME: 0930	SSN/PSEUDO SSN:

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC		4.7-6.1 x 10^6	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.:

20yo ♂
NKDA
NPO x12+ hrs

(11 DEC03)
13.4/15/320 / 48

3/14/98
3.7

MEDICAL RECORD - ANESTHESIA

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

WASTE

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION													
DRUG	(Units)												
Midazolam	(mg)	(3)											
Fentanyl	(mcg)	150	100			100	150						
Propofol	(mg)	300											
Vecuronium	(mg)		5	5									
Morphine	(mg)				3-3								
	( )												
VOLAT AGENT ~~Forane~~	% del		1.5	1.5	2.0	2.0	2.0	0.5 X					
	% e.t.												
AIR	L/Min												
N2O	L/Min												
O2	L/Min	N –	1.0 –	1.0 –	1.0 –	1.0	1.0	2.0	10	10 X			
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS →													
FLUIDS — LINE site (L) AC 18G	☑ Warmed		(1)										
	☐ Warmed												
	☐ Warmed												
	☐ Warmed												
LOSSES — EST BLOOD LOSS													
URINE -													

TOTALS		TOTAL EBL
3	2	<50
500		TOTAL URINE
6	4	Ø

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

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 80 (KG) LB

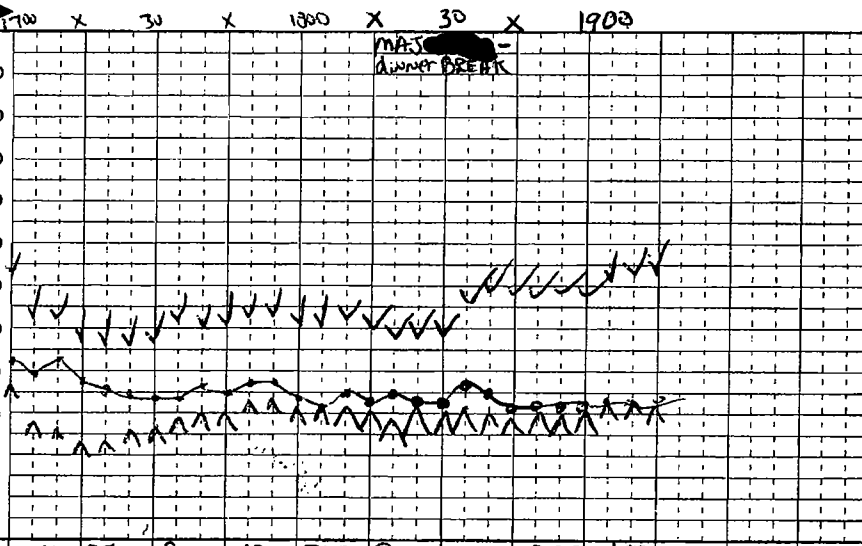
HEMATOCRIT: 46

INITIAL DATA: BP- 130/65 HR- 80

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? Y TIME- 1655

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



VENTIL										
I:E 1:2 VT - ml	650	750	800	780	760	800	670	300	450	
f - breaths/min	12	12	10	9	8	8	5	8	6	
Peak inf pres / PEEP	—	18	19	19	19	19	17	—	—	
MODE - S(pon), A(ssist), C(on)	S/A	C	C	C	C	C	C	A/S	SV	

MONITORS/ACCESSORIES										
BP/Auto Cuff / ET CO2 (torr)	+	34	30	29	29	32	36	34	42	
BP/oth / FIO2 (Frac or %)	.52	.52	.52	.52	.52	.52	0.56	0.55	.56	
ART line / SpO2 (%)	100	100	100	100	100	100	100	100	100	
Steth- PC/ES / ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	
Gas analyzer / TEMP-site AX.		35.7 →		35.8	35.8	35.9	36.0	35.8	—	
/ N-M Block (T/4)		2/4	0/4				4/4	4/4	—	
							Succ Tet			
							75RR			
Warming blkt										
Conv warmer										

REMARKS

Code drugs with numbers, events with letters

1635 ID'd pt in ICW, chart reviewed. IV placed.
1650 Transport to OR via gurney.
1705 Nasal intubation.
1740 10mg Decadron – 4mg Zofran
1806 1% xylocaine 1:100K epi perineural x 8ml
1839 Neostigmine 5mg Glycopyrrolate 0.8 IV
1920 Extubated, O2 applied. To PACU stable. Report given.

THROAT PACK: IN: 1730 OUT: 1825

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

CONDITION: stable
RESP- 14 SpO2- 99%
BP- 121/82 HR- 99

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1635	1657	1930
	Ready	Begin	End
PROC	1710	1734	1840

Mark with letters & symbols, explain under REMARKS EVENTS Position → Supine (R) arm tucked (L) arm secured, padded, <90°

PROCEDURES and CPT Codes:
Closed reduction of mandible fx (L) angle of (R) body

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
GETA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
Afrin to (R) nare 30' then 32F nasal trumpet placed c ease. Oral nasal RAE tube advanced thru cords c mag lift & jaw assist, ⊖ETCO2 bilat BS=, chest ↑↓. Secured. Atraumatic intub.

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rank, Medical facility*
#[redacted] b(6)-1

SURGEONS: [redacted]

ANESTHETIS[redacted] b(6)-1

PROCEDURE LOCATION: OR2

DATE: 13 DEC03

PAGE 1 OF 1

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)													
MS (1mg)	1												
FENTANYL ( )			200	50	150								
Vecuronium ( )		70											
Propofol ( )		200											
Lidocaine ( )		100											
Diphenhydramine 50)	50												
VOLAT AGENT % del	X	1.5	2.0	2.0	2.0	2.0	2.0	1.0	X	X	X	X	
VOLAT AGENT % e.t.	X												
AIR L/Min													
N2O L/Min													
O2 L/Min	10	10	10	10	2	2	2	2	2	2	2	2	2
	2	2	2	2	2	2	2	2	10	10	10		

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

TOTALS	TOTAL EBL
1	Ø
400	
70	TOTAL URINE
200	Ø
100	
50	

FLUIDS - SUMMARY

CRYSTALLOID- 700

COLLOID- Ø

BLOOD- Ø

FLUIDS

LINE site 18 RI ACF ☐ Warmed	50	100	200	250	300	350	400	550	600	650			
ONDANSETRON ☐ Warmed													
DEXAMETHASONE ☐ Warmed	8												8
GLYCOPYROLATE ☐ Warmed	.3												.3

LOSSES — EST BLOOD LOSS / URINE -

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 140 KG LB

HEMATOCRIT:

INITIAL DATA: BP- 132/71

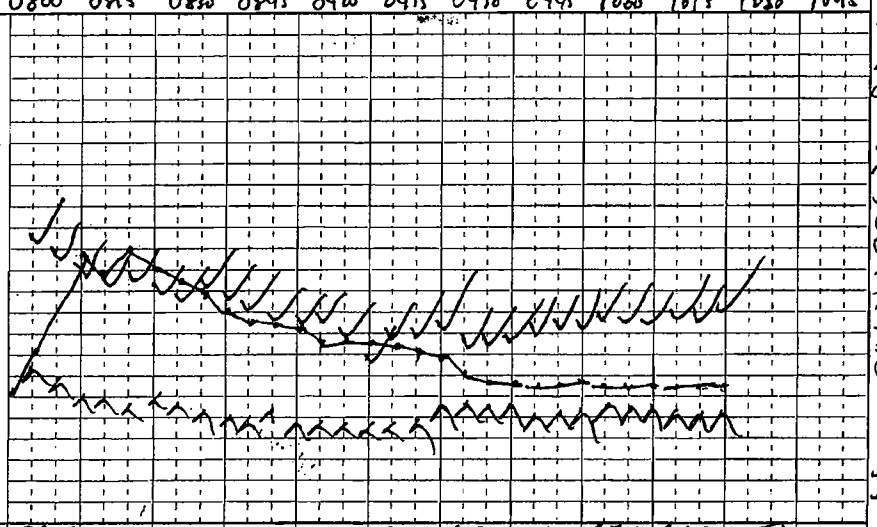
HR- 88-125

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? Yes

TIME- 0800

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



VENTIL

VT - ml	SPT	550	560	560	560	560	630	630	630	SPT	SPT
f - breaths/min	12	10	10	10	10	10	10	10	10	12	12
Peak inf pres / PEEP											
MODE - S(pon), A(ssist), C(on)	S	A	A	C	C	C	C	C	C	S	S

MONITORS/ACCESSORIES

BP/Auto Cuff — ET CO2 (torr)	36	34	34	33	32	32	33	33	33	33	33	
BP/oth — FIO2 (Frac or %)	50	50	50	50	50	50	50	50	50	50	50	
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	36.0	36.0	36.0	36.0	36.0	36.0	36.0	36.0	36.0	36.0	—	
N-M Block (T/4)	4/4	4/4	0/4	0/4	4/4	0/4	0/4	0/4	0/4	4/4	4/4	
ANCEF 2g												
Dex/Glyco							4/8					4/8
Warming blkt												
Conv warmer												

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

REMARKS

Code drugs with numbers, events with letters

Surgical Theatre 1
Supine Head on pillow EKG Lead II, SaO2, BP q5min, arms to padded boards <90° (RT) arm tucks. comfort confirms pre meds given (MS, Dexamethasone) Notes RLO raised rash at insertion site (-) paresthesia (-) pain where (-) Hemodynamic Δ's. 8 MS allergic. Prep 100% Iodine Start stamped #7 NRET passed (LT) nare tube unable to pass via RN Dr. [redacted] w/ #3 Mlm passed w/. Bag & Mask after nasal tube

RECOVERY AT

PACU ICU _____ (Specify)

OTHER _____

CONDITION:

RESP: 16 SpO2: 99

BP: 129/74 HR: 85

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0800	0817	1035
PROC	Ready 0855	Begin 0900	End 1015

PROCEDURES and CPT Codes: ORIF Mandible Winter of Mandible,

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

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

[redacted]

AIRWAY [redacted] tubation route, blade, technique, comments

(LT) [redacted]

SURGEON: DR [redacted]

[redacted] CRNA

PROCEDURE LOCATION: 01

DATE: 31 Dec 03

PAGE 1 OF

DA FORM 7389, FEB 1998 — COPY 3 - ANESTHESIA DEPARTMENT — USAPA V1.00

MEDCOM - 26220

ANESTHESIA PLAN OF CARE PR[redacted]OCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age ___ **DAYS MOS YRS** **Sex** (X) **MALE** ( ) **FEMALE**

PROPOSED PROCEDURE: ORIF MANDIBLE REMOVAL OF TEETH
SURGICAL SERVICE: _____
NPO SINCE: _____

ASA Physical State 1 (2) 3 4 5 E
WT: 140 KG (LB) HT: 5'5" IN.
ALLERGIES: Poss Morphine.

HABITS:
TOBACCO: ?
ETOH: ?
DRUGS: ?

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) _____
( ) _____
( ) _____
( ) _____
( ) _____
( ) _____

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

LABORATORY STUDIES:

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

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
Hypertension (N) Y _____
Angina (N) Y _____
MI (N) Y _____
CVA (N) Y _____
Other (N) Y _____

Pulmonary System:
Asthma (N) Y _____
Bronchitis/URI (N) Y _____
COPD (N) Y _____
Other (N) Y _____

Renal System:
Acute/Chronic RF (N) Y _____

Gastrointestinal:
Hepatitis (N) Y _____
Hiatal Hernia (N) Y _____
PUD/GERD (N) Y _____

Endocrine System:
Diabetes (N) Y _____
Steriods (N) Y _____
Thyroid (N) Y _____

Neurological:
Seizures (N) Y _____
Neuropathy (N) Y _____
Other (N) Y _____

Gynecological :
Pregnancy (N) Y _____

Other Significant Hx:
(N) Y _____
(N) Y _____

Familial HX (N) Y _____

ASSESSMENT
PAST SURGICAL/ANESTHETIC
ORIF MAND. 12 Dec 03

PHYSICAL EXAMINATION
BP/ 112/72 HR 88 R 16 T 98
Pain Scale 0-10 (3)
HEENT - Teeth WNL
Trachea MIDLINE
TMJ/Neck WNL
Oropharnyx —
Nares PATEN
CHEST: CTA
CARDIAC: Regular
EXTREMITIES:
IV Access: (RD) ACF
Ulnar Filling: Brisk
BACK: Clear
OTHER: WNL

NPO Since 24 hr

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

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

The p[redacted]derstand and agrees. Questions answered.
Si[redacted] _____ Date: 31 Dec 03 Time: 800 Hrs

POS[redacted]OTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER
BLW-2
S[redacted] _____ Date: 31 Dec 03 Time: 1130 Hrs

Patient Identification: (Ward) _____

SEDATION KEY:

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4

#[redacted]

NURSING UNIT | ROOM NO. | BED NO.

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

11 Dec 03 @ 2252

b(6)-2

1. Admit to WCW 2 D[redacted]
2. Dx: mandible fracture
3. cond: Stable
4. Vitals: per routine
5. aller: NKDA
6. activ: ad lib
7. Nuro: HOB ↑ 30° Yankauer suction to BS
8. Diet: clear liquid
9. IV: D5 @ 125cc/hr
10. meds: Clindamycin 900mg IVq8; MSO4 2-4 mg IV q 1° pm pain; Tylenol 650mg PO/PR q 4° pm T >101
11.

PATIENT IDENTIFICATION

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

12 Dec 03 | 0830 | [redacted]

1. V.O NPO p MN for OR

13 Dec 03

b(6)-2

[redacted]

Noted 12 Dec 0830

NURSING UNIT | ROOM NO. | BED NO.

24° V [redacted] 13DEC03 0005

PATIENT I[redacted]ON

b(6)-2

DATE OF ORDER | TIME OF ORDER | HOURS

21 Dec 03 @ 1633

1. D/C IV + IV meds [redacted]
2. Ambien 5mg crush[redacted] po qhs pm insomnia
3. D/C Yankauer suction

NURSING UNIT | ROOM NO. | BED NO.

24° V [redacted] 22DEC03 0010

[redacted]

b(6)-2

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

MEDCOM - 26222

ICAL 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
	13DEC03 1930 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 2-3 mg IV now and 2-3 mg q 3-5 min prn pain for a		
	max dose of 20 mg. RR ≥ 10/min		
4	Zofran____mg IV prn N/V q 15 min, may repeat x ____.		2
5	Metoclopramide____mg IV prn N/V x 1.		b(2)
6	Droperidol____mg IV prn N/V x 1.	Noted 12/13/03	[redacted]
7	Phenergan____mg IV prn N/V x 1.	1930 SGT	
8	Benadryl 25-50mg IVP q1 hr prn, itching while in PACU.		
9	IVF: LR @ 150 cc/hr.		
10	Discharge from recovery status when PACU discharge criteria met.		
	b(2)-2 [redacted]		

PATIENT IDENTIFICATION

[redacted]

b(2)-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

b(6)-2 All unless otherwise noted

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 13 Dec 03 TIME OF ORDER @ 1830 HOURS | LIST TIME ORDER NOTED AND SIGN

1. Admit to 2LCW 1-D [redacted]
2. Dx: S/P closed reduction of mandible fx's
3. Cond: Stable
4. Vitals: Per routine
5. Aller: NKDA

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER

6. Activ: ad lib HOURS
7. Nurs: HOB ↑ 30°
   Yankauer suction to BS
   * Wire cutters hanging @ nurses station @ all times

Noted [redacted] 13 Dec 03 2055

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

8. Diet: full liquid diet
9. IVF: NS @ 125 cc/hr then HLIV when taking PO

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

10. meds: MSO4 2-4 mg IVq 10 pm pri
    Clindamycin 900 mg IVq 8°

[redacted]

MMS/DC

NURSING UNIT | ROOM NO. | BED NO.

249 [redacted] 14 DEC 03 0045

PATIENT IDENTIFICATION [redacted]

DATE OF ORDER 14 Dec 03 TIME OF ORDER @ 1432 HOURS

1. Δ diet to BTS

[redacted]

Noted [redacted] 14 Dec 03 1433

NURSING UNIT | ROOM NO. | BED NO.

249 [redacted] 16 DEC 03 0130 12/17/03 1000

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

2. V.O. Mgr. [redacted]
   Hold Clindamycin [redacted]

~~249 [redacted] 17 DEC 03 0230~~

No new orders [redacted] 21 DEC 03 0110

b(a)-2 all unless otherwise noted

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(a)-4 [redacted]				23 DEC 03 @	0822 HOURS	
				(1) Add ensure and milk T every BTS meal please		
NURSING UNIT	ROOM NO.	BED NO.		[redacted]		
					MAJ	

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
b(a)-4 [redacted]				25 DEC 03 @	1009 HOURS	
				(1) immodium 20ml PO then 10CC after each performed stool up to 5 doses.		
NURSING UNIT	ROOM NO.	BED NO.		[redacted]		

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

b(6)-2 All unless otherwise noted

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 [redacted] BELOW.

24° ✓ 24° ✓ 28 DEC 03 @ 0400 [redacted] 1LT, AN

PATIENT IDENTIFICATION 25 DEC 03 @ 0240 [redacted] 2LT, AN

b(6)-4 [redacted] noted 30 Dec 03 [redacted] 0800

NURSING UNIT	ROOM NO.	BED NO.
KW1		

DATE OF ORDER: 30 Dec — TIME OF ORDER: 0755 HOURS — LIST TIME ORDER NOTED AND SIGN

1. Double the BTS diet Pt is still hungry
2. NPO ~~P~~ MN for Sx in AM. [redacted]

PATIENT IDENTIFICATION 24° ✓ 30 Dec 03 [redacted]

24° ✓ 1 JAN 04 [redacted] 1LT, AN @ 0130

[redacted] 1/1/04 1600

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 01 JAN 04 @ 1548 HOURS

1. Decadron 10mg IV q8° x 2 doses then decadron 8mg q8° x 1 dose then decadron 6mg q8° x 1 dose then D/C

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 1/1/04 — TIME OF ORDER: 1800 HOURS

1. Hold Decadron
2. Tylenol Elixir for T > 101.5 30cc [illegible]

V.O. Dr [redacted]

[redacted]

No new orders [redacted] 03 JAN 04 0350 — 24° ✓ 02 JAN 04 @ 0355 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

[redacted] noted [redacted] 3 Jan 04 0800

b(6)-4

DATE OF ORDER: 3 Jan 04 — TIME OF ORDER: 0725 HOURS

1. D/C IV meds
2. D/C IV

V.O Dr [redacted]

NURSING UNIT	ROOM NO.	BED NO.

24° ✓ [redacted] 04 JAN 04 @ 0400

DA [redacted] 256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

b(a)-2 All unless noted otherwise

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(a)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 31 DEC 03 @ 1018 TIME OF ORDER HOURS | LIST TIME ORDER NOTED AND SIGN

1. Admit to PACU then ICW 1 - Dr Perkins
2. Dx: S/P ORIF mandible fracture
3. Cond: Stable
4. Vitals: Per routine
5. aller: NKDA
6. Activ: Ad lib
7. Nurs: HOB ↑ 30°
8. Diet: BTS - (Double BTS) diet
9. IV: HLIV
10. Medd (*) clindamycin 900mg IVq8 x 3 days only
    (*) MSO4 2-4mg IVq1° pm pain
    (*) Toradol 30mg IVq6° pm pain
11. ★ When pt awake please have dental take a PANOREX XRAY on him ★
12. Phenergan 12.5-25mg IVq4° pm N/V
13. Tylenol 650mg PRq4° pm T > 101 [redacted] MDS
14. Wire cutters (*) nurses station @ all times

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

PATIENT IDENTIFICATION [redacted] 1/1/04 1600

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

24° ✓ 02 JAN04 @ 0355 [redacted] ICT, AN [redacted]

NURSING UNIT | ROOM NO. | BED NO.

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

MEDCOM - 26227

...EDICAL 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 _____mg IV now and _____mg q 3-5 min prn pain for a		
	max dose of _____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_____mg IV prn N/V x 1.		
7	Phenergan_____mg IV prn N/V x 1.		
8	Benadryl 25-50mg IVP q1 hr prn, itching while in PACU.		
9	IVF:_____@_____cc/hr.		
10	Discharge from recovery status when PACU discharge criteria met.		
11	Narcan 20mcg IV x 1 prn apnea or RR<7bpm		
	[redacted] b(6)-2		

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

b(6)-2 A11

CLINICAL RECORD

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

Mo. 12 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 12	13	14	15	16	17	18	19	20	21	22	23	24
	[redacted]	BRADEN SCALE	10		/	/	/	/	/	/		/	/	/	/	/
		EVAL														
12 Dec	[redacted]	Vitals: Routine	06	[redacted]												
			18	[redacted]												
12 Dec	[redacted]	Activity: Ad Lib	06	[redacted]												
			18	[redacted]												
12 Dec	[redacted]	Nurs: HOB ↑ 30°	06	[redacted]												
			18	[redacted]												
12 Dec	[redacted]	Yankeur suction to BS	06	[redacted]												
			18	[redacted]												
12 Dec	[redacted]	Diet: Clear Liquids	06	[redacted]												
			18	[redacted]												
13 Dec 03	[redacted]	Vitals per routine	06 12		/	[redacted]										
			18 06		/	[redacted]										
13	[redacted]	Activ: ad lib	06 12		/	[redacted]										
			18 06		/	[redacted]										
13	[redacted]	HOB ↑ 30°	06 12		/	[redacted]										
			18 06		/	[redacted]										
13	[redacted]	Yankauer suction to	06 12		/	[redacted]										
		BS	18 06		/	[redacted]										
13	[redacted]	wire cutters hanging	06 18		/	[redacted]										
		2 nurses station 2	18 06		/	[redacted]										
		all times														
13	[redacted]	Diet: Full liquid diet	06 18		/	[redacted]										
			18 06		/	[redacted]										
14	[redacted]	diet to BTS	06 18		/	[redacted]										
23	[redacted]	Add milk & ensure	18 06		/	[redacted]										
		to every meal														

PRE-OP

Add 14 Dec

ALLERGIES: ☐ YES ☑ NO
NKDA

PRIMARY DIAGNOSIS:
S/P CLOSED REDUCTION OF MANDIBLE FX'S
Mandible fractures

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 All

Verity 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
12 Dec	[redacted]	Admit to ICW 2 Dr. [redacted]	12Dec	—	—	[redacted]
12Dec	[redacted]	Cond: Stable	12Dec	—	—	[redacted]
12Dec	[redacted]	NPO p MN for surgery 13Dec	13Dec	0001	—	[redacted]
13 Dec	[redacted]	Admit to ICW1 - Dr [redacted] Cond. Stable	13	—	—	[redacted]
12/21	[redacted]	~~D/c IV, IV Meds, IV Fluids,~~ [redacted]	12/21	—	—	[redacted]

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

USAPA V1.00

b(6)-2

CLINICAL RECORD

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

Mo. DEC Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 25	26	27	28	29	30	31	1	2	3	4	5	6
	[redacted]	BRADEN SCALE Q7 DAYS	06	/	/	/					/		/			
			18	/	[redacted]	/					/		/			
13 DEC 03	[redacted]	VITALS PER ROUTINE	06	[redacted]												
			18	[redacted]												
13 DEC	[redacted]	ACTIV: AD LIB	06	[redacted]												
			18	[redacted]												
13	[redacted]	HOB ↑ 30°	06	[redacted]												
			18	[redacted]												
13	[redacted]	WIRE CUTTERS HANGING @	06	[redacted]												
		NURSES STATION @ ALL	18	[redacted]												
		TIMES	X	[redacted]												
14	[redacted]	Δ DIET TO BTS, ADD	06	[redacted]												
		MILK & ENSUR TO EVERY MEAL	18	[redacted]												
		(Double the portions)														
4 JAN	[redacted]	N10: Fall Risk Assessment	10										[redacted]			
	[redacted]	Q7D & prn	/													

ALLERGIES: ☐ YES ☒ NO
NKDA
MORPHINE
W/ SOB!

PRIMARY DIAGNOSIS: S/P CLOSED REDUCTION OF MANDIBLE FX'S

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

PATIENT IDENTIFICATION: REWRITTEN

[redacted]

b(6)

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(a)-2 All

Verity 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
30Dec	[redacted]	NPO pMN for SX in Am	31Dec	0001	—	[redacted]
31Dec	[redacted]	s/p ORIF Mandible Fracture	31Dec	1200	—	[redacted]
	[redacted]	Cond: stable				
Now	[redacted]	When pt awake please have panorex	—	DONE	—	
	----	x-ray on him				

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

USAPA V1.00

b(4)-2 911

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 12	13	14	15	16	17	18	19	20	21	22	23	24	25
12Dec	[redacted]	IV: NS @ 125cc/hr	06	[redacted]													
			18														
12Dec	[redacted]	Clindamycin 900mg	06														
		IV Q8°	14														
			22														
13 Dec 03	[redacted]	NS @ 125cc/hr then	06														
		HL IV when taking po	18														
13	[redacted]	Clindamycin 900mg	06														
		IV q8°	14														
			22														
~~12/21~~	~~[redacted]~~	~~H2IV~~	~~6~~														
			~~18~~														
			31	1	2	3	4	5	6	7	8	9	10	11	12	13	14
12/31	[redacted]	H2IV	6														
			~~18~~														
12/31	[redacted]	~~Clindamycin 900mg IV~~	6	X	3	6	9										
		~~q8° X 3 days only~~	14	1	4	7	X										
			22	2	5	8	X										

PRE-OP

[redacted]

ALLERGIES: ☐ YES ☑ NO
NKDA

PRIMARY DIAGNOSIS:
S/P CLOSED REDUCTION OF MANDIBLE FX'S
Mandible fracture

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

PATIENT IDENTIFICATION:

[redacted]

b(4)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

b(6)-2 All

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
17 DEC	[redacted]	Add Clindamycin	17	—	—	[redacted]
21 DEC	[redacted]	D/C IV, IV meds, IV fluids	21	—	—	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
10 Dec	[redacted]	MSO4 mg 2-4 mg IV	D/T												
		q6° pain	D/I												
10 Dec	[redacted]	Tylenol 650 mg PO/PR	D/T												
12/31		q4° PRN T > 101	D/I												
13 DEC 03	[redacted]	MSO4 2-4 mg IV q1° pm pain	D/T	13 DEC 2300 4mg	16 DEC 0930 4mg										
			D/I	[redacted]											
12/21	[redacted]	Ambien 5mg Crushed po qhs prn insomnia	D/T												
			D/I												
12/25	[redacted]	Immodium 20ml p.o then 10cc													
		after each unformed													
		stool up to 5 doses.													
12/31	[redacted]	Toradol 30-60mg IV q6° prn pain	D/T												
			D/I												

PICC OF

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

b(6)-2 A11

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 1 Yr. 04

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 31	1	2	3	4	5	6	7	8	9	10	11	12
12/31	[redacted]	HLIV	6	[redacted]												
	---		18	[redacted]												
12/31	[redacted]	Clindamycin 900mg IV	6	X [redacted]												
	-----	q8° x3 days only	12	[redacted]			X									
	[redacted]		20	[redacted]			X									
1/1	[redacted]	Decadron 10mg q8° x2	8	X	8											
	-----	doses, then 8mg	16	[redacted]	6	HOLD										
	-----	q8° x1 dose, then	24	X												
	-----	6mg q8° x1 dose	32													

DCd 3 Jan

ALLERGIES: ☐ YES ☑ NO
MORPHINE
NKDA WsUA

PRIMARY DIAGNOSIS: S/P ORIF mandible Fx

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

PATIENT IDENTIFICATION:

[redacted]

b(6)-1

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.

b(6)-2 A11

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. 1 Yr. 04

Order Date	Clerk/ N[redacted]	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
1/3	[redacted]	D/C IV, IV meds	1/3		[redacted]	

Order/ Expir Date	Clerk/ N[redacted]	PRN MEDICATION, DOSE, FREQUENCY	D/T	31 DEC 1900	1 JAN 0700											
				INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
12/31	[redacted]	Tylenol 650mg PO/PRN	D/T													
		Q4° PRN T>101	D/I													
12/31	[redacted]	MSO4 5-2mg IV q1°	D/T													
		PRN PAIN	D/I													
12/31	[redacted]	Toradol 30-60mg IV q6° prn pain	D/T													
			D/I	60mg	10											
12/31	[redacted]	Phenergan 12.5-25mg IV	D/T													
		q2° prn N/V	D/I													
12/21	[redacted]	Ambien 5mg Crushed	D/T													
		PO QHS prn insomnia	D/I													
12/25	[redacted]	Immodium 30cc po then 10cc p	D/T													
		each unformed stool up to 5 doses	D/I													
1/1	[redacted]	Tylenol Elixir 30cc PO prn q4° for T>101.5	D/T	3pm 0700												

D/C'd

2000 [redacted]

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

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: 13Dec03 Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block

Time In: 1825

Allergies: NKDA OR Intake: Crystalloid 1300 Colloid

Pre-op V/S: 130/65 80 OR Output: UOP 0 EBL <50

Procedures: Jaw fx Repair Meds/Times: Versed, Fentanyl, MSO4

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

Pre Op Meds History

Time	1825	1835	1845	1855	1910
SaO2	100	100	100	100	100
FiO2	4L	4L	4L	2L	/
Methods	NC	NC	NC	NC	RA
240					
220					
200					
180					
160					
140					
120	✓	✓	✓	✓	
100		•			
80	• ^		•	^	
60		^	^	•	^
40					
20					
RR	10	14	12	11	11
T	98	98	97.2		

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
	LR	400	(R) AC		
	NS	100	(L) AC		

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	1	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C,	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

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

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 13Dec03

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

[redacted]

b(6)-4

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

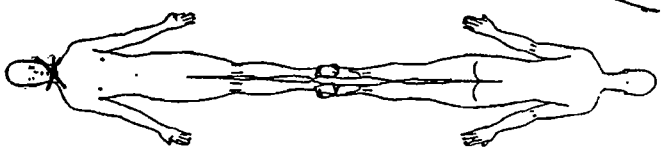
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

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



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1955	SR	NO	NO

NURSING NOTES

1930 Rec'd pt from OR. Hooked up to monitor. Maintaining own airway. SPO_2 90% RA - placed on 4L O_2 NC. SPO_2 ↑ 100%. VSS
SGT [redacted] PM

1931 Wire Cutters, Sx, & nasal airway @ BS SGT [redacted] PM

2015 Report given to LT [redacted] and pt transported via litter SGT [redacted]

b(6) 2 All

Discharge Criteria:
Date: 30 Dec 03 **Time:** **PARS:** 10
BP: 119/76 **T:** 97.2 **HR:** 72 **RR:** 11 **Sa02:** 100% RA
Pain Level at D/C (0-10): 0
Intake: 500 cc **Output:** 0
Additional Data:
Transferred To: ICW
Report Given To: LT [redacted]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: SGT [redacted]
Cleared IAW Recover [redacted]
Charge Nurse Signat [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: 31Dec 03
Time In: 1035
Allergies: MSO4
Pre-op V/S: 132/71 88-125
Procedures: ORIF of mandible + wiring

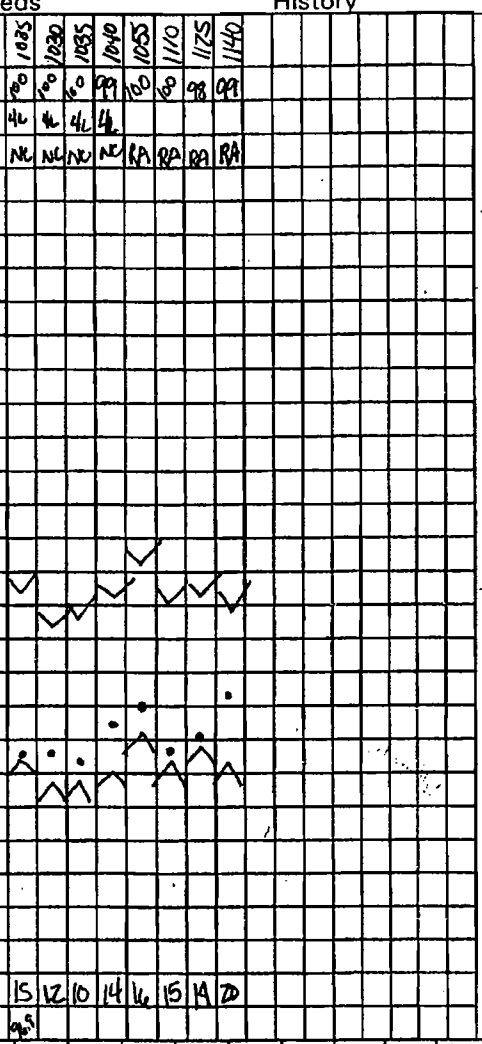
Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 600 Colloid
OR Output: UOP – EBL –
Meds/Times: 1 MSO4 400 mcg Fent 70 Vec 200 propofol

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds / History

Time	1035	1030	1035	1040	1055	1110	1125	1140
SaO2	100	100	100	99	100	100	98	99
FiO2	4L	4L	4L	4L				
Methods	NC	NC	NC	NC	RA	RA	RA	RA
RR	15	12	10	14	16	15	19	20
T	96.5							



Time	
Pain (0-10)	
LOS	

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

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1035	LR	100	LAC		

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

V/S
X = A-line BP
• = Cuff BP
= Pulse

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

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

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 31Dec 03

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

[redacted] b(6)-4

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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1055		20mcg Narcan	IV			[redacted]

NEUROVASCULAR

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

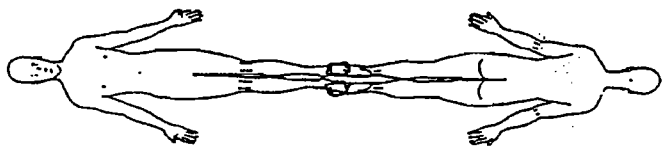
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

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



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0935	NSR	—	—

WAMC OP 173-E

NURSING NOTES

Pt received from OR s/p ORIF of mandible and rewiring. Pt SpO_2 85% upon arrival put NC @ 4L sats ↑ 99%. Pt had allergic reaction to MSO4 in OR, given Benedryl. VSS. Will continue to monitor for any further reactions. Pt does not breathe unless stimulated. Dr [redacted] brought to bedside. 20mcg Narcan given. Pt now breathing with no difficulty. Transferring to ICW 1. Report given to Lt [redacted]

b(a)-2 A11

Discharge Criteria:
Date: 31Dec03 **Time:** 1146 **PARS:** 10
BP: 119/72 **T:** 97.4 **HR:** 97 **RR:** 14 **Sa02:** 99%
Pain Level at D/C (0-10):
Intake: 100 **Output:** —
Additional Data: —
Transferred To: ICW 1
Report Given To: Lt [redacted]
Transferred Via: W/C Litter / Gurney Ambulance
Transferred By: Sgt [redacted]
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:

b(2)-2

Admission and Coding Information

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

1. Reporting MTF [redacted]	2. MTF Locatio IZ			
3. Register Number [redacted]	Name (Last, First, MI) [redacted] b(6)-4		4. Pay Grade FGN	5. Sex M
6. DoB (YYYYMMDD) 1983-01-01	7. Age at Admission 20Y	8. Race X	9. Ethnicity 9	Religion
10. Length of Service	ETS	11. FMP 99	12. Social Security Number [redacted] b(6)-4	
Organization (Active Duty Only)		13. Marital Status	Hour of Admission 21:20	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 DIS	Prev. Admission NO	
20. Source of Admission Direct from ER	Ward: ICW1	Name / Relationship of Emergency Addressee		
		Address of Emergency Addressee		
[redacted] b(2)-2		Telephone Number of Emergency Addressee		
21. Type of Disposition TRF-A	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2004-01-04		
24. Clinic Svc - Admitting ABF - ORAL SURGERY	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-12-11		
27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission 2003-12-11		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: MANDIBLE FX

Procedure Narrative(s):

Cause of Injury Narrative:

DX 80228
80225
PROC 7676
7909
7819
Trauma 9
Inj 999
b(4)

[redacted] b(6)-2

Signature of Admitting Clerk [redacted]

[redacted] FORM 2985, MAR 2000

b(6)-2

BATES PAGES MEDCOM 26242-26414 ARE NONRESPONSIVE AND HAVE NOT BEEN PROVIDED

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] b(6)-4 | 3. Grade FGN | Admission Remarks

4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm
M	60Y	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
	K78-PRISONER OF WAR/INTER			DIS

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	21:07	AEA - ORTHOPEDICS

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

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer
		2003-12-14	[redacted] b6-2

29. ReportingMTF	30. Date Init Adm	32 Units Blood Components
[redacted] b(2)-2	2003-12-14	

31. Selected Administrative Data

Marital Status: DoB: 1943-07-01

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

FEMOVAL NECK FX ®

ORIF

820.8
753.10
E888.9

79.35

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	11	11

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	11	11

[redacted] ding Medical Officer b(6)-2 Signature of PAD or Medical Records Officer [redacted] b(6)-2

[redacted] RM 3647, May 79

MEDCOM - 26415

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

59 y/o ♂ 7 DPW sustained fall in 8 days ago, was transferred here for tx of (R) femoral neck fx. No apparent LOC. No other reported injuries

PMH	Meds	PSH	Allergies
HTN	- Diovan - ASA	4	

PHYSICAL EXAMINATION

PE: (+) log roll / (C) pain to (R) hip
(C) ecchymosis bruising to (R) hip & anterior chest
Pulses present DP/PT
Xray: Garden III Femoral Neck Fx

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

A. Femoral Neck Fx (R)
P. 1.0 IF / Screw fixation

CBC WNL 11,600
Hct 12.8/43.3
INR 1.34

[redacted] b(6)-2

SIG[redacted]	TC, MC	DATE 14 DEC 2003	IDENTIFICATION NO.	ORGANIZATION
PA[redacted]	*[redacted] 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

VITAL SIGNS

Rectal Temp: 98.2°F

GCS: 15

TIME	BP	HR	RHY	RR	SAO_2	FIO_2	MODE	E	V	M	T
909	141/80	98		20	100%						
924	144/59	91		23	100%						

GLASGOW COMA SCALE

EYE OPENING	VREBLE RESPONSE	MOTOR RESPONSE
(4) Spontaneous	(5) Oriented	(6) Obeys Commands
3 - To Voice	4 - Confused	5 - Localizes Pain
2 - To Pain	3 - Inapp Words	4 - Withdraws to Pain
1 - None	2 - Incomp Speech	3 - Flexion to Pain
	1 - None	2 - Extension to Pain
		1 - None

TIME	PROCEDURE	PERFORMED BY:
	☐ Backboard Removed	BY:
	☐ Downgraded	BY:

NOTES

PMH - ~~[illegible]~~
HYPERTENSION

INJURY OCCURRED
5 X AGO

PT. SLIPPED ON
WATER

2109 - Pt arrived via medic
Ø resp distress. Arrived
c̄ 1 18G IV to RAC c
2nd bag NaCl running.
2115 - XRays taken,
Chest, Abdomen, pelvis.
2117 - labs drawn +
sent to lab.
2118 - Pt states he was

66-2

born on 1944. [redacted] IRAN

→ Pt Staff note: 59 yo Iraqi ♂ s/p "fall" 5 days ago
Pt c̄ Contusion (R) chest - appears old by color.
Pt alert, oriented, answering questions
Pt states fell on water in his cell.
Ø LOC. Ø Head/neck Pain.
Pt Ø ambulatory since.

→ PMH
HTN

PE: USS gen NAD
CV: RRR c̄ (M)
Lungs: CTA (B) (R) chest c̄ Contusion, wound
old Based on Δ's.
abd: soft, (+)BS, FAST (-). Foley c̄ Dark Urine
Ext: (R) ant hip c̄ (+) ecchymosis, (+) Pain c̄
(R) hip/femur [redacted] leg is ext. Rotated.
Distal pulses 2+ Symm; (+) ecchymosis (L) ant leg, (+) foot
Dorsum c̄ ecchymosis.
A/P: (1) (R) femur - head

PSH Ø

Meds
Diovan
Aspirin

NKDA

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-68; the proponent agency is the Office of The Surgeon General.

REPORT TITLE: TRAUMA FLOWSHEET
The proponent is Dept of Surgery

OTSG APPROVED (Date): QI Appr 11 Jun 97

EMS REPORT

TIME: 909 ETA: 909 UNIT:

MED COM: [Y] [N]

ARRIVAL STATUS

TIME 909 ☐ IV x 1 ☐ O_2 ____ l/min ☐ C-Spine Immob

Meds: ☐ UKN ☑ None ☐ Yes: Dovan / ASPIRIN

Allergies: ☐ UKN ☑ None ☐ Yes:

Tetanus: ☑ UKN ☐ Current Last Meal/Fluid Intake ____ hrs

LMP: ____ ☐

PRIMARY SURVEY

AIRWAY

☑ Natural Patient [Y] [N]

☐ ETT ____ ☐ ____

☐ Secretions ____

BRETHING

☑ Labored ☐ Unlabored ☐ Absent

TRACHEA: ☑ Midline ☐ Deviated [L] [R]

CHEST SYMMETRY: [L] > = < [R]

CIRCULATION

PULSE: ☑ Present ☐ Absent

BLEEDING: [Y] [N]

HEART TONES: ☐ Clear ☐ Muffled

SKIN: ☑ Warn ☐ Cool ☐ Hot

☑ Pink ☐ Pale ☐ Cyanotic ☐ ____

☑ Dry ☐ Moist ☐ Diaphoretic

SECONDARY SURVEY

DISABILITY

GCS: E 15

V ____

M ____

SPHINCTER TONE:

☑ WNL

☐ None

HEAD

PUPILS: ☑ Equal ☐ Fixed ☐ React ☐ Dilated [L] [R]

TM: ☑ Clear ☐ Blood [L] [R]

NECK

C-Spine Tenderness: [Y] [N]

Pain @ ____

JVD: [Y] [N]

HEART

RHYTHM: ☑ Regular ☐ ____

PULSES: ☐ Central ☐ Peripheral

LUNGS

BREATH SOUNDS: ☑ Bilat ☐ Equal ☑ Clear

Decreased [L] [R] Absent [L] [R]

Wheezes [L] [R] Crackles [L] [R]

ABDOMEN

☑ Soft ☐ Rigid ☐ Non-Tender

☐ Tender: —|—

PELVIS

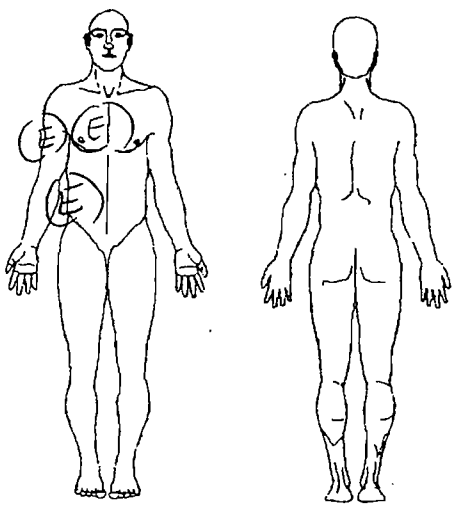
☑ Stable ☐ Unstable ☐ ____

Blood at meatus/vagina: [Y] [N]

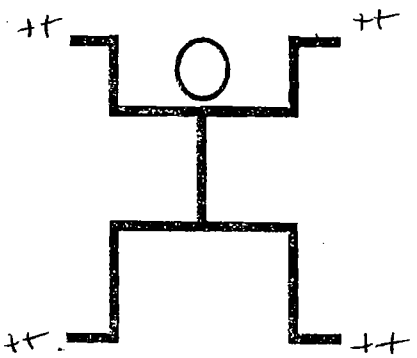
Heme + / - Prostate: ☑ WNL ☐ Abnl

USE DIAGRAM TO DOCUMENT INJURIES AND PAIN

(AB)rasion
(AMP)utation
(AV)ulsion
Battle's Signs
(BL)eeding
(B)urn
(D)eformity
(E)cchymosis
(F)oreign Body
(H)ematoma
(LAC)eration
(P)uncture (W)ound
(Pain)
(S)eatbelt (S)ign
(S)tab (W)ound
(GSW) Gun Shot Wound



VASCULAR ASSESSMENT



+ + Strong	+ Palpable	D Dopler

RN: LT [redacted] b(6)-2

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

(Continue on reverse)

PREPARED BY: [redacted]

DEPARTMENT/SERVICE/CLINIC: EMT

DATE: 14 DEC 03

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

[redacted] b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

MEDCOM - 26418

DA FORM 4700

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
14 Dec 03	(2350) VSS. Ø c/o pain. Pt arrived from EMT ~2300. (+) Foley draining clear, light amber urine. BS CTA, BS (+) x4 quads. Pt presents c̄ multiple bruises on body; ~~a~~ BIL dorsal feet, forehead above (L) eyebrow, (R) LQ. Pt able to move fingers in BIL UE & able to move toes in BIL LE. (+) 2 pedal pulses in BIL LE. IV fluids: LR @ 100cc/hr. in (R) AC. Pt NPO p̄ MN for O.R. 15 Dec. Pt aware to be NPO p̄ MN. Pt verbalized understanding to interpreter. Ice to (R) side of hip. Will monitor. b(6)-2 [redacted] 29 YAN
	(0400) ~~Abd~~ Abd soft & non tender upon palpation [redacted]
15 DEC Ø3 @ Ø8Ø5	pt taken to OR for Sx. 850 cc Urine emptied from foley, [redacted] PFC 9/W/O b(6)-2
15 DEC Ø3 @ 1245	pt back from OR @ 1205 c̄ ORIF in place, ~~b~~ on (R) hip, Drsg CDI. Kerlix wrapped around (R) elbow, drsg CDI. VSS. Foley intact, draining to gravity. (+) PMS on bilat foot. (+) PMS on bilat UE. A&O, speaking Arabic. (−) c/o pn at this time. IV site on (L) forearm patent. Will continue to monitor. b(6)-2 [redacted] PFC 9/W/O.
15 DEC @ 1800	1400 cc CYU emptied from FTG, b(6) [redacted] 9/W/O
16 Dec Ø3	(0100) VSS x̄ temp of 99.8. Will monitor temp. Ø c/o pain. BS CTA, BS (+) x4 quads. Abd soft & non tender on palpation. Multiple bruises on body. (R) hip ~~has~~ DSG CDI + ice.

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 All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(cont') ⊕2 pedal pulse to B/L LE, able to move toes, warm to touch. ⊕ Foley to gravity ō clear, lightamber urine. IV fluids LR@[redacted] 100cc/hr into (L) Arm IV ⅁ difficulty. Will continue to monitor pt. [redacted]
16 Dec 03 0745	Pt c/o pain in (R) arm. Pt given II percocet per MD orders. Reassess — [redacted] 9IWMO
16DEC03 @ 1545	Assumed care @ 0600. VSS. A&O, speaking arabic. IV site on (L) forearm patent. Drsg on (R) hip CDI. Drsg on (R) arm CDI. ⊕ PMS on bilat LE. ⊕ PMS on bilat UE. Voiding ⅁ difficulty. Ice on hip D/C'd per MD. IVLR @ 100cc/hr. ⊖ c/o discomfort at this time. Reg diet tol well. ~~will~~ ⊖ signs of skin breakdown on restraints. will continue to monitor. b(6)-2 [redacted] 9IWO
	Concur [redacted]
16DEC @ 1710	1400 cc. of clear, yellow urine from foley. Foley intact and draining well. [redacted] 9IWO
16Dec03	(2230) VSS x temp of 100. Med ⓒ & percocets. Will continue to monitor. BS CTA, BS + x4 quads. ⊕ Foley to gravity, draining clear, yellow urine. DSG to (R) elbow CDI, ⊕2 radial pulse, warm to touch, move fingers. DSG (R) hip CDI. ⊕2 pedal pulse. IV to (L) Arm infusing. LR@100cc/hr. Will monitor. [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
15 Dec 2003	PreopDx: (R) Femoral Neck Fx
	PostopDx: Same
1100	Operation: ORIF (R) Femoral Neck Fx
	Surgeon: [redacted] b(6)-2
	Assist - 1
	Anesth: [redacted]
	EBL: 75 cc
	Fluid 1000 LR
	U/O 600
	Comp. ϕ
	Intraop Course Satisfactory
	[redacted] b(6)-2
	[redacted] RC,
	[redacted] MC

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

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

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

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

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
17 Dec 03 1130	Rec'd report and assumed care of pt. Pt awake in bed ⊖ c/o pain, dyspnea or resp distress @ present time. Pt IV leaking spoke c̄ Dr [redacted] pt IV D'cd per verbal order. Drsg Δ to ® elbow, pt has @ 3cm open wound, clean and cover c̄ 2x2. Resp CTA ⊕BS ⊕ distal pulses greater toe has black spot but cap refill K̄ 5. ® hip drsg D&I ⊖ drainage. 2-point restraint in place ⊖ skin breakdown noted b(6)-2 [redacted] RN/WHG
18 DEC 03	(0055) Assumed care @ 0700. Pt alert, speaking Arabic. VSS. ⊖ c/o pain. Pt OOB to W/C to tx to new room. Tol. well. Dsgs to ® elbow and ® hip CDI. Tol. reg diet well. Foley draining quantity sufficient clear yellow urine. 2 point restraints in place c̄ s/sx complications. Will continue to monitor. b(6)-2 [redacted]
18 Dec 03	@ 0730 - Assumed care of pt. Sleep yet easily arousable. AFOX3. speaking arabic lungs clear HRRR Active BS x4 quads tolerating PO well. Urinating per FTG clear yellow urine BS. Wounds

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 names, give: Name (last, first, middle) IC No or DSN Date Care at Birth Rank/Grade)

REGISTER NO.

WARD NO. KW

PROGRESS NOTES
Medical Record

STANDARD FORM 6
Prescribed by DOD/DA/AF/DLA/DSA

[redacted] b(6)-4

b(6)-2 A11

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
19 Dec cont 0700	- to (R) elbow and (R) thigh dsg's CDI complaint of pain medicated per order. percocet II tabs. Will cont to monitor — b(6)-2 [redacted]
19 Dec 03	(0150) VSS. Ø C/O pain. (R) Femur DSG CDI. Pt able to move toes B/L. (+) 2 pedal pulses ≠ B/L LE. (+) Foley draining clear, yellow urine. BS CTA, BS + x4 quads. (R) Elbow Ø DSG. CTA. Ø signs of infection. Elbow ~~raised~~ slightly swollen + appears red. Will monitor. ↓ mobility to (R) Arm. Will cont. to monitor. — [redacted]
19 Dec 03	(0845) assumed care of pt @ 0800. VSS, Ø pain to (R) femur incision SAC & (R) thigh. Percocet given c̄ good relief noted. LS CTA, HRR, (+) BS, tol reg diet, void per foley amber urine QS. (R) femur dsg Δ completed, incision CDI, staples in place, dry dsg replaced. (+) CMS to RLE, brisk capr refill, +1 edema to (R) thigh & (R) toes noted. 2 pt restraints on S/S of skin/circulation compromise. Plan: CDBTC, ~~[illegible]~~ monitor neuro, pain control, encp intake, incr H2O intake — [redacted]
19 Dec @ 1800	Avided 800cc per foley. Pt c/o pain well-controlled pain relief. Will monitor. — [redacted]
20 Dec 03	(0110) VSS. Ø C/O pain. BS CTA, BS + x4 quads, voids clear, yellow s̄ difficulty. (R) Femur: DSG CDI; (+) 2 pedal pulse, Ø signs of vascular compromise. (R) elbow: CTA, Wound intact, Ø signs of infection. ~~Will cont~~ (+) Foley - clear, yellow. Will cont. monitor. — [redacted]
20 Dec 03	- D/C'D FOLEY, PT VOI VIA FOLEY PRIOR TO D/C 400cc CLR, YELLOW URINE. WILL CONTINUE TO MONITOR — [redacted]

STANDARD FORM 508 REV. APRIL 1983

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
20 DEC 03 @1220	assumed care of pt @ 0600. VSS - Pain controlled c̄ Percocet well. (R) groin dsg CDI, edema noted, staples intact. LS CTA, tol liq diet well, [redacted] foley D/C'd this AM, DTV by 1600. Pt ↑ OOB/TC c̄ assistance tol well. Pt c̄ 40 oz BM x 10 days, supp given p̄ lunch, will monitor effect. (+) CMS to RLE, brisk cap refill noted. Spt neurovas ms S/Sx of skin/circulation compromise. Plan: enc OOB, enc po intake, monitor pain, monitor neuro. b(6)-2 [redacted] MD
20 Dec 03	Assumed care of Pt @ 1800. VSS. Denies Pain A&O. LS CTA (R), (+) BS x 4 quads. Pt voided Dark Amber clear urine qs s̄ difficulty. Tol Po Well. Drsg to Anterior (R) thigh. CDI. Drsg to (R) Elbow CDI. Will cont [redacted] tor. b(6)-2 [redacted] Sgt 91WM6
21 DEC 03 1330.	VSS. AO. PERRLA. HRR. OOB to BR [redacted] and performed self care. Incision to RUE CDI, sutures covered c̄ dry DSG. Elbow DSG changed c̄ 2nd. days. Elbow washed over s̄ d/s infection. Med c/o pain and provided relief. Verity spontaneously c̄ difficulty. b(6)-2 [redacted]

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

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

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

PROGRESS NOTES
Medical Record

STANDARD FORM 51
Prescribed by SGHRCMR 8PMD (1 NOV 87)

[redacted]

b(6)-4

b(6)-2 A11

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
21Dec03	Assumed care @ 1800. A&O VSS Denies Pain. LS CTA (R) (+) BS x4 quads. Lat incision to R [redacted] thigh OTA well approximated. (−) S/Sx infection. Pt Denies Pain. Void qs CXU [redacted] difficulty. Will cont to monitor pt. — [redacted] Spc 91WMb
22Dec03 1320	VSS. AO. (+)2 pulse to RLE & CVS intact. Dry BDG Δ to (R) elbow. Elbow sub cm elbow diminished in size. Small amount of clear drainage noted. ¢ odor. Voiding spontaneously. All other systems WNL. ¢ S/S skin breakdown. [redacted]
22Dec03 1833	VSS A&O Denies pain. LS CTA (R) (+) BS x 4 quad. Lateral incision to (R) Thigh OTA closed c̄ sutures. Well approximated (−) S/Sx of infection. Voids qs CXU S̄ difficulty. Tol PO well [redacted] will cont to monitor. — [redacted] Spc 91WMb
23Dec03 1630	Assumed care @ 0600. Pt AAO. OOB → BR c̄ crutches. NWB to (R) LE. Incision to (R) thigh with staples intact & wound edges well approximated. No drainage or odor noted. OOB → chair & ambulate. Consumed 50% of meals. ¢ c/o pain voiced. Will continue plan of care. [redacted]
23DEC04	Assumed care @ 1800 pt AAO x3, LS pt has ¢ c/o pain at this time, staples to (R) thigh well approximated and intact OTA. dsg to (R) elbow Δd 2x̄ minimal drainage noted, restraints x2 in place. Will monitor [redacted] Concur c̄ above.

STANDARD FORM 509 (REV. 5/1999) RA
USAFA

[redacted] b(4)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
24 Dec 2003	Iraqi EPW sustained (R) hip FX, taken to OR for ORIF 4 days ago. 3 6.5mm screws placed into head & neck. IV & SF complications. Pt doing well. No major c/o. Wound looks good – no s/s infection. Able to be DC to EPW Prison. Must ambulate c crutches.
	b(4)-2 [redacted]
	LTC, MC

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

DEPART. SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

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(4)-4

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

4. PROPOSED SURGICAL PROCEDURE:
ORIF Rt. Hip

5. ADDITIONAL INFORMATION:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL X Potential for anxiety related to Procedure & outcome	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 Positioning Anesthesia	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 Immobility, pooling of fluids, positional aids	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)-9
6940 ♂

[redacted] b(2)-2

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 Immobility, positioning	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 Pain positioning E.2. X Potential discomfort due to 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 pre-med F.2. X Potential for decreased communictaion due to language barrier F.3. Potential injury due to dentures.	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from either side. o Validate pt.'s understanding of verbal communications. o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS. Or continuation of above interventions.

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

Karen Meyer CPT/AN 15 Dec 03 DATE

11. POSTOPERATIVE EVALUATION:

12. PREOPERTIVE EVALUATION PREPARED BY	13. PREOPERTIVE EVALUATION PREPARED
[redacted] CPT/AN blw-2 DATE: 15 Dec 03 TIME: 0810	[redacted] blw-2 DATE: 15 Dec 03 TIME: 1100

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.01

MEDICAL RECO. INTRAOPE. 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. PATIEN[redacted]VED AND PROCEDURE VERIFIED BY [redacted] CPT/AN
3. DATE 15 Dec 03 TIME PATIENT ARRIVED IN SUITE →	4. PATIENT IN[redacted] TIME 0810 b(4)-2 NUMBER 2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] b(4)-2	RELIEF SCRUB	b(4)-2
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR INT:	CPT [redacted] (10:25-end)

7. POSITION AND POSITIONAL AIDS *(Specify)*

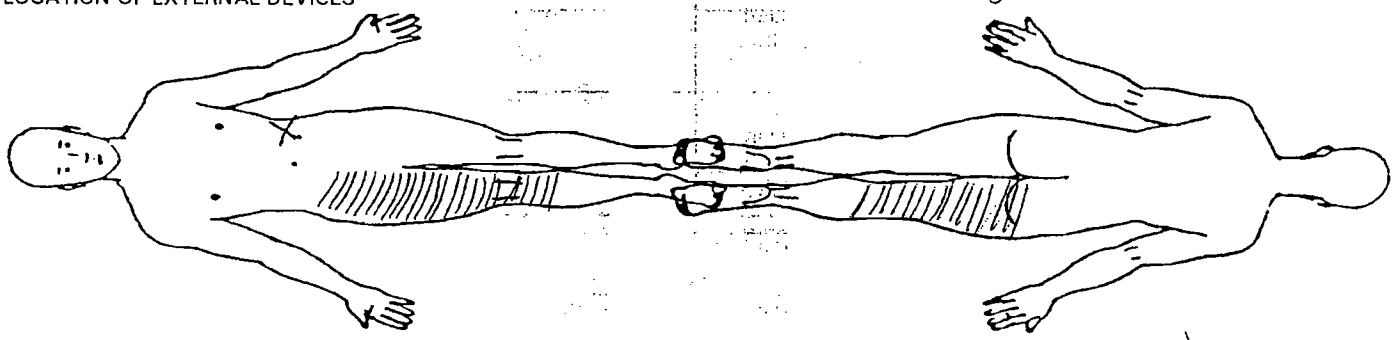
☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: on fx table w/ (L) leg in padded stirrup. Rt. arm flexed across chest

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO [redacted] DONE BY: ☐ OR ☐ NURSING UNIT METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP COMMENTS: No skin nicks	PREP SOLUTION *(Specify)* Betadine scrub/soln SITE: Rt. leg BY WHOM [redacted] SITE: BY WHOM: [redacted] COMMENTS: No pooling of fluids

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect Initial C [redacted] b(4)-2

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(4)-4

6940 ♂

b(2)-2

[redacted]

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

☒ ESU NO: Force 40 R8E10530S 50/50

GROUND PAD: BRAND Valleylab REM

LOT NO: 69441

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

PROSTHESIS, IMPLANTS ☒ YES ☐ IF YES NAME: ID NUMBER; ACTUF

Synthes ASIF
Lg Frag Screws
Load # 0334703

6.5 cancellous screws
short thread
85mm X1
90mm X2

4. 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 [redacted] b(6)-2		

PHYSICIAN'S SIGNATU [redacted] RC, MC

15. X-RAY IN OPERAT [redacted] IF YES, SITE
YES ☒ NO ☐ [redacted] C-Arm Rt. Hip

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)*

4V8's

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

19. ADDITIONAL INFORMATION

Surg: [redacted] Anesth. [redacted] CRNA Type: ~~General~~ Spinal w/ sedation

b(6)-2

20. OPERATION(S) PERFORMED

ORIF Femeral Neck Fx

b(6)-2

21. PATIENT TRANSFERRED TO	TIME	METHOD
PACU	1110	stretcher

22. [redacted] SIGNATURE CPT/AN / [redacted] CPT/AN

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.00

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY: 21 | 22 | 23 | 24 | 25 | 26 | 27

MONTH-YEAR: DEC 2003 — DAY / HOUR

PULSE (O) / TEMP. F (•)

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. ICU 1

[redacted] b(4)-4

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																		
POST-	DAY	DEC		DEC		DEC												
MONTH-YEAR	DAY	14	15	15	16	16		17		18 DEC		19		20				
19	HOUR									0715								
PULSE (0)	TEMP. F (°)																	TEMP. C
	105°																	40.6°
180	104°																	40.0°
170	103°																	39.4°
160	102°																	38.9°
150	101°																	38.3°
140	100°																	37.8°
130	99°																	37.2°
	98.6°																	37.0°
120	98°																	36.7°
110	97°																	36.1°
100	96°																	35.6°
90	95°																	35.0°
80																		
70																		
60																		
50																		
40																		
RESPIRATION RECORD		24	24		26	28		18	28	18		20		18				
BLOOD PRESSURE		134/71	130/66	120/55	123/62	124/64	124/58		129/68	121/60	130/62	116/61	121/63	129/68				
		98	128/67	92	125/64		89			124	80		79					
		78	99.4	98%	99.8	99.8	98.0			99.1	97.2		99.3					
HEIGHT:	WEIGHT →	98%	99.9	99.8	99.7		94%	98%		98%	98%	96%	93%	98%				
			98%		98%	98%	RA			RA	RA	RA	RA	RA				
			RA		RA	RA												
			96%		97%													
			RA		RA													

Record special data only when so ordered

(Centigrade Equivalents, for Reference only)

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 [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. b(6)-4 [redacted]	DATE 14DEC 03 / TIME 2110	SSN/[redacted] b(6)-4

(Hematology) CBC			Urinalysis			Microbiology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3	Color	DK Yellow	N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App	HZY	N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu	NEG	Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili	NEG	Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket	LRG	Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG	1.010	N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld	NEG	Negative	H. pylori		Negative
(Hematology) Manual Differential			pH	8.0	N/A	Micro Parasites		
Segs		Mono	Prot	NEG	Negative	Malaria		
Bands		Eos	Urob	8	0.2-1.0	O & P		
Lymph		Baso	Nit	NEG	Negative	Other		
Atyp		Imm	Leuk	NEG	Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative	ACE - LRG		
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.:

b(6)-2

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

(i-STAT)

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

ID: [redacted] 15-12-03
WB 05:57

			Patient Limits	
WBC	12.2 H	x10^3/uL	4.5	10.5
RBC	4.26	x10^6/uL	4.00	6.00
Hgb	12.5	g/dL	11.0	18.0
Hct	40.6	%	35.0	60.0
MCV	95.2	fL	80.0	99.9
MCH	29.4	pg	27.0	31.0
MCHC	30.9 L	g/dL	33.0	37.0
Plt	279.	x10^3/uL	150.	450.
LY%	11.6 *L	%	20.5	51.1
LY#	1.4 *	x10^3/uL	1.2	3.4

ID: [redacted] 16-12-03
WB 05:47

			Patient Limits	
WBC	8.2	x10^3/uL	4.5	10.5
RBC	3.67 L	x10^6/uL	4.00	6.00
Hgb	10.1 L	g/dL	11.0	18.0
Hct	34.2 L	%	35.0	60.0
MCV	93.3	fL	80.0	99.9
MCH	28.2	pg	27.0	31.0
MCHC	29.5 L	g/dL	33.0	37.0
Plt	312.	x10^3/uL	150.	450.
LY%	14.1 *L	%	20.5	51.1
LY#	1.2 *L	x10^3/uL	1.2	3.4

======= PICCOLO =======
15/12/03 05:59
REFERENCE RANGE: MALE
PATIENT #: [redacted] blu)-d
METLYTE 8
DISC LOT #: 3152AA4
OPER #[redacted] DR #: 00
SERIAL #: 000010069/

GLU	108	73-118	MG/DL
BUN	9	7-22	MG/DL
CRE	0.9	0.6-1.2	MG/DL
CK	310	39-380	U/L
NA+	[redacted] 139	128-145	MMOL
K+	3.1*	3.3-4.7	MMOL
CL-	102	98-108	MMOL
tCO2	21	18-33	MMOL

blu)-2

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

[redacted]

			Patient Limits	
WBC	11.6 H	x10^3/uL	4.5	10.5
RBC	4.55	x10^6/uL	4.00	6.00
Hgb	13.8	g/dL	11.0	16.0
Hct	43.3	%	35.0	60.0
MCV	95.2	fL	80.0	99.0
MCH	28.2	pg	27.0	31.0
MCHC	29.6 L	g/dL	33.0	37.0
Plt	316.	x10^3/uL	150.	450.
LY%	14.6 *L	%	26.5	51.1
LY#	1.7	x10^3/uL	1.2	3.4

======= PICCOLO =======
15/12/03 03:2?
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
ELECTROLYTE
DISC LOT #: 3241BA4
OPER #: 034 DR #: 034
SERIAL #: 0000100684

NA+	135	128-145	MMOL/L
K+	3.4	3.3-4.7	MMOL/L
CL-	99	98-108	MMOL/L
tCO2	24	18-33	MMOL/L

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

======= PICCOLO =======
11/15/03 09:40 PM
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3382AA4
OPER #: 034 DR #: 702
SERIAL #: 0000100494

ALB	3.4	3.3-5.5	G/DL
ALP	62	26-84	U/L
ALT	22	10-47	U/L
AMY	15	14-97	U/L
AST	24	11-38	U/L
TBIL	2.1*	0.2-1.6	MG/DL
BUN	14	7-22	MG/DL
CA++	8.5	8.0-10.3	MG/DL
CHOL	149	100-200	MG/DL
CRE	0.7	0.6-1.2	MG/DL
GLU	135*	73-118	MG/DL
TP	7.0	6.4-8.1	G/DL

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

[illegible] 21:45

Patient ID: 1554
Test Name :PT
Test Result:= 14.6 sec.
Ratio = 1.2
Calculated INR = 1.34
Sample Type:citrated wh. blood
Test Date :12/14/03
Test Time :21:41
Card Lot :080201
Operator : MCCARTER

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 12/14/03 21:45

Patient ID: [redacted] b(6)-4
Test Name :APTT
Test Result:= 21.2 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :12/14/03
Test Time :21:43
Card Lot :110210
Operator : [redacted]

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

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

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

TEST	*RESULT*	*REF. RANGE*
Color	Dk Yellow	N/A
App	HZY	N/A
Glu	NEG	Negative
Bili	NEG	Negative
Ket	LRG	Negative
SG	1.010	N/A
Bld	NEG	Negative
pH	8.0	N/A
Prot	NEG	Negative
Urob	8	0.2-1.0
Nit	NEG	Negative
Leuk	NEG	Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

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

UNIT	*TYPE*	*CROSSMATCH*

Misc. Serology

TEST	*RESULT*	*REF. RANGE*
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

ACE -

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

REPORTED BY:	**DATE:**	**LAB ID NO.:**

NSN 7540-00-634-4165

MEDICAL RECORD	REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1. OPERATION OR PROCEDURE

OR IF (R) Femoral Neck Fx

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be Reduction of (R) hip fx + PINNING.
(Description of operation or procedure in layman's language)

which is to be performed by or under the direction of Dr. [redacted] b(6)-2

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

4. Exceptions to surgery or anesthesia, if any, are: None -
(If "none", so state)

5. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.

6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures.

b. Said pictures be used only for purposes of medical/dental study or research.

b(6)-2

(Cross out any parts above which are not appro[redacted]

C. SIGNATURES *(Appropriate items in Parts A and B must be completed b[redacted]*

1. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the [redacted] attendant risks involved, and expected results, as described above.

[redacted] TC, MC

b(6)-2

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, [redacted] described above, and hereby request such procedure(s) be performed.

[redacted] ICTAN [redacted] 14 Dec 2003
(Signature of Witness, excl[redacted]mbers of operating team) *(Signature of Patient)* *(Date and Time)*

b(6)-2 [redacted]

3. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I, _____ sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team) *(Signature of Sponsor/Legal Guardian)* *(Date and Time)*

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

REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

Medical Record

STANDARD FORM 522 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)

USAPPC V2.00

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)												
Versed (mg)	1 1						1				1	
Fentanyl (Mcg)	50					50			50			
Ketamine (mg)	20/20/20					10	10		10	10		
( )												
( )												
( )												
VOLAT AGENT % del												
VOLAT AGENT % e.t.												
AIR L/Min												
N2O L/Min												
mask O2 L/Min	6	6	6	6	6	6	6	6	6	6	6	X

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

TOTALS	TOTAL EBL
4mg	
150mg	75
100mg	TOTAL URINE
	600

FLUIDS - SUMMARY

CRYSTALLOID- 1000cc

COLLOID- Ø

BLOOD- Ø

FLUIDS

LINE site												
RAC ☐ Warmed	HL											
LFA ☐ Warmed	LR	500	T		#2			800			1000	
☐ Warmed												
☐ Warmed												

LOSSES

EST BLOOD LOSS								50			75	
URINE - Foley					550						600	

REMARKS

Code drugs with numbers, events with letters

(1) To OR via litter, SOC mons positioned rt lateral for SAB.
(2) SAB in. Pt left in RLD x5 mins then positioned for prep. Level on rt T8.
(3) To PACU stable. Report given.

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 75 (KG) LB

HEMATOCRIT: 43.3

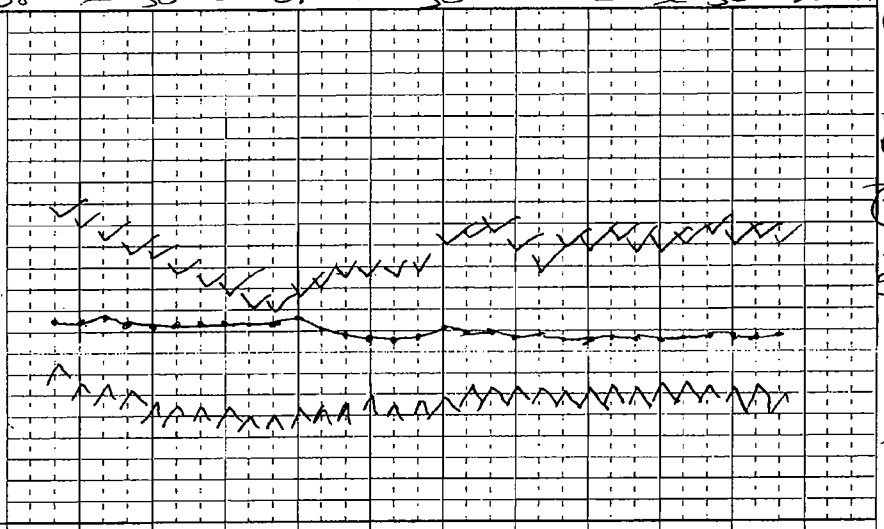
INITIAL DATA: BP- 146/73 HR- 95

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? ✓ TIME- 0755

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

TIME → 08 — 30 — 09 — 30 — 10 — 30 — 11



VENTIL

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

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	ET CO2 (torr)											
BP/oth	✓ FIO2 (Frac or %)	>.21	>.21	>.21	>.21	>.21	>.21	>.21	>.21	>.21	>.21	>.21
ART line	✓ SpO2 (%)	96	96	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											
	N-M Block (T/4)											
				Bue turked on Fx Table								
Warming blkt												
Conv warmer												

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

RECOVERY AT 1050

PACU ICU ____ (Specify)

OTHER ____

CONDITION:

RESP- 22 SpO2- 95

BP- 124/61 HR- 94

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0755	0810	1055
PROC	Ready	Begin	End
	0825	0932	1045

PROCEDURES and CPT Codes:

ORIF Rt Fem Neck Fx

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

[redacted] 59 yo ♂ EPW

NKDA b(4)

Hx: HTN; ? cystic kidneys

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

RLD. Back prep Betadine x3. 24g Sprotte via 18g introd @ L3-4 space ∓ 1% Xylo infiltration. Clear CSF on 3rd pass, ∅ heme, ∅ paresth. 15mg hyperbaric bupivacaine & all needles removed

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

SURGEONS: Dr. [redacted]

ANESTHETISTS: [redacted] b(4)-2 [redacted] MAJ, CRNA

PROCEDURE LOCATION: 1

DATE: 12/15/03

PAGE 1 OF 1

[redacted] HESIA PROVIDER

DA FORM 7389, FEB 1998 — MEDCOM - 2439 — USAPA-V1.00

(2) SAB is 0820 (1)

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.
[redacted] b(6)-4					
	FILM NO.				PREGNANT ☐ YES ☐ NO
	REQUESTED BY *(Print)*				TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR				DATE REQUESTED

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

1) Multiple cystic lesions (6) in bilateral kidney: probable simple cysts — 3 were too small to characterize

2) (R) fem fx and hematoma

3) (R) psoas study [redacted] b(6)-2

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*

LOC[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

b(6)-2 All unless noted otherwise

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: 14 Dec 2003 TIME OF ORDER: 2112 HOURS

LIST TIME ORDER NOTED AND SIGN

- √ ATSOL ICW 1
- √ Dx: Femoral Neck Fx (R)
- √ NS q 8° WA
- √ Regular diet p fully awake (Hold)
- √ Ice to hip
- √ CBC, chem 7 in AM

PATIENT IDENTIFICATION

b(6)-4 [redacted]

14 Dec 03 (2345)

[redacted] ROOM NO. 9/1W BED NO.

DATE OF ORDER: 14 Dec 2003 TIME OF ORDER: 2112 HOURS

- √ IV LR 1000 cc @ 100 cc/h
- √ MSO4 2-5 mg IV q 30 p prn
- √ Phenergan 25 mg IM q 30 p prn N/V
- √ Percocet tabs 5/325 mg ii PO q 4° p prn
- error ~~Lovenox 40 mg + PO bid~~

[redacted]

PATIENT IDENTIFICATION

[redacted] b(6)-4

DATE OF ORDER: 14 Dec 2003 TIME OF ORDER: 2112

- √ NPO p MN
- √ Cx in AM

[redacted]

NURSING UNIT | ROOM NO. [redacted] 15 Dec 03 @ 0400

Chart

PATIENT IDENTIFICATION

b(6)-4 [redacted]

noted 16 Dec 03 [redacted]

DATE OF ORDER: 16 Dec 2003 TIME OF ORDER: 1230 HOURS

- √ 1. BSC for BRP
- √ 2. Side to side roll tid
- √ 3. up to chair BID
- √ 4. IS q 2° WA
- √ 5. Dressing [redacted] /bowel daily.
- 6. DC [redacted] 24°

NURSING UNIT | ROOM NO. | BED NO.

24° 17 Dec 03 @ 0100 [redacted]

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

b(6)-2 all except where otherwise noted

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4 [redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
15 Dec 2003	1110 HOURS	
✓ VS Per PACU then q4 WA		
✓ Tice to (R) hip		
✓ Regular diet as tolerated		
✓ Labs: CBC in am		
✓ Xrays: (R) hip, PA, lat		
(R) Elbow, PA, lat, oblique		

PATIENT IDENTIFICATION

15 Dec [redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
15 Dec 2003	1110 HOURS	
✓ IV LR @ 100cc/h		
✓ MSO4 - 2-5 mg IV q 3° PRN pain		
✓ Phenergan 25 mg IM q 3° PRN pain		
✓ Percocet 5/325 mg 1 po q 4° PRN pain		
✓ Lovenox 40 mg q 24 hr		

PATIENT IDENTIFICATION

No new orders [redacted] 16 Dec 03 @ 0300 [redacted]

b(6)-4 [redacted] 15 320 18 Dec 03

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
[redacted]	[redacted]	
18 Dec 03	1530 HOURS	
① Dry Drsg A to (R) hip incision Daily		
V.O. Dr [redacted]		

PATIENT IDENTIFICATION

24°V 19 Dec 0200 [redacted]

NURSING UNIT	ROOM NO.	BED NO.
24°V		

DATE OF ORDER	TIME OF ORDER	
Ø New Orders 20 Dec 03 @ 0100 [redacted]		
20 Dec 03	0330 HOURS	
① D/C Foley		
② DM Colax supp XT now		
V.O. Dr [redacted] Good Ball		

noted [redacted]

NURSING UNIT	ROOM NO.	BED NO.
24°V [redacted]		

21 Dec 03 0355

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

b(6)-2 ?? except where noted

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]		12/21/03 1605 HOURS	
	①	D/C Dry DSG & to Ⓡ thigh leave OTA. Dr. [redacted]	
NURSING UNIT [redacted] ROOM NO. BED NO.			
24° [redacted] 22DEC03 0435 [redacted]			
PATIENT IDENTIFICATION 23DEC0225 [redacted]		[redacted] ?, AN TIME OF ORDER	
b(6)-4 [redacted] noted 23DEC03 1540 [redacted]		23DEC03 1540 HOURS	
	①	D/C staples to Ⓡ hip/thigh wound tomorrow	
		V.O Dr [redacted] 2LT	
NURSING UNIT ROOM NO. BED NO.			
24°V 24Dec@0220 [redacted] AN			
PATIENT IDENTIFICATION		DATE OF ORDER / TIME OF ORDER	
b(6)-4 [redacted]		24DEC2003 1010 HOURS	
		DC to Camp	
		[redacted]	
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.

MEDCOM - 26443

b(6)-2 A11

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 12 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 14	15	16	17	18	19	20	21	22	23	24	25	26
14Dec	[redacted]	Skin & Wound	D	[redacted]	/	/	/	/	/	/	[redacted]	/	/	/	/	/
	[redacted]	assessment form														
14Dec	[redacted]	VS q4°	06	/	[redacted]											
			18	[redacted]												
14Dec	[redacted]	Regular Diet p fully	06	/	[redacted]											
	[redacted]	awake	18	[redacted]												
14Dec	[redacted]	Ice to hip	16	/	[redacted]											
			18	[redacted]												
15Dec	[redacted]	VS per PACU, then Q4 rad	06	/	[redacted]											
			18	/												
			06	/												
15Dec	[redacted]	Ice to (R) hip	06	/												
			18	/												
			06	/												
15Dec	[redacted]	Regular diet as tolerated	06	/												
			18	/												
			06	/												
16Dec	[redacted]	BSC for BRR	06	/	/											
			18	/	/											
			06	/	/											
16Dec	[redacted]	side to side roll	06													
		TID	18													
			06													
16Dec	[redacted]	Up to chair BID	06													
			18													
			06													
16Dec	[redacted]	IS q2° WA	06													
			18													
			06													
16Dec	[redacted]	Dsg Δ to (R) elbow daily	10	/	/	/										
18 Dec	[redacted]	Dry Dsg Δ to (R)	10	/	/	/	/									
		Hip incision Daily	X													

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: Femoral Neck Fx (R)

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(4)-2

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo ____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
14Dec	[redacted]	Admit to ICW #1	14Dec	—	—	[redacted]
14Dec	[redacted]	Regular diet p fully awake - HOLD	14Dec	—	—	[redacted]
14Dec	[redacted]	CBC, chem7 in AM	15Dec	0500	05	[redacted]
14Dec	[redacted]	NPO p MN	15Dec	0000	—	[redacted]
14Dec	[redacted]	Sx in AM	15Dec	AM	AM	[redacted]
15Dec	[redacted]	CBC in AM	16 Dec	AM	0530	[redacted]
15Dec	[redacted]	X-Ray (R) hip, PA, lat (R) elbow, PA lat	15 Dec	PM	PM	[redacted]
	[redacted]	oblique				
20Dec	[redacted]	D/C Foley	20 Dec	0930	0930	[redacted]
21	[redacted]	D/C dry dsg Δ to (R) thigh - leave OTA	21	—	—	[redacted]
23Dec	[redacted]	D/C staple to (R) thigh incision tomorrow	23Dec	1000	0900	[redacted]

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

b(6)-2

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 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
~~14Dec~~	[redacted]																
15 Dec	[redacted]	IV LR@ 100cc/°	06 18	[redacted]													
	----		18														
15Dec	[redacted]	lovenox 60mg BID	08														
	-----		20														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Femoral Neck Fx (R)

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 EXHAUS

b(6)-2 A11

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 12 Yr. 03
Order Date	Clerk/ [redacted]	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
14Dec	[redacted]	IV LR 1000cc @ 100cc/hr°	14Dec	—	—	[redacted]
20D[redacted]		Duleolax Supp x T now	20Dec			

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED														
14Dec. 15Dec	[redacted]	MSO4 2-5mg IV	D/T														
		q3° PRN Pain	D/I														
14Dec. 15Dec	[redacted]	Phenergan 25mg IM	D/T														
		q3° PRN N/V	D/I														
14Dec 15Dec	[redacted]	Percocet tabs 5/325mg	D/T	15Dec 2100	16Dec 0745	16Dec 1015	16Dec 1100	16Dec 0800	16Dec 0930	16Dec 1120							
		11 11 PO q4° for pain	D/I	1	11	2	11	11	11	2							

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

TIME	PROCEDURE	SIZE	SITE	BY	RESULTS
	ET Intubation		☐ Oral ☐ Nasal Teeth		☐ $ETCO_2$ Change ☐ BBS Post Int ☐ Post CXR
	Gastric Tube		☐ Oral ☐ Nasal		☐ Air ☐ Contents ☐ Verified_____ Suction: Y N
ON ARRIVAL	Urinary		☑ Meatus ☐ Supra-Public		☐ Return_____cc ☐ Heme Dip: + - ☐ Secured
	DPL		☐ Opened ☐ Closed		☐ Grossly: + - Cell count Sent@_____
	Chest Tube #1		L R		☐ Air ☐ Blood ☐ Pleuravac____cm ☐ Autotransfuser
	Chest Tube #2		L R		☐ Air ☐ Blood ☐ Pleuravac____cm ☐ Autotransfuser
	12 Lead	Rhythm:		Comments	

ABG SITE	TIME	$\%O_2$	pH	BE	pCO_2	PO_2	O_2 Sat	HCO_3
1)								
2)								

LABS

TIME	LABS
	☐ D-stick_____ ☐ SHct_____
	☐ D-stick_____ ☐ SHct_____
	☑ CBC ☑ Chem ☑ PT/PTT
	☐ ETOH ☐ T&S ☐ T&C x_____
	☐ Tox Screen
	☑ UA ☐ HCG
	☑ OTHER TYPE/SCREEN
	☐ OTHER

X-RAYS

TIME	LABS
	☑ Chest Initial
	☐ Chest Post ET
	☐ Chest Post CT
	☐ C-Spine
	☑ Pelvis
	☑ ABD
	☑ (E) HIP
	☐

TIME	PROCEDURE	ACCOMPANED BY	RETURN
	CT Scan: ☐ Contrast		
	☐ Head ☐ Abd ☐ Pelvis		
	☐ C-Spine ☐ T/L Spine ☐ Chest		
	☐		
	A-Gram Site:		

IV ACCESS & FLUIDS

TIME	#	GA	IAW SOP		SITE	IVF TYPE	AMT UP	AMT IN
ON ARRIVAL		18	Y	N	(R) A C			
			Y	N				
			Y	N				
			Y	N				

MEDICATIONS

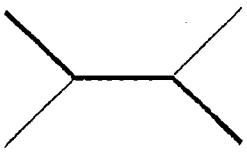
MEDICATION	TIME	DOSE	RTE	TIME	DOSE	RTE	TIME	DOSE	RTE

BLOOD PRODUCTS

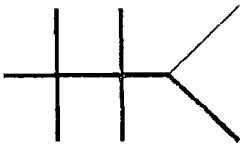
START	#	TYPE	UNIT#	AMT UP	AMT IN	END	INT

LAB RESULTS

CBC:



Chem:



INTAKE & OUTPUT

INTAKE	AMOUNT	OUTPUT	AMOUNT
IVF		Urine	
NGT		NGT	
Blood		EBL	
Other		Other	
TOTAL		TOTAL	

TRAUMA TEAM ARRIVAL

TITLE	NAME (Print)	PAGED	RESPONDED	ARRIVED
ED Phys	Dr. [redacted]			
Surgeon				
Anesth	Hoyt			
X-Ray				
RT				
Ortho				
Neuro				
Chaplain				

VALUABLES & CLOTHING

V	STATUS	C
	None Found	
	Given to Patient	
	Given to Family	
	Inventoried and Released to Patient Trust Fund/NCOO See DA Form 3696	
	Other: See Nursing Notes	

DISPOSITION

☐ Home ☐ _____

Admitted to_____

Report Called to_____

Time Transferred_____

Accompanied By_____

☐ Stretcher ☐ Wheelchair

Admission and Coding Information

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

1. Reporting MTF	2. MTF Locat.	3. Register Number	Name (Last, First, MI)	4. Pay Grade	5. Sex
[redacted] b(2)-2	IZ	[redacted] b(6)-4		FGN	M

6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
1943-07-01	60Y	X	9	

10. Length of Service	ETS	11. FMP	12. Social Security Number
		99	[redacted] b(6)-4

Organization (Active Duty Only)	13. Marital Status	Hour of Admission	Branch / Corps:
		21:07	

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	ICW2	Address of Emergency Addressee
Name and Location of Medical Treatment Facility: [redacted] b(2)-2		Telephone Number of Emergency Addressee

21. Type of Disposition	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD)
TRF-OTH		2003-12-24

24. Clinic Svc - Admitting	25. MTF Transferred From	26. Date this Admission (YYYYMMDD)
AEA - ORTHOPEDICS		2003-12-14

27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission
		2003-12-14

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: FEMOVAL NECK FX®

Procedure Narrative(s): T: 9 Dx: 8208 PR: 7935 E8889 Inj: 929

Cause of Injury Narrative:

[redacted] b(6)-2

...ture, as required) Signature of A[redacted] b(6)-2

...tf Cmr

BATES PAGES MEDCOM 26450-26911 ARE NONRESPONSIVE AND HAVE NOT BEEN PROVIDED

Automated Facsimile

IN-PATIENT 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] b(6)-4 | 3. Grade FGN | Admission Remarks

4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm
M	53Y	X				NO

11. FMP 99 | 12. SSN [redacted] | 13. Organization b(6)-4 | 14. Ward MORGUE

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

21. Source of Admission: Carded for Record Only (CRO)

22. Hour Of Adm: 01:40

23. Clinic Service: XXX - CARDED FOR RECORD

24. Name/Relation of Emergency Addressee

25. Type Disp: CRO/DOA

26. Date of Disp: 2003-12-26

27a. Address of Emergency Addressee

27b. Telephone No

28. Date This Adm: 2003-12-26

AdmittingOfficer: [redacted] b6-2

29. ReportingMTF [redacted] b(2)-2

30. Date Init Adm: 2003-12-26

32. Units Blood Components

31. Selected Administrative Data

Marital Status:

DoB: 1950-06-01

In/Out Patient: Inpatient

MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

CARDIAC ARREST

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	1	1

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	1	1

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

Signature of PAD or Medical [redacted]

Automated Facsimile - DA FORM 3647, May 79

Sept 3L IVF
2atr Narcan

AUTHORIZED FOR LOCAL REPRODUCTION

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

gasping respirat

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
DATE:	501ST FSB APO AE 09324 OPERATION IRAQI FREEDOM BAGHDAD multiple bruxi extremi
25 Dec 03 2323	patient brought in, pretty unresponsive, small moans, unconscious, pinpoint pupils used oxygen. Then bagged. bruising around pelvis. rashes
T	started IV (2327) can't hear breathing, performed CPR (2330)
B/P	giving epi (2333) 2mLs narcan (2335) % SpO_2 67 Pulse 125
P	2nd dose epi (2336) suction (2240) ~~rectal temp~~
R	2nd IV (neck 2342) 3rd dose epi (2342) NG going in foley (2355)
SPO2	~~rectal temp~~ SpO2 68% (2358) IM valium (2353)
ALLERGIES	Inhibated (2355) EPI (24:00) O_2 45% (24:00) Pulse (24:00)
	Temp 96° (24:00) pupils nonreactive
MEDICATIONS	rectal temp #2 2407 still below 96°F atropine .8mg (2400)
	bruising left lateral chest, upper extremities bruising
PMHX	left iliac crest abrasions on both wrists multiple bruises
	abrasions left lower extremities ziptie removed from
	right lower extremities, % SpO_2 81% pulse 62 (0014)
PSHX	% SpO_2 82, pulse 73 (2417) rectal temp (0025)
	temp not going up (94.1°F) rectal temp (hypothermic Therm)
	not registering, ~~[illegible]~~ stopped bagging, patient breathed
TOB	on his own (0033). ~~atropine .8mg~~ heart rate of 30 on own (0037)
	% SpO_2 83 heart 73 - compressions 4th dose epi (0040)
	atropine 1mg (0042) stopped at (0045) drew breath continued (0046)
	Urine output (100cc) (0049)

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
501ST FSB BATTALION AID STATION			
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.)* blu) -2

REGISTER NO. | WARD NO.

NAME [redacted] DOB

SSN Det # [redacted] RANK

UNIT Local National (Detainee)

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

MEDCOM - 26913

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
DATE:	501ST FSB APO AE 09324 OPERATION IRAQI FREEDOM BAGHDAD b(2)-2
T	Iraqi detainee brought to [redacted] Detention
B/P	Center this pm ~2000 p detained @ 2/3X
P	~2d. Brought to BAS ~2320, noted to have
R	agonal resp, agonal heart rhythm, unresponsive. CPR started, pt intubated
SPO2	IV started. Pt noted to be extremely
ALLERGIES	cold, warmer placed below pt, blankets on.
	Pt given total 5 doses epi, 2 doses atropine.
MEDICATIONS	Pt init noted to have p inpt pupil on (L),
	unresp. on (R), pt given Narcan 1 amp
PMHX	c Ø response. Pt c Ø sig response to meds
	noted - CPR ~~stop~~ [redacted] continued. Rescuse stopped
PSHX	several times, pt noted to have continued
	agonal resp. Temp remained <92°
	despite available warming measures
TOB	D/w D[redacted] @ [redacted] (0,1) b(4)-2
	have pt via AIREVAC.
	[redacted] b(4)-2
	Sep1
	Zatropine
	2L IVF
	Narcan b(4)-2
	MD
	CPT, MC

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
[redacted] b(4)-2			
SPONSOR'S NAME [redacted]	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* [redacted]

REGISTER NO. | WARD NO.

NAME [redacted] DOB b(4)-4

SSN _____ RANK _____

UNIT Detainee

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

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: **TRAUMA FLOWSHEET**
The proponent is Dept of Surgery

OTSG APPROVED (Date): QI Appr 11 Jun 97

EMS REPORT

TIME: 0145 ETA: _____ UNIT: _____

MED COM: [Y] [N]

ARRIVAL STATUS

TIME 0145 ☐ IV x NS ☐ O_2 _____ 1/min ☐ C-Spine Immob

Meds: ☐ UKN ☐ None ☐ Yes: _____

Allergies: ☒ UKN ☐ None ☐ Yes: _____

Tetanus: ☐ UKN ☐ Current Last Meal/Fluid Intake _____ hrs

LMP: [redacted] ☐ _____

77 [redacted] O_2 saturation No carotid pulse by Dr [redacted]

b(6)-2

PRIMARY SURVEY

AIRWAY

☐ Natural Patient [Y] [N]

ETT 8.0 ☐ 25 @ 1.0

☐ Secretions _____

BRETHING

☐ Labored ☐ Unlabored ☒ Absent

TRACHEA: ☐ Midline ☐ Deviated [L] [R]

CHEST SYMMETRY: [L] > = < [R]

CIRCULATION

PULSE: ☐ Present ☒ Absent no carotid

BLEEDING: [Y] [N]

HEART TONES: ☐ Clear ☐ Muffled

SKIN: ☐ Warm ☒ Cool ☐ Hot

☐ Pink ☐ Pale ☒ Cyanotic ☐ _____

☐ Dry ☐ Moist ☐ Diaphoretic

SECONDARY SURVEY

DISABILITY

GCS: E 1

V 1

M 1

SPHINCTER TONE:
☐ WNL
☐ None

HEAD

PUPILS: ☐ Equal ☒ Fixed ☐ React ☐ Dilated [L] [R]

TM: ☐ Clear ☐ Blood [L] [R]

NECK

C-Spine Tenderness: [Y] [N]

Pain @ _____

JVD: [Y] [N]

HEART

RHYTHM: ☐ Regular ☒ Irregular

PULSES: ☐ Central ☐ Peripheral

LUNGS

BREATH SOUNDS: ☐ Bilat ☒ Equal ☐ Clear

Decreased [L] [R] Absent [L] [R]

Wheezes [L] [R] Crackles [L] [R]

ABDOMEN

☒ Soft ☐ Rigid ☐ Non-Tender

☐ Tender: _____

PELVIS

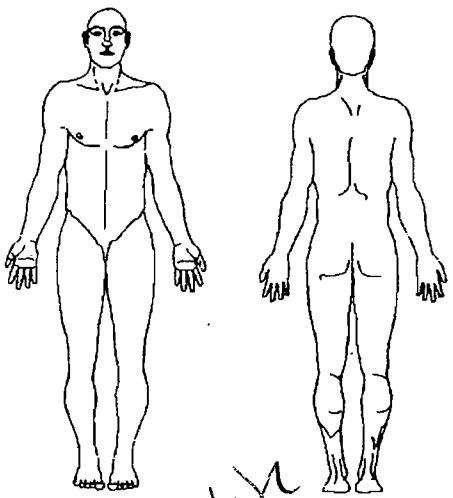
☒ Stable ☐ Unstable ☐ _____

Blood at meatus/vagina: [Y] [N]

Heme+/- Prostate: ☐ WNL ☐ Abnl

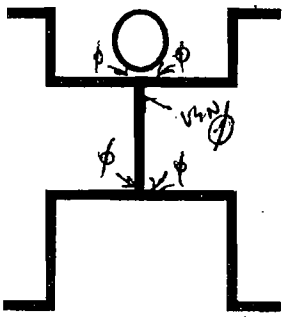
USE DIAGRAM TO DOCUMENT INJURIES AND PAIN

(AB)rasion
(AMP)utation
(AV)ulsion
Battle's Signs
(BL)eeding
(B)urn
(D)eformity
(E)cchymosis
(F)oreign Body
(H)ematoma
(LAC)eration
(P)uncture (W)ound
(Pain)
(S)eatbelt (S)ign
(S)tab (W)ound
(GSW) Gun Shot Wound



b(6)

VASCULAR ASSESSMENT



++ Strong	+ Palpable	D Doppler

RN: [redacted]

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

PREPARED BY (Sig[redacted]

DEPARTMENT/SERVICE/CLINIC: Emg

DATE: 20 Dec 03

PATIENT'S IDENTIFICAT[redacted] (Type or print. Where entries give: Name--last, first, middle; grade; date; hospital or medical facility)

EPW[redacted]

b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

TIME	PROCEDURE	SIZE	SITE	BY	RESULTS
Around 8	ET Intubation	7.0	☑ Oral ☐ Nasal Teeth	[redacted]	☐ $ETCO_2$ Change ☑ BBS Post Int ☐ Post CXR
Around 8	Gastric Tube	18	☐ Oral ☑ Nasal	[redacted]	☐ Air ☑ Contents ☐ Verified____ Suction: Y (N)
Around 8	Urinary	16	☑ Meatus ☐ Supra-Public	[redacted]	☐ Return 200 cc ☐ Heme Dip: + - ☑ Secured
	DPL		☐ Opened ☐ Closed		☐ Grossly: + - Cell count Sent@____
	Chest Tube #1		L R		☐ Air ☐ Blood ☐ Pleuravac____cm ☐ Autotransfuser
	Chest Tube #2		L R		☐ Air ☐ Blood ☐ Pleuravac____cm ☐ Autotransfuser
	12 Lead	Rhythm:		Comments	

ABG SITE	TIME	$\%O_2$	pH	BE	pCO_2	PO_2	O_2 Sat	HCO_3
1)								
2)								

LABS

TIME	LABS
	☐ D-stick_____ ☐ SHct_____
	☐ D-stick_____ ☐ SHct_____
	☐ CBC ☐ Chem ☐ PT/PTT
	☐ ETOH ☐ T&S ☐ T&C x_____
	☐ Tox Screen
	☐ UA ☐ HCG
	☐ OTHER
	☐ OTHER

X-RAYS

TIME	LABS
	☐ Chest Initial
	☐ Chest Post ET
	☐ Chest Post CT
	☐ C-Spine
	☐ Pelvis
	☐
	☐
	☐

TIME	PROCEDURE	ACCOMPANED BY	RETURN
	CT Scan: ☐ Contrast		
	☐ Head ☐ Abd ☐ Pelvis		
	☐ C-Spine ☐ T/L Spine ☐ Chest		
	☐		
	A-Gram Site:		

IV ACCESS & FLUIDS

TIME	#	GA	IAW	SOP	SITE	IVF TYPE	AMT UP	AMT IN
Around 8	[redacted]	18	Y	N	L AC	NS	200	~ 500
			Y	N				
			Y	N				
			Y	N				

MEDICATIONS

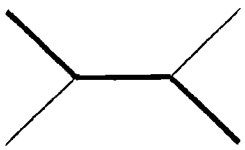
MEDICATION	TIME	DOSE	RTE	TIME	DOSE	RTE	TIME	DOSE	RTE
Tocomyl [redacted]									
Fentanyl	0155	100mg	IV						
Versed	0200	5mg	IV						

BLOOD PRODUCTS

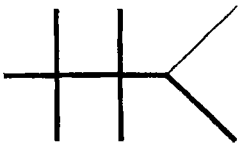
START	#	TYPE	UNIT#	AMT UP	AMT IN	END	INIT

LAB RESULTS

CBC:



Chem:



INTAKE & OUTPUT

INTAKE	AMOUNT	OUTPUT	AMOUNT
IVF		Urine	
NGT		NGT	
Blood		EBL	
Other		Other	
TOTAL		TOTAL	

TRAUMA TEAM ARRIVAL

TITLE	NAME (Print)	PAGED	RESPONDED	ARRIVED
ED Phys				
Surgeon				
Anesth				
X-Ray				
RT				
Ortho				
Neuro				
Chaplain				

VALUABLES & CLOTHING

V	STATUS	C
	None Found	
	Given to Patient	
	Given to Family	
	Inventoried and Released to Patient Trust Fund/NCOD See DA Form 3696	
	Other: See Nursing Notes	

DISPOSITION

☐ Home ☐ _____

Admitted to _____

Report Called to _____

Time Transferred _____

Accompanied By _____

Via: ☐ Stretcher ☐ Wheelchair

VITAL SIGNS

Rectal Temp:

TIME	BP	HR	RHY	RR	SAO_2	FIO_2	MODE	GCS: E	V	M	T
0145	90/81	26		6	77%			1	1	1	3
0158	/										
0215	UTA	Called									
	/										
	/										
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GLASGOW COMA SCALE

EYE OPENING	VERBLE RESPONSE	MOTOR RESPONSE
4 - Spontaneous	5 - Oriented	6 - Obeys Commands
3 - To Voice	4 - Confused	5 - Localizes Pain
2 - To Pain	3 - Inapp Words	4 - Withdraws to Pain
1 - None	2 - Incomp Speech	3 - Flexion to Pain
	1 - None	2 - Extension to Pain
		1 - None

TIME	PROCEDURE	PERFORMED BY:
	☐ Backboard Removed	BY:
	☐ Downgraded	BY:

NOTES

Prior to arrival pt recd 5 epinephrine, 2 atropine injections. Also, ↑ Narcan + value of vital quantity.
CT performed. ∅ obvious deficits

To EMT via litter from 501st FSB. See SF 600 from FSB.
Intubated on arrival. 9 V NS Lt [redacted] on arrival.
5mg Versed 100 Fentanyl at 0153 by CPT [redacted]
RT SGT [redacted] bagging pt. Pupils dilated on arrival. b(6)-2
To CT for CT head 0156. [redacted] TC, MN

EPW - Found down at ≈ 2300 to [illegible]. pt Brought to
501 FSB - No pulse, unresponsive, GCS (3) pinpoint pupils.
Intubated - Resuscitated until 0100 c̄ no response but still
ō ≈ 6 Breaths Per minute. Aerowed head.
pt GCS 3T on arrival c̄ Intubated (R) pupil Fixed & Dilated. CT scan gathers - ø Blood Found. Pt no longer Breathing. Code called @ 0215. ØHR/ø pulse/ø Br
ø Respiration.

[redacted] NO

2265

b(6)-2

CERTIFICATE OF DEATH *(OVERSEAS)*
Acte de décès *(D'Outre-Mer)*

b(6)-4

NAM	[redacted]	GRADE Grade: EPW	BRANCH OF SERVICE Arme: ~~EP~~ N/A	SOCIAL SECURITY NUMBER (Numéro de l'Assurance Sociale): [redacted]
ORG	on	NATION *(e.g., United States)* Pays	DATE OF BIRTH Date de naissance	SEX Sexe: ☒ MALE Masculin ☐ FEMALE Féminin

Race	MARITAL STATUS État Civil		RELIGION Culte	
que	☐ SINGLE Célibataire	☐ DIVORCED Divorcé	☐ PROTESTANT Protestant	OTHER *(Specify)* Autre *(Spécifier)*
	☐ MARRIED Marié	☐ SEPARATED Séparé	☐ CATHOLIC Catholique	
RAQI	☐ WIDOWED Veuf		☐ JEWISH Juif	

NAM om du plus proche parent	RELATIONSHIP TO DECEASED Parenté du décédé avec le susdit
STR é à (Rue)	CITY OF TOWN AND STATE *(Include ZIP Code)* Ville (Code postal compris)

MEDICAL STATEMENT Declaration médicale

CAUSE OF DEATH *(Enter only one cause per line)* Cause du décès (N'indiquer qu'une cause par ligne)		INTERVAL BETWEEN ONSET AND DEATH Intervalle entre l'attaque et le décès
DIS Ma ECTLY LEADING TO DEATH[1] ent responsable de la mort.	CARDIAC Arrest Unknown Etiology	Unknown.
ORBID CONDITION, IF ANY, EADING TO PRIMARY CAUSE condition morbide, s'il y a lieu, nant à la cause primaire		
NDERLYING CAUSE, IF ANY, IVING RISE TO PRIMARY AUSE aison fondamentale, s'il y a lieu, ant suscité la cause primaire		
OT Au TIONS[2] s[2]		

TOPSY PERFORMED Autopsie effectuée ☐ YES Oui ☐ NO Non	CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES Circonstances de la mort suscitées par des causes extérieures
JOR FINDINGS OF AUTOPSY Conclusions principales de l'autopsie	
ME OF PATHOLOGIST Nom du pathologiste	
NATURE Signature / DATE Date	AVIATION ACCIDENT Accident à Avion ☐ YES Oui ☐ NO Non
DA Da *(month, year)* *, le mois, l'année)* / PLACE OF DEATH Lieu de décès	

EIWED THE REMAINS OF THE DECEASED AND DEATH OCCURRED AT THE TIME INDICATED AND FROM THE CAUSES AS STATED ABOVE.
examiné les restes mortels du défunt et je conclus que le décès est survenu à l'heure indiquée et à, la suite des causes énumérées ci dessus

N Nom du médecin militaire ou du médecin sanitaire	TITLE OR DEGREE Titre ou diplômé
G INSTALLATION OR ADDRESS Installation ou adresse: [redacted] b(6)-2	
D 3 SIG [redacted]	

complication which caused death, but not mode of dying such as heart failure, etc.
ding to the death, but not related to the disease or condition causing death.
maladie, de la blessure ou de la complication qui a contribué à la mort, mais non la manière de mourir, telle qu'un arrêt du coeur, etc.
a contribué à la mort, mais n'ayant aucun rapport avec la maladie ou la condition qui a provoqué la mort.

FOR USE OF T

SPITAL REPORT OF DEATH

40400; THE PROPONENT AGENCY IS OFFICE OF THE SURGEON GENERAL.

NAME AND LOCATION OF HOSPITAL

Instructions - Medical Officer in attendance will:

Prepare, Print or t, only, Items 1 through 10 and sign Item 11. Send form, without delay to the Registrar or Administrative Officer of the Day, for necessary action and for preparation of required number of copies.

SECTION A - ATTENDING MEDICAL OFFICER'S REPORT

PERSONAL DATA

1. PATIE *identifying* *tient's ward plate will be used to imprint able)*

[redacted]

Patient's n Social Sec *irst, middle initial) Grade, No., Register Number and Ward Number*

2. TIME OF DEATH *(Hour-day-month-year)*

0215 26 Dec 03

3. MEDICAL EXAMINER/ CORONER'S CASE ☐ YES ☒ NO

4. RELIGION

5. CHAPLAIN NOTIFIED ☐ YES ☐ NO

6. NAME, ADDRESS AND RELATIONSHIP OF RELATIVE OR FRIEND PRESENT AT DEATH

CAUSE OF DEATH

			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7a. DISEASE DEATH *(This heart failure, or complicati*	*N DIRECTLY LEADING TO the mode of dying, e.g., means the disease, injury, death)*	DUE TO *(or as a consequence of)* CARDIAC Arrest unknown Etiology	UNKNOWN
7b. ANTECE *giving rise to condition las:*	*rbid conditions, if any, sting the underlying*	DUE TO *(or as a consequence of)* (1) CARDIAC Arrest unknown Etiology	unknown.
		(2)	
8. OTHER S TO THE DEA OR CONDITIC	*DITIONS CONTRIBUTING ELATED TO THE DISEASE*	a.	
		b.	

9. DATE	10. TYPED OR PRINTED NAME AND GRADE OF MEDICAL OFFICER IN ATTENDANCE	11. SIGNATURE OF MEDIC
26 De	[redacted] b(6):2 O-4	[redacted]

SECTION B - ADMINISTRATIVE ACTION

	PE OF ACTION	HOUR	DAY	MONTH	YEAR	INITIALS OF RESPONSIBLE OFFICER
12. TELEGRA	N OR OTHER AUTHORIZED PERSON					
13. POST AD	L NOTIFIED					
14. IMMEDIA	SED NOTIFIED					
15. INFORMA	IFIED					
16. POST MO	NOTIFIED					
17. RED CRO						
18. OTHER *(Sp*						
19.						

SECTION C - RECORD OF AUTOPSY

20. AUTOPSY	*es, give date and place)*	21. AUTOPSY ORDERED BY *(Signature)*
☐ YES		

22. PROVISI *AL FINDINGS*

23. DATE	24. TYPED NAME AND GRADE OF PHYSICIAN PERFORMING AUTOPSY	25. SIGNATURE OF PHYSICIAN PERFORMING AUTOPSY
26. DATE	27. TYPED NAME AND GRADE OF REGISTRAR	28. SIGNATURE OF REGISTRAR

[redacted] b(2)-2 IZ

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

3. Register Number	Name (Last, First, MI)	4. Pay Grade	5. Sex
[redacted]	b(4)-4	FGN	M

6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
1950-06-01	53Y	X	9	

10. Length of Service	ETS	11. FMP	12. Social Security Number
		99	000-00-1640

Organization (Active Duty Only)	13. Marital Status	Hour of Admission	Branch / Corps:
	Z	01:40	

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
Carded for Record Only (CRO)	MORGUE	Address of Emergency Addressee
Name and Location of Medical Treatment Facility: [redacted] b(2)-7		Telephone Number of Emergency Addressee

21. Type of Disposition	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD)
CRO/DOA		2003-12-26

24. Clinic Svc - Admitting	25. MTF Transferred From	26. Date this Admission (YYYYMMDD)
XXX - CARDED FOR RECORD ONLY		2003-12-26

27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission
		2003-12-26

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: CARDIAC ARREST

Dx: 4275 92410 9221 9139 92321 9928

Trauma 9

Injury 989

427.5 924.8

Procedure Narrative(s):

Px 9960 966

Cause of death #1

Cause of Injury Narrative:

Admitting Officer [redacted] b(4)-4

Signature of Admitting Clerk [redacted] b(4)-2

Automated Facsimile - DA FORM 2985, MAR 2000

BATES PAGES MEDCOM 26922-27240 ARE NONRESPONSIVE AND HAVE NOT BEEN PROVIDED

b(6)-4

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NO. [redacted]			NAME (Last, First, MI) EPW # [redacted]			3. GRADE EPW	ADMISSION REMARKS
4. M	60	UNK	7. RELIGION UNK	8. LENGTH OF SVC —	9. ETS —	10. PREVIOUS ADMISSION N	
11. FMP 99	12. [redacted]			13. ORGANIZATION b(6)-4		14. WARD ICU	
15. FLYING STATUS —	16. RATING/ DSG —	17. DEPT/ BEN K70		BRANCH/CORPS —	19. UIC/ZIP —	20. TYPE CASE NBI	

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: direct from ER	22. HOURS OF ADMISSION: 0050	23. CLINIC SERVICE: ABMA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: UNK	25. TYPE DISPOSITION: 50	26. DATE OF DISPOSITION: 9 JUL 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK	27b. TELEPHONE NO.: UNK	28. DATE OF THIS ADMISSION: 5 JUL 03	ADMITTING OFFICER b(6)-2 [redacted]
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b(2)-2		30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA [redacted]

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

2° burns, @ buttocks, chest pain

786.50

942.24

E 924.8

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	4	4

36. Total Days All Facilites [redacted] b(6)-2

a. ABSENT SICK DAYS	b. [redacted]	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS [redacted]	e. BED DAYS b(6)-1	f. TOTAL SICK DAYS

SIGNATURE OF [redacted]

MEDCOM [redacted]

2-77(1)

MEDICAL RECORD	b2-2 ABBREVIATED MEDICAL RECORD

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

60 ish ♂ Iraqi evac'd to [redacted] c̄ ① Buttocks 2° Burns. 2° to seating a hot surface
② Chest Pain. "Squeezing" since ≈1300 today. Ø n/v was given ASA @ aid station. Had 5 sec of ® sided pain while in IR.
UIR c̄ tonsectomy

Pmhx
- MI 3 mos ago
- MI years ago
Cardiac Arrest c̄ MI 2002 c̄ cath & stent.
- "Weak heart" by echo.
h/o Anxiety

Meds
- ASA 81 mg
- ? Cardiac Rx

NKDA

PHYSICAL EXAMINATION 11/68 Morbidly obese, AAO x 3, speaking easily.
lungs = CTA ®
Chest = non reproducible on ①; reproducible on ② Ø JVD
♡ = distant heart sounds
ABD = Soft Non tender, obese, soft
Buttocks =
2nd burn, red Ø vesicles Ø D/C areas preserved.
Sxtr = Ø edema in ankles

ECG = 1° AV block. Ø morphology
CXR = Ø effusions. nl.
128 | 106, 14 / 4.1 | 21 | 0.9 (82 CK 109
PT/PTT =

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

- Td given
- Silversulfadiazine applied
- IVF
- Admit to R/O.

- Burns 2° = 1-2% = burn care.
- Chest Pain = R/O MI
nl Ecg ≅ 1° AV block
nl CK 12° ↑ pain started

b(6)-2

SIGNATURE OF PHYSICIAN [redacted]	DATE 5 July 03	IDENTIFICATION NO.	ORGANIZATION

PATIENT'S IDENTIFICATION [redacted] *(Written entries give Name last, first, rank; date; hospital or medical facility)*	REGISTER NO.	WARD NO.

[redacted]
b(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

b(6)-2

NOTES

09 Jul 1120 Pt Lying in bed & sleeping, Appears to be resting Comfortably @ this time. Will continue to Monitor. — [redacted] /WMG

1215 Pt complained of CP. Placed on 2L NC, BP taken, & EKG obtained. DR [redacted] Notified & gave V.O. for 2mg MSO4. 2mg MSO4 given, Will continue to Monitor. — [redacted] /WMG

1345 Pt Lying in bed sleeping & appears to be resting Comfortably @ this time. Will continue to Monitor. — [redacted] /WMG

1600 Pt Lying in bed sleeping & appears to be resting Comfortably @ this time. Will continue to Monitor. [redacted] /WMG

1700 Report given to Night shift. — [redacted] /WMG

1730 Report recieved from SPC [redacted]. pt VSS no significant Changes in pt condition. pt currently lying in bed, no c/o pain or discomfort. — [redacted] /WMG

2400 Pt sleeping comfortably in bed. VSS, afebrile Ø c/o SOB or Chest pain. VOP adequate. Will continue to monitor — [redacted]

10 July, 0500 Received report & Assumed care of Pt. VSS, Pt sleeping in bed & Appears to be resting Comfortably @ this time. Will Monitor. — [redacted] /WMG

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

SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

#[redacted]

b(6)

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCT

:AL RECORD | PROGRESS NOTES

:E	NOTES b(6)-2
10 July 0800	Pt ↑ OOB to BSC. Ambulated from bed to BSC [redacted] minimal assisstance. Ø Ntd complaint @ this time. — [redacted]
1055	Pt sitting ↑ in bed @ this time. VSS. Ø complaints Ntd. Will Monitor. — [redacted] A(W)M
1300	Pt Lying in bed sleeping + appears to [redacted] comfortably @ this time. Will Monitor. — [redacted] VMG

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

SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCT

:AL RECORD | D/C Summary. PROGRESS NOTES

'E | NOTES

10 July 03 | 58 yo Iraqi ♂ admitted 5 July c̄ ① CP
② Buttock 2° burn (2%)

Pt. has a significant Cardiac Hx (MI 3 mos ago, stent/cath 2001)
"Squeezing" for ≈ 8 hrs before presentation.
No CP in ER. ECG = nl; had neg CK & other labs.
1° AV block.

R/O'd by CK x2 40°. Did have Chest pain twice while in the ICU. Both ~~reason~~ resolved SNTG & c̄ time. EGG's were nl (not even 1° AV block). Was tx'd c̄ Zantac during stay. BP's improved to 110/60's

Burns tx'd c̄ Silvadene & Dsg. Δ's. Burns resolved. Burns were reported to Headquarters as suspicious for forced burns during questioning.

(A) 2%. 2° burns to buttocks. (* nice patient)
Chest pain. R/O'd CK; ? GERD / Anxiety
CAD
(B) - NTG PRN CP D/C to Cardiac.
Zantac / Tylenol

b(6)-2

[redacted]

SHIP TO SPONSOR | LAST | FIRST | MI | SPONSOR'S ID NUMBER (SSN or Other)

SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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

DD FORM 1 NOV 71 1289
DOD PRESCRIPTION

FOR (Full name, address & phone number.) (If under 12 years, give age.)

[redacted] b(6)-4 (DLC Meds)

MEDICAL FACILITY | DATE 5 July 03

℞ Gm. or ml.

Percocet I–II tabs
po q 4-6° PRN pain
~~Heat~~ #12

[redacted]

MFGR: | EXP DATE:
LOT NO: | FILLED BY: [redacted] b(6)-2

℞ NUMBER | SIGN[redacted]RANK AND DEGREE

EDITION OF 1 JAN 60 M[redacted]ED.

Medcom 27246

DD FORM 1 NOV 71 128[redacted]
DOD PRESCRIPTIO[redacted]

FOR (Full name, address & phone number.) (If under 12 years, give age.)

[redacted] b(6)-4 (DLC Meds)

MEDICAL FACILITY | DATE 5 July 03

℞ Gm. or ml.

Zantac 150mg I po
BID #30

Tylenol 325mg II po q 4°
PRN pain #20

ASA 81mg I po qd #30

[redacted] b(6)-2

MFGR: | EXP DATE:
LOT NO: | FILLED BY:

℞ NUMBER | SIGN[redacted]RANK AND DEGREE

EDITION OF 1 JAN 60 MAY BE USED.

NSN 7540-00-634-4178 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	D/C Summary
	58yo Iraqi ♂ presents c̄ 1) 2° burns to the buttocks p̄ sitting
D/C meds	on a hot surface. Cleansed. silvadiazine, Td given)
	2) Chest Pain x 10 hrs. Pt. has
ASA 81mg qd	a significant Cardiac hx to include 3 mos ago MI,
Zantac 150mg BID	MI 2001 c̄ stent/cath/Echo w/ low EF. CRF (Tob+, MI+, FHX)
Tylenol PRN	Pt. had low Asymptomatic BP (90's systolic). No NTG given.
Percocet	Pain comes & goes @ rest. ∅ leg edema ∅ Failure. nl Pulse OXS
	CK's nl 109/164/164/
	Lovenox given, ASA, EKG nl (1° AV block on admission); CXR = nl
	(A) 2° Burn Buttocks: Wound care performed.
	Chest Pain = R/o'd by CK (no troponins here); no EKG Δ's. Although
	pt. has a significant hx/risk. CP atypical @ this presentation. Started Zantac

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

[redacted]

b/w-4

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

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

MEDCOM - 27247

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
05 July 0055 male, ♂ burn	60 year old ♂ ICIV vs. EPW admitted to ICU3 from the ER c̄ diagnosis of 2° burns to the buttocks and chest pain. Hx of MI, 3 mos ago and a year ago c̄ cardiac cath and stent placement. Pt alert + awake, do speak or understand English. Buttocks burn area debrided and dressed c̄ silvadene cream. See flow sheets + assessment data for other pertinent information
	VS: 98.9 - 78 - 12 - 112/65, sat 95 @ RA. In NAD middly obese.
	b(6) 2 [redacted] Maj/AN
05 July 03 0300	Pt restless c/o pain to the burn buttocks, redressed earlier + was medicated c̄ MSO4 @0100 c̄ 2 mg + 2 mg @0200 c̄ any sustained effect. At 1430 asked for more given 2 mg additional c̄ any result. Gave another MSO4 2 mg at this time. Monitor pain level in an hour. b(6) 2 [redacted] Maj/AN
0330	Pt up to the BSC, had BM large loose stool. Pt had been medicated up to MSO4 10 mg IVP up to this time for c/o severe pain to the buttocks, dressing applied X3 pt continue to loose them or intentionally remove tape to remove dressing. Has not voided in the urinal. Must have voided c̄ having BM [redacted] Maj/AN b(6) 2

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

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

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

b(6)-2 AM

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
5 Jul 03 0656	Nursing: VSS, Ø pain, Ø SOB, Ø N/V. Pt sleeping quietly. Receiving NS @ 150cc/hr. Ø s/s of infection from IV site. Chem 8 drawn + sent to ~~lab~~ PRP 0659 lab. Will continue to monitor. [redacted] b(6)-1
5 July	HA+1 CP / Burn / ↓ Na^+
	CK 109 / 164 / 164 $\frac{125}{38}$ $\frac{103}{32}$ $\frac{13}{0.5}$ 75 nl Tamina.
	little CP pain / ↑ Buttocks. pain. rest while, No CP.
	[redacted] Lovenox ASA Zantac IVF Colace
5 Jul 03 0900	Nursing: Pt c/o pain from burns in buttocks area. Pt given 2mg HSO4 IV @ 0808. Medication effective. Ø CP or SOB, ~~w/ Resting~~ Resting, 5 pain. [redacted]
5 Jul 03 1350	Nursing: Dressing change completed on buttocks (B). Skin beefy red 5 [redacted] 1335 s/s of infection. Silvadene cream applied. Given 4mg HSO4 IV total during dressing change. Pt c/o midsternal chest pain described as squeezing pain [redacted] 1337 during dressing change. Dr. Wynn notified. ECG completed, pt placed on O2 2L NC. Ø SOB, ~~Ø diaphoresis~~ [redacted] 1338 Ø diaphoresis, Ø N/V. Ø ECG Δs noted. 2nd set of CK negative. Pt given 30cc Maalox and first dose of Lovenox, Zantac, and Colace. Pt in + out of sleep. No distress noted. Pt assessed by Dr. [redacted] Will continue to monitor. [redacted]
5 Jul 03 1700	Nursing: VSS. Pt denies any CP, SOB, [redacted] sitting up on edge of bed eating dinner. [redacted]

STANDARD FORM 600 (REV. 6-97) BACK

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

b(6)-2 A11

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
5Jul03	Received Report from Day Shift. Pt appears
1700	to be resting comfortably in Bed IV to
	OAC ~~@~~ c̄ NS @ 150cc/hr. Will continue
	pain management [redacted] SPC, 91WM6.
1800	Drew chem 8, Pt tolerated procedure
	well. VSS, Will continue to monitor closely
2000	Pt resting in bed. Continue pain
	management Will continue to
	monitor [redacted] SPC, 91WM6 —
2200	Dressing complete. Pt tolerated
	procedure well. Premedicated c̄
	percocet II tab VSS Will continue to
	monitor — [redacted] SPC, 91WM6 —
2400	Pt appears to be resting comfortably VSS,
	Pt off O2, SATS WNL. Continue pain
	management, Will continue to monitor closely
0200	Pt appears to be sleeping comfortably
	VSS. Will continue to monitor [redacted] SPC, 91WM6
0400	Pt appears to be sleeping peacefully. VSS
	Will continue to monitor [redacted]
1700	Reported off to on coming shift [redacted]

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

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

EPW [redacted]

b(6)-4

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

b(4)-2 A11

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6 Jun 03 0830	Nursing: Pt ate 85% of breakfast. VSS. Pt denies any CP, SOB, N/V. Resting quietly @ this time. [redacted]
6 Jun 03 1015	Nursing: Pt c/o SOB. Sats 95% on RA, RR-25. HOB↑45° and placed on 2L NC. Sats 98% and RR-20. Breathing more 1020 regular. Pt denies CP. Pt sleeping [redacted]
6 Jun 03 1345	Nursing: Dressing change to buttocks completed. Skin beefy red ⊼ exudate or foul odor. Silvadene cream applied. Received 2 tabs Percocet for premedication and 1mg MSO4 IV during dressing change. Tolerated procedure well. ØCP, Ø SOB. Ate 90% of lunch. Voiding ⊼ difficulty. [redacted]
6 Jul 03 1700	Received Report from day shift. Pt appears to be resting comfortably in Bed. VSS. Will continue to monitor - Rosanne Lazel, SPC, 91WM6 -
2100	Pt appears to be resting comfortably in bed, VSS, Dressing & complete area looks red & beefy. Will continue to monitor [redacted]
2400	Pt pulled out IV. Replaced ⊼ 20G to ⓛ wrist. IV ⊕ Flush ⊼ NS @ 15Dcc/hr. Pt tolerated procedure well, will continue to monitor hourly [redacted]
7 Jul 03 0400	Pt appears to be sleeping [redacted] Will continue to monitor. VSS - [redacted] SPC 91WM
0500	Reported off to oncoming shift - [redacted]
07 July 03 @ 0700	report received from Spc Rand' pt VSS NO complaints @ present pt resting in bed ⊼ s/s of distress noted will continue to monitor [redacted]

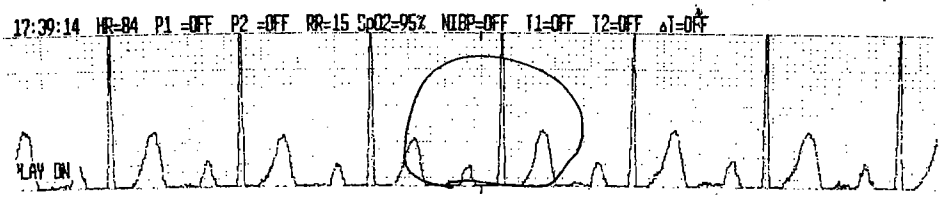
STANDARD FORM 600 (REV. 6-97) BACK

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

b(6)-2 #1

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
07 Jul 03 1000	Initial assessment completed earlier. Dressing to buttocks changed. Skin to buttocks red with dead tissue removed at the border of the burn. Buttocks healing with no signs of infection. Moy given a dressing Δ: Sits at bedside making it hard to keep dressing on. Silverdene applied to burn & reinforced. IVF infusing as ordered. ↑ uop. v.s.s. Ø CP. Cont. to monitor. Plan: Dressing Δ's, pain management [redacted] c/n
7 July (1715)	Pt care. Rep A Receives from LTC [redacted] PFC [redacted] Pt Resting Awake in Bed c̄ distress noted/ Reposted. — [redacted]
PR .22 QRS .04 QT .40	
7 July (1800)	Pt ↑ in chair @ Bedside to eat dinner. Transfers independently c̄ staff @ hand. Back to Bed @ 1840. — [redacted] Glume
7 July (2000)	Dressing Δ to Bilat gluteus per RC. Wound pink, moist c̄ ~~some~~ minimal bleeding c̄ hibiclens scrub. 1x1 Blisters scattered at edge of wound lancet & skin trimmed c̄ adverse effects noted. Pt resting Quiet c̄ care. — [redacted] Glume

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

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

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

b(6)-2 All

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
(2050 7July)	Percocet tab ii po, ambien 10mg given for c/o Buttock discomfort & Requests pt ambien for sleep. Pt resting quietly & Cooperative. [redacted] Glumb
7July 03 (LE 1900)	Pt tearful & relating than another English Speaking pt his Request for [redacted] assistance in contacting daughter in Baghdad. States daughter being detained "in jail" on charges against fugitive husband. Pt understands that request must go to Iraqi Security [redacted] Glumb
8July 03	(0515) Pt care report given to Pt [redacted] Pt Resting asleep c̄ acute Episode noted [redacted] Glumb
8 July 03 @0520	received pt report @ 0520 pt resting quietly in bed pt has no complaints @ this time assessment complet see ~~AA form 4160~~ [redacted] pt assessment form for details. will continue to monitor. ~~Kathy Banks~~
@1130	pt resting quietly with no complaints @ present will continue to monitor throughout day [redacted] PC Hunter
09 Jul 0500	Received report + assumed care of pt. VSS, pt lying in bed + sleeping, Appears to be resting comfortably @ this time. Will continue to monitor. [redacted] WMG
0730	Applied silvadine + bulky dressing to burn area on buttock. Will continue to monitor. [redacted] WMG
0920	Pt sitting up in bed bathing. VSS, Ø Ntd complaints. Will continue to monitor. [redacted] Glwm

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

b(2)-2

NSN 7540-01-075-3786

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

PATIENT'S HOME ADDRESS OR DUTY STATION			ARRIVAL	
STREET ADDRESS			DATE *(Day, Month, Year)* 4 JUL 03	TIME 2327
CITY	STATE	ZIP CODE	TRANSPORTATION TO FACILITY Medevac	

SEX	DUTY/LOCAL PHONE		MILITARY STATUS				THIRD PARTY INSURANCE		
M	AREA CODE	NUMBER	ITEM	YES	NO	N/A	ITEM	YES	NO
			PRP				ADDITIONAL INSURANCE		
AGE	HOME PHONE		FLYING STATUS				DD 2568 IN CHART		
59	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
NHPO	IS THIS AN INJURY?			WHERE	TETANUS	
ALLERGIES	INJURY/SAFETY FORMS				DATE LAST SHOT	COMPLETED INTITIAL SERIES ☐ YES ☐ NO
NKDA	HOW					

CHIEF COMPLAINT
Chest pains

CATEGORY OF TREATMENT		VITAL SIGNS					
☐ EMERGENT	TIME 2330	TIME 2328					
		BP 89/55					
☐ URGENT		PULSE 77					
	b(6) IN [redacted]	RESP 18					
		TEMP					
☐ NON-URGENT		WT					

LAB ORDERS						X-RAY ORDERS		
X	CBC/DIFF	ABG	PT/PTT		BHCG/URINE/BLOOD/QUANT		CXR PA & LAT/PORTABLE	C-SPINE
X	URINE C&S	UA MSCC/CATH		X	CHEM: Met 8		ACUTE ABDOMEN	LS SPINE
	BLOOD C&S X						SINUS	HEAD CT
							ANKLE R/L	
						X	CXR	

ORDERS

☒ PULSE OX 99% ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
	CXR 8				
	CBC, Met 8, 9				

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

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

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

[redacted]

b(6)-4.

FPW

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

PATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / Dry

Skin : Temperature Warm

Color: Pale / Cyanotic / Jaundiced NFR

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils: PERRL

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials Pedals

Capillary Refill: brisk Seconds Homan's Sign

Jugular Venous Distension Ø Edema

Heart Sounds S1, S2

Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns: Reg. R+R

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: None

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate:

Stool: Character Formed

Drains: None

GENITOURINARY

Urine Color: Clr Yellow Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

PATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / Dry

Skin : Temperature

Color: Pale / Cyanotic / Jaundiced

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials Pedals

Capillary Refill: Seconds Homan's Sign

Jugular Venous Distension Edema

Heart Sounds

Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral
Waveforms				
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns:

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm.

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Locatic
Crackles		
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings:

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Draina

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character

Drains:

GENITOURINARY

Urine Color: Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

#344 10 JUL 14

	05	06	07	08	09	10	11	12	13
Temp			97.7				98.6		
HR			75				72		
RR			16				18		
SaO2			94%				95%		
BP			114/66				104/60		
INPUT									
PO			300						
IV									
NGT									
TOTAL									
OUTPUT									
Urine			170						
NGT									
Stool				X1					
TOTAL									
BALANCE									

MEDCOM - 27256

PATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / Dry

Skin : Temperature warm

Color: Pale / Cyanotic / Jaundiced Normal For Race

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials + Pedals +

Capillary Refill: ≤ 3 Seconds Homan's Sign

Jugular Venous Distension None Edema None

Heart Sounds S S2

Rhythm NSR HR - 80 PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			(L) Arm	
Solution			Hep-lock	

Chest Pain None @ Present

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns: 22

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	CTA	CTA
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: CDI

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate:

Stool: Character

Drains

GENITOURINARY

Urine Color: Clear Yellow Character:

Voiding Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

PATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / Dry

Skin : Temperature

Color: Pale / Cyanotic / Jaundiced

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials Pedals

Capillary Refill: Seconds Homan's Sign

Jugular Venous Distension Edema

Heart Sounds

Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns:

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings:

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character

Drains:

GENITOURINARY

Urine Color: Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

#[redacted] b(6)-4

8 Jul 03

[redacted] /

8 July 03

PTS NAME

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP						120/62				115/69				110/65				110/68				113/58		
TEMP	97.9					97.4				97.3				97.4				97.9				97.5		
HR	80					95				73				84				80				81		
RR	22					~~18~~ 20				20				20				21				18		
SA02	95					96				98				98				98				98		
MODE	RA					RA				RA				RA				RA				RA		
MEAN																								
INPUT			(+)																					
PO			300				400																	
IV																								
NGT																								
TOTAL			300				700																	
OUTPUT																								
URINE		600			200					400						500								
NGT																								
STOOL					(+)																			
TOTAL		600			800					1200														
B. [redacted] E																								

MEDICAL FORM 2125B

b(6)-2

PATIENT ASSESSMENT

TIME: 0615 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry
Skin: Temperature Warm
Color: Pale / Cyanotic / Jaundiced NFR
Mucous Membranes: Moist / Dry / Cracked
Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:
Orientated / Disoriented Pupils:
Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials +3 Pedals +3
Capillary Refill: brisk Seconds Homan's Sign
Jugular Venous Distension Ø Edema
Heart Sounds S1, S2
Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			L wrist	
Solution			Heplocked	

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical
Respiration / No Distress / SOB / Labored / Use of Access Muscles
Breathing Patterns: Reg. R+R
Cough: Productive / Nonproductive / None
Sputum: Color / Amount / Consistency / Odor
Chest Drainage System Gravity: Suction cm:
Air Leak No Yes Crepitus
Character of Drainage:
Trachea / Midline / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	CTA	
Diminished	bilat	
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth
Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent
Dressings:
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate:
Stool: Character
Drains NONE

GENITOURINARY

Urine Color: Clr Yellow Character:
Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

PATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry
Skin: Temperature Warm
Color: Pale / Cyanotic / Jaundiced NFR
Mucous Membranes: Moist / Dry / Cracked
Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:
Orientated / Disoriented Pupils:
Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials +3 Pedals +3
Capillary Refill: Seconds <3 Homan's Sign −
Jugular Venous Distension Ø Edema Ø
Heart Sounds S1 S2
Rhythm RRR NSR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			L wrist	
Solution			Heplock	

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical
Respiration / No Distress / SOB / Labored / Use of Access Muscles
Breathing Patterns: RRR
Cough: Productive / Nonproductive / None
Sputum: Color / Amount / Consistency / Odor
Chest Drainage System Gravity: Ø Suction cm.
Air Leak No Yes Crepitus
Character of Drainage:
Trachea / Midline / Deviated (R) / Deviated (L)
Artificial Airway Size: Ø Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	CTA	
Wheezes		
Diminished	Bilat	
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth
Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent
Dressings:
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate
Stool: Character
Drains: Ø

GENITOURINARY

Urine Color: yellow Character: Clear
Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

09 Jul 03

[redacted] b(6)-4

PATIENT ASSESSMENT b(6)-2

TIME: 0) Pulse 0) SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin Temperature: warm 98.4

Color: Pale / Cyanotic / Jaundiced: Normal For Race

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials ++ Pedals ++

Capillary Refill: ≤3 Seconds Homan's Sign

Jugular Venous Distension: NO Edema: NO

Heart Sounds: NSR - 74 S_1S_2

Rhythm: NSR - 74 PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			(L) wrist	
Solution			NS @ 150 c/hr	

Chest Pain: Not @ Present

RESPIRATORY

Chest Expansion: Symmetrical / Asymmetrical

Respiration: No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns: 19

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm:

Air Leak: No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	CTA	CTA
Diminished		
Absent	C thorax	Snoasting

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: CDI

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate:

Stool: Character

Drains:

GENITOURINARY

Urine Color: Clear Yellow Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER: [redacted]

PATIENT ASSESSMENT b(6)-2

TIME: 1715 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature: WARM

Color: Pale / Cyanotic / Jaundiced: Membranes pink

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size: SEE SFGOC

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): +3 Radials: palp +3 Pedals: palp

Capillary Refill: < 3 Seconds Homan's Sign: neg

Jugular Venous Distension: Ø Edema

Heart Sounds: S_1S_2

Rhythm: SR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			(L) wrist IV	
Solution			Saline lock	

Chest Pain: Denies

RESPIRATORY

Chest Expansion: Symmetrical / Asymmetrical

Respiration: No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns: Regulars

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor: Ø

Chest Drainage System Gravity: N/A Suction cm.

Air Leak: No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	CTA	B/lat
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended Obese cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: B/LAT gluteals

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character: Ø

Drains: Ø

GENITOURINARY

Urine Color: VOIDS in urinal Character: dark yellow

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

See [redacted] SF 600

OTHER: [redacted]

b(6)-2

EPW

b(a)=2

PATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature Warm

Color: Pale / Cyanotic / Jaundiced NFR

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Buttocks Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils: 3mm PERRL

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials +3 Pedals +3

Capillary Refill: Seconds <3sec Homan's Sign

Jugular Venous Distension N/A Edema

Heart Sounds S1 S2

Rhythm 2° AV Block 2° Ectopy PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			TB(L) AC	
Solution			NS 150cc/hr	

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns: RR + Rhythm

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	CTA BILAT	
Diminished	ZLNC	
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: C/D/I to Buttocks

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate:

Stool: Character NONE at this time

Drains:

GENITOURINARY

Urine Color: Clear yellow Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

Pt Resting comfortably in bed.

OTHER: Restraints to (R) Hand + R foot

EPW

PATIENT ASSESSMENT

TIME: 0800 SIGNATURE: [redacted] N/A

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature Warm

Color: Pale / Cyanotic / Jaundiced Normal for Race

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: 2° Burn Size Buttocks

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials +3 (B) Pedals +3 (B)

Capillary Refill: <5 Seconds Homan's Sign (-)

Jugular Venous Distension (-) Edema (-)

Heart Sounds S1 S2

Rhythm 1° AV Block PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			(D) AC	
Solution			NS	

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns: Regular

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	CTA	
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: Buttocks

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character

Drains:

GENITOURINARY

Urine Color: Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

[redacted] Cooperative, Calm

OTHER:

EPW [redacted] b(6)-4

PATIENT ASSE 'ENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES	
Skin : Loose / Tight / Diaphoretic / Shiny / Dry	
Skin : Temperature	Warm
Color: Pale / Cyanotic / Jaundiced	NFR
Mucous Membranes: Moist / Dry / Cracked	
Skin Breakdown: None Location: Buttocks	Size:
NEUROLOGICAL	
Loc / Alert / Lethargic / Unresponsive	GCS:
Orientated / Disoriented	Pupils: 3mm PERRL
Extremity Movement: Full / Limited / None	
CARDIOVASCULAR	
Pulse (0 - 4): Radials +3	Pedals +3
Capillary Refill: Seconds <3sec	Homan's Sign
Jugular Venous Distension N/A	Edema
Heart Sounds S1 S2	
Rhythm 1° AV Block Ø Ectopy	PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			[redacted]	
Site			RB (1) AC	
Solution			NS 150cc/hr	
Chest Pain				

RESPIRATORY	
Chest Expansion / Symmetrical / Asymmetrical	
Respiration / No Distress / SOB / Labored / Use of Access Muscles	
Breathing Patterns:	RR + Rhythm
Cough: Productive / Nonproductive / None	
Sputum: Color / Amount / Consistency / Odor	
Chest Drainage System Gravity:	Suction cm:
Air Leak No Yes	Crepitus
Character of Drainage:	
Trachea / Midline / Deviated (R) / Deviated (L)	
Artificial Airway Size: Type:	Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	CTA BILAT	
Diminished	ILNC	
Absent		

GASTROINTESTINAL	
Abdomen: Soft / Firm / Hard / Distended	cm Girth
Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent	
Dressings: C/D/I to Buttocks	
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage	
NG Drainage: Color	Character
Tube Feeding: Day No: Strength:	Rate: Aspirate:
Stool: Character	NONE at this time
Drains:	
GENITOURINARY	
Urine Color: Clear yellow	Character:
Voiding: Continent / Incontinent /	Catheter
EMOTIONAL/PSYCHOSOCIAL	
Pt Resting comfortably in bed.	
OTHER: Restraints to (L) Hand + R foot	

EPW

TIENT ASSESSMENT b(6)-2

TIME: 0800 SIGNATU[redacted] N/A

SKIN AND MUCOUS ME[redacted]	
Skin : Loose / Tight / Diaphoretic / Shiny / Dry	
Skin : Temperature	Warm
Color: Pale / Cyanotic / Jaundiced	Normal for Race
Mucous Membranes: Moist / Dry / Cracked	
Skin Breakdown: None Location: 2° Burn to	Size Buttocks
NEUROLOGICAL	
Loc / Alert / Lethargic / Unresponsive	GCS:
Orientated / Disoriented	Pupils:
Extremity Movement: Full / Limited / None	
CARDIOVASCULAR	
Pulse (0 - 4): Radials +3 (B)	Pedals +3 (B)
Capillary Refill: <5 Seconds	Homan's Sign (-)
Jugular Venous Distension (-)	Edema (-)
Heart Sounds S1 S2	
Rhythm 1° AV Block	PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			[redacted]	
Site			(D) AC	
Solution			NS	
Chest Pain				

RESPIRATORY	
Chest Expansion / Symmetrical / Asymmetrical	
Respiration / No Distress / SOB / Labored / Use of Access Muscles	
Breathing Patterns:	Regular
Cough: Productive / Nonproductive / None	
Sputum: Color / Amount / Consistency / Odor	
Chest Drainage System Gravity:	Suction cm:
Air Leak No Yes	Crepitus
Character of Drainage:	
Trachea / Midline / Deviated (R) / Deviated (L)	
Artificial Airway Size: Type:	Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	CTA	
Diminished		
Absent		

GASTROINTESTINAL	
Abdomen: Soft / Firm / Hard / Distended	cm Girth
Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent	
Dressings: [redacted] Buttocks	
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage	
NG Drainage: Color	Character
Tube Feeding: Day No: Strength:	Rate: Aspirate
Stool: Character	
Drains:	
GENITOURINARY	
Urine Color:	Character:
Voiding: Continent / Incontinent /	Catheter
EMOTIONAL/PSYCHOSOCIAL	
[redacted] ~~Cooperative~~ Cooperative, Calm	
OTHER:	

EPW 399 / 6 Jul 03

PTS NAME

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP		117/82				114/61				108/59				110				109				110		
TEMP		96				95.7				97.2				97.2				97.4				98.8		
HR		72				70				69				63				59				66		
RR		17				22				20				18				22				20		
SA02		95				98				94				95				95				96		
O2		RA				2LNC				RA				RA				RA				RA		
INPUT																								
PO				240				300						400			50			50			50	
NG IV	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150
NGT																								
TOTAL																								
OUTPUT																								
URINE				525					400						675				675				625	
NGT																								
STOOL																								
TOTAL																								

E CE

MEDCOM : 27263

PATIENT ASSESSMENT

TIME: SIGNATUI

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / Dry

Skin : Temperature Warm

Color: Pale / Cyanotic / Jaundiced NFR

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Burn to Size: (B) Buttock

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials +3 Pedals +3

Capillary Refill: Seconds <3 sec Homan's Sign

Jugular Venous Distension Edema

Heart Sounds S_1 S_2

Rhythm RR+Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site		20G	IV to (L) wrist	
Solution			ĪNS @ 150cc/hr	

Chest Pain Ø S/S CP

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns: RR+Rhythm

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	CTA Bilat	
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: CDI to (B) Buttock

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate:

Stool: Character NONE at this time

Drains:

GENITOURINARY

Urine Color: clear yellow Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

pt Resting comfortably in Bed

OTHER:

PATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / Dry

Skin : Temperature

Color: Pale / Cyanotic / Jaundiced

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials Pedals

Capillary Refill: Seconds Homan's Sign

Jugular Venous Distension Edema

Heart Sounds

Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripher
Waveforms				
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns:

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm.

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Locat
Crackles		
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings:

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drain

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character

Drains:

GENITOURINARY

Urine Color: Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

b(6)-J [redacted]

9 Jul 10

	05	06	07	08	09	10	11	12	13	14	15	16	18 00 JS	18	19	20	21	22 ✓	23	24	01	02	03
BP		103/67				118/76				114/51			117/66					111/69				108/62	
Temp		97.9				96.8				98.2			98.2					94.6				98.7	
HR		86				90				87			96					83				79	
RR		14				18				16			18					16				16	
SAO2		95%				96%				99%			99%					99				99	
INPUT																							
PO		240	240																				
IV																							
NGT																							
TOTAL																							
OUTPUT																							
urine		450												300					400				
NGT																							
STOOL																							
TOTAL																							
Net																							

04

400

MEDCOM - 27265

EPW

PTS NAME [redacted]

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP	110/68				108/52				119/55				102/51				110/56							
TEMP	99.1				98.4								98.7											
HR	74				80				76				80				76				87			
RR	19				18				20				18				14				24			
SA02	94%				97%				96%				95%				95				97			
	RA				RA				RA				RA				RA				RA			
INPUT																								
PO						240	240																	
IV	150	150	150	150	150	150	150	150	150	150	Heplock →													
NGT																								
TOTAL	150	300	450	600	750	1140	1530	1680	1830	1980														
OUTPUT																								
URINE	350	0	500	0	100	800	650		650			500	475		475									
NGT																								
STOOL																								
TOTAL	350	350	850	850	950	1750	1400		2050			2550												

BALANCE

IV 1500
PO 480
1980

Urine 4500

2520 Balance

MEDCOM - 27266

5 Jul 03

EPW [redacted]

PTS NAME

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP	85/59	116/73	104/65	100/61	106/59	86/52	127/57	126/68	127/70	118/66	105/64	95/61	103/59	105/56	100/53	117/57	110/62	115/71	96/59	96/59	113/61	119/57	107/62	99/57
TEMP	98.6				97.9			98																
HR	74	77	72	73	73	69	75	75	84	78	67	72	77	74	72	74	77	70	70	70	67	67	69	90
RR	31	19	20	24	21	23	14	20	25	22	20	20	22	13	19	19	21	21	10	14	15	17	27	10
SA02	95	98	97	97	95	95	97	97	97	98	99	98	98	98	98	93	94	94	94	94	92	94	90	94
O2	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	2LNC	2LNC	2LNC	2LNC	2LNC	RA	RA	RA	RA	RA	RA	RA	RA	RA
MAP						65																		
INPUT																								
PO				240				118	60					400	50									
NS IV	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150
NGT																								
TOTAL																								
OUTPUT																								
URINE												325							525					
NGT																								
STOOL																								
TOTAL																								
B E																								
Initials		JR	JR	JR	JR	JR	JR	JR	JR	JR	JR	JR	JR	JR	JR	JR	JR	JR	JR	JR	JR	JR	JR	JR

b(3)

MEDCOM - 27267

4 Jul 03

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	1	2	3	4
BP																				112/65			116/72
Temp																			(A)	98.9		98.6	
HR																				78	81	76	74
RR																				12	26	26	25
SaO2																				99	100	96	95
																				RA	RA	RA	RA
INPUT																							
PO																							
IV																							
NGT																							
TOTAL																							
OUTPUT																							
urine																							
NGT																							
stool																						T large loose	
TOTAL																							
NCE																							

MEDCOM - 27268

b(6)-2

Ward Section: EMT

LAST, FIRST, MI: EPW

[redacted]YSICIAN:

DATE: 4/24/03 | TIME: 2328

[redacted] b(6)-4

[redacted]MISTRY RESULT FORM

(Subject to the Privacy Act of 1974)

(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%
Bleed		(-2) - (-3) mmol/L
AnGap		10-20 mmol/L
iCa		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		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(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	82	73-118 mg/dl
BUN	14	7-22 mg/dl
CRE	0.9	0.6-1.2 mg/dl
CK	109	39-380 u/l (M) 30-190 u/l (F)
NA^+	128	128-145 mmol/l
K^+	4.1	3.3-4.7 mmol/l
CL^-	106	98-108 mmol/l
tCO_2	21	18-33 mmol/l

(Pi[redacted]) 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:

b(6)-4

REPORTED BY: [redacted]

DATE: 4/24/03

LAB ID NO.:

Chemistry Only

Section: ICU 3 | REQUESTING PHYSICIAN: DR. (MAJ) [redacted] b(6)-2 | **CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)

FIRST: [redacted] b(6)-4 | DATE: 5/7/03 | TIME: 1215 | SSN/PSEUDO SSN:

[redacted]			(Piccolo) Chemistry 12			(Piccolo) Metabolic Panel		
T	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
		138-146 mmol/L	ALB		3.5-5.5 g/dl	GLU		73-118 mg/dl
		3.5-4.9 mmol/L	ALP		26-84 u/l	BUN		7-22 mg/dl
		98-109 mmol/L	ALT		10-47 u/l	CA^{++}		8.0-10.3 mg/dl
		7.31-7.45	AMY		14-97 u/l	CRE		0.6-1.2 mg/dl
		35-45 mmHg (art) 41-51 mmHg (ven)	AST		11-38 u/l	NA^+		128-145 mmol/l
		80-105 mmHg (art) N/A (ven)	TBIL		0.2-1.6 mg/dl	K^+		3.3-4.7 mmol/l
					7-22 mg/dl	CL^-		98-108 mmol/l
					8.0-10.3mg/dl	tCO_2		18-33 mmol/l
					100-200 mg/dl	(Piccolo) Liver Panel Plus		
					0.6-1.2 mg/dl	TEST	RESULT	REF. RANGE
					73-118 mg/dl	ALB		3.3-5.5 g/dl
					6.4-8.1 g/dl	ALP		26-84 u/l
					[redacted]	ALT		10-47 u/l
					LT REF. RANGE	AMY		14-97 u/l
					73-118 mg/dl	AST		11-38 u/l
					7-22 mg/dl	TBIL		0.2-1.6 mg/dl
					0.6-1.2 mg/dl	GGT		5-65 u/l
					39-380 u/l (M) 30-190 u/l (F)	TP		6.4-8.1 g/dl
[redacted]					128-145 mmol/l	(Piccolo) Electrolyte		
T	RESULT				3.3-4.7 mmol/l	TEST	RESULT	REF. RANGE
					98-108 mmol/l	NA^+		128-145 mmol/l
					18-33 mmol/l	K^+		3.3-4.7 mmol/l
						CL^-		98-108 mmol/l
						tCO_2		18-33 mmol/l

PICCOLO
05/07/03 12:43
REFERENCE RANGE [redacted] MALE
PATIENT #: [redacted] b(6)-2
METLYTE 8
DISC LOT #: 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(6) 0000100684

GLU	80	73-118	MG/DL
BUN	13	7-22	MG/DL
CRE	0.7	0.6-1.2	MG/DL
CK	164	39-380	U/L
NA+	126*	128-145	MMOL/L
K+	4.0	3.3-4.7	MMOL/L
CL-	102	98-108	MMOL/L
tCO2	22	18-33	MMOL/L

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

[redacted] RESULT

REMARKS:

RTED BY: | LAB ID NO.:

Chemistry Only

Section: ICU 3 b(6)-4

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

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

FIRST, MI	DATE	TIME	SSN/PSEUDO S
EPW [redacted]	5 Jul 03	1800	EPW [redacted] b(6)-4

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
		138-146 mmol/L
		3.5-4.9 mmol/L
		98-109 mmol/L
		7.31-7.45
		35-45 mmHg (art) 41-51 mmHg (ven)
		80-105 mmHg (art) N/A (ven)
		23-27 mmol/L (art) 24-29 mmol/L (ven)
		22-26 mmol/L (art) 23-28 mmol/L (ven)
		95-98%
		(-2) – (+3) mmol/L
		10-20 mmol/L
		1.12-1.32 mmol/L
		8-26 mg/dl
		70-105 mg/dl
		0.7-1.5 mg/dl
		38-51% PCV
		12-17 g/dl

MEST Chemistry

TEST	RESULT	REF. RANGE

(Piccolo) Chemistry 12

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

(Piccolo) Metabolic 8

TEST	RESULT	REF. RANGE
GLU	108	73-118 mg/dl
BUN	13	7-22 mg/dl
CRE	1.0	0.6-1.2 mg/dl
CK	178	39-380 u/l (M) 30-190 u/l (F)
NA^+	127	128-145 mmol/l
K^+	4.2	3.3-4.7 mmol/l
CL^-	103	98-108 mmol/l
tCO_2	21	18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY: [redacted] b(6)-2

DATE: 05 July 03

LAB ID NO.:

Chemistry Only

Section: ICU 3	REQUESTING PHYSICIAN: DR. (KAT[redacted] b(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)	
FIRST, MI: b(6)-4 [redacted]	DATE: 5 Jul 03	TIME: 0620	SSN/PSEUDO SSN:

(STAT)

T	RESULT	REF. RANGE
		138-146 mmol/L
		3.5-4.9 mmol/l
		98-109 mmol/L
		7.31-7.45
		35-45 mmHg (art) 41-51 mmHg (ven)
		80-105 mmHg (art) N/A (ven)
		23-27 mmol/L (art) 24-29 mmol/L (ven)
		22-26 mmol/L (art) 23-28 mmol/L (ven)
		95-98%
		(-2) – (+3) mmol/L
		10-20 mmol/L
		1.12-1.32 mmol/L
		8-26 mg/dl
		70-105 mg/dl
		0.7-1.5 mg/dl
		38-51% PCV
		12-17 g/dl

Misc. Chemistry

T	RESULT	REF. RANGE

(Piccolo) Chemistry 12

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU	75	73-118 mg/dl
BUN	13	7-22 mg/dl
CRE	0.5	0.6-1.2 mg/dl
CK	164	39-380 u/l (M) 30-190 u/l (F)
NA^+	125	128-145 mmol/l
K^+	3.8	3.3-4.7 mmol/l
CL^-	103	98-108 mmol/l
tCO_2	22	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

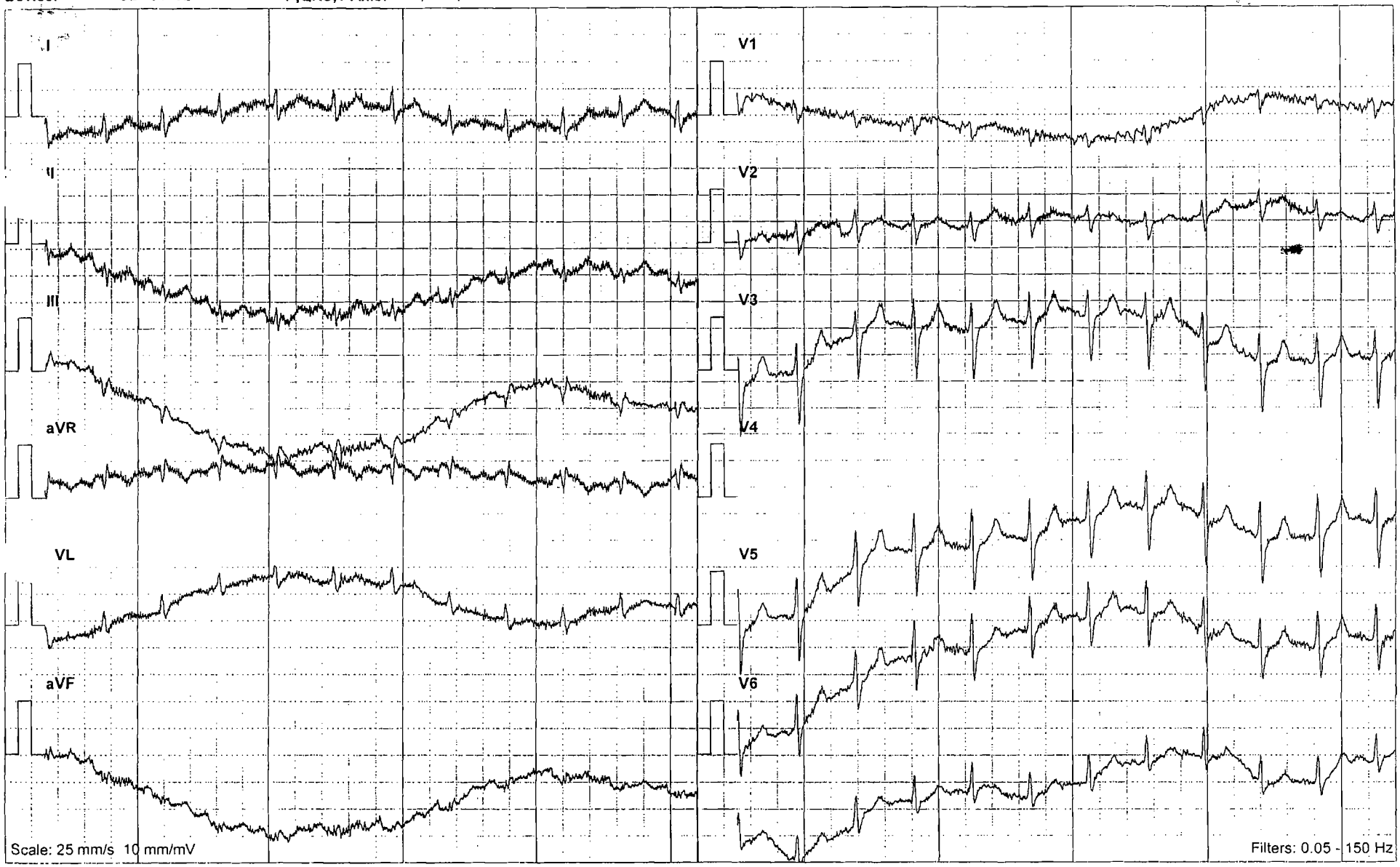
TEST	RESULT	REF. RANGE
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

ARKS:

RTED BY: [redacted] b(6)-2	DATE: 5 Jul 03	LAB ID NO.:

6x2 ECG Report

Name:	[redacted]	Measurements		Interpretation (Unconfirmed)
Number:		Heart Rate:	140 bpm	Sinus tachycardia
Sex:	Male	P Duration:	106 ms	Multifocal ventricular extrasystole(s)
Date of Birth:	7/3/1960 (43 years)	PR Interval:	112 ms	Ventricular extrasystole(s) with full compensation
Height/Weight:	70in / 209lb	QRS Duration:	108 ms	Short PR interval
		QT Interval:	292 ms	Inferior infarction, probably old
Recorded:	7/3/2003 3:43:25 PM	QTc Interval:	446 ms	
Device:	CL 131132	P,QRS,T Axis:	58°, -10°, 32°	



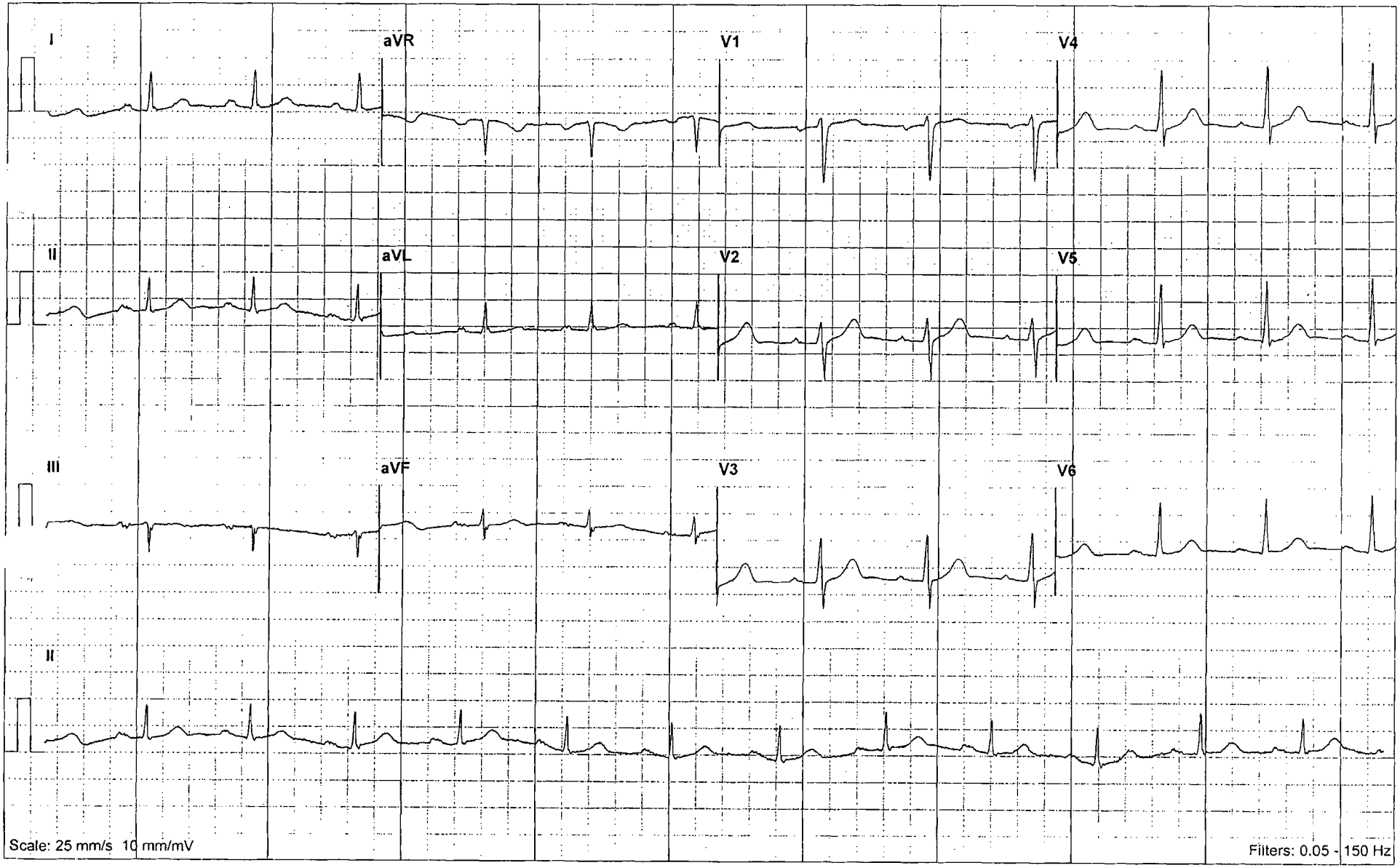
MEDCOM - 27273

(Data must be reviewed by a qualified physician)

Confirmed by:

3x4 Simultaneous Report

Name:	epw iraqi	**Measurements**		**Interpretation (Unconfirmed)**	
Number:	[redacted]	**Heart Rate:**	77 bpm	Normal sinus rhythm	
Sex:	Male	**P Duration:**	110 ms	Normal morphology	
Date of Birth:	7/5/2003	**PR Interval:**	194 ms	[redacted]	
Height/Weight:	71in / 245lb	**QRS Duration:**	84 ms		
		QT Interval:	360 ms		
Recorded:	7/5/2003 6:10:10 PM	**QTc Interval:**	407 ms		
Device:	CL 131134	**P,QRS,T Axis:**	39°, 11°, 39°		



MEDCOM - 27274

(Data must be reviewed by a qualified physician)

Confirmed by:

6x2 ECG Report

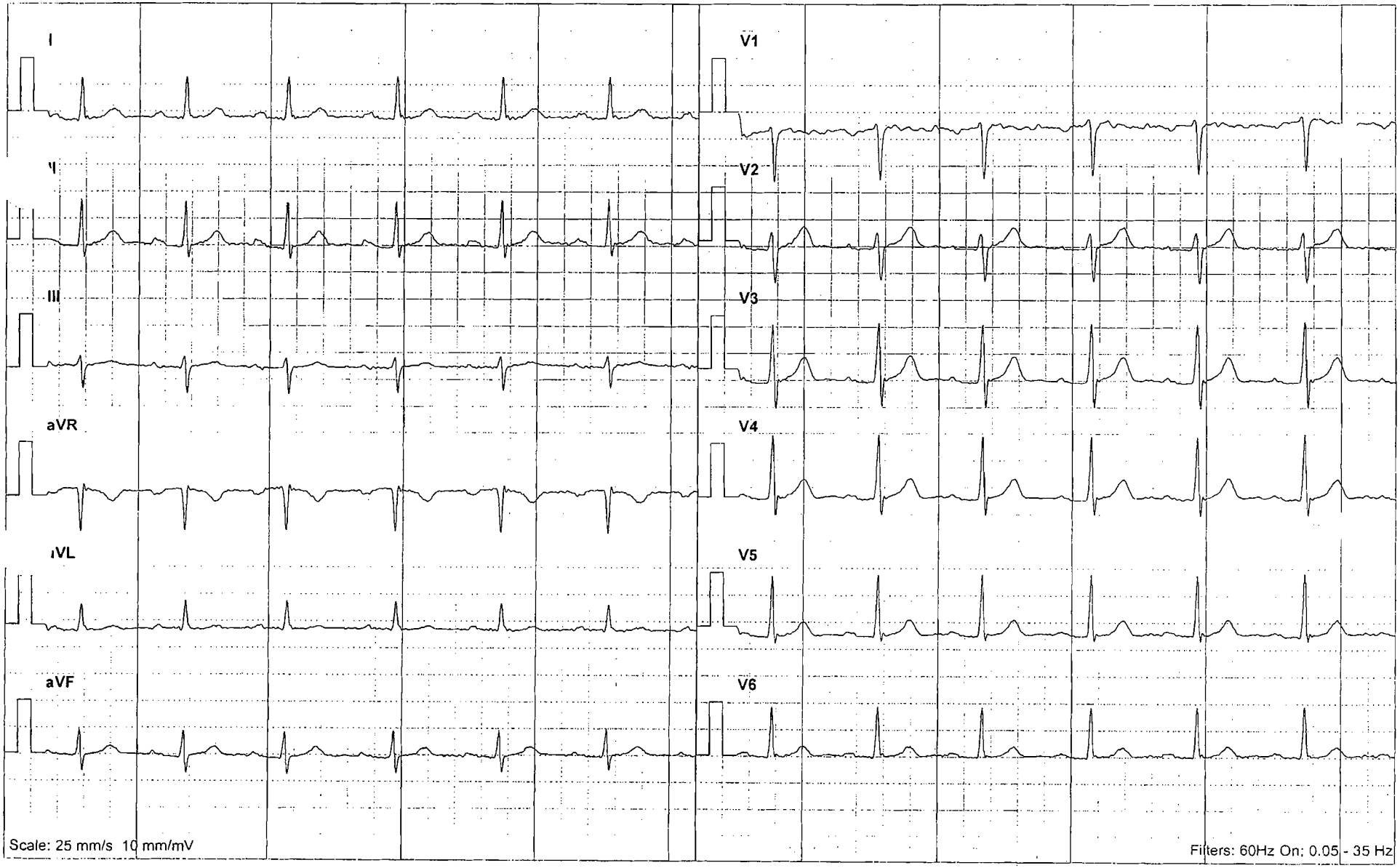
b(6)-4

Name:	[redacted]
Number:	
Sex:	Male
Date of Birth:	1/1/1948 (55 years)
Height/Weight:	71in / 300lb
Recorded:	7/4/2003 11:34:42 PM
Device:	CL 131132

Measurements	
Heart Rate:	77 bpm
P Duration:	138 ms
PR Interval:	224 ms
QRS Duration:	86 ms
QT Interval:	366 ms
QTc Interval:	414 ms
P,QRS,T Axis:	39°, 25°, 46°

Interpretation (Unconfirmed)
Sinus rhythm with 1st degree AV block
Normal morphology

Prolonged PR 1° AV block w/o ml [redacted]



MEDCOM - 27275

(Data must be reviewed by a qualified physician)

Confirmed by:

6x1 ECG Report

J. B. F

Name: [redacted]
Number:
Sex: Male
Date of Birth: 7/9/2003
Height/Weight: 72in / 300lb

Interpretation (Unconfirmed)
Normal sinus rhythm
Normal morphology

Recorded: 7/9/2003 12:51:21 PM
Device: CL 131132

MEDCOM - 27276

(Data must be reviewed by a qualified physician)

Confirmed by:

6x1 ECG Report

Name: [redacted]
Number:
Sex: Male
Date of Birth: 7/9/2003
Height/Weight: 72in / 300lb

Interpretation (Unconfirmed)
Normal sinus rhythm
Normal morphology

Recorded: 7/9/2003 12:51:21 PM
Device: CL 131132

MEDCOM - 27277

(Data must be reviewed by a qualified physician)

Confirmed by:

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 5 July 03 TIME OF ORDER 0010 HOURS

LIST TIME ORDER NOTED AND SIGN

Adm = ICU
Dx = 2° Burns / Chest pain.
Cond = Guarded
VS = per routine
All = NKDA
Act = Bedrest
Nursing = Wound care i S

noted AN

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

b(6)-2 24° [redacted] CPT/AN 5 Jul 03 0540

DATE OF ORDER TIME OF ORDER HOURS

Diet = Reg.
IV = 150 cc/hr NS
Labs = met 8 @ 0600 / 1200 / 1800
Meds = MSO4 2-4 mg IV q 2° PRN pain
ASA qd PO 81 mg
Phenergan 25 mg IV q 8° PRN N & V MSO4

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

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER [redacted] 5 July 03 TIME OF ORDER HOURS

1. Lovenox 1 mg/kg SC q 12°, first now ≈ 100 mg X 4 doses.
2. Maalox 30 cc - 10 cc PO q 4° PRN heartburn.
3. Zantac 150 mg i PO BID, first now
4. Ambien 10 mg i PO qhs PRN insomnia
5. Tylenol 325 mg ii PO q 4° PRN
   Percocet i - ii PO q 4° PRN if Tylenol not given

b(6)-2 [redacted]

PATIENT IDENTIFICATION

b(6)-4 # [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

6. If CP; get ECG, 2 LNC O2, VSigns
   if BP > 120/70 may give one spray of NTG.
7. Colace 100 mg i PO BID
8. ~~Saline lock IV.~~ Nasal Saline Nasal Spray PRN

[redacted] 5 July 03 1404 SR

NURSING UNIT | ROOM NO. | BED NO.

24° [redacted] b(6)-2 CPT/AN [redacted] / NAJ MD b(6)-2 6 Jul 03 0535

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)-1

NURSING UNIT	ROOM NO.	BED NO.
ICU 3	24 [redacted]	

DATE OF ORDER: 6 Jul 03 TIME OF ORDER: 0725 HOURS

(1) VS Q4 hr [redacted]

V.O. per [redacted] CT/AN

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

AN 2300 — LIST TIME ORDER NOTED AND SIGN: 10 Jul 03 0725

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.
24		

DATE OF ORDER: 7 Jul 03 TIME OF ORDER: 1640 HOURS

V.O. Heplock IV.

From Dr. [redacted] / KR OL LTC

[redacted]

~~Chart Check 0100 09JUL~~ [redacted] ILT/AN

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.
24	[redacted]	CT/AN

DATE OF ORDER: 9 July 03 TIME OF ORDER: 1310 HOURS

(1) MSO4 2mg IVP prn chest [redacted]

V.O. Dr [redacted] AN

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

1749 10 Jul 03

noted 1310 9 July

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

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

b(6)-2

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 7 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 5	6	7	8	9	10	11							
05Jul03	[redacted]	Activity: Bedrest	05	[redacted]													
			17														
			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
05Jul	[redacted]	VS per routine q1°	05	JR													
		for 18° then q4° if	17														
		R/O MI	X														
05Jul	[redacted]	Labs: Met 8 @	060	[redacted]	X												
			120	[redacted]	X												
			18	[redacted]	X												
			X														
5Jul03	[redacted]	VS per routine	05	[redacted]													
			17	[redacted]													
			X														
5Jul03	[redacted]	Burn care per protocol	05	[redacted]													
			17	[redacted]													
5Jul03	[redacted]	Diet: Regular	05	[redacted]													
			12	[redacted]													
			17	[redacted]													
5Jul03	[redacted]	If CP, get ECG, Or	05	[redacted]													
		2 IV NC, VS if BP > 120/70	17	[redacted]													
		may give spray of NTG															
6Jul03	[redacted]	VS 24 hrs	05	[redacted]													
			17	[redacted]													

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: Chest Pain, 2° Burns/Buttocks

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

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

CIV/EPW

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

b(e)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo _____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
05Jul	[redacted]	Admit to ICU	5Jul	0100	Done	[redacted]
05Jul	[redacted]	Condition : Stable	5Jul	Noted		[redacted]
5Jul03	[redacted]	Condition Guarded	5Jul03		Done	[redacted]

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

b(6)-2

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. JULY Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 05	06	07	08	09	10	11							
05JUL	[redacted]	ASA QD PO 81 mg	08	[redacted]													
			X														
05Jul.	[redacted]	IV NS @ 150cc/hr	05	[redacted]													
			17	[redacted]													
			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
5Jul03	[redacted]	Lovenox 1mg/kg SC	08	1350 [redacted]													
		Q12°, First Now ≈ 100mg	20	[redacted]													
		x 4 doses															
5Jul03	[redacted]	Zantac 150mg ī PO	08	1350 [redacted]													
		BID: First Now	20	[redacted]													
5Jul03	[redacted]	Colace 100mg ī PO	08	[redacted]													
		BID	20	[redacted]													
7Jul	[redacted]	Heplock (flush q	05	/	/	[redacted]											
		5hrs)	17	/	/	[redacted]											

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: Chest Pain 5% BSA 2° Burns

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. 1

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	Mo. JUL 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														
05JUL ~~05MA~~	[redacted]	MSO4 2-4mg IV	D T	05JUL 0100	05JUL 0200	05JUL 0300	5Jul03 0405	5Jul03 1250	5Jul03 1310	5JUL 2000	5JUL 2315	6Jul03 0945	6Jul 2330	7JUL 0330	7JUL 0925	7JUL 1245	7JUL 1245	
-----	-----	q2° PRN PAIN	D I	2mg	2mg	2mg	2mg	2mg	2mg	2mg	2mg	2mg	2mg	2mg	2mg 10° (E)	2mg 10° (E)	4mg 10° Q	
-----	-----		E		(E)		(E)											
05JUL -----	[redacted]	Phenergan 25mg IV q8° PRN Nausea	D	05JUL 0100	05JUL 2315	6JUL 2000												
-----	-----	and ē MSO4	D I	25mg IM	25mg IM	25mg IM												
-----	-----		E															
5Jul03	[redacted]	Maalox 10 - 30cc PO		5Jul03 30cc														
-----	-----	Q4° PRN Heartburn		1345 [redacted]														
5Jul03	[redacted]	Ambien 10mg ī PO		Jul 2030														
-----	-----	Q6hrs PRN insomnia		10mg [redacted]														
5Jul03	[redacted]	Tylenol 325mg ī																
-----	-----	PO Q4° PRN																
-----	-----																	

USAPA V1.00

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED														
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ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Chest Pain 5% 2° Burns

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO. 2

PATIENT IDENTIFICATION: EPW [redacted]

b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED														
25 Jul [redacted]	- - - - -	MSO4 2-4 mg IV	8 Jul 1840	[redacted] 2015	09 Jul 1306												
Recapped 8 July 03		q2° PRN pain	4 mg SN	IVP 2mg	2mg [redacted]												
9 Jul 4	[redacted]	MSO4 2mg IVP prn	09 Jul 1320														
- - - - -	- - - - -	chest pain	2mg [redacted]														
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USAPA V1.00

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*

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

Mo. July Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED														
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ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: Chest Pain, 2° Burn

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

EPW [redacted] bw-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

	-----	HW-2				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY		INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
5 Jul 03	[redacted]	Percocet 1-2 PO		5 Jul 2315	6 Jul 1206	6 Jul 19	7 Jul 2050	8 Jul									
-----	-----	Q4° PRN if Tylenol			[redacted]												
-----	-----	Not Given															
5 Jul 03	[redacted]	[redacted] Saline Nasal	D	05 Jul 5													
-----	-----	Spray PRN	T	1400 to 1630													
-----	-----		D	Doctor's 1330													
-----	-----		I	[redacted]													
05JUL	[redacted]	NTG spray if	D														
-----	-----	BP > 120/70	T														
-----	-----		D														
-----	-----		I														
08 Jul 05	-----	MSO4 2-4 mg IV	D	8 Jul 1430	Doctor's 0610												
-----	-----	q2° PRN PAIN	T	0ms	2mg												
-----	-----		D														
-----	-----		I	[redacted]													

USAPA V1.00

1. LAST NAME, FIRST NAME / NOM ET PRÉNOM: [redacted] | RANK / GRADE | MALE / HOMME | FEMALE / FEMME

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

2. UNIT / UNITÉ

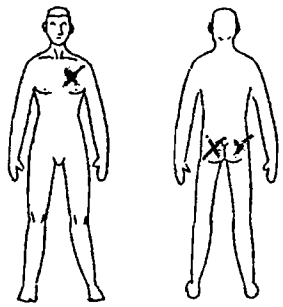
FORCE / ÉLÉMENT | NATIONALITY / NATIONALITÉ

A/T | AF/A | N/M | MC/M

BC / BC | NBI / BNC | DISEASE / MALADIE | PSYCH / PSYCH

3. INJURY / BLESSURE

FRONT / DEVANT | BACK / ARRIÈRE



- AIRWAY / TRACHÉE
- HEAD / TÊTE
- WOUND / BLESSURE
- NECK/BACK INJURY / BLESSURE AU COU/AU DOS
- BURN / BRÛLURE
- AMPUTATION / AMPUTATION
- STRESS / TENSION
- OTHER (Specify) / AUTRE (Spécifier)

Chest Pain
Rule Out MI
Deep 2° Burns
Blast Injuries

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE

- ALERT / ALERTE
- PAIN RESPONSE / RÉPONSE À LA DOULEUR
- VERBAL RESPONSE / RÉPONSE VERBALE
- UNRESPONSIVE / SANS RÉPONSE

5. PULSE / POULS | TIME / HEURE

6. TOURNIQUET / GARROT: NO / NON | YES / OUI | TIME / HEURE

7. MORPHINE / MORPHINE: NO / NON | YES / OUI | DOSE / DOSE | TIME / HEURE

8. IV / IV | TIME / HEURE

9. TREATMENT / OBSERVATIONS / CURRENT MEDICATION / ALLERGIES / NBC (ANTIDOTE)
TRAITEMENT / OBSERVATIONS / PRESENTE MEDICATION / ALLERGIES / ANTIDOTES

Blood Bolus
CXR
1 NSR
Hx of MI & Cardiac
Cath & Stent Placement

10. DISPOSITION / [redacted] UNITÉ | TIME / HEURE

DATE/DATE (YYMMDD)

b(6)-2

DEC 91 [redacted] of DD Form 1380 (TEST) [redacted]

U.S. FIELD MEDICAL CARD
MÉDICALE DE L'AVANT ÉTATS-UNIS

ADMISSION AND CODING INFORMATION

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

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

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
Z Z Z Z Z Z Z Z	6 0 Y	X	9	UNK

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—	Z	0050	b(4)-4

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

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

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

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

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
5 0		Ø 3 Ø 7 Ø 9

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
A B M A		Ø 3 Ø 7 Ø 5

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

FOR LOCAL USE

Chest pain, 2° burns Ⓑ buttocks

Dx: 94222
94229
94800
E924

Px: 8622

b(6)-2

ADMITTING OFFICER [redacted]

ADMITTING CLERK [redacted]

DA FORM [redacted]

BATES PAGES MEDCOM 27290-27298 ARE NONRESPONSIVE AND HAVE NOT BEEN PROVIDED

b(2)-2

1. Reporting MTF	2. MTF Locat.	Admission a[illegible]oding Information
[redacted]	IZ	For use of this form, see AR 40-400; the proponent agency is OTSG

3. Register Number	Name (Last, First, MI)	4. Pay Grade	5. Sex
[redacted] b(6)-4		FGN	M

6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
1973-03-30	30Y	X	9	MUSLIM

10. Length of Service	ETS	11. FMP	12. Social Security Number
		99	[redacted] b(6)-4

Organization (Active Duty Only)	13. Marital Status	Hour of Admission	Branch / Corps:
	Z	17:00	

14. Flying Status	15. Beneficiary Category	16. Zip Code of Residence:
N/A	K78-PRISONER OF WAR/INTERNEES	

17. Unit Location	18. MOS	19. Trauma	Prev. Admission
		Inj	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: [redacted] b(2)-2		Telephone Number of Emergency Addressee

21. Type of Disposition	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD)
TRF-OTH		2004-01-24

24. Clinic Svc - Admitting	25. MTF Transferred From	26. Date this Admission (YYYYMMDD)
ABA - GENERAL SURGERY		2004-01-20

27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission
IZ		2004-01-20

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: MULTI CONTUSIONS

Procedure Narrative(s):

Cause of Injury Narrative: BEATING

T: 9
Inj: 999

Dx: 920
36441
72981
9160
9110
9140
3888
7905
E9689

Admitting Officer (Signature, as required)	Signature of Admitting Clerk
[redacted] b(6)-2	[redacted] b(6)-2

Automated Facsimile - DA FORM 2985, MAR 2000

US9IZ-157082CI

Last Name	[redacted] b6-4
First Name	
Middle	
Category	CI-CIVILIAN INTERNEE
Power	IZ-Iraq
Arm of Service	
MOS	
COS	
Service No	
Grade	
Geneva Cat.	
ICRC	
Camp Name	BCF DB-2
Enclosure	04-CLINIC
Holding/Cel	[redacted] b2-2

THIS PHOTO HAS BEEN WITHHELD PURSUANT TO FOIA EXEMPTIONS 6 AND 7, 5 U.S.C. 552(B)(6) AND (B)(7)(C).

Photo depicting Deceased

Height		Nationality	IZ-Iraq	Sex	M
Weight				Blood Type	
Hair Color		Religion		DOB	1973/03/30
Eye Color		Race		Complexion	
		Marks			

THIS PHOTO HAS BEEN WITHHELD PURSUANT TO FOIA EXEMPTIONS 6 AND 7, 5 U.S.C. 552(B)(6) AND (B)(7)(C).

Photo depicting Deceased

CI-CIVILIAN INTERNEE				ID Particular 26171 Marks	
	Geneva Cat.				
ht (in)	Weight(lbs)	Hair	Eye		
Birth /03/30	Blood Type	ICRC		Left Index	Right Index
[redacted] b(6)-4					

Issuing Facility: BCF DB-2 Date Issued: 2004/01/20

Issuing UIC: WYS7Y2

ABBREVIATED MEDICAL RECORD

1. ADMISSION DATE *(YYYYMMDD)*: 2004/01/20

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

31 y/o civilian detainee brought in by SF with evidence of bruising trauma to face. Swollen hands, ~~scrape~~ Abrasions back, hands. Able to give good history for interpreter. No food/water x 2 days. Denies pain, just tired and fatigued.

PMHx: ⊘ PSHx: ⊘ Pers/Soc Hx: worksat petroleum station Meds: ⊘ NKDA

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

General → poorly kept 144/63 115 20 99.4 Lungs: CTA⊖ CK → too high to measure

Neuro → awake, appropriate, gives good history, alert, oriented → to interpreter

CV: RRR NES, S2

Ext: hands swollen

CT of head ⊖ 140/44/22 / 49/133/.8

Heent → ⊕ hyphema both eyes, raccoon hematomas ⊖ nasal/oral blood, swelling ⊕ ears, abrasions knees

Back/Abdomen ⊖

12.4 > 12/39 < 221

ALT/AST → 73/135

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

Impression ① Multiple Abrasions/bruising with ↑CPK

Plan ① Aggressive IV hydration x 3-4 liters
② monitor CPK and urine output
③ Rhabdo possible

5. ADMITTING OFFICER

a. SIGNATURE: [redacted] b(6)-2

b. DATE SIGNED *(YYYYMMDD)*: 2004/01/20

6. [redacted] course, diagnoses, procedures, condition on discharge, pertinent discharge inform[redacted]ding medications, diet, activity limitations, follow-up instructions).)

7. DISCHARGE DATE *(YYYYMMDD)*:

. DISCHARGING OFFICER

NAME *(Last, First, Middle Initial)*	b. GRADE	c. TITLE	d. SIGNATURE

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

10. OUTPATIENT/HEALTH RECORD MAINTAINED AT:

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
20JAN04 1203 HRS	CI 157082 BROUGHT IN FOR MEDICAL TREATMENT. PT WAS/IS A SF DETAINEE, AND HAS SIGNS OF MULTIPLE INJURIES. CI HAS RACCOON EYES BI-LATERAL WITH EDEMA OF THE (L) EAR. CI HAS EDEMA OF BOTH HANDS WHICH ARE COLD TO THE TOUCH. CI HAS/EXHIBITS PAIN ON THE (L) LATERAL SIDE OF CHEST. CI HAS ABRASIONS BELOW BOTH KNEES. PGSI CI IS EXHIBITING STRESS AND IS AGITATED.
BP-	
98 P-	
R-	
SPO2-	
TEMP-	
DRUG ALL.-	
∅	
MEDS-	
unk	• CI RECEIVED (1) L 4/R WITH 25 mg PHENERGEN IV
	• CI RECEIVED (1) L N/S WITH (2) PERCOCET FOR PAIN
	• CI GROUND EVAC TO [redacted] b2-2
MEDHX-	CONSULT CT SCAN b(6)-2
unk	[redacted]
	MSG 91W
FAMMEDHX-	
unk	

HOSPITAL OR MEDICAL FACILITY	STATUS	RECORDS MAINTAINED AT
320 TH BAS		
SPONSOR'S NAME	SSN/ID NO	RELATIONSHIP TO SPONSOR

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

REGISTER NO.	WARD NO

NAME- [redacted]

RANK-

SSN-

UNIT-

DOB- b(6)-4

SEX- M or F

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

USAPA V2.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
23 Jan 04	Discharge Summary
0930	30 y.o. Iraqi civilian detained assaulted with bruising/hematomas and CK 911. CPK decreasing, alkalinized, good urine output. No evidence of Rhabdomyolysis or acute renal failure
	Impression ① Elevated CPK after assault
	Plan: Return to Camp b(6)-2
	[redacted] M.D

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 7540-01-075-3786

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

CK - two high, two regular

TEST RESULTS

CBC		SMAC		ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
WBC 12		140 / 101 / 20		SUP 02	PH	PO2	RESULTS CT head - normal	
H/H 12/39		4.9 / 23 / 95		PCO2	SAT	OTHER		
PLT 221								
PT		0.8		U/A DIP small blood			EKG INTERPRETATION	
APTT	BHCG	ETOH	GLU	MICRO 2-10 RBC's				

PROVIDER HISTORY/PHYSICAL

S: 30yo assault victim. Little hx but signs of facial injury.

O: A+O, MAD, ⊕ bilat raccoon eyes
Eyes - bilat conjunctival hemorrhage ± hyphema
Face/orbit ⊖ bony crepitance; ⊕ nl. bite
Extrem - pretty tender ± slt. tenderness
⊖ bony tenderness or crepitus
Able to make fists ± ↑ pain.

Lungs - CTAB
Heart - tachy but reg.
Abd - soft, non-tender, non-distended

P: Admit / IV hydration / follow

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP
[redacted] LTC, MC b(6)-2

PRO[redacted]ATURE AND STAMP
pp/ [redacted]

DIAGNOSIS
A: Blunt trauma injuries. Possible early rhabdo.

CODES b(2)-2

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

[redacted]
b(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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
20JAN04	~~(2120)~~(2200) VSS. Ø c/o pain. Admitted from EMT @ 2000. ~~BS GI~~ BS - Insp wheezes in upper lobes. (+) BS x 4 quads. Large abd. Nontender on palpation. Pt has IV to (R) AC 18G infusing NS @ 200cc/hr x 2L. Pt on 1st liter. Pt amb to BR c steady gait. Unable to assess pt's urine ∵ pt flushed toilet. BIL eyes ~~purp~~ ecchymosis. Sclera BIL bright red. Eye gtts at BS, but Ø orders written for eye gtts. BIL upper extremities has trace edema. Will continue monitor. b(6)-2 [redacted] 7AN
21JAN04@ 0145	Assumed care of pt. @ 2200. VSS, Ø c/o pain. BS: inspiratory wheezing to upper lobes bilat. (+) BS x 4 quads, voids amber urine c̄ difficulty. Strict I & Os. NS @ 200cc/h to (R) AC. Orbital bruise to OU. Sclera red to OU. Pt. in 2 pt. restraints, Ø signs of skin breakdown. 1-2 + pitting edema to bilat. hands, elevated on blankets. All other assessments WNL. Pt. sleeping @ this time. Will cont. to monitor. [redacted] T, AN

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES b(6)-2+1
21 Jan 04	assumed care @ 0600 VSS A+O.
1130	Pt with Raccon eyes a & red [redacted] sclera. Hands edematous non-pitting. Edema noted to knees + [redacted] lower legs c̄ [redacted] small abrasion noted to knees. (R) AC saline lock implace and intact. OOB ⇒ BR for dinner tolerated well. Ø skin breakdown noted. Ambulatory c̄ steady gait. Ø c/o dizziness. Urine clear. Lungs clear. BS (+) x4 quad. ABD soft, round, non distended. Consume 60% of meals. Will continue to monitor. 2pt restraints implace without compromising skin integrity/circ. b(6)-2 [redacted]
(1840)	Pt a&O, VSS, Ø complaints, sclera red, raccoon eyes, head CT negative per report, hands c̄ +1 non-pitting edema abrasions to (B) knees + bruising to upper arms, ICTA abd non-distended, soft, round, (+) BS x4, +2 peripheral pulses, voiding * moderate clear yellow urine, see I/O for output. Ambulating c̄ difficulty, good appetite 2pt restraints on c̄ compromise. Cont to monitor. b(6)-2 [redacted] LPN
22 JAN 04 @ 0120	Assumed care of pt. @ 2200. Temp. 99.8, other VSS. I.S. encouraged. Pt. compliant. Ø c/o pain. Slight inspiratory wheeze. (+) BS x4 quad. Pt has not voided this shift. Sclera red to OU, bruising around OU. Scabbed over abrasions to bilat knees. +1-2 pitting edema to bilat hands, elevated. (+) pulses to all extremities. IVSL to (R) AC, flushes well. Pt in 2 pt. restraints, Ø signs of skin breakdown. [redacted] ICT, AN

b(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

* - urine

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.
head CT	30	M	[redacted]	EMST	
	FILM NO.		b(6)-4		PREGNANT ☐ YES ☐ NO
	REQUESTED BY (Rank)		[redacted]		TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR		b(6)-2		DATE REQUESTED 20 Jan 03

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

raccoon eyes

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

RADIOLOGIC REPORT

normal

Hu MD [redacted]

b(2)-2

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*

EP iv b(6)-4

[redacted]

LOCATION OF MEDICAL RECORDS

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

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

20Jan04 1900

1. Admit to ICW
2. Diagnosis: assault/bruising
3. Condition: stable
4. Vitals q shift
5. NKDA
6. Activity → EPW restrictions
7. Nursing: Ø

[redacted] b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

8. Diet: regular
9. IV with NS 200cc/hr x 2 liters flow saline lock
10. meds Ø
11. Labs CPK, lytes, chem 12 QD
12. monitor I/O and note color of urine

b(6)-2 [redacted]

PATIENT IDENTIFICATION [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

22JAN04 1700

1. Tylenol 650mg Q6° prn

V/O Young / LT [redacted]

b(6)-2 [redacted]

noted [redacted] 22Jan b(6)-2 1700

b(6)-4 # [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

NEW SHEET!

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
22 Jan 04 1030	Assumed care @ 0600 VSS Pt AxO. Lungs clear. BS(+) x4 quad. Abd round soft non-distended. Voiding large and clear amb urine. P.O fluid intake Qs. Poor intake of solids. Bruising centered around eyes. OU sclera = redness. Ø c/o pain voiced. Peripheral pulses palpable +2. Labs drawn. 2 pt restraints in place without b(4)-2 compromising circ/skin integrity. [redacted]
(2000)	Assumed care @ 1400, temp 104.2, MD made aware, ordered Tylenol, enc. IS & ambulated. ice packs, temp ↓ to 102.0. I/O's recorded on form. Pt last void was in BR ⊽ showering @ 1800. (unable to record urine color). Interpreter unavailable @ this time. abd: soft, round, non-distended, bruising to eyes & red sclera unchanged from previous. 2 pt restraints on 3 compromise. Cont to monitor — [redacted] ON —
b(4)-2 23JAN04 @ 0300	Assumed care of pt. @ 2200. Temp 101.7 @ 2330. ⅡⅡ Tylenol PO for fever. I.S. encouraged 10x/°, pt. compliant. Temp @ 0300: 99.8°. Bruising noted to (R) LE & around eyes bilat. Sclera red to OU. Ø c/o pain.

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(4)-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

b(4)-2 A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
(cont.)	Abrasions noted to bilat. knees, scabbed over. +1 edema, pittings noted to bilat. hands. Ø IV access. Pt. in 2 pt. restraints. Ø signs of skin breakdown. All other assessments WNL. Will cont. to monitor. —— b(6)-2 [redacted] LT, AN.
23 Jan Ø7ØØ	Temp 99. Lungs clear. BS(+) x4 quad. ABD round soft non-distended. HOB ↑ 30°. Discoloration continues around eyes. OU sclera red. Denies pain @ this time. Consumed 60% of Breakfast. Peripheral pulses palpable +2. 2pt restraints in place. Urine [redacted] I+O and monitor color of urine. [redacted]
23 Jan Ø4 1630	Assumed pt @ 1400 hrs., VS WNL, bilateral black eyes; ⓞ sclera filled c̄ blood. Thoracic cavity wnl, bowel sounds x 4 quad., bladder nondistended, nontender upon palpation. Ø/10 on pain scale, equally strong extremities. Pt. will be discharged tomorrow per physicians orders. will cont. to monitor I+O's. —— [redacted] LVN.
23 Jan Ø4 1700	Pt. urinated, 900cc - clear yellow, no floating particles —— [redacted] LVN.
23 Jan Ø4 1838	Pt. I+O's - ate 30% of [redacted] no complaints at this time —— [redacted] LVN.
23 Jan Ø4 1910	Pt. urinated - 225cc - cl[redacted] LVN
	(0030) Assumed pt care @ 2200; VS WNL; pt restricted to [redacted]; Pt c/o pain to Heplock site (R) A/C - warm to touch c̄ ecchymosis; Pt given Tylenol 600mg; Heat pack placed to (R) A/C; bruised/discoloration around eyes; ⓞ sclera filled c̄ blood; pt on restraints; urine dark yellow Ø sediment. Pt is to be discharged back to com[illegible] per physians orders. —— [redacted]

STANDARD [redacted] (REV. 5/1999) BAC

USAPA V1.0

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
24 Jan 04 0700	VSS AOO. Voiding clear yellow urine. Bruising around OU decreasing as well as redness to sclera. Continue to have good appetite. Lungs clear. BS (+) 4 quad. Abd soft round non-distended. Peripheral pulses +2. D/C sensory taken to PAD. 2 pt restraints in place without compromising circ/skin integrity. [redacted] 2028
24 Jan 04 1200	D/C to MP for Camp [redacted] 207 b(4)-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

b(2)-2

NSN 7540-01-075-3786

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

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS: Iraqi Detainee

CITY: | STATE: | ZIP CODE:

ARRIVAL

DATE *(Day, Month, Year)*: 20 Jan 04 | TIME: 1655

TRANSPORTATION TO FACILITY:

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

CURRENT MEDICATIONS: Ø

ALLERGIES: Ø

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: NA | COMPLETED INTITIAL SERIES: ☐ YES ☒ NO

CHIEF COMPLAINT: SOB

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☒ NON-URGENT

TIME: 1555

INITIALS: bb-2 [redacted]

VITAL SIGNS

TIME	1655				
BP	144/63				
PULSE	115				
RESP	20				
TEMP	99.4				
WT					

LAB ORDERS

✓	CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT	
	URINE C&S	✓ UA MSCC/CATH		✓ CHEM: 12 / lytes	
	BLOOD C&S X				

X-RAY ORDERS

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

ORDERS

☒ PULSE OX 96% ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE

DISPOSITION: ☐ HOME ☐ FULL DUTY

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

MODIFIED DUTY UNTIL | RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE | TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

EPW b(6)-4

[redacted]

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																							
POST-	DAY																						
MONTH-YEAR	DAY	20			21			22			23			23			24						
19	HOUR	8			0	12		0	1	2	0	1		2			0						
PULSE (0)	TEMP. F (°)	1 3 0			2 0 0	5 0 0		1 0 0	6 0 0	3 0 0	1 0 0	6 4 0		3 0 0			7 0 0						TEMP. C
	105°																						40.6°
180	104°																						40.0°
170	103°																						39.4°
160	102°																						38.9°
150	101°																						38.3°
140	100°																						37.8°
130	99°																						37.2°
	98.6°																						37.0°
120	98°																						36.7°
110	97°																						36.1°
100	96°																						35.6°
90	95°																						35.0°
80																							
70																							
60																							
50																							
40																							
RESPIRATION RECORD		1 8			1 0	2 0 2		1 8	2 2		1 8			2 2			1 4						
BLOOD PRESSURE												166/55		135/55									
					128/56			125/62				98.8 99											
HEIGHT:	WEIGHT →																						
	SAT Ox	98% RA			98% (RA)	96% RA		96% (RA)	97% RA		97%	97%		100%			98%						

(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.

[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

~~OUTPUT~~

URINE					
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0545	650	650cc			

IV Fluids ~~NASOGASTRIC~~			
TIME	AMOUNT	TYPE	ACCUM TOTAL
2000		NS@200	300
22-06	200cc/o	NS	1600

CHEST					
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

~~THORAC~~ PO FLUIDS			
TIME	AMOUNT	TYPE	ACCUM TOTAL
0500	800cc	H20	800cc

STOOLS				
TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT			
TIME	AMOUNT	TYPE	ACCUM TOTAL
GRAND TOTAL OUTPUT			

REMARKS

Start: 20Jan@2000

End: 21Jan@0600

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

[redacted] b/w-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

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

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974)

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET	FROM 06 HOURS TO 06 HOURS	TOTAL HOURS COVERED 24	DATE 21 Jan 04

INTAKE

ORAL				INTRAVENOUS					
TIME	TYPE	AMOUNT	ACCUM TOTAL	TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0700	Juice	180		0600	500	NS	500	0830	520
	Milk	180							
	H_2O	200	560						
1800	H_2O	500	1060						
1800	Juice	200	1260cc						

IRRIGATIONS (N/G, Bladder, etc.)			
TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES				
TIME STARTED	PRODUCT (i.e. B1, A1b, P. cells etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE			
TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
GRAND TOTAL INTAKE			

DD FORM 792, JAN 74 (EG) EDITION OF 1 SEP 54 IS OBSOLETE. Designed using Perform Pro, WHS/DIOR, Jun 94

[redacted] b(6)-4

OUTPUT

URINE						NASOGASTRIC			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL
08	300	300							
1530	400	700cc							
1830	800	1500cc							

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

STOOLS					OTHER OUTPUT			
TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL
					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

OUTPUT

URINE						NASOGASTRIC			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL
0700	1000	1000							
0940	1000	1000							
1400	200	2200cc							

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

STOOLS				
TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT			
TIME	AMOUNT	TYPE	ACCUM TOTAL
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

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974)

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET	FROM 06 HOURS TO 06 HOURS	TOTAL HOURS COVERED 24	DATE 22 Jan 04

INTAKE

ORAL				INTRAVENOUS					
TIME	TYPE	AMOUNT	ACCUM TOTAL	TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0700	H_2O	200	200						
	Juice	180	380						
0830	Juice	180	560						
	Juice	180	740						
	H_2O	200	940						
2000	H_2O	600cc	1540cc						
0600	H_2O	200cc	1740cc						

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. B1, A1b, P. cells etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

DD FORM 792, JAN 74 (EG) EDITION OF 1 SEP 54 IS OBSOLETE. Designed using Perform Pro, WHS/DIOR, Jun 94

[redacted] b(6)-4

OUTPUT

URINE						NASOGASTRIC			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL
ϕ 900	1000	1000							
1700	900	1900cc							
2330	1000	2900cc							

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

STOOLS				
TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT			
TIME	AMOUNT	TYPE	ACCUM TOTAL
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

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974)

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET	FROM 06 HOURS TO 06 HOURS	TOTAL HOURS COVERED 24	DATE 23 Jan 04

INTAKE

ORAL				INTRAVENOUS					
TIME	TYPE	AMOUNT	ACCUM TOTAL	TIME STARTED	AMOUNT	TYPE *(Include Medications)*	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0800	Juice	180	180						
	water	200	380						
1130	water	450	830						
	Juice	180	1010						
1700	H2O	500	1510						
1800	Juice	500	2010cc						
2230 ~~2300~~	H2O	350	2360cc						
2330	Juice	400	2760cc						

IRRIGATIONS *(N/G, Bladder, etc.)*			
TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES				
TIME STARTED	PRODUCT *(i.e. B1, A1b, P. cells etc.)*	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE			
TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
GRAND TOTAL INTAKE			

DD FORM 792, JAN 74 (EG) EDITION OF 1 SEP 54 IS OBSOLETE. Designed using Perform Pro, WHS/DIOR, Jun 94

[redacted] b(6)-4

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

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
EPW	20 Jan	16 55	[redacted] b(6)-4

(i-STAT)			(Piccolo) Chemistry 12			(Piccolo) Metabolic Panel		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
					3.5-5.5 g/dl			
					26-84 u/l			
					10-47 u/l			
					14-97 u/l			
					11-38 u/l			
					0.2-1.6 mg/dl			
					7-22 mg/dl			
					8.0-10.3mg/dl			
					100-200 mg/dl			
					0.6-1.2 mg/dl			
					73-118 mg/dl			
					6.4-8.1 g/dl			

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 01/20/04 17:13

Patient ID: [redacted] b(6)-4
Test Name :PT
Test Result:= 13.4 sec.
Ratio = 1.1
Calculated INR = 1.16
Sample Type:citrated wh. blood
Test Date :01/20/04
Test Time :17:12
Card Lot :080201
Operator [redacted] b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 01/20/04 17:16

Patient ID: [redacted] b(6)-4
Test Name :APTT
Test Result:= 28.8 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :01/20/04
Test Time :17:13
Card Lot :110213
Operator [redacted] b(6)-2

(Piccolo) Metlyte 8		
TEST	RESULT	REF. RANGE
		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
		18-33 mmol/l

(Piccolo) Electrolyte		
TEST	RESULT	REF. RANGE
		73-118 mg/dl
		7-22 mg/dl
		0.6-1.2 mg/dl
		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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

b(6)-2

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. EPW	DATE 30 Jan / TIME 1655	SSN/PSEUDO SSN: [redacted]

b(6)-4

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3	Color	Amber	N/A	RPR		Negative
RBC		4.7-6.1 x 10^6	App	Clear	N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu	neg	Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili	neg	Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket	mod	Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG	1.020	N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld	small	Negative	H. pylori		Negative
(Hematology) Manual Differential			pH	6.0	N/A	Micro Parasites		
Segs		Mono	Prot	2+	Negative	Malaria		
Bands		Eos	Urob	0.2	0.2-1.0	O & P		
Lymph		Baso	Nit	neg	Negative	Other		
Atyp		Imm	Leuk	neg	Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative	SSA-3+ 7-10 RBC Acetest - large 2-5 WBC 5-7 Hyline casts		
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.:

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

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

(Hematology) CBC

TEST	RESULT	REF. RANGE
V		4.8-10.8x10³

======= PICCOLO =======
01/20/04 17:12
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3294AA4
OPER #: [redacted] b(6)-2 DR #: 034
SERIAL #: 0000100494

GLU	95	73-118	MG/DL
BUN	20	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	♦♦♦	39-380	U/L
NA+	140	128-145	MMOL/L
K+	4.9*	3.3-4.7	MMOL/L
CL-	101	98-108	MMOL/L
tCO2	23	18-33	MMOL/L

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

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		
Glu		
Bili		
Ket		
SG		
Bld		
pH		
Prot		
Urob		
Nit		
Leuk		
HCG		
Cell Count		
Directigen		

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
		Negative
		Negative
		Negative

Microbiology

oscopic Urinalysis

Blood Bank

BMIT SF 518 WITH NIT REQUESTED

tch
UNIT OF BLOOD

CROSSMATCH

(M

======= PICCOLO =======
01/20/04 17:12
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3463AA7
OPER #: [redacted] b(6)-2 DR #: 000
SERIAL #: 0000100697

ALB	3.7	3.3-5.5	G/DL
ALP	79	26-84	U/L
ALT	73*	10-47	U/L
AMY	20	14-97	U/L
AST	135*	11-38	U/L
TBIL	1.3	0.2-1.6	MG/DL
BUN	22	7-22	MG/DL
CA++	8.9	8.0-10.3	MG/DL
CHOL	180	100-200	MG/DL
CRE	0.8	0.6-1.2	MG/DL
GLU	99	73-118	MG/DL
TP	7.2	6.4-8.1	G/DL

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

REPORTED BY:	DATE:	LAB ID NO.:

4A

Ward/Section: 1CW#1 | REQUESTING PHYSICIAN: [redacted] b(6)-2 | CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: [redacted] b(6)-4 | DATE: 21JAN04 | TIME: 0400 | SSN/PSEUDO SSN:

(i-STAT)			(Piccolo) Chemistry 12			(Piccolo) Metabolic Panel		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Na		138-146 mmol/L	ALB		3.5-5.5 g/dl	GLU		73-118 mg/dl
K					26-8			/dl
Cl					10-4			mg/dl
pH					14-9			mg/dl
PCO					11-3			mmol/l
PO2					0.2-			mol/l
TCO					7-22			mmol/l
HCO					8.0-			mol/l
sO2					100			Plus
BEec					0.6-			RANGE
AnGa					73-			g/dl
Ca					6.4			/l
BUN								/l
GLU								/l
Creat					73-			/l
Hct					7-2			mg/dl
Hgb					0.6			l
					39			g/dl
TEST					30			
					12			e
Troponi					3.3			RANGE
Drug o Abuse					98			5 mmol/l
					18			mmol/l
								mmol/l
								mmol/l

```
======= PICCOLO =======
01/21/04                05:38 AM
REFERENCE RANGE:        MALE
PATIENT #: [redacted] b(6)-4
LIVER PANEL PLUS
DISC LOT #:             3415AA7
[redacted]#: 77         DR #: 034
SERIAL #: b(6)-2        0000100676
.......................
ALB   3.3   3.3-5.5   G/DL
ALP   54    26-84     U/L
ALT   68*   10-47     U/L
AMY   25    14-97     U/L
AST   121*  11-38     U/L
TBIL  1.2   0.2-1.6   MG/DL
GGT   40    5-65      U/L
TP    6.0*  6.4-8.1   G/DL

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

```
======= PICCOLO =======
01/21/04                05:3C
REFERENCE RANGE:        M
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #:             3291
[redacted]#: 77         DR #:
SERIAL #: b(6)-2        000010069
.......................
GLU   102   73-118    MG/DL
BUN   15    7-22      MG/DL
CRE   1.1   0.6-1.2   MG/DL
CK    ***   39-380    U/L
NA+   139   128-145   MMOL/L
K+    3.9   3.3-4.7   MMOL/L
CL-   103   98-108    MMOL/L
tCO2  22    18-33     MMOL/L

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

(Piccolo) Metlyte

RESULT

CK-75000

REMARKS: [redacted]

REPORTED BY: | DATE: | L

[redacted] b(6)-4

Ward/Section: ICW 1	REQUESTING PHYSICIAN: [redacted] b(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI. 1881	DATE 22 Jan	TIME 0910	SSN/PSEUDO SSN: [redacted] b(6)-4

======= PICCOLO =======
01/22/04 10:27
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3294AA4
OPER #: [redacted] b(6)-2 DR #: 000
SERIAL #: 0000100494

GLU	175*	73-118	MG/DL
BUN	11	7-22	MG/DL
CRE	1.0	0.6-1.2	MG/DL
CK	4234*	39-380	U/L
NA+	129	128-145	MMOL/L
K+	4.5	3.3-4.7	MMOL/L
CL-	100	98-108	MMOL/L
tCO2	23	18-33	MMOL/L

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

======= PICCOLO =======
01/22/04 10:32 AM
REFERENCE RANGE: MALE
PATIENT #: [redacted]
GENERAL CHEMISTRY 12
DISC LOT #: 3463AA7
OPER #: [redacted] DR #: 000
SERIAL #: 0000100676

ALB	3.3	3.3-5.5	G/DL
ALP	97*	26-84	U/L
ALT	82*	10-47	U/L
AMY	32	14-97	U/L
AST	103*	11-38	U/L
TBIL	1.2	0.2-1.6	MG/DL
BUN	11	7-22	MG/DL
CA++	8.7	8.0-10.3	MG/DL
CHOL	206*	100-200	MG/DL
CRE	0.8	0.6-1.2	MG/DL
GLU	180*	73-118	MG/DL
TP	6.4	6.4-8.1	G/DL

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
LU		73-118 mg/dl
UN		7-22 mg/dl
A++		8.0-10.3 mg/dl
RE		0.6-1.2 mg/dl
A+		128-145 mmol/l
+		3.3-4.7 mmol/l
L-		98-108 mmol/l
CO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

Chem 12 - Lytes, CPK

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICW#1	...STING PHYSICIAN: b(6)-4	CL...STRY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI: [redacted]	DATE: 23JAN04	TIME: 1700	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 =======

01/23/04 06:16

REFERENCE RANGE: MALE

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

METLYTE 8

DISC LOT #: 3294AA4

OPER #: [redacted] DR #: 000

SERIAL #: b(6)-4 0000100676

GLU	113	73-118	MG/DL
BUN	11	7-22	MG/DL
CRE	0.7	0.6-1.2	MG/DL
CK	2328*	39-380	U/L
NA+	130	128-145	MMOL/L
K+	3.9	3.3-4.7	MMOL/L
CL-	97*	98-108	MMOL/L
tCO2	24	18-33	MMOL/L

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 0

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

01/23/04 06:20

REFERENCE RANGE: MALE

PATIENT #: [redacted]

GENERAL CHEMISTRY 12

DISC LOT #: 3463AA7

OPER #: [redacted] DR #: 000

SERIAL #: 0000100494

ALB	3.3	3.3-5.5	G/DL
ALP	104*	26-84	U/L
ALT	242*	10-47	U/L
AMY	34	14-97	U/L
AST	214*	11-38	U/L
TBIL	1.2	0.2-1.6	MG/DL
BUN	12	7-22	MG/DL
CA++	8.6	8.0-10.3	MG/DL
CHOL	153	100-200	MG/DL
CRE	0.9	0.6-1.2	MG/DL
GLU	115	73-118	MG/DL
TP	7.0	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK

HEM 1+, LIP 0 , ICT 0

REMARKS: MET 8, CHEM 12, CPK

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICW #1	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI.	DATE 23JAN04 / TIME 0600	SSN/PSEUDO SSN:

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

			CSF			Blood Bank	
Spun Hematocrit		42-52% (M) 37-47% (F)					
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: MET

REPORTED BY:	**DATE:**	**LAB ID NO.:**

#[redacted] b(6)-4

b(6)-4

Ward/Section: (cw)

REQUESTING PH

CHE[illegible] RESULT FORM
(Subject to the Privacy Act of 1974)

LAST, FIRST, MI.: [redacted]

DATE: 24 Jan 04

TIME: 0530

SSN/PSEUDO SSN: [redacted]

(i-STAT)

TEST	RESULT	RE
Na		133-1
K		3.5-4.
Cl		98-109
pH		7.31
PCO2		35-45
PO2		41-51
TCO2		27 mol
HCO3		23-26 mmol/l
sO2		95-98%
BEecf		(-2)-(+3) mmol/l
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

TEST	RANGE
Troponin-1	
Drug of Abuse	

REMARKS:

REPORTED BY: DATE: LAB ID

ni[illegible]stry 12

(Piccolo) Metabolic Panel

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

======= PICCOLO =======
01/24/04 05:55
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3463AA7
OPER # [redacted] DR #: 000
SERIAL #: b(6) 0000100676

ALB	3.2*	3.3-5.5	G/DL
ALP	116*	26-84	U/L
ALT	207*	10-47	U/L
AMY	31	14-97	U/L
AST	133*	11-38	U/L
TBIL	0.9	0.2-1.6	MG/DL
BUN	9	7-22	MG/DL
CA++	9.1	8.0-10.3	MG/DL
CHOL	171	100-200	MG/DL
CRE	0.7	0.6-1.2	MG/DL
GLU	121*	73-118	MG/DL
TP	7.1	6.4-8.1	G/DL

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

======= PICCOLO =======
01/24/04 05:59
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3294AA4
OPER #: 13 DR #: 000
SERIAL #: b(6) 0000100494

GLU	118	73-118	MG/DL
BUN	8	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	1297*	39-380	U/L
NA+	134	128-145	MMOL/L
K+	4.0	3.3-4.7	MMOL/L
CL-	102	98-108	MMOL/L
tCO2	26	18-33	MMOL/L

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

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] Notified 2 3 0130 b(6)-4			↓	23 Jan 04	09 30 HOURS	
				Return to He Camp		
				[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.				

b(a)-2

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 20	21	22	23	24								
	[redacted]	Braden Scale on admission	08	DONE												
		& QTD										ERROR				
	[redacted]	Skin integrity & circulation														
		checks to restrained limbs														
20Jan	[redacted]	Vitals : QShift	D	[redacted]												
			E													
			N													
20Jan	[redacted]	Activity → EPN instruction	D													
			E													
			N													
20Jan	[redacted]	Nursing: Ø	D													
			E													
			N													
20Jan	[redacted]	Diet: Regular	D													
			E													
20Jan	[redacted]	Labs: CPK, lytes,	04													
		Chem 12 QD														
20Jan	[redacted]	Monitor I/O + note	D	[redacted]												
		color of urine	E													
			N													

ALLERGIES: ☐ YES ☑ NO

PRIMARY DIAGNOSIS: assault / Bruising

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

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]	[redacted] b(6)-4	FGN	

4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm
M	30Y	X	MUSLIM			NO

11. FMP	12. SSN	13. Organization	14. Ward
99	[redacted] b(6)-4		ICW1

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

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service:
Direct from ER	17:00	ABA - GENERAL SURGERY

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	TRF-OTH	2004-01-24

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2004-01-20	[redacted] b6-2

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
[redacted] b(2)-2	2004-01-20	

31. Selected Administrative Data

Marital Status: Z DoB: 1973-03-30

In/Out Patient: Inpatient MOS:

33. Cause Of Injury: BEATING

34. Diagnosis / Operations and Special Procedures:

MULTI CONTUSIONS

Dx

790.5
276.5
920
921.0
923.9
922.31
E960.0

Px

87.03
99.29

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	Ø	Ø4	Ø4

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	Ø	Ø4	Ø4

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

Automa[redacted]47, May 79

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*				Mo _____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
20 Jan	[redacted]	Admit to ICW: Condition-Stable	20 Jan			
22 Jan		Return to Camp	Next Camp	Run		
	----	b(6)-2				

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

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