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: **24 - HOUR COMPREHENSIVE CARE RECORD Part 1**

OTSG APPROVED (Date)

DATE: 22 Mar 03

Prep DX: ① DSW to ⓡ shoulder c̄ exc̄

HOSPITAL DAY NO. wound over ⓡ scapula

② DSW to ⓛ mid abdomen c̄ exc̄

POST OP DAY NO. wound over ⓡ UQ abdomen

③ Shock

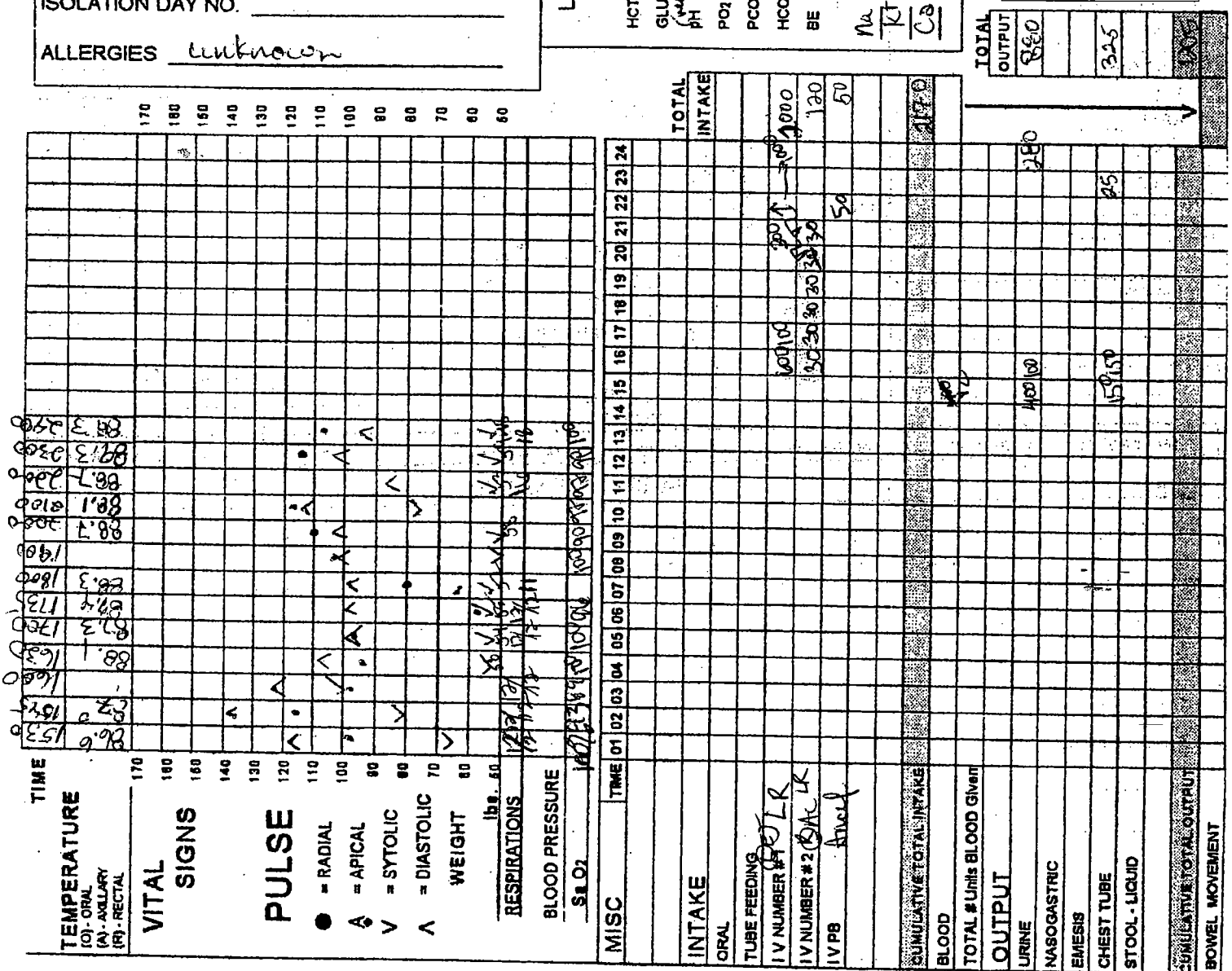
ISOLATION DAY NO.

ALLERGIES unknown

(b)(3)-1

LAB STUDIES

	TIME	TIME	TIME
HCT		30	10
GLU		197	
pH		7.446	
PO2			
PCO2			
HCO3			
BE			
Na	149		
K	3.6		
Cl	1.15		



PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC

DATE 22 Mar 03

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

EPW (b)(6)-4

(b)(3)-1

DIAGNOSIS: ~~[illegible]~~ Thru & Thru gastrotomy over greater curvature

② Multiple exit [illegible] jejunum

③ ② Intra live [illegible]

☐ HISTORY/PHYSICAL

☐ OTHER EXAMINATION OR EVALUATION

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

☐ FLOW CHART

☐ OTHER (Specify)

24 - HOUR COMPREHENSIVE CARE RECORD Part 2

	0700-1900	1900-0700
ACTIVITY BR - D - AA - A		
BATH B - P - S		
FOLEY / PERI CARE		
ORAL CARE		
ENDOTRACHEAL TUBE CARE		
ORAL / ET SUCTION		
OXYGEN VIA AT LPM		
VENTILATOR		
Fi O2 21%		
RATE: 12		
TIDAL VLOUME 500		
PEEP Ø		
DIET:		
DRESSING CHANGE		

SIGNATURES	INITIAL
(b)(6)-2 NAT/AN	(b)(6)-2
(b)(6)-2	

NEURO GUIDE
✓ Normal
– Sluggish
+ Fixed
C Eyes Closed by Swelling

PUPIL SIZE
2 mm
4 mm
6 mm
8 mm

COMA SCALE		TIME	1530	1730	(b)(6)-2
PUPILLARY REACTION	RIGHT	SIZE			
		REACTION			
	LEFT	SIZE			
		REACTION			
EYES OPEN	SPONTANEOUS	4			4
	TO SPEECH	3			
	TO PAIN	2			
	NONE	1	1	1	
BEST MOTOR RESPONSE	EYE COMMANDS	6			
	PULLS TESTERS HAND AWAY WHEN PINCHED	5			5
	FLEXION WITHDRAWAL	4			
	DECORTICATE POSTURING	3			
	DECEREBRATE POSTURING	2			
	NONE (intubated)		1	1	
BEST VERBALE RESPONSE	ORIENTED	5			
	CONFUSED	4			
	INAPPROPRIATE	3			
	INCOMPREHENSIBLE SOUNDS	2			
	NONE	1	1	1	
	TOTALS				

BR - BEDREST D - DANGLE AA - AMBULATE WITH ASSISTANCE A - AMBULATORY B - BED P - PARTIAL S - SHOWER

NARRATIVE NOTES

TIME	
1530	Pt. received from OR. Intubated. Breath sounds clear bilaterally. (L) ET IV c̄ LK @ TKO, IVP's LR @ TKO (R) AC. Sedated. Vent settings SIMV rate 12, FIO2 21%, TV 500. Midline abd incision c̄ intact dry. Drsg to RUQ intact c̄ noted bloody drainage copy to rt. side. Drsg reinforced c̄ 4x4's. (R) lat CT site intact, (2) drainage noted, connected to low suction. Foley drain clear yellow urine. Oral ETT 21cm @ lip to (R) side. (R) NGT clamped. Temp 86.6. Pt covered c̄ fire blankets. Will monitor for ↑'d temp. (b)(6)-2
1615	Pt. attempted to wake up. Biting ETT c̄ ↓'d O2 sat (80-85%). Temp remains @ 87.0°F. Given 5mg MSO4 + 3mg Versed IV per anesthesia. (b)(6)-2
1730	Pt. biting on ETT. Attempting to wake. Temp decreasing @ 87.4. Given 3mg MSO4 + 1.5mg Versed IV. Pt. now less agitated. (b)(6)-2
1830	Pt extubated per anesthesia. Placed on FM @ 10L/min. Tolerating well. (b)(6)-2
2000	Pt. agitated & groaning. Attempting to turn + pulling to free self. Given 2mg MSO4 + 1.5mg Versed IV. (b)(6)-2
2300	Pt. continue c̄ moaning. Given 3mg MSO4 IV. Temp @ 89.3. Pt. continues with being covered c̄ multiple blankets. (b)(6)-2

Initial Assessment
Date 23 MAR 03 Time 1615HRS

(b)(3)-1

ICU ✓
OR

NEUROLOGICAL ASSESSMENT

2 3 4 5 6 7 8 9

Pupil	Size	Reaction	Pupil	Size	Reaction
OD			OS		

Pupil Reaction: R - Reactive N - Non-Reactive

Level of Consciousness
✓ Awake ✓ Alert — Drowsy
— Restlessness — Lethargic
— Unconscious

Orientation:
X Time X Place X Person

Eyes Open:
X Spontaneous
— To Speech
— To Pain
— No Response

Best Verbal:
X Oriented & Converses
— Disoriented & Converses
— Inappropriate Words
— Incomprehensible Sounds
— No Response

Best Motor:
X Obeys Commands
— Localizes Pain
— Extension
— No Response

Motor Ability & Strength:

	Strong	Weak	Absent
RA	✓		
LA	✓		
RL	✓		
LL	✓		

PSYCHOLOGICAL
X Calm — Combative
X Cooperative — Anxious

INTEGUMENTARY

Color:	Skin:
X Normal	X Warm
— Pale	X Dry
— Flushed	— Diaphoretic
— Cyanotic	— Cool
— Jaundiced	— Clammy

RESPIRATORY
X Unlabored — Labored

Breath Sounds:
— Clear Bilaterally
— Absent R L
X Rales (R) L
— Wheezes R L

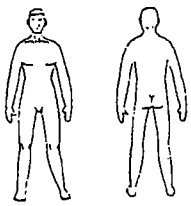
ABDOMINAL
— Soft X Tender
— Rigid — Non-Tender
— Distended — Rebound

Bowel Sounds:
— Active — Hypoactive
— Hyperactive — Absent

CARDIOVASCULAR

Pulses	Right	Left
Brachial		
Radial	+2	+2
Femoral		
Pedal	+2	+2
Edema		

0-Absent + 2-Normal
- 1-Weak + 3-Bounding



(b)(6)-4

25 yrs old

Time	Temp	P	R	B/P
1615hrs	98.8	119	18	118/59
1830		113	20	112/59
1910				

NURSING OBSERVATIONS/INTERVENTIONS

SPO_2 97% on 5L O_2 via Nasal canula. Pt transported to (b)(3)-1 ICU Section via litter by FLA. VSS on arrival. Pt has chest tube to (R) side which is to low suction. Draining bloody red fluid at this time. NG tube to low suction draining dark red fluid. 18ga IV to (L) wrist saline locked. 18ga to (R) AC infusing LR @ 150cc/hr. Δ'd dressings to (R) upper chest, back and (L) side with 4x4 & tape. Δ'd Chest tube dressing with 4x4's. Dressings to (R) abdomen and midline abdomen Δ'd c̄ Kerlix soaked in NaCl 0.9% irrigation solution. Foley catheter to gravity drainage c̄ clear amber urine at this time. (b)(6)-2 SSG/LN

Interpreter explained pain scale to pt who verbalized understanding and gave his name and age. Pain level was 9/10. Pt medicated c̄ 5mg MSO_4 (b)(6)-2 SSG/LN

Allergies NKDA

Time	IV MEDICATIONS (dose/route site)
1700	Cefotetan 2g IVPB in 100ml NaCl.
1845	5mg MSO_4 IVP
1700	5mg MSO_4 IVP
1900	5mg MSO_4 IVP 9/10 pain.
2330	6mg MSO_4 IVP 9/10 (b)(6)-2

INTAKE/OUTPUT

Time	IV	Urine	Chest	Gastric
		300 (1930)		
Total:				

Pertinent Lab Values
1830 hrs.

pH 7.374	Na 138
pCO_2 44.4	K 4.8
PO_2 99	iCa 1.17
Base Excess +1	Hct 22
Bicarb. 26	Hbg 7
TCO_2 27	
SO_2 97	

S WORKUP SHEET DA FO. 00 (b)(3)-1

MEDCOM - 4375

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 **24 - HOUR COMPREHENSIVE CARE RECORD Part 1**

OTSG APPROVED *(Date)*

DATE: 23 Mar 03

HOSPITAL DAY NO. 2

POST OP DAY NO.

ISOLATION DAY NO.

ALLERGIES

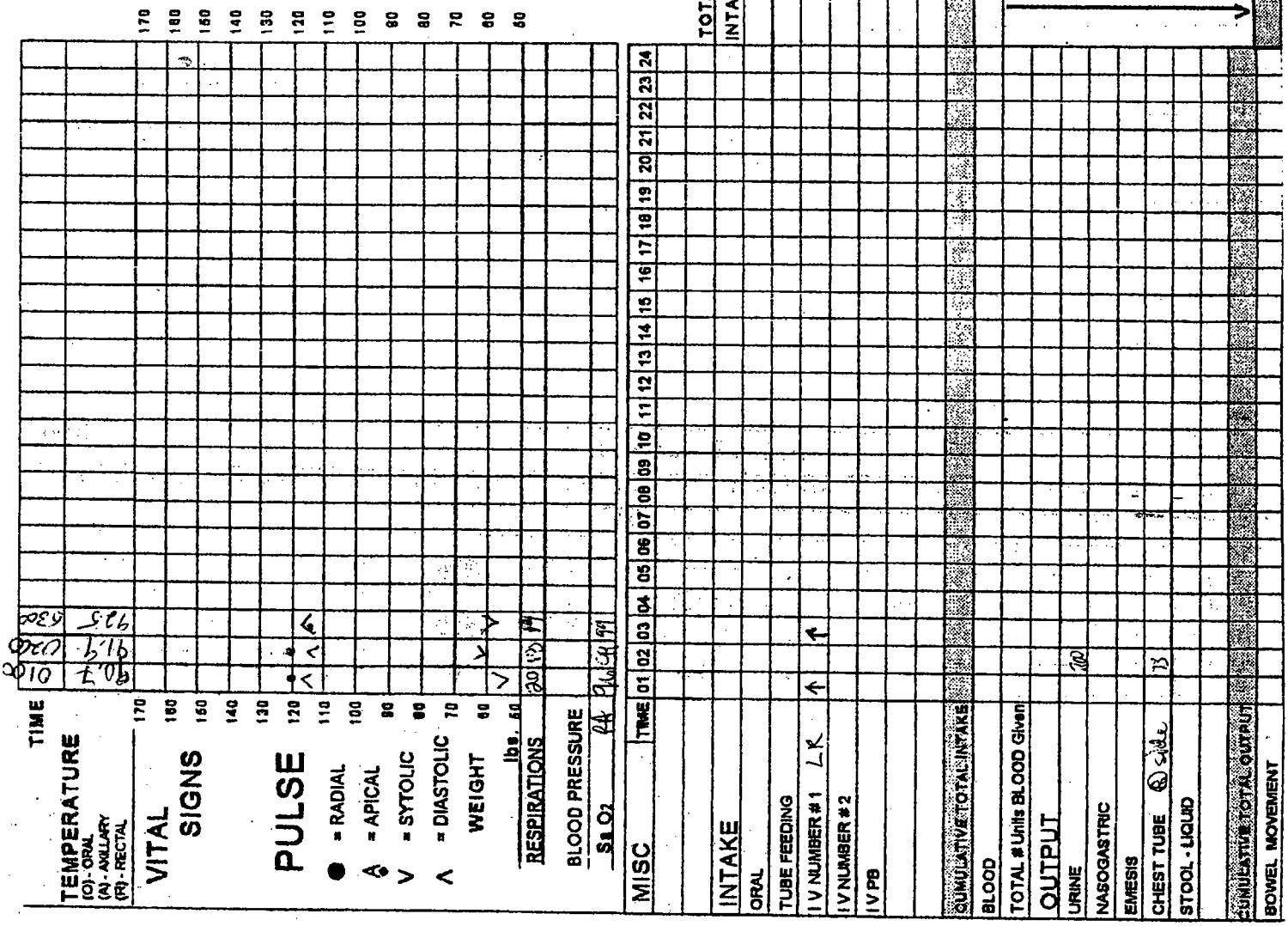
LAB STUDIES

	TIME	TIME
HCT		
GLU		
pH		
PO2		
PCO2		
HCO3		
BE		

(b)(3)-1

TOTAL OUTPUT

TOTAL INTAKE



PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC

DATE

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

EPLO (b)(6)-4

(b)(3)-1

DIAGNOSIS: ① Thru & Thru Gastrostomy over greater curvature
② Multiple enterotomies proximal jejunum
③ ⓑ low liver GSW

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

MEDCOM - 4376

24 - HOUR COMPREHENSIVE CARE RECORD Part 2

	0700-1900	1900-0700
ACTIVITY BR - D - AA - A		
BATH B - P - S		
FOLEY / PERI CARE		
ORAL CARE		0100
ENDOTRACHEAL TUBE CARE		
ORAL / ET SUCTION		
OXYGEN VIA AT LPM		
VENTILATOR		
Fi O2 ____		
RATE: ____		
TIDAL VLOUME ____		
PEEP ____		
DIET: ____		
DRESSING CHANGE		

SIGNATURES		INITIAL
(b)(6)-2	MAJ AN	(b)(6)-2
(b)(6)-2	[illegible]	(b)(6)-2

TIME

NEURO GUIDE
✓ Normal
– Sluggish
+ Fixed
C Eyes Closed by Swelling

PUPIL SIZE
2 mm
4 mm
6 mm
8 mm

COMA SCALE

PUPILLARY REACTION	RIGHT SIZE	
	REACTION	
	LEFT SIZE	
	REACTION	
EYES OPEN	SPONTANEOUS	4
	TO SPEECH	3
	TO PAIN	2
	NONE	1
BEST MOTOR RESPONSE	EYE COMMANDS	6
	PULLS TESTERS HAND AWAY WHEN PINCHED	5
	FLEXION WITHDRAWAL	4
	DECORTICATE POSTURING	3
	DECEREBRATE POSTURING	2
	NONE	1
BEST VERBALE RESPONSE	ORIENTED	5
	CONFUSED	4
	INAPPROPRIATE	3
	INCOMPREHENSIBLE SOUNDS	2
	NONE	1
TOTALS		

BR - BEDREST D - DANGLE AA - AMBULATE WITH ASSISTANCE A - AMBULATORY B - BED P - PARTIAL S - SHOWER

NARRATIVE NOTES

TIME	
0100	Care continued from 22 Mar 03. Pt awake and very uncomfortable. Unable to communicate d/t language barrier, however pt. moaning. Given 3 Mg MSO4 for pain. Will continue to monitor. Temp 1d 90.7.
0200	2 Mg MSO4 IV (b)(6)-2

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF: (b)(3)-1
2. LOCATION (State or Country Code): P Z
3. REGISTER NUMBER: (b)(6)-4
NAME (Last, First, Middle Initial): (b)(6)-4
4. PAY GRADE:
5. SEX: M
6. DATE OF BIRTH (Y Y Y Y M M D D): 1978 01 01
7. AGE AT ADMISSION: 25
8. RACE: X
9. ETHNIC BACKGROUND: 9
RELIGION:
10. LENGTH OF SERVICE:
ETS:
11. FMP: 20 ~~29~~ ~~49~~
12. SOCIAL SECURITY NUMBER: (b)(6)-4
ORGANIZATION (Active Duty Only):
13. MARITAL STATUS: Z
HOUR OF ADMISSION: 0920
BRANCH / CORPS:
14. FLYING STATUS:
15. BENEFICIARY CATEGORY: ~~K98~~ ~~K9~~/K78
16. ZIP CODE OF RESIDENCE: 09330000
17. UNIT LOCATION (State or Country Code):
18. MOS:
19. TRAUMA: INJ
PREV. ADMISSION: YEAR ☐ NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 1 DTR
WARD: ICW2
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE:
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code):
NAME AND (b)(3)-1
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE:
21. TYPE OF DISPOSITION: 05
22. MTF TRANSFERRED TO:
23. DATE OF DISPOSITION (Y Y M M D D): 030502
24. CLINIC SVC - ADMITTING: ABAA
25. MTF TRANSFERRED FROM:
26. DATE THIS ADMISSION (Y Y M M D D): 030418
27. LOCATION OF OCCURRENCE (Battle Casualty Only): IZ
28. MTF OF INITIAL ADMISSION:
29. DATE INITIAL ADMISSION (Y Y M M D D):

FOR LOCAL USE

DX: 8631 GSW to R anterior & posterior chest - E969
8603 GSW to R Lower Quadrant of abdomen Trauma
86415
86339
9584
5180
99832
E9110
E9200

Injury
450

ADMITTING OFFICER (Signature, as required): (b)(6)-2 MD

SIGN: (b)(6)-2

DA FORM 2985, MAR 89 EDITION OF MAY 79 IS OBSOLETE

X: 4562
5061

MEDCOM - 4378

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF: 1 2 3 4 5 6 7 8 — (b)(3)-1 — I 6

MTF LOCATION (State or Country Code)

3. REGISTER NUMBER: 9 10 11 12 13 14 15 — (b)(6)-4

NAME (Last, First, Middle Initial): # (b)(6)-4 — (b)(6)-4

4. PAY GRADE: 16 17

5. SEX: 18 — M

6. DATE OF BIRTH (Y Y Y Y M M D D): 19 20 21 22 23 24 25 26

7. AGE AT ADMISSION: 27 28 29

8. RACE: 30

9. ETHNIC BACK-GROUND: 31

RELIGION

10. LENGTH OF SERVICE: 32 33 34

ETS

11. FMP: 35 36

12. SOCIAL SECURITY NUMBER: 37 38 39 40 41 42 43 44 45

ORGANIZATION (Active Duty Only)

13. MARITAL STATUS: 46

HOUR OF ADMISSION: 0920

BRANCH / CORPS

14. FLYING STATUS: 47 48 49

15. BENEFICIARY CATEGORY: 50 51 52

16. ZIP CODE OF RESIDENCE: 53 54 55 56 57 58 59 60 61

17. UNIT LOCATION (State or Country Code): 62 63

18. MOS: 64 65 66 67 68 69 70

19. TRAUMA: 71 — INJ

PREV. ADMISSION: YEAR ☐ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 72 — DIR

WARD: 1CW2

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AN (b)(3)-1

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION: 73 74

22. MTF TRANSFERRED TO: 75 76 77 78 79 80

23. DATE OF DISPOSITION (Y Y M M D D): 81 82 83 84 85 86 — 0 3 0 5 0 2

24. CLINIC SVC - ADMITTING: 87 88 89 90 — A B A A

25. MTF TRANSFERRED FROM: 91 92 93 94 95 96

26. DATE THIS ADMISSION (Y Y M M D D): 97 98 99 100 101 102 — 0 3 0 4 1 8

27. LOCATION OF OCCURRENCE (Battle Casualty Only): 103 104

28. MTF OF INITIAL ADMISSION: 105 106 107 108 109 110

29. DATE INITIAL ADMISSION (Y Y M M D D): 111 112 113 114 115 116

FOR LOCAL USE

GSW to R anterior & posterior chest - ~~E969~~
GSW to R Lower Quadrant of abdomen

(b)(6)-2

...ired) — MD

SIG (b)(6)-2

EDITION OF MAY 79 IS OBSOLETE

MEDCOM - 4379

ADMISSION AND CODING INFORMATION

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

30. AGE AT DISP			31. AUTOPSY Y / N	32. UNDERLYING CAUSE OF DEATH / SEP	33. RESIDUAL DISABILITY			34. DO NOT USE - DATA FILLER #1									35. CAUSE OF INJURY		
117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136
			N																

36. FIRST DIAGNOSIS *(Principal Diagnosis)*								37. SECOND DIAGNOSIS								38. THIRD DIAGNOSIS							
137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160
	E	9	9	1		2																	

39. FOURTH DIAGNOSIS								40. FIFTH DIAGNOSIS								41. SIXTH DIAGNOSIS							
161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184

42. SEVENTH DIAGNOSIS								43. EIGHTH DIAGNOSIS							
185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200

44. FIRST PROCEDURE *(Principal Diagnosis)*								45. SECOND PROCEDURE								46. THIRD PROCEDURE							
201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224

47. FOURTH PROCEDURE								48. FIFTH PROCEDURE								49. SIXTH PROCEDURE							
225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248

50. SEVENTH PROCEDURE								51. EIGHTH PROCEDURE							
249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264

52. NUMBER OF DIAGNOSTIC FIELDS CONTAINING CODES		53. NUMBER OF PROCEDURAL FIELDS CONTAINING CODES		54. PRIMARY PROVIDER SPECIALTY CODE			55. BLOOD USAGE Y/N
265	266	267	268	269	270	271	272
Ø	1						

MEDCOM - 4380

1.

[redacted]ENT TREATMENT RECORD COVE[redacted]

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

1. REGISTER NUMBER (b)(6)-4	2. (b)(6)-4				3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE	6. RACE Iraqi	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
11. FMP 99	12. SSN (b)(6)-4		13. ORGANIZATION			14. WARD 1C01
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE INJ
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct			22. HOURS OF ADMISSION 0605	23. CLINIC SERVICE ABAA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE		25. TYPE DISPOSITION Trans		26. DATE OF DISPOSITION 21 apr 03		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)		27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION 11 apr 03		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1				30. DATE OF INTIAL ADMISSION		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW L Chest ~~E922.3~~

DX: 86130
8603
8911
7990
E9654

PPX: 5411
331
3404

Trauma
1

Injury
450

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
					10

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER (b)(6)-2 (b)(6)-2 MAJ, MC

SIGNATU (b)(6)-2 R

DA [redacted] 79

EDITION OF 1 AUG 76 IS OBSOLETE

USAPPC V1.10

MEDCOM - 4381

pre-op ws

DOCTOR'S ORDERS *(Date and sign all orders)*

Admit to ICU
Dx: s/p E-lap, thoracotomy, chest tube x 2
Cond: good p chest tubes
Vitals q4
Activities - bed rest
Tx ii units PRBC Done
IVF NS @ 125 cc/hr Done
Med: MSO4 10 mg IV q 2-3 PRN
Tylenol 650 mg po q4 Temp 7101
phenergan 25 mg IV q 6 PRN
Ancef i gm IV q8 x 24 Done
NGT if emesis Done
Ctr in a.m.
Albuterol Inhaler q4

(b)(6)-2

TEMPERATURE - PULSE - RESPIRATION

DATE AND TIME	T	P	R	STOOLS	WEIGHT	
0530	99.2	110	20	123/77	96%	@6L
						1 unit PRBC 2045 08 APR 03
						1 unit PRBC 2140 08 APR 03
						1 gm Ancef IV ☒ 07 ☒ 15 ☒
						3 mg MSO4 @ 0530
						1400 cc UOP

10 55820 10 55942

V1.00

MEDCOM - 4382

08 APR 03

VS 2300 130/73 22 RR HR116 92% ON 6L

Patient received 2 units PRBC, CT #1 & #2 to LCS, T99.4

received 1gm Ancef IV, PA inserted Subclavian Line, patient

No other problems noted @ this time — (b)(6)-2 [redacted] cpn 4hrs

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
08Apr03	Brief Op Note
0915Z	Preop Dx: ① ~~Thoracoabdominal~~ GSW
	② ① hemothorax
	③ Acute Abdomen
	Postop Dx: ① Same
	② GSW to ① lower lobe of lung c̄ ① hemothorax
	Procedure: Exp'l lap, exploratory thoracotomy
	Findings ① No intraperitoneal or retroperitoneal abdominal injury. Diaphragm intact
	② GSW to ① lower lobe of lung c̄ round embedded in ~~lung~~ ① lower lobe. Bullet not removed. Heart & mediastinal structures c̄ injury.
Surgeons	(b)(6)-2 [redacted]
	EBL: 200 cc
	Fluids: 3.5 l crystalloid, 1 unit of albumin.
	Specimens: ∅
	Complications: ∅
	Disposition: to RR stable.
	(b)(6)-2 [redacted]
	(b)(6)-2 [redacted]
	MAJ, MC, USA General Surgeon
	(b)(3)-1 [redacted]

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

(b)(6)-4 [redacted]

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

CHRONOLOGICAL RECORD OF MEDICAL

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

(b)(3)-1 [redacted]

MEDCOM - 4384

509-113 NSN 7540-00-634-4122

MEDICAL RECORD — PROGRESS NOTES

DATE

8 apr, 2003, 0920 Recover fm O.R. w/ CRNA & Surgeon, S/P Thoracotomy

CT in place, pt shivering, F/C w/ 1500 in bag, monitor w/ wrong TIME!

wrong time is charted per monitor setting.

pupils +2 & reactive
IV sites (R AC & Lt AC.
Patent 18 gage.

RT LS CTA, w/ good
air movement
Lt LS w/ WND, drsg
CDI, CTube draining
10 cc so far,

as of 0430 - "monitor
time" = to 1030 Z, pt
not tolerating < 3L
N/C.

	HR	SAT	BP	RR	O2	
0304,	130,	72,	133/57			pt moving air well,
0310	115	80	135/67	35	6L MASK	but poor O2 saturation
0315	115,	80,	134/67	35	↓	per monitor, checked
0320	118	82,	147/63	41		@ different sites eg.
0325	111	84,	159/71	40		ear & fingers,
0330	100	88	154/70	28	←	40 mg Lasix given
0335	102	89%	143/70	26		Peripheral pulses weak,
0340	91	92%	150/69	24		cap refill < 3 sec, pale skin.
0345	92	94%	142/71	21	↓ 3L	Space blanket applied.
0350	92	94%	141/69	23	RA	IVF @ 40cc/° bilat.
0355	98	82%	120/60	21	↑ 5L	
0400	94	93%	133/66	21		
0405	98	94%	122/63	22		PER CRNA - Rec.d
0410	100	96%	126/64	22		3000 IVF &
0415	98	96%	128/65	26	↓ 3L	100 ALBUMIN w/
0420	100	95%	120/62	30	↓ 2L	1600 OUT VIA F/C &
0430	1 mg	MSO4	94%	23		EBL
0430	102	98%	125/63	22		0430 - PACU 400 FC
0445	109	97%	127/62	22	RA	
0500	115	90%	133/64	23	2L	2 mg MSO4 IVP
0540	104	99%				1500 Out Via foley.

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

PROGRESS NOTES

Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8/03 2129	Male Iraqi brought to (b)(3)-1 [redacted] S/P E. lap + ① thoracotomy c̄ ① chest tube. Pt. presented hypotensive tachycardic tachypnic c̄ ↓'d ① BS. ABD. flat + soft c̄ dry dressing. Pt. improved c̄ 2ND thoracostomy tube. Now he remains tachycardic + appears pale. Imp S/P E lap / thoracotomy, chest tube x 2. Critical. Plan ICU Tt c̄ u PRBC O2 mask mon. for. Ctr in a.m. (b)(6)-2 [redacted]

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

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

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 - 4386

934th FST

DOCTOR'S ORDERS *(Date and sign all orders)*

2130 Midline dressing changed, healing well, chest tube draining to air seal with intermittent suction. Requires O_2 @ 6L sats at 96. Urine output QS, VSS. — (b)(6)-2 -LPN

0330 - VSS, moaning seems to be in pain received 4mg MSO4 IV with good results sleeping quietly, O_2 >90% no other problem currently noted — (b)(6)-2 [illegible]

TEMPERATURE · PULSE · RESPIRATION						NURSE'S NOTES
DATE AND TIME	T	P	R	~~STOOLS~~ BP	~~WEIGHT~~ SaO2	MEDICATION AND NURSE'S NOTES
09 9 APR 03 2130	99.2	101 / 101	26 / 21	126/73	98 / 5LPM	R Ancef ☒ Last Dose
				131/70	96(5L)	1320 1000ml URINE OUTPUT
0600 10 APR 03	100.6	92	20	143/78	91@2L	U/O 07 = 900 cc = 400 cc — 1900
						600 cc U/O
						MSO4 - 4mg 1700
						MSO4 - 4mg @ 2030
						MSO4 - 4mg 0350
						1200 cc U/O
						Inhalen Aid to PRN by RN
						PT Respiratory status improved
10 APR	99.4	100	24	130/73	92/2L NC	— Albuterol 2 q

☒ ☐ ☐ ☐ ☐ USAPPC V1.00

see next page

04

MEDICAL RECORD	PROGRESS NOTES

DATE

10 APRIL 03

1600

GENERAL SURGERY SUI

3/yo Iraqi Male EPW transferred from [redacted] (b)(3)-1 after GSW Left Chest 08 Apr 03. He was hypotensive w/ nonlimited exp thoracotomy and laparotomy w/ neg. exp lap. Finding of injury to Left lower lobe not resp. intervention.

PMH/PSH ∅ NKDA

Tubes: ① CT x1 Lime Left subclavian Cardia

Foley cath.

CT - functioning. Minimal output

Lab renal - H/H 8.1/25

O: T-100.1 P-96 R-12 129/72

CXR - Lung up - 1 thoracotomy tube pipe

No A/F level.

① CT in place - Dry intact

LUNGS - Shallow breathing. No accessory m.

HEART - RRR 5 (2)

Abdom - Dry intact ↓ BS. No grunting or rigidity.

A: POD 2 Exp Thoracotomy / Laparotomy - Hem Stable

P: ① Agree w/ Plan

② Would not pull CT as the pt will leave via air ambulance for 86th CSH soon. ③ Leave in LNCSF for CT coverage

[redacted] (b)(6)-2

[redacted] (b)(6)-2 MAJ, MC GEN SURGEON

(Continue on reverse side)

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

[redacted] (b)(6)-4

REGISTER NO.

WARD NO.

PROGRESS NOTES

Medical Record

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

USAPPC V1.00

Start 1014 end 1155

MEDICAL RECORD — INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA litter BY

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY

3. DATE 08 Apr 03 TIME PATIENT ARRIVED IN SUITE 1000

4. PATIENT IN ROOM TIME 1000 NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SGT (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	SSG (b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

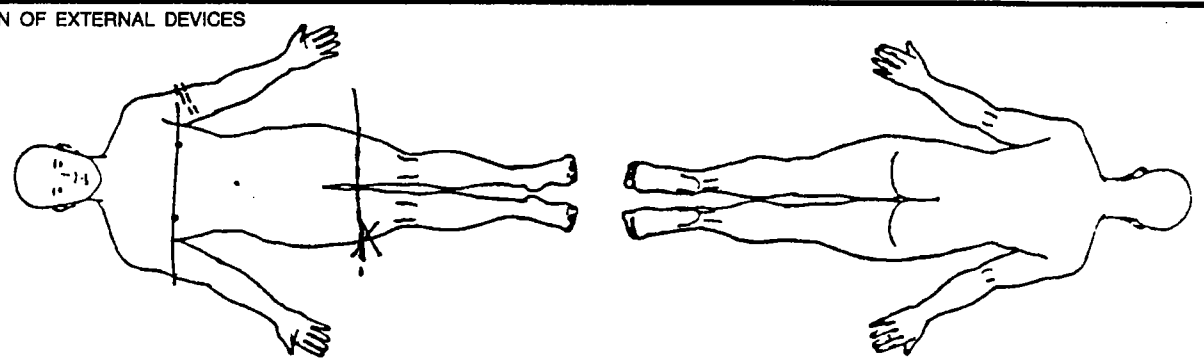
COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☒ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP
COMMENTS: Pubic area & abdomen

PREP SOLUTION *(Specify)*
SITE: Nipple line to Mid thigh BY WHOM: SSG (b)(6)-2
SITE: BY WHOM:
COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C = Correct I = Incorrect

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

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

(b)(6)-4

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

☐ ESU NO: Valleylab REM Polyhesive II
GROUND PAD: BRAND
LOT NO: 55808

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLAC FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOL

Start 1019 end 1155

MEDICAL RECORD — **INTRAOPE[illegible] 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 litter BY	2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY
3. DATE 08 Apr 03 TIME PATIENT ARRIVED IN SUITE 1000	4. PATIENT IN ROOM TIME 1000 NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SGT (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	SSG (b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

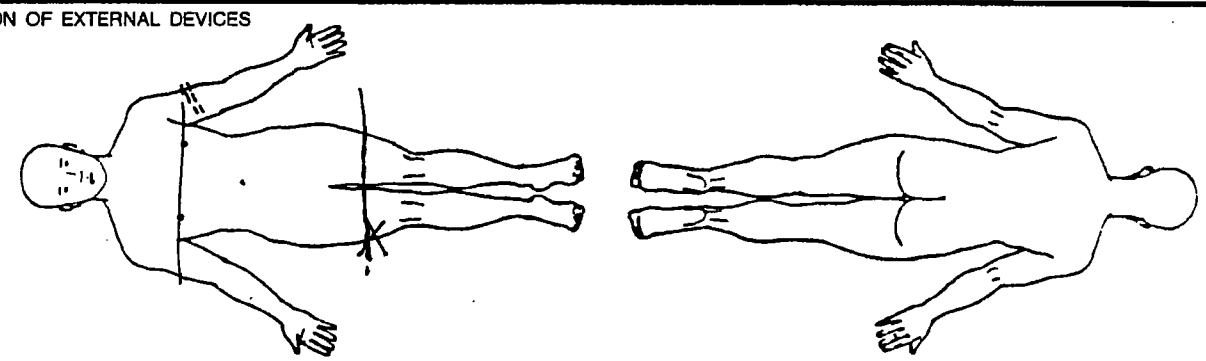
HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☒ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP

COMMENTS: Pubic area & abdomen

PREP SOLUTION *(Specify)*
SITE: Nipple line to Mid thigh BY WHOM: SSG (b)(6)-2
SITE: BY WHOM:

COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

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

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

(b)(6)-4

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

☐ ESU NO: Valleylab REM Polyhesive II
GROUND PAD: BRAND
LOT NO: 55808

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

13. PROSTHESIS, IMPLANTS ☐ YES ☐ IF YES NAME: ID NUMBER UFACTURER

14. MEDICATIONS/ORDERS (b)(6)-2

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Naci	2		Irrigation		

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN (b)(6)-2 (b)(6)-2 MAJ, MC, USA

15. X-RAY 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. 32FR Thoracic Tube	2.	3.
SITE	1. (L)	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

19. ADDITIONAL INFORMATION

Exploratory laparotomy, exploratory (L) thoracotomy

20. OPERATION(S) PERFORMED

21. PATIENT TRANSFERRED TO	TIME	METHOD
Recovery	1200	litter

22. REGISTERED NURSE SIGNATURE

TEST(S)

SPECIMEN TAKEN

DATE | TIME A.M. P.M.

REQUESTED

RESULTS

WBC 7.1
RBC 4.01
Hgb 10.3
Hct 34.1
MCV 85.0
MCH 25.8
MCHC 30.3
Plt 323
%Ly 21.8

(b)(6)-2

REMA

(b)(6)-2

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—D

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY

(b)(6)-2

(b)(6)-4

DATE

LAB ID NO.

MISC

URGENCY
☐ ROUTINE
TODAY ☐
☐ PRE-OP
STAT ☐

PATIENT STATUS
☐ BED ☐ AMB
OUTPATIENT ☐
☐ NP ☐ DOM

SPECIMEN SOURCE (Specify)

SPECIMEN/LAB RPT. NO.

PATIENT'S MED. RECORD

MISCELLANEOUS 557-107

STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505

MEDICAL RECORD - DOCTOR'S ORDERS

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

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

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
08 April 0310	RR		
0905	SP exp lap, expl. @ Thoracotomy		
	Condition: Fair		
	Vitals [illegible]	(b)(6)-2	
	IV [illegible]	0930	
	Call for SBP < 100, RR > 30, SaO2 < 92%		
	O2 to keep SaO2 > 95%, UOP < 50 cc/2°		
	Fuley to gravity	(b)(6)-2	0930
	NGT to gravity	(b)(6)-2	0930
	~~[illegible]~~ IVF NS @ 80 cc/o		
	MSO4 2-4 mg IV g 2-3 pr - pain		
	NPO		
	Lasio 40 mg IV on arrival to RR.	(b)(6)-2	0930
	(b)(6)-2		

PATIENT IDENTIFICATION

(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.

MEDCOM FORM 688-R (TEST) (MCHO) [illegible] 99 PREVIOUS EDITIONS ARE OBSOLETE

MC V1.00

DOCTOR'S ORDERS *(Date and sign all orders)*

TEMPERATURE · PULSE · RESPIRATION						NURSE'S NOTES
DATE AND TIME	T	P	R	~~STOOLS~~ BP	~~WEIGHT~~ Sp02	MEDICATION AND NURSE'S NOTES
10 APR 03	99.4	80	20	134/70	96% 2.5 L NC	

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

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 10 APR 03 TIME OF ORDER: _____ HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit Patient to ICU 3
2. Diagnosis: 6SW CHOST
3. Condition: Stable/Serious/Critical
4. Allergies: NKDA/
5. Vital signs q hr/q2hr/q6hr/q8hr/q shift
6. Cardiac respiratory monitoring
7. Diet: NPO/ regular/ soft/ clear liquid

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: TIME OF ORDER: _____ HOURS

8. Activity: AD LIB/ Strict BR/ BR with BSC/ NWB R or L LE
9. HOB up 30 degrees
10. Nursing I/O: CDB/ NG to LIS/ LCS
11. Labs: Chem 7/ H/H/ PT/PTT/ CBC q AM/ 4 hrs/ 8 hrs/ BID
12. EKG q AM

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: TIME OF ORDER: _____ HOURS

13. PCXRAY q AM/QOD
14. IVF NS/ LR/ D5NS/ D51/2NS To run @ 100 cc/hr.
15. Ancef 1 GM IV Q 8 hrs
16. Gentamycin IV Q
17. Cefoxitin 2gm IV q8hrs.
18. O2 titrate to keep SPO2 > 93%
19. Versed gtt 1-10mg/hr IV titrate to

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: TIME OF ORDER: _____ HOURS

(b)(6)-4

Ramsey Scale of
20. Fentanyl gtt start at 50mcg/hr titrate for adequate pain control. MAX DOSE of
21. Vecuronium 1mcg/kg/min
22. MSO4 2-4 MG IV q/-4 HR PRN Pain
23. Phenergan 12.5-25mg IV q 4-6hrs PRN N/V
24. MOM 30cc PRN Gastric upset

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

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

25 NS/ LR bolus X liters

26 Neuro checks q 1hr/ 2hr/ 4hr/ 6hr/ q shift

27 Vascular checks q 1hr/ 2hr/ 4hr/ 6hr/ q shift

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDE

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER _____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER _____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD

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

Mo. 04 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 10	11
10 Apr 03	- - - - - -	IVF NS (LR) / D5NS D5 1/2NS To run	07	/	(b)(6)-2
	- - - - - -	@ 100 cc/hr	19	(b)(6)-2	
10 Apr 03	- - - - - -	Ancef 1 GM IV q 8 HRs	06	/	
	- - - - - -		14	/	
	- - - - - -		22	(b)(6)-2	
	- - - - - -	Gentamycin IV Q			
	- - - - - -				
	- - - - - -	Cefoxitin 2 gm IV q 8hrs			
	- - - - - -				
	- - - - - -				
10 Apr 03	- - - - - -	02 titrate to keep SPO2 > 93%	07	/	(b)(6)-2
	- - - - - -		19	(b)(6)-2	
	- - - - - -	Versed gtt 1-10mg/hr titrate to Ramsey	07		
	- - - - - -	scale of	19		
	- - - - - -	Fentanyl gtt start at 50mcg/hr titrate for	07		
	- - - - - -	adequate pain control MAX Dose of	19		
	- - - - - -	Vecuronium 1mcg/kg/min	07		
	- - - - - -		19		
	- - - - - -				
	- - - - - -				
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	- - - - - -				
	- - - - - -				
	- - - - - -				

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: GSW Chest

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

(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

Treatment Facility: (b)(3)-1

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 04 Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
	- - - - -					
	- - - - -					
	- - - - -					
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	- - - - -					
	- - - - -					

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
10 Apr 03	(b)(6)-2	Morphine Sulfate 2-4 mg IV q 1-4 hr PRN pain														
- - - - -	- - - - -	~~Phenergan 12.5-25mg IV q 4-6 hrs~~ prn N/V														
- - - - -	- - - - -	~~MOM 30cc PRN Gastric Upset~~														
- - - - -	- - - - -	~~NS / LR bolus X ____ liters~~														
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															

USAPA V1.00

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 04 Yr 03

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 10	11
10 Apr 03	------	Vital signs q hr / q 2hr / q6h4 / q8hr /	07	/	(b)(6)-2
	------	q shift	19	(b)(6)-2	
10 Apr 03	------	Cardiac Respiratory Monitoring	07	/	(b)(6)-2
	------		19	(b)(6)-2	
10 Apr 03	------	Diet: NPO / Regular / Soft / Clear	07	/	(b)(6)-2
	------	Liquid	19	(b)(6)-2	
10 Apr 03	------	Activity: Ad Lib / Strict BR / BR with	07	/	(b)(6)-2
	------	BSC / NWB R or L LE	19	(b)(6)-2	
10 Apr 03	------	HOB up 30 Degrees	07	/	(b)(6)-2
	------		19	(b)(6)-2	
10 Apr 03	------	Nursing I/O, CDB / NG to LIS / LCS	07	/	(b)(6)-2
	------		19	(b)(6)-2	
	------	Labs: Chem 7 / H&H / PT/PTT /	04		
	------	CBC q AM / 4 hrs / 8 hrs / BID	08		
	------		12		
	------		16		
	------		20		
	------		24		
	------	EKG q AM / QOD	06		
	------	PCXRAY q AM / QOD	06		
	------	Neuro checks q 1hr / 2 hr / 4 hr / 6 hr /	07		
	------	q shift	19		
	------	Vascular checks nq 1hr / 2 hr / 4 hr /	07		
	------	6 hr / q shift	19		

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: GSW Chest

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

(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

Treatment Facility: (b)(3)-1

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*				Mo 04 Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
	.....	Admit Patient to ICU				
	.....	Diagnosis: GSW Chest				
1P	.....	Condition: Stable / Serious / Critical	W			(b)(6)-2
	.....	Allergies: NKDA				
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					

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

USAPA V1.00

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. 04 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 15	16	17	18	19	20	21
15 Apr	(b)(6)-2	Diet: Regular	B	/	(b)(6)-2					
			L	/						
			D							
15 Apr	(b)(6)-2	✓ Sa O2 q Shift	07	/						
			15	/						
			23		(b)(6)-2					
15 Apr	(b)(6)-2	Incentive Spirometer	07	/	(b)(6)-2					
			15	/						
			23		(b)(6)-2					
15 Apr	(b)(6)-2	VS: q 4°	03	/						
			07	/	(b)(6)-2					
			11	/	(b)(6)-2					
			15	/						
			19		(b)(6)-2					
			23							
15 Apr	(b)(6)-2	Activity - Up ad lib	07		(b)(6)-2					
			19							
			19							
			07							
17 APR 03	(b)(6)-2	AMBULATE	07	/	(b)(6)-2					
			19							
			19	/						
			07							

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 1 OCT 78 4677

EDITION OF 1 DEC 77 MAY BE USED.

MEDCOM - 4401

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. APR Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 11	12	13	14	15
3-APR 03	(b)(6)-2	LR @ 125 cc/hr HL	4	(b)(6)-2				
	-----	WHEN TOLERATING PO FLUIDS	16	(b)(6)-2				
	-----	ANCEF 1gm IVPB	4	(b)(6)-2				
	-----	q 8°	12					
	-----		20	(b)(6)-2				

DC'd

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: S/P Ex lap /(L) thoracotomy

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION: (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 1 FEB 79 4678

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

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

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													
11 Apr 03	(b)(6)-2	MSO4 1-2 mg IVP	2mg 1 HAR	2mg 1 Dp	4/12 2mg	4/14 2mg										
		1-2° prn pain	1030	1700	2005	1920										
			(b)(6)-2													

*U.S. GPO: 1996-454-110/95216

FROM (Medical treatment facility)
ORIGINE (Installation de traitement médical)
(b)(3)-1

NAME (Last—first—middle initial)
NOM (Nom de famille—premier prénom—initiale deuxième prénom)
EPW 1

SERVICE NUMBER / NUMÉRO MATRICULE	RANK/RATING/GRADE / GRADE	CATEGORY OF PERSONNEL (Service or employer and nationality) / CATÉGORIE DE PERSONNEL (Service ou employeur et nationalité)
N/A	N/A	EPW

DIAGNOSIS / DIAGNOSTIC
GSW (L) LUNG

CLASS—CLASSE		DISEASE / MALADIE	BATTLE CASUALTY / BLESSÉ AU COMBAT	INJURY / BLESSURE
1A	2A			
1B	2B			
1C				
3	4			

CABIN OR COMPARTMENT NO. / NO. CABINE OU COMPARTIMENT	BUNK NUMBER / NUMÉRO COUCHETTE

VSI / TRÈS GRAV. MAL.
☐ Yes / Oui ☒ No / Non

BAGGAGE TAG NUMBER(S) / NUMÉROS ÉTIQUETTES BAGAGE 218254

DESTINATION / DESTINATION
212

SHIP/AC (Number/type) / NAVIRE/AVION (Matricule/type)

TREATMENT RECOMMENDED EN ROUTE (If no treatment is required a notation to this effect is made)
TRAITEMENT RECOMMANDÉ EN ROUTE (Indiquer si aucun traitement n'est nécessaire)

Chest tube tosuction

SIGNATURE OF / SIGNATURE DU
(b)(3)-1

DATE / DATE
10 APR 03

REGULAR DIET / RÉGIME NORMAL	SPECIAL DIET (Describe) / RÉGIME SPECIAL (Description)
	NPO

SHIP'S RECORD OFFICE TAB – FICHE POUR ARCHIVES TRANSPORTS

FROM (Medical treatment facility)
ORIGINE (Installation de traitement médical)
(b)(3)-1

NAME (Last—first—middle initial)
NOM (Nom de famille—premier prénom—initiale deuxième prénom)
(b)(6)-4

SERVICE NUMBER / NUMÉRO MATRICULE	RANK/RATING/GRADE / GRADE	CATEGORY OF PERSONNEL / CATÉGORIE DE PERSONNEL
N/A	N/A	EPW

BAGGAGE TAG NUMBER(S) / NUMÉROS ÉTIQUETTES BAGAGES	DATE OF SHIPMENT / DATE DÉPART
218254	10 APR 03

DESTINATION / DESTINATION	ARRIVAL DATE / DATE ARRIVÉE
(b)(3)-1	10 APR 03

EMBARKATION TAB – FICHE D'EMBARQUEMENT

12. REASSESSMENT / RÉASSESSMENT

DATE / DATE (YYMMDD)	TIME OF ARRIV	D'ARRIVÉE

TIME / HEURE				
BP / PS				
PULSE / POULS				
RESP / RESP				

DATE / TIME
DATE / HEURE

13. CLINICAL COMMENTS / DIAGNOSIS
INFORMATION MÉDICALE / DIAGNOSTIQUES

14. ORDERS / ANTIBIOTICS (Specify) / TETANUS / IV FLUIDS
DIRECTIVES MÉDICALES / ANTIBIOTIQUES (Spécifier) / TÉTANOS / IV FLUIDE

0830 Vitals unable
BP - 2° wounds
D-90
IV - unable to start 2° wounds
Ancef 1 gram 8:40

15. PROVIDER / OFFICIE (b)(6)-2 DATE/DATE (YYMMDD) 030407

16. DISPOSITION / DISPOSITION
- [ ] RETURNED TO DUTY / RETOUR À L'UNITÉ
- [x] EVACUATED / EVACUÉ
- [ ] DECEASED / DÉCÉDÉ

TIME / HEURE

17. RELIGIOUS SERVICES / SERVICES RELIGIEUX
- [ ] BAPTISM / BAPTISÉ
- [ ] ANOINTING / ONCTION
- [ ] CONFESSION / CONFESSION
- [ ] PRAYER / PRIÈRE
- [ ] COMMUNION / COMMUNION
- [ ] OTHER / AUTRE

CHAPLAIN / CHAPELAIN

DD Form 1380, DEC 91 (Back)

1. LAST NAME, FIRST NAME / NOM ET PRÉNOM: IRAQ
RANK / GRADE
- [x] MALE / HOMME
- [ ] FEMALE / FEMME

SSN / NUMÉRO MATRICULE
SPECIALTY CODE / GPM
RELIGION / RELIGION

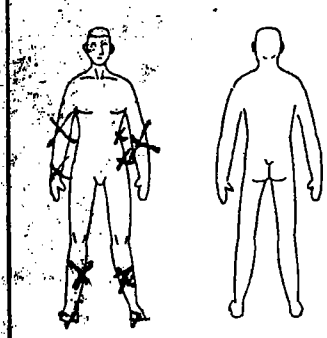
2. UNIT / UNITÉ

FORCE / ÉLÉMENT: A/T | AF/A | N/M | MC/M
NATIONALITY / NATIONALITÉ

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)

multiple schrapnel wounds.

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE
- [x] ALERT / ALERTE
- [ ] PAIN RESPONSE / RÉPONSE À LA DOULEUR
- [ ] VERBAL RESPONSE / RÉPONSE VERBALE
- [ ] UNRESPONSIVE / SANS RÉPONSE

5. PULSE / POULS: N — TIME / HEURE
6. TOURNIQUET / GARROT: [x] NO / NON [ ] YES / OUI — TIME / HEURE
7. MORPHINE / MORPHINE: [ ] NO / NON [x] YES / OUI — DOSE / DOSE — TIME / HEURE: 7 Apr
8. IV / IV — TIME / HEURE

9. TREATMENT / OBSERVATIONS / CURRENT MEDICATION / ALLERGIES / NBC (ANTIDOTE)
TRAITEMENT / OBSERVATIONS / PRESENTE MEDICATION / ALLERGIES / ANTIDOTES

~~[illegible]~~

10. DISPOSITION / DISPOSITION
- [ ] RETURNED TO DUTY / RETOUR À L'UNITÉ
- [ ] EVACUATED / EVACUÉ

TIME / HEURE

(b)(6)-2 ÉDÉ

DATE/DATE (YYMMDD)

...ditions
...m
1380 (TEST), which are obsolete.

U.S. FIELD MEDICAL CARD
FICHE MÉDICALE DE L'AVANT ÉTATS-UNIS

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

Iraqi POW transfered from (b)(3)-1 for further care. He underwent ex lap + thoracotomy 8 Apr T GSW to LLL of lung c/b hemothorax, found left in LLL, CT x2 placed, ⊖ ex-lap. He also has shrapnel wound to ⓛ ankle. Has been stable.

PHYSICAL EXAMINATION VS T 100.1 P 100 BP 136/86 O2SAT 91-93 % on 2 LPM NC

Gen: Iraqi EPW in no acute distress
ENT: PERRLA
Neck: supple
Lp: BS equal bilateral, ⓛ SCV line
Cor: regular, ⊖ @ 1 gallop
Abd: soft ⊖ BS & guarding GU - Foley in place
End: shrapnel wound ⓛ ankle

4.3	104 / 21	4 / 1.0	97
11.7	8.1 / 25		182

A/B 3.0
AST 63
ALT

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

A/P ① S/P GSW ⓛ thorax c/b hemothorax; CT placed; ⊖ ex lap
pain control, pulm toilet, IVF
② evac to (b)(3)-1

(b)(6)-2

	DATE	IDENTIFICATION NO.	ORGANIZATION
	10 Apr		

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

REGISTER NO.	WARD NO.

(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

JICAL RECORD - SUPLEMENTAL MI DATA [redacted]

r use of this form, see AR 40-66; the proponent agency is the Office of the Surgeon Gene...

OTSG APROVED (Date)

EPORT TITLE

TRAUMA FLOWSHEET

INITIAL ASSESSMENT ☐ IMMEDIATE ☐ DELAYED ☐ MINIMAL

ate: 11 Apr 03 Arrival Time: 0550 Sex: (M) F Age: _____ Wt: _____

llergies: NKDA Tetanus Status: UTD Unknown

MP: Last Meal:

hief Complaint: GSW chest

MH: Medications:

reatments PTA:

ITAL SIGNS: BP: 131/73 P: 89 RR: 20 TEMP: SAO2: 89

HEST
RAUMA ☒ YES ☐ NO
AIN ☐ YES ☒ NO
OB ☐ YES ☒ NO
UNG SOUNDS
R L
☒ ☒ CLEAR
] ☐ WHEEZES
] ☐ DECREASED
] ☐ ABSENT

SKIN
☒ WARM
☒ DRY
☐ PALE
☐ DUSKY
☐ MOIST

ABDOMEN
☒ SOFT
☐ DISTENDED
☐ TENDER
BOWEL SOUNDS
☐ YES ☒ NO
GUIAC TEST
☐ POS ☐ NEG

NEURO
PERRL ☐ YES ☐ NO R_____mm L_____mm
GLASCOW SCORE:_____

PUPIL SIZES: 2 3 4 5 6 7 8 9

GLASCOW COMA SCALE

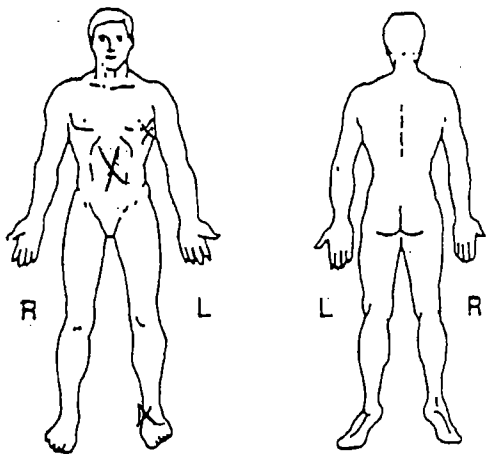
1. EYE OPENING		2. VERBAL RESPONSE		3. MOTOR RESPONSE	
Spontaneous	- 4	Oriented	- 5	Obedient	- 6
To Voice	- 3	Confused	- 4	Purposeful	- 5
To Pain	- 2	Inappropriate	- 3	Withdrawal	- 4
None	- 1	Incomprehensible	- 2	Flexion	- 3
		None	- 1	Extension	- 2
				None	- 1

XTREMETIES
☒ DISTAL PULSES.
] RT X 2 ☐ LT X 2
☒ MOVES EXTREMETIES X 4
☒ NO EDEMA
☒ NO DEFORMITIES

XCEPTIONS TO BOVE ARAMETERS:

SPLINTS:

REATMENTS:
2: LPM NC MASK ORAL AIRWAY
TT # MM NASAL AIRWAY
IONITOR ☐ Y ☐ N EKG ☐ Y ☐ N
IG TUBE #
OLEY: # DPL ☐ POS ☐ NEG
HEST TUBE ☐ R ☐ L CM H20



A = Abrasion
AP = Amputat
AV = Avulsion
B = Burn
C = Contusion
D = Deformity
E = Erisipelas
OF = Open F
CF = Closed
G = GSW
L = Laceration
PW = Puncture
S = Slab Wo
O = Other

(Continue on

REPARED BY (Signature & Title) | DEPARTMENT/SERVICE/CLINIC 399th CSH | DATE

ATIENT'S IDENTIFICATION (For typed or written ntries give: Name - last; first; middle; grade; date; ospital or medical facility)

(b)(6)-4

(b)(3)-1

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11APR03	Gen Surg Admit
	~35 yo Iraqi ♀ S/P GSW (L) chest S/P (-) Ex lap /
	(L) thoracotomy for LLL lung injury @ FST on
	8 APR 03 HD stable c̄ (L) CT. ϕ other injuries
	PE: P89 BP 131/78 RR 30 sats 89% (RA)
	A&O, GCS 15
	HEENT - WNL
	Neck - supple
	CV - RRR ϕ vlglm
	Lungs - ↓BS (L), CTA (R) (L) CT ϕ leak min output
	Abdom - soft, ND, clean midline wound, appropriate
	TTP, (+) BS
	GU - Foley intact
	Rectal - ϕ blood
	Ext - ϕ c/c/E, (L) ankle cutdown site c/d/open c̄
	granulation
	Neuro - nonfocal
	A/P: S/P GSW (L) chest S/P (-) Ex lap / (L) thoracotomy
	- Admit ward - Ancef - Foley
	- CT to suction - pulm toilet

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

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. (b)(6)-2 | WARD NO. MAJ, MC

(b)(6)-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11 Apr 03 1330	Pt arrived from EMT. A&O x3. Breathing S Cng diff on rm air. Has Chest tube to (L) side on low Cont Suc. bulky drsg to (L) chest wall dry & intact. Small drsg to (L) ankle dry & intact. IV Started to (R) arm. Has LR running @ 125/hr. DC'd Cordis per Dr order. Has foley drng clear yellow urine. [redacted] SSG 9/Win 630
11 Apr 1630	Pt. S/S Ex Lap c̄ Staples C/D/I. has (L) thoracotomy c̄ CT to suction VSS. Pt alert x3. Minimal c/o pain Or pain Receiving Antibiotics TX. Well contin to monit. [redacted]
12APR03	PT AOX3. COMPLETE BED BATH GIVEN. ORAL CARE PROVIDED. PT TOLERATE WELL VSS. PERRL. NEURO INTACT. LUNGS CLEAR IN ALL (R) LOBES DIMINISHED IN (L) BASES, LL, CARDIAC RRR, SATS ≥95% ON RA. ACTIVE BS IN ALL 4 QUADS NON DISTENDED NONTENDER ABD. MIDLINE STAPLES INTACT. IODINE APPLIED TO STAPLES. (L) CHEST TUBE IN PLACE AND DRAINING SANGUINEOUS FLUID TO 20cm SUCTION. CXR COMPLETED. PT DENIES CHEST PAIN AND SOB. FOLEY TO GRAVITY DRAINING CYU QS. 600cc OUT @ 0600. (L) ABOVE THE ANKLE SHRAPNEL WOUND CLEANED AND W/D DRSNG APPLIED (2cm x 2cm). PT TOLERATED 12oz OF WATER WELL AND PROGRESSED TO 6 BISQUET CRACKERS. NO C/O N/V. WILL CONT ABX TX AND TO MONITOR THE PT. [redacted]
	1330 D/C Foley to gravity 1100cc OUT THIS SHIFT [redacted]
	1340 POST Foley VOID/INCONT x1 [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	R[redacted] 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.

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
12APR03	1700 - CHEST TUBE (L) CHEST TO WATER SEAL - DRESSING DRY AND INTACT, SMALL DRESSING LOWER (L) EXTREMITY - DRY AND INTACT, IV - LR @ 125 cc/HR INFUSING IN (R) FOREARM, LUNGS CLEAR (R) LOBES - DIMINISHED (L) LOWER LOBES, MIDLINE ABD. STAPLES INTACT, BOWEL SOUNDS PRESENT IN ALL QUADRANTS. SGT [redacted] - 9/WM6 2230 - PT. VOIDED 300cc URINE SGT [redacted] 9/WM6 Ø330 - PT. VOIDED 350cc (L) CT Ø OUTPUT. SGT [redacted] - 9/WM6 @0634z pt had 2 oz of urine output SPC [redacted] 9/W10 [redacted]
13April03 1008z	Nutrition - Patient w chest tube s/p GSW to chest s/p EX Lap. Patient new on leg Diet. Consuming crackers, poptart, tang, Jello. Patient need more protein for wound healing will breakage shakes & Ensure. Will follow tolerances [redacted] MAJ GARD
1830 Z	Report received - pt resting in bed & complaint. Lungs auscultated c̄ CTA noted BS+x4 quads. CT - (L) chest intact. Drsgs D+I, Rhemanoe → Rocer H2O seal pt voided 300 cc/4. mid Abd incision noted c̄ staples intact edges well approximated. IV infusing well in (R) FA & s/s infiltrate or infection. Drsg to (L) LE D+I. MAEW x4 distal lobes 3+x4 - [redacted] 9/WM6
0300 Z	Pt resting comfortably in bed CT → (L) chest intact - Drsg D+I - CT Drained 160 cc Serous drainage. CXR done - Pt voided 1000 cc urine throughout shift. IV infusing well & s/s infiltrate or infection - assessment remains unremarkable - [redacted]

STANDARD FORM 600 (REV. 6-97) BACK

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
0945 14APR03	Patient had chest tube removed @ 0830. X-ray completed c̄ results pending. Lung sounds CTA, sating 94-96% on RA. NSR c̄ HR 80's, BP 120's/70's c̄ good cap refill. Pt alert, PERL 2-3mm. Hypoactive BS x 4 quads c̄ no BM @ this time. Patient resting @ this time. Will continue to monitor. [redacted] (b)(6)-2 ICT, RN
15APR03	0300 - PT. VOIDED X 1 BP 115/74 P 105 R 18 T 99.2 POX 93% ON RA. SGT [redacted] (b)(6)-2 RN MC
4-15-03	TOL reg diet, pert, lungs CTA [redacted] (b)(6)-2
15Apr03 0638	97 / 79% RA eve - deep breaths - breathing shallow HR 120 R 40 98/58
0640 02	pt received - assessment completed - pt denying ∅ major problems but O2Sat @ 75% - RR 32 - lung sounds are clear in ⓡ lobes and crackles to all ⓛ lobes - no nebs - pt put on O2 face mask (non-rebreather) & Sat ↑ to 88% on 6l - pt O2 ↓ to 8l O2Sat ↑ 90% - pt ⓛ flank tender to touch - during CDT - pt has wound to ⓛ scapula area - midline abdominal incision c̄ staples CDT - bowel sounds hyperactive - pt requested to sleep - HOB in semi fowlers - [redacted] (b)(6)-2
4/15/02 1535	Patient c̄ tachypnea and desats to 73% RA RR - 32-40 lungs ↓ BS (ⓛ) base otherwise clear P 122 CV - tachy ∅ murmur Ext - ∅ swelling ∅ clubbing / cyanosis of DVT

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
N / TACHypnea	/ Desats		
SPONSOR'S NAME	**SSN/ID NO.**	**RELATIONSHIP TO SPONSOR**	
Consorted	P.C. / PVC	Mother AX / Pelvic hemiplegia	

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

Pneumonia / Effusion

P
① Lovenox 100cg SQ now
② CXR (AP/LAT)
③ FM O2 to keep SaO2 > 90%
④ Transfer to 86 CSH ✓

CHRONOLOGICAL RECORD OF
Medical Reco
STANDARD FORM 600
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-
[redacted] (b)(6)-2

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
21 APR 03 1023	Pt given discharge teaching for dressing change and I.S. Pt discharge to SGT [redacted] C 320TH MP CO at 1025. — [redacted] CPT ANC

STANDARD FORM 600 (REV. 6-97) **BACK**

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1627	Admit Note. (b)(6)-4
15 April 2003	
	S/P laparotomy, chest tube
	transferred to minimal area today
	RA SaO_2 71% RR 30-40
	returned to EMT area for evaluation
	GCS 15
	Chest & BS (R) base
	(L) sided chest tube dressing
	Abdomen soft, healing incision
	no pedal edema
	CXR - some ↑ fluid (L) base
	IMP: hypoxia
	- doubt PE
	- no evidence pneumonia
	- some ~~B~~ volume loss
	PLAN: Supplemental O_2 (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.

(b)(6)-4

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

DATE	NOTES
16 APR 03 2100	Pt A&O x3. VS 100.5 107 20 114/74 O2 SAT 92% 5L NC. Resting in bed ō c/o pain or discomfort. IV HL to (R) FA Flushing well ō s/s infection/infiltration. Instructed on use of IS. verbalized/demonstrated understanding. [redacted]
17 APR 03 0750	Pt VS P 99 SPO2 93 T 99.0 BP 117/68 SPC SALERNS
17 APR 03 1123	Pt VS SPO2 93% ON ROOM AIR, P 105, RR 20, BP 110/70. CV: RRR, TEMP 100.3, CAP REFILL <5 SECONDS. Pt A&O x3 (+) BS THROUGHOUT, MIDLINE STAPLES INTACT, AND STAPLES ON (L) MIDDLE CHEST INTACT ō DRAINAGE. Pt ambulated for 10 MIN and O2SP 92% ON ROOM AIR. [redacted]
16:18	VS BP 122/74, S PO2 93 [redacted] 18 T 98.7
17 APR 03 1843	Pt SPO2 is 92% on room air and VSS. Pt ō 1 BM ADLIVEP; POB TO bathroom. Pt midline and (L) staple sites open to air. CXR completed this AM. Pt A&O x3 and ō c/o and ate all 3 meals ō c/o (95%). PT AMBULATED TO CXR PROCEDURE [redacted]
17 APR 03 0630	Pt A&O x 3. VSS. uneventful night. O2 Sats 91-92% RA Abd incs. wall approx healing well. Lat incs open to air healing well. c/o neck discomfort. medicated ō Tylenol 650mg PO. ō good results. slept thru night. continue to monitor [redacted]
18 Apr. 03 1125	B/P - 122/78 P - 90 R - 16 Temp - 99.3 O2S - 97 — SPC [redacted] S/W
18 Apr. 03 1430	B/P 116/56 P - 99 R - 16 O2S - 96 Temp. 98.9
18 APR 03 1635	Pt A&O x3 given ii TYLENOL for non specific neck pain, patient expressed [redacted] relief in 30 MIN ō MEDICATION GIVEN. Pt O2SP 96-97% ON ROOM AIR. Pt ō WOUND (L) UPPER BACK 1½ X ¾ IN PINK ō DRESSING CHANGE AND BACITRACIN. Pt ō WOUND (L) LOWER LEG ō OLD BLOOD; CHG DRESSING ō BACITRACIN ō 2X2 [redacted]

FPI LEX Printed on Recycled Paper

STANDARD FORM 509 (REV. 5-99) BACK

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
15 APR 03 2200	Pt Rcvd in ward. A&O X3. VS 99.8 111 20 122/79 97% on O2 10L NRB mask. Δ'd to NC @ 6L sats Holding @ 94-95%. Abd Inc well approx healing well. IV HL to (R) FA S̄ S/S of infection/infiltration flushing well. Ø c/o pain/discomfort @ this time. continue to monitor [redacted] 9/W3M6 LPN
16 APR 03 1115	Pt received A&O X3. He speaks limited English and responds well to commands. Pt has a midline ABD INC C̄ staples that is S̄ drainage and healing well. IV HL (R) FA S̄ S/S of infecions (CCFAN, DRY, AND FLUSHED well). Pt C̄ a wound on his upper ~~R~~ (L) back the wound is the size of two ~~quarters~~ quarters approx The wound is without drainage and DR. [redacted] is aware of the patient's wound. Pt BP 130/85, P98, RR27, T 99.2, and SPO2 94% C̄ 6L of O2 VIA NC. Pt able to bathe at bed side and wash his face (BRUSH his teeth). Pt has an order to D/C anef, but the is no order to start it. [redacted] CPT AN
16 APR 03 1810	Pt is A&O X3; OOB to void C̄ BM X1. Pt BP 110/70, HR 98, TEMP 100.2, RR 24, AND SPO2 92% C̄ 6L of O2. Pt S̄ c/o of pain. Pt C̄ IS VOLDYNE 5000 at the bed side. [redacted] CPT AN

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

(b)(6)-4

ICW 1

DATE	NOTES
19 Apr 03	pt (b)(6)-4 – T 99.8° P 94 R 20 BP 112/74 O2SAT 98% RA pt A&Ox3, LS clear encourage I.S. 10x hr while awake. BS x4, UOP dark clear urine. (L) ankle & back ulcers c̄ Bacitracin & redressed. midline incisional wound & (L) flank staples intact ∅S/S infection noted, ∅ dehiscence noted. pt has ∅ IV site, (R) arm old IV site c̄ hardened quarter size area ∅ redness or infection noted (IV D/C'd 19 Apr 03). pt has minimal c/o pain, rested well throughout night and did not require pain meds. Continue to monitor. (b)(6)-2 CPT/AN pt did not ambulate this shift. (b)(6)-2 CPT/AN
20 Apr. 03	B/P 134/66 P-99 R-20 T-98.9 O2S-98-SPC (b)(6)-2 91W —
20 APR 03	Pt is A&O x3 and given 2 TYLENOLS FOR HA pt verbalized relief within 30 MIN. PT (L) BACK AND (L) LEG (LOWER) PRESSURE CHANGED BOTH c̄ PINK MEAT (FLESH) and old red blood on old ~~dressing~~ dressings. Pt educated on dressing changes for his leg and back and demonstrated correctly how to change the dressing for his leg. Pt is aware of pending discharge to EPW CAMP OR MOVE c̄ CA FINTERVIEW. PENDING PAD F/U c̄ CA FOR TRANSFER. Pt c̄ staples midline and (L) RSB CAME APART. STAPLES TO BE REMOVED BY NEXT NURSING SHIFT. — (b)(6)-2 CPT AN
20 Apr 03	2300 – pt A&Ox3, LS clear, BS x4, UOP cool. ~~w/ 70 dsg~~ dsg c̄ bacitracin & tobach done; (L) ankle dsg d/d. Staples removed as ordered c̄ diff. ∅S/S infection noted. ∅ c/o pain Continue to monitor. J Elsbury CPT/AN
21 Apr 03 1718	PT VS. P86 BP 119/75 SPO2 98 T 98.3 R 16 — SPC (b)(6)-2
21 APR 03 1004	Pt released to MP and will receive dressings △ AT NEXT LOCATION. (b)(6)-2 CPT AN

FPI LEX Printed on Recycled Paper

STANDARD FORM 509 (REV. 5-99) BACK

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
18 Apr 03 2100 -	T 99.5° P 92 R 24 BP 122/76 Pox 98% RA A/O X 3, LS clear, BS X 4, last BM 4/17. UOP cont. pain med prn. ulcer (L) back redressed c̄ bacitracin, (L) foot ulcer has 2 stitches dsg c/d/I. midline incision staples and (L) flank staples intact slight redness around site ⊘ S/S infection (L) flank has scabbed quarter size area c̄ some sanguinous old drainage. O2 Sats 98% RA, pt resting comfortably. Continue to monitor. (R) FA ~~8~~ 20g X 3 dep o/c'd has hard area above site. Continue to monitor. Dsg Δ to back c̄ bacitracin. [redacted] CPT/AN
19 Apr. 03 1955	B/P 120/68 P-89 R-20 Pox-96 Temp-98.4 SPC [redacted] 9/W
19 Apr. 03 1407	B/P 102/68 P-109 R-20 O2S-98 Temp-98.7 SPC [redacted] 9/W
19 APR 03 1844	Pt is A&O X 3 P 99, R 20; O2SP 97%. Pt wound (L) upper back 1½ X 3/4 IN c̄ PINK flesh; Pt wound (L) LOWER LEG c̄ pink and red flesh both dressings changed and BACITRACIN APPED to the sites. Pt ambulated ~~the~~ throughout the ward X 5. Pt c̄ 1 BM AND 1 VOID at 1620. Pt ambulated c̄ a steady gait. Pt midline and (L) wound staples removed every other, c̄ well healed edges. [redacted] CPT, AN

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; ...k/Grade)

[redacted]

REGISTER NO.	WARD NO.
	ICW/

PROGRESS NOTES
Medical Record

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

NSN 7540-01-075-3786

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

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)* 10 Apr 03 | TIME 1910

TRANSPORTATION TO FACILITY

SEX

AGE

DUTY/LOCAL PHONE	
AREA CODE	NUMBER

HOME PHONE	
AREA CODE	NUMBER

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

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

CURRENT MEDICATIONS

ALLERGIES

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT

SP DX Lap SP CT

CATEGORY OF TREATMENT

☐ EMERGENT

☒ URGENT

☐ NON-URGENT

TIME 1910

INITIALS (b)(6)-2

VITAL SIGNS

TIME 1915					
BP 133/78					
PULSE 89					
RESP 16					
TEMP					
WT 85 kg					

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

☑ PULSE OX 85% on RA ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1952					

DISPOSITION ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

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

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ | TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

(b)(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

(b)(3)-1

NSN 7540-01-075-3786

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

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

31 yo EPW Txd @ EST/CSH for GSW (L) chest
S/p ex lap / thoracotomy - 2 days ago.

PE: Absent BS (L) - pulse ox 83%
Disconnected CT - reconnected + reexpansion
Dressing intact → 91% RA

A/P: Stable after CT reconnected
Observe
Eval

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

(b)(6)-2

CODES

DIAGNOSIS

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

(b)(6)-4

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

1. NAME (Last, First, Middle, Initial) (b)(6)-4	SSN	3a. STATUS	3b. SE	4. PRECEDENCE	5. GRADE
		EDW		U / P ✓ / R	

6. AGE	7. SEX	8. WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F	11. ACCEPTING MD	12. CITE/AUTH #
31	✓ MALE / FEMALE			AMBUL ✓ / LITTER		

13. APPT/SURG DATE	14a. ORIGINATING FACILITY (b)(3)-1	15a. DESTINATION FACILITY (b)(3)-1	16. # OF ATTENDANTS	
10 APR 03	14b. ORIGINATING FACILITY PHONE NUMBER (b)(3)-1 ICU #3	15B. DESTINATION FACILITY PHONE NUMBER	16a. MED: Ø	16b. NON-MED: Ø

17. DIAGNOSIS

GSW CHEST

18. ✓ BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

20. PHYSICIANS ORDERS

20a. DATE	20b. TIME	20c. ALLERGIES
10 APR 03		

20d. DIET: ✓ REG | GM NA | CARDIAC | DIABETIC ___ CALS

RENAL ___ Gm Pot ___ Gm Na ___ MagK ___ mg PO4

TUBE ___ TYPE ___ cc/hr, 1/2, 3/4 FULL STRENGTH

NPO

PEDIATRIC: AGE ___ | OTHER (Specify)

TPN: Change to ___ at ___ cc/hr for max of ___ days

TUBE FEEDING ___ at ___ strength at ___ cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

SUCTION		TRACTION	✓ FOLEY CATH
NG TUBE		IV PUMP	ORTHO BRACES
STRYKER		TRACH	✓ CHEST/HEIMLICH
INCUBATOR		MONITOR	RESTRAINTS
			OTHER (USE 23)

CENTRAL LINE

OXYGEN: ___ PERCENT of 3 LITERS ROUTE: ___

VENT SETTINGS

20g. ALTITUDE RESTRICTION: Yes / No ___ feet

20h. RECORDS TO ACCOMPANY PATIENT

✓	OUTPATIENT RECORDS	X	XRAYS	OTHER:
X	INPATIENT RECORDS		OB	
	NARRATIVE SUMMARY		DENTAL	
	FINANCIAL			

20i. MEDICATIONS / TREATMENTS

Ancef 1gm IV Q 8°

O_2

~~Ketlex~~ Ar

MSO4 2-4 mg Q1° PRN pain

19. CLINICAL ISSUES (Please indicate Yes or No on clinical issues. Explain YES comments in Section 23)

	YES	NO	ISSUE		YES	NO	
a.			Hypertension	i.			Bowel Problem
b.			Cardiac H	j.			Self-care
c.			Diabetes	k.	X		Ambulatory
d.			Respirator	l.			Ambulatory Aid
e.			Ears/Sinus	m.			Self-meds
f.			Motion Sic	n.			Adequate Supply of Meds
g.			Vision Impaired	o.			Other:
h.			Voiding Pr				

21. PRE-FLIGHT VITALS

21a. DATE / TIME	21b. TEMP:	21c. PULSE	21e. BP
	21d. RESP:		

22. BRIEF NARRATIVE

GSW CHEST

S/P EX LAP / THORACOTOMY

CT / Foley / CENTRAL LINE

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

24. STAMP AND SIGNATURE (b)(6)-2

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF Form 3899 (433

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																	
POST-	DAY																
MONTH-YEAR	DAY	11 Apr		12 APR		13 Apr		13 APR		14 APR		15 APR			20 Apr		
19	HOUR	1700	0300	1200	1800	0245		1200	0300	0800	1200	0300			2000		
PULSE (O)	TEMP. F (•)																TEMP. C
	105°																40.6°
180	104°																40.0°
170	103°																39.4°
160	102°																38.9°
150	101°																38.3°
140	100°																37.8°
130	99°																37.2°
	98.6°																37.0°
120	98°																36.7°
110	97°																36.1°
100	96°																35.6°
90	95°																35.0°
80																	
70																	
60																	
50																	
40																	

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD				18	16	16		20 20						16		
BLOOD PRESSURE	132/75			127/77	130/78	132/82	→	128/78	135/76	126/75	126/70			124/66		
Spoz	98%	94		92%	93%	92%	→	94%	94	P-83 94%	P-112 96%			P-90 98%		
HEIGHT: WEIGHT →						P.R.										
Intake	1750						240 PO 1500 cc IV									
Output Urine	3350		12 Apr 03 1800 200		12 Apr 03 1300 2700		12 April 650cc		13 Apr 03 1202.							
Output CT	92	12 Apr 03 0275			90		400 7300 C-660									

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.

(b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD		VITAL SIGNS RECORD														
HOSPITAL DAY		1														
POST- DAY																
MONTH-YEAR	DAY	11														
19	HOUR	48 12 48 12														
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°	X														37.2°
	98.6°															37.0°
120	98°															36.7°
110	97°															36.1°
100	96°	•														35.6°
90	95°	O														35.0°
80																
70		^														
60																
50																
40																
RESPIRATION RECORD		6														
BLOOD PRESSURE		130/66														
HEIGHT:	WEIGHT →															
Intake																
Output CT / UOP		2000														

(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.

(b)(6)-4

STANDARD FORM 511 (REV. 7-95) BACK

*U.S. Government Printing Office: 1995 - 609-626

~~347~~

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

DATE OF ORDER: 11 APR 03 TIME OF ORDER: 0605 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit ICU # / Gen Surg - (b)(6)-2
2. Dx: S/P Ex lap ⊖ / (L) thoracotomy / (L) CT
3. Stable
4. VS per routine
5. NKDA
6. LR @ 125 cc/hr
7. NPO

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: TIME OF ORDER: HOURS

8. Foley → gravity
9. CT to -20 cm suction
10. D/C (L) cordis & place peripheral IV
11. OOB → Chair BID
12. Ancef ÷ gm IVPB q 8°
13. PCXR in EMT & q AM
14. MSO4 1-2 mg IV q 1-2° PRN pain

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: TIME OF ORDER: HOURS

15. Encourage pulmonary toilet
16. Notify MD for T>101.5 P>120<60 SBP>180<100 UOP<250 cc/shift
17. O2 per FM/NC - wean/titrate to keep ≥95%

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2 MD

(b)(6)-2 MAJ, MC

PATIENT IDENTIFICATION

DATE OF ORDER: 12 APR 03 TIME OF ORDER: 0445 HOURS

1. Reg Diet
2. Heplock IV once tolerating clears
3. CT → H2O seal
4. D/C Foley 1200 Z

(b)(6)-2 MD

NURSING UNIT | ROOM NO. | BED NO.

4/13/03

1. Lovenox 100 mg SQ Q 24° ~~NC~~ ③ FM O2 to keep SaO2 ≥ 90%
2. CXR (PA/LAT)

(b)(6)-2

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1996—409-924

MEDCOM - 4423

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 _____ HOURS | LIST TIME ORDER NOTED AND SIGN

1624 Admit ICW - temper
15 April 2003 ① VS - Q4L
② Incentive Spirometry
③ Heparin 5000 units sub Q
Q 12L
④ Regular diet

NURSING UNIT | ROOM NO. | BED NO.

noted [redacted] 9:00 AM 15 April @ 2050

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER _____ HOURS

① Spot check SaO2 Q shift
② O2 per Lasal canulae to keep SaO2 > 92%
③ Upad lib
④ [redacted]

NURSING UNIT | ROOM NO. | BED NO.

4/14/03 ~~① Repeat CXR~~ error

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER [redacted]

24° chart check 15 APR 03 2330 [redacted]

24° ✓ 17 APR 03 0230 OPTAN

4/16/03 ① Bacitracin to wound on back TID
② D/C Anref
③ D/C heparin

NO ANREF FOUNDON [redacted] NOTED NOS OPTAN

NURSING UNIT | [redacted] | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | T[redacted]RS

NURSING UNIT | ROOM NO. | BED NO.

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

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION (b)(6)-4

DATE OF ORDER 4/17/03 TIME OF ORDER 0755 HOURS

LIST TIME ORDER NOTED AND SIGN

D/C O2

(b)(6)-2

NOTED

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

CPT, AN

PATIENT IDENTIFICATION (b)(6)-4

DATE OF ORDER 17 Apr 03 TIME OF ORDER _____ HOURS

CXR

Ambulate

(b)(6)-2

NOTED

24PV 4/19/03 0600

NURSING UNIT (b)(6)-2 | ROOM NO. CPT/AN | BED NO.

(b)(6)-2

CPT AN

PATIENT IDENTIFICATION (b)(6)-4

DATE OF ORDER TIME OF ORDER _____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION (b)(6)-4

DATE OF ORDER TIME OF ORDER _____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

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

4/8/03

① Tylenol 325 mg T-III po q 4-6° prn

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

CPT/AN

(b)(6)-2

(b)(6)-2

(b)(6)-2

DATE OF ORDER | TIME OF ORDER

20 APR 03 | 0730 HOURS

(b)(6)-4

① Remove staples

② D/C to OPW Compound vs home depending on status

(b)(6)-2

MO

(b)(6)-2

Q4° 4/21/03 0400

NURSING UNIT | (b)(6)-2 | D NO.

ICW 1 | CPT/AN

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER _____ HOURS

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

ICW 1

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER _____ HOURS

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

ICW 1

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

CLINICAL RECORD

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

Mo. APR Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 11	12	13	14	15
11-APR03	(b)(6)-2	VS per routine	04	/	(b)(6)-2			
			12	(b)(6)-2				
			20					
11-Apr03	(b)(6)-2	~~NPO~~ REG DIET	4					
			16					
11-Apr03	(b)(6)-2	Foley → Gravity	4	(b)(6)-2		D/C		
			16					
11-APR03	(b)(6)-2	CT to low cont	4	(b)(6)-2		D/C		
		Suction	16					
11-APR03	(b)(6)-2	OOB → Chair BID	04	(b)(6)-2				
			16					
11 APR03	(b)(6)-2	CXP q AM	05	/	(b)(6)-2			
11-APR03		Encourage pulmonary	04	(b)(6)-2				
		toilet	16					
11-APR03	(b)(6)-2	Notify MD for T 101.5	04	(b)(6)-2				
		P >120 <60, SBP >180 <100	16					
11-APR 03	(b)(6)-2	Urine op <250cc per shift	04					
		O_2 per FM/NC -	16					
		wean/titrate to keep						
		≥95%						
12 APR	(b)(6)-2	CT → H_2O SEAL	D	/	(b)(6)-2	D'CD 14 APR 03		
			N	/				

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: S/P Ex lap / (L) thoracotomy

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION: (b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*				Mo _____ Yr _____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
11 Apr 03	(b)(6)-2	Admit ICU #2			11 Apr 03 0730	(b)(6)-2
11 Apr 03		D/C (L) cordis ; place peripheral IV			[illegible]	
	- - - - -					
	- - - - -					
	- - - - -					
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	- - - - -					
	- - - - -					

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

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. 04 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 15	16	17	18	19	20	21
15 Apr	(b)(6)-2	Diet: Regular	B	✓ (b)(6)-2						
			L	✓ (b)(6)-2						
			D							
15 Apr	(b)(6)-2	✓ Sa O2 q shift	07	✓ (b)(6)-2						
			15	✓ (b)(6)-2						
			23	(b)(6)-2						
15 Apr	(b)(6)-2	Incentive Spirometer	07	✓ (b)(6)-2						
			15	✓ (b)(6)-2						
			23	(b)(6)-2						
15 Apr	(b)(6)-2	VS: q 4°	03	✓						
			07	✓ (b)(6)-2						
			11	✓ (b)(6)-2						
			15	✓ (b)(6)-2						
			19	(b)(6)-2						
			23							
15 Apr	(b)(6)-2	Activity - up ad lib	07							
			19							
			19	(b)(6)-2						
			07							
17 APR 03	(b)(6)-2	AMBULATE	07	✓ (b)(6)-2						
			19							
			19	✓						
			07							

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 1 OCT 78 4677 EDITION OF 1 DEC 77 MAY BE USED.

MEDCOM - 4429

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)				Mo 04 Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
15Apr	(b)(6)-2	Admit ICW-1 Temper	15APR	1624	1624	(b)(6)-2
		CXR —	17APR03	ASAP	1110	
20APR03	(b)(6)-2	REMOVE STAPLES	20APR03	~~1800~~ 2200	2200	
		DC TO EPW COMPOUND VS HOME				
		DEPENDING ON STATUS				

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

☆ U.S. GPO:1997-418-290/55267

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. 04 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
15 Apr03	(b)(6)-2	O2 nasal cannula	07	/	(b)(6)-2					
		to keep SaO2 > 90%	19 07	(b)(6)-2		D/C				
15 Apr	(b)(6)-2	Heparin 5000 u sub q	08	/	(b)(6)-2					
	-----	q 12°	20	(b)(6)-2	/	D/C				

16APR03	(b)(6)-2	~~BACE~~ BACITRACIN TO	06	/	/			(b)(6)-2		
	-----	WOUND ON BACK TID	14	/	(b)(6)-2					
	-----		22	/						

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				Mo. _____ Yr. _____
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													
18APR03	(b)(6)-2	TYLENOL 325mg	11 Sm	18APR 2100	20 APR03	20 APR 3										
		T-TTT PO Q 4-6° PRN	1010 18 APR03	3 (b)(6)-2	2 1618 (b)(6)-2	2245 (b)(6)-2										

☆U.S. GPO:1998-432-786/85214

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF (1–8): (b)(3)-1
2. MTF LOCATION (State or Country Code.)
3. REGISTER NUMBER (9–15): (b)(6)-4
NAME (Last, First, Middle Initial): (b)(6)-4 (b)(6)-4
4. PAY GRADE (16, 17)
5. SEX (18): M
6. DATE OF BIRTH (Y Y Y Y M M D D): 19720101
7. AGE AT ADMISSION (27–29): 31
8. RACE (30): Black
9. ETHNIC BACKGROUND (31)
RELIGION
10. LENGTH OF SERVICE (32–34)
ETS
11. FMP (35, 36): 55
12. SOCIAL SECURITY NUMBER (37–45): (b)(6)-4
ORGANIZATION (Active Duty Only)
13. MARITAL STATUS (46)
HOUR OF ADMISSION: 0605
BRANCH / CORPS
14. FLYING STATUS (47–49)
15. BENEFICIARY CATEGORY (50–52)
16. ZIP CODE OF RESIDENCE (53–61)
17. UNIT LOCATION (State or Country Code) (62, 63)
18. MOS (64–70)
19. TRAUMA (71): IRS
PREV. ADMISSION: YEAR ☒ NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72): 1
WARD: 1C01
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
21. TYPE OF DISPOSITION (73, 74): D/C: Trans
22. MTF TRANSFERRED TO (75–80)
23. DATE OF DISPOSITION (Y Y Y Y M M D D): 20030421
24. CLINIC SVC - ADMITTING (89–92): ABAA
25. MTF TRANSFERRED FROM (93–98)
26. DATE THIS ADMISSION (Y Y Y Y M M D D): 20030401
27. LOCATION OF OCCURRENCE (Battle Casualty Only) (107, 108)
28. MTF OF INITIAL ADMISSION (109–114)
29. DATE INITIAL ADMISSION (Y Y Y Y M M D D) (115–122)

FOR LOCAL USE

GSW L Chest

DX: 86130
8603
8911
7990
E9654

PX: 5411
331
3404

Trauma
1

Injury
450

ADMITTING OFFICER (Signature, as required): (b)(6)-2 (b)(6)-2 (b)(6)-2

MAJ, MC

DA FORM 2985, MAR 2000 EDITION OF MAR 89 IS OBSOLETE USAPA V1.00

MEDCOM - 4433

..NPATIENT TREATMENT RECORD COVE.. SHEET

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

1. REGISTER NUMBER (b)(6)-4	2. NAME (Last, First, MI) (b)(6)-4			3. GRADE	ADMISSION REMARKS
4. SEX: F	5. AGE	6. RACE: IRAQI	7. RELIGION	8. LENGTH OF SVC	9. ETS
10. PREVIOUS ADMISSION					
11. FMP: 99	12. SSN (b)(6)-4	13. ORGANIZATION		14. WARD: ICW3	
15. FLYING STATUS: NO	16. RATING DSG	17. DEPT. BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct			22. HOURS OF ADMISSION: 2205	23. CLINIC SERVICE: ABNA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE		25. TYPE DISPOSITION		26. DATE OF DISPOSITION: 8 11 APR 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)		27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION: 2 MAY 03	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY				30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

S/P GSW ® Neck, Carotid Dissection

874

443.21

874.8
443.21
344.1
344.2

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
4	4				4

36. Total Days All Facilites

a. ABSENT SICK DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF (b)(6)-2

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER (b)(6)-2

DA F

EDITION OF 1 AUG

MEDCOM - 4434

USNS COMFORT

,

CH Name: (b)(3)-1 (b)(6)-4 (b)(6)-4

copy

Date of Admission: 4/10/2003

Date of Transfer:

Age:18 Gender: M

History:

18 y/o Iraqi Woman, with GSW vs shrapnel to right side of neck, injury reportedly occurred 12 days ago, with exploration to
neck 10 days ago at original (b)(3)-1, then transferred to (b)(3)-1 4/9/03, arrived to (b)(3)-1 4/10/03,for neuro eval and possiblesepsis

Hospital Course:

Admitted to ICU3 for close monitoring. Broad spectrum abx for presumed sepsis. Will require collar for 12 weeks. NEUROLOGY: Greenflield filter placed 21 APR due to excess risk of DVT

Diagnoses:

GSW vs Shrapnel Right side Neck, with C-6 Spine injury with paralysis of all extremities except LUE., Rt. Parietal lobe stroke, Rt. Common Carotid traumatic aneurysm; Right vertebral and Right internal jugular occlusion

Surgeries/Treatment:

CT scan head/Neck 4/10/03; Head/Neck Angio 4/10/03; IV antibiotics, ,

Recommendations:

Keep in C collar for now, may sit up. No surgical intervention required for c-spine. NEUROLOGY: Maintain on Low dose Coumadin (2 mg/day) for 3 mos due to Carotid dissection. Priorities are mobilization, rehab, optimize function r arm

Special Needs:

Prognosis: Guarded

Physician: (b)(6)-2 CDR Dept of NEUROLOGY

4/24/2003

(b)(6)-4

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER (b)(6)-4	2. NAME (Last, First, MI) (b)(6)-4			3. GRADE	ADMISSION REMARKS
4. SEX F / 5. AGE	6. RACE IRAQI	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
11. SMR 99	12. SSN (b)(6)-4		13. ORGANIZATION		14. WARD ICW3
15. FLYING STATUS NO	16. RATING DSG	17. DEPT. BEN K78	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE inj
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct			22. HOURS OF ADMISSION 2205	23. CLINIC SERVICE ABAA	
24. NAME RELATIONSHIP OF EMERGENCY ADDRESSEE		25. TYPE DISPOSITION		26. DATE OF DISPOSITION 8 MAY 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)		27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION 2 MAY 03	ADMISSION REMARKS
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY				30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD COMPONENT TRANSFER

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES OPERATIONS AND SPECIAL PROCEDURES

S/P GSW (R) Neck, Carotid Dissection

894

443r21

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.
4	4				4

36. Total Days All Facilites

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

SIGNATURE OF A... (b)(6)-2

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER (b)(6)-2

DA F...

EDITION OF 1 AUG...

MEDCOM - 4436

MEDICAL RECORD	PROGRESS NOTES
DATE	
2 May 03 2355	PT arrived to unit and placed in bed. VS 99.8 120, 20 128/86 94%. PT c̄ C-Collar, has bilat AFD to LEs PT has sensation to LE but none movement or tone. PT c/o generalized pain x 3 during Exam — MS04 4mg IV — PT has foley — emptied 450cc of clear yellow urine. Lungs c̄ bilat crackles to bases, BS x4 nonactive. (b)(6)-2 MAJ AN
2355	2200 Elavil & Tegretol given @ 2355. (b)(6)-2 MAJ AN
3 May 03 0600	PT required pain medication x 2 for remaining portion of shift. See med sheet. Currently pt resting quietly — 200cc urine emptied from foley. (b)(6)-2 MAJ AN
3 May 03 0835	REQUEST "MORPHINE" FOR PAIN. GIVEN MS04 [illegible] RESTING IN BED — DOES NOT DESIRE TO EAT @ PRESENT (b)(6)-2
3 May 03 1000	VS bp 152/70 - P - 110, R - 20, T - 99.0, Pt asleep when arrived on shift, Pt responds to verbal stimuli, able to move upper extremities upon command, Lungs CTA, (+) BS, Foley to gravity draining amber color urine, Pt c/o of "(b)(6)-4" pt given 4mg Morphine per IVP May (b)(6)-2, — (b)(6)-2 LPN
3 May 03 1200	Consulted c̄ anesthesia about pain control, Fentanyl order, see medication sheets. (b)(6)-2
3 May 03 1400	Pt started on Fentanyl, pt > 10, pt sat 91-96 on RA, pt took total of 150 fentanyl, pt had some relief, able to turn off pt on side, will continue to

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

(b)(6)-4

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

PROGRESS NOTES

DATE	
3 May 03 1400	monitor for changes.
3 May 03 1500	Pass on to 3-11 shift to give Morphine q 2hr on schedule, Fentanly right before turns. (b)(6)-2 PN.
3 May 03 1530	T - 101.5, pt given 2 tylenol. (b)(6)-2
3 May 03 1600	T - 100.3, will continue to monitor for changes (b)(6)-2
3 MAY 03 1925	Pt c/o pain. Given 4 mg MSO_4 IV. (b)(6)-2
1939 3 MAY 03	VS T 98.5 / R 24 / P 108 / 115/80 (b)(6)-2 9/W
2245 03 May 03	pt had I.V changed from (L) ac area to (R) hand. Pt said the IV was painful, IV was Red and irritated. Pt has not complained of pain that much. Pt was moved at 1939 and didnt require any fentanyl. (b)(6)-2 9/W
3 May 03 2345	PT resting in bed c̄ BM - Linen Δed PT, Turned - MSO4 4mg given for movement p̄ c/o pain. VS: 144/86 100.4, 118, 18, IV (R) Hand LR @ 125 hr, C-Collar in Place PT have Sensation but No movement to LEs bilat 2° to Injury. (b)(6)-2 MAJ AN
0600	Held PO Reglan 2° NPO for Procedure - PT was Nauseated - given Zofran 4mg IV, (b)(6)-2 MAJ AN
04 May 03	OP Note
1016	Preop D(x): Urinary retention EBC = 35cc IUF = 800cc
	Post op D(x): above Procedure: Suprapubic catheter
	Surgeon: (b)(6)-2 complication none

☆U.S. GPO:1995-397-405 (b)(6)-2 ANDARD FORM 509 BACK (Rev. 11-77)

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | Physical Therapy Note | **PROGRESS NOTES**

DATE	NOTES
	(S) Pnt - 18 yo ♀, GSW to (R)
5-3-03	Side of neck, C-6 Spine injury c̄ paralysis of all extremities x̄
	(C) UE - Rt. Parietal Stroke, Rt Common Carotid traumatic
	aneurysm, Rt vertebral and Rt internal jugular occlusion
	(O) Resting in supine - asleep
	(R) UE Flaccid
	(L) LE Flaccid c̄ trace toe ext
	(R) LE Flaccid and painful to touch - movement
	(L) UE 3+/5 Biceps, 3/5 triceps, 3+/5 wrist ext, Finger
	flexion 2° to wrist ext. FF of Shoulder to shoulder
	height
	- No Bed mobility
	- unable to sit edge of bed 2° to (Rt) LE leg pain
	- Thorax of manual resistance - (L) Biceps, triceps
	and PROM of (R) UE, (L) LE
	(A) Poor functional prognosis, may, overtime, be able to
	assist c̄ basic ADLs such as feeding, hygene -
	likely require max care in future.
	Cont ROM and attempts of sitting edge of bed -
	probable d/c tomorrow per Nursing staff.
	O/w c̄ Physician about (R) LE pain. (b)(6)-2 PT, ATC

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)

(b)(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4 May 03 ~~to~~ 0945	HR - 136, 98%, 123/85, RR 17, 98.5 (A)
0950	HR - 105, 97%, 120/86, RR 20, 98.7 (A)
0955	HR - 115, 98%, 118/85, RR 20. Administered 50 mcg Fentanyl IV for c/o pain. Will continue to monitor. (b)(6)-2 LT, AN
1000	Patient returned from OR @ 0945 c̄ PM ~~H~~ suprapubic cath in place. Emptied 300ml of bloody drainage c̄ large clots. ST c̄ HR 130's. Lung sounds CTA bilaterally, sating 95% on RA. Pupils 2mm / sluggish. Patient alert @ this time. Weak palpable pulses x 4. (R) fingertips slightly cyanotic. Will continue to monitor. (b)(6)-2 LT, AN
1015	142 (HR); 98%, 125/88, 21-RR, 99.1 (A). Administered 3TSP ~~Acetc~~ Childrens Tylenol Suspension. Will continue to monitor. (b)(6)-2 LT, AN
1030	HR 152, 97%, 134/84, RR-31, Temp 101.1 (A). Applied Cold packs to under arm, Administered 25mg Demerol for c/o pain. Supra. Pubic cath c̄ 100ml of bloody output c̄ clots and clearing some. IVF currently @ 165ml, will continue to monitor. (b)(6)-2 LT, AN
1056	HR 153, 96%, 112/70, RR 20, 102.5. Encouraged patient to drink fluids, applied more ice-packs, notified Anesthesia - no interventions desired at this time. Pt remains ST c̄ HR 140-150's, BP 90/40's. Administered 500ml bolus. Will continue to monitor. (b)(6)-2 LT, AN
1120	HR 152, 97%, 104/51, 20's. T-100.9. Patient c̄ c/o pain to surgical site. Holding pain meds @ this time until bolus complete to monitor pressures. (b)(6)-2 LT, AN

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.

(b)(6)-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4 May 03 1300	Pt recieved from OR via stretcher, pt placed in bed, AtO x3, responds to verbal stimuli, able to squeeze hand c̄ LUE hand, unable to squeeze hand c̄ RUE hand, responds to tactile stimuli on feet bil. Able to move toes on LLE, unable to move toes on RLE, Lungs CTA, cap refill >3sec, Faint BS in L quad, (+) pedal pulses bil. Pt c/o of "[redacted]", pt given 4mg morphine per Dr's order, will monitor pt. for changes, V/S BP 122/65, P-131, R- , T- 100.4, Sat 94%-97% on Ra c̄ encouragement of C&D&B, Foley to gravity draining bloody urine. [redacted]
4 May 03 1330	Pt RUE, dusky, unable to move hand, PT/OT worked c̄ pt, Dr aware, no further orders exept therapy & work on getting pt to Hospital in Austria or Saudi Arabia for rehab — [redacted]
4 May 03 1400	T- 101.4, pt given 2 tylenol will monitor pt. for changes. [redacted]
4 May 03 1445	T-100., will continue to monitor for changes. [redacted]
4 May 03 1505	BP 123/71 SpO2 98, P 144, Temp. 100.3 [redacted] pt complained of pain and was given 50 mcgs at 1020. of fentanyl. Pt was repositioned on her left side and was given another 50 MCG of fentanyl at 10:23 [redacted] 9/WB
2000	Pt c/o bladder pain, has suprapubic catheter that is not putting out urine. Dr [redacted] at bedside, attempted to flush

STANDARD FORM 600 (REV. 6-97) BACK

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
4 May 03 2000 cont.	Suprapubic catheter, 16 Fr 3 way catheter inserted in urethra c̄ 1000 cc bloody urine output. HR-124 R-14 SaO_2 96. Pt resting more comfortably now (b)(6)-2 CPT
2300	VS: T-98[8] P-139 R-16 BP 118/80 SaO_2 96% Pt awake c/o lower extremity and lower abdominal pain, given Fentanyl 50 meg. Pt in C-collar c̄ AFD devices on bilaterally. PIV in LFA infusing Ds ½NS c̄ 20 meg KCl @ 129 cc/hr. Supra pubic catheter to BSD, Foley catheter to BSD c̄ bloody colored UOP. Pt given Zofran 4 mg IV for nausea (b)(6)-2 CPT
0600	Pt resting quietly - Foley UOP - 1100 cc dark hematuric urine Suprapubic UOP - 100 cc blood-tinged urine
5 MAY 03	Urology - SP tube initially draining well then able to flush but not withdraw - performed antegrade cystogram that showed extraperitoneal extravasation - attempted to manipulate back into bladder but unsuccessful and D/c'ed SP tube Plan: con't levoflox, change hematuria with over to soft foley tommorrow re-attempt SP tube when appropriate equipment available

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. (b)(6)-4

- EVAC thru international red cross.

(b)(6)-2

Medical Record

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

DATE	NOTES
5May 03 @	1230. Pt given 4mg MSO4 IV for c/o pain [redacted] LIRN
5 may 03 0900	v/s – 128/60, 86, 18, 98.9, Sat 98% on RA, Pt Lungs CTA, (+) BS (+) pedal pulses, O.T. worked c̄ pt on RUE, P.T. supposed to make splint or cast for pt.
5 may 03 1400	Pt given 4mg Morphine per Dr's order will continue to monitor pt. for changes. [redacted] LPN
5 may 03 1400	Dr wrote orders for D/C to red cross, no hospital available to send pt yet. [redacted]
5 may 1645	VS. 120/74, p 133, SpO2 96, R. 18. Temp 100.9. P.T. did put splint on pt's (R) wrist & forearm. pt. is eating. pt was in pain and was given 4mg of MSO4. [redacted] 9/WD
1655.	pt was running a fever at 100.9. will monitor for changes. [redacted] 9/WD
1700.	pt voided. 400 mL of dk Brunish colored urine it was dumped out of foley bag. [redacted] 9/WD
1716.	pt feeling nauseated will monitor and give phenergan if needed [redacted] 9/WD
2250	pt recieved ancef at 2245 [redacted] 9/WD
2340	Assumed pt care @ 2245 hrs. Pt has D5½NS c̄ 20K @ 125 to CLFA PIV. IV site shows ∅ signs of infiltration. Pt has m c-spine ollar. Pt has bilateral AFP footer. Good circulation to Blat LE. Pt disg to suprapubic area C/D/I. Pt has foley to gravity draining dark amber urine. Pt has splint c̄ ace to (R) arm. (+) BS, x4, Lungs CTA. VS – 98.9, P-85, 125/68, 97% RA, R-20. Will continue to monitor pt thru shift [redacted]

FPI LEX Printed on Recycled Paper

(b)(6)-4 [redacted]

99) BACK

MEDICAL RECORD	PROGRESS NOTES
DATE	
6 May 03 0745	Pt AtO x3, Lungs CTA, (+) BS, Abd, soft, tender, (+) pedal pulses. Pt c/o of pain given 4mg morphine per IVN per RN. (b)(6)-2 [redacted] LPR
6 May 03 0800	VS 122/72, 100, 20, 99.0, Sat 99% on RA.
6 May 03 1300	T - 99.5
6 May 1430	Pt resting in bed ⊘ changes, will continue to monitor for changes. (b)(6)-2 [redacted] LPR
6 May	Pt incontinent of feces, loose, brownish color, pt cleaned up, will continue to monitor pt for changes
6 May 03 2300	T100' P125 R16 BP118/70 SP02 97% (b)(6)-2 [redacted]
Foley 1200cc	Assumed pt care @ 2245 hrs. Pt has foley to gravity draining efficient amounts of yellow urine. Pt has APD boots to bilateral feet. Pt has drsg to supropubic area C/D/I. Pt has C-collar on w/out any complaints. (R) arm drsg C/D/I. Pt has PIV to (L)PA, D5½NS c̄ 20KCl infusing @ 125cc/hr. Pt verbalized pain to bilateral LE. 50mg Fetanyl administered. Will continue to reassess pain status and patient throughout shift. (b)(6)-2 [redacted] 12D AW (+) BS x4, lungs CTA.

(Continue on reverse side)

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

(b)(6)-4 [redacted]

REGISTER NO.	WARD NO.

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

PROGRESS NOTES

DATE

6 May 03 2200 LATE ENTRY: Slept most of shift p̄ bed. Δ'd medicated x2 for pain & x'T for nausea, Husband attentive @ bedside. Splint in place on (R) hand. Neuro V's wnl. Ø significant Δ's in status. [redacted]

7 May/0530 800cc of blood tinged urine drained from foley. [redacted]

7 MAY/0900 O.T. NOTE: Pt seen initially 4 MAY 03 for edema and (−) ROM of the (R) UE and digits. Today she was provided with retrograde massaging to reduce swelling, ROM to the digits and wrist, and Coban wrapping of digits and wrist. Splint is in place and keeps hand/wrist in a functional position. Staff instructed on keeping the hand elevated to assist w edema control. Will re-check splint 8 MAY 03. [redacted] SFC, COTA

7 May 03 0935 – 4mg MSO4 IVP pain. [redacted] Gamb

1220 – 4mg MSO4 IVP pain [redacted] 9cc/mg/sgc

7 May 03 0900 VS 122/80 – 80, 20, 98.5, Sat 99% on RA, A&O x3, (+) BS, ↑ pain, pt given pain medication per Drs order, see medication sheet. [redacted]

2355 Assumed pt care @ 2245 hrs. Pt has splint c̄ are bard to (R) arm. Pt has AFD foolies to bilateral LE. Suprapulse drsg C/D/I. Pt has 20g to (L) FA c̄ D5½NS c̄ 20 KCl @ 125cc/hr.

[redacted]

☆U.S. GPO: 1995-397-405 STANDARD FORM 509 BACK (Rev. 11-77)

MEDCOM - 4445

MEDICAL RECORD	PROGRESS NOTES
DATE	Pt lungs CTA. (+)BS x4. Pt has foley draining to gravity. Pt medicated c̄ 4mg IV Morphine @ 2350 hrs prn pain. Will continue to monitor pt throughout shift. [redacted]
8 May / 0000	VS - 98', 110/68, 97% RA, R 85, R 18. [redacted]
0100	Pt sitting up in bed drybreaking c/o nausea and pain. 50mg Fetanyl, 4mg IV Zofran administered. Will continue to access pt throughout shift. [redacted]
8 May 0830	Pt asleep in bed c̄ eyes close, no discomfort noted, will continue to monitor pt for any changes. [redacted]
8 May 1150	Emptied 900ml of dark amber urine. [redacted]
8 May 1200	Pt A+O X3, Lungs CTA, (+) BS, (+) Pedal Pulse, VS - T 99.5, 80, 20, 98% on RA, pt assisted c̄ am care. [redacted]

(Continue on reverse side)

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

[redacted]

REGISTER NO.

WARD NO.

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

(THIS FORM IS SUBJECT TO THE PRIVACY A... 174 - AS A CLINICAL RECORD FORM, IT IS COVERED BY DD 220

ANESTHESIA RECORD

Page 1 of 1

ES. START	IN OR	ANES. END	DATE
0920	0920	1035	4 MAY 03
TOTS	SURG START	DRESSING	OR NO
0925	0945	1025	2L

OPERATION PERFORMED: Supra pubic Cath Placement

SURGEON: (b)(6)-2

PREOPERATIVE

- ☐ IDENTIFIED ☐ ID BAND ☐ QUESTIONING
- ☐ CHART REVIEWED ☑ NPO SINCE mid
- ☐ PRE-OP MEDICATION:

Drug	Dose	Route	Time
Valium	5mg	IV	

Pre-Anesthetic State:
- ☐ CALM
- ☑ APPREHENSIVE
- ☐ AWAKE
- ☐ SEDATE
- ☐ UNRESPONSIVE

MONITORS AND EQUIPMENT

- ☑ ANES. MACHINE # 2L & EQUIP. CHECKED
- ☑ NON-INV. B/P
- ☑ CONT. EKG
- ☐ ESOPH. STETH.
- ☑ PULSE OXIMETER
- ☐ END TIDAL CO2
- ☑ TEMPERATURE Axil
- ☐ WARMING BLANKET ☐ FLUID WARMER
- ☐ AIRWAY HUMIDIFIER
- ☐ N/G TUBE ☐ O/G TUBE
- ☑ IV(s) 20g R WRIST
- ☐ ARTERIAL LINE
- ☐ CENTRAL LINE
- ☐ SWAN-GANZ
- ☐ FOLEY INSERTED: ☐ O.R. ☐ FLOOR
- ☐ EYE CARE
- ☐ PRESSURE POINTS CHECKED / PADDED
- ☐ PNS
- ☐ V LEAD EKG
- ☐ PRECORD STETH.
- ☐ O2 ANALYZER
- ☐ MASS SPEC.

ANESTHETIC TECHNIQUE

- ☑ GENERAL
- ☑ LOCAL / MAC
- ☐ REGIONAL
- ☐ NERVE BLOCK
- ☐ TIVA

INDUCTION

- ☐ PREOXYGENATION
- ☐ RAPID SEQUENCE
- ☐ INTRAVENOUS
- ☐ INHALATION
- ☐ INTRAMUSCULAR
- ☐ RECTAL

AIRWAY MANAGEMENT

- ☐ INTUBATION ☐ ORAL ☐ NASAL
- ☐ DIRECT VISION ☐ BLIND ☐ AWAKE
- ☐ FIBER OPTIC ☐ STYLET USED
- ☐ ATTEMPTS x ____ ☐ BLADE ____
- ☐ ETT SIZE ____ ☐ DOUBLE LUMEN
- ☐ STRAIGHT ☐ RAE ☐ ANODE
- ☐ CUFFED ____ ML AIR INJECTED
- ☐ UNCUFFED, LEAKS AT ____ CM H2O
- ☐ ETT SECURED AT ____ CM
- ☐ BREATH SOUNDS
- ☐ AIRWAY ☐ ORAL ☐ NASAL ☐ NATURAL
- ☐ MASK CASE ☐ VIA TRACHEOSTOMY
- ☐ NASAL CANNULA ☑ SIMPLE O2 MASK
- ☐ LMA SIZE
- ☐ NATURAL

																		TOTAL
		1ms	30	y	1000	x	30	x										
AGENTS	Robinul	.3																.3mg
	Valium	5mg																5mg
	Ketamine mg		100	-50		50												200
	MSO4		5		5													10mg
	Ephedrine				10													10mg
	Fentanyl				50	50	50											150mcg
	N2O L/min																	
	O2 L/min Fm	4	4		4	4	RA											
FLUIDS	Urine																	
	EBL																	
MONITORS	EKG	ST	ST	ST	ST	ST												
	% O2 Inspired	.21	.21	.21	.21	.21												
	O2 Saturation	100	100	100	100	100												
	End Tidal CO2																	
	Temperature																	
	PNS																	
RESP	Tidal Volume																	
	Resp Rate																	
	Peak Pressure																	
	Symbols for Remarks	SV	SV	SV	SV	SV												
	Position	Supine																

TIME

VITAL SIGNS

PRE-OP VALUES	
140/91	B/P
130	P
16	R
94	SAT
	H/H

200 180 160 140 120 100 80 60 40 20

SYMBOLS: X ANESTH; ⊙ OPERAT; V ^ B/P CU PRESSI; ⊥ T ARTER LINE PRESSI; ● PULS; C SPONT/ OUS R; ⊂ ASSIS RES; ⊠ CONTRO RES; T TOURNI; F CRYS LOID F; E BLO

REMARKS:
- ☑ Patient reevaluated. No change from preop plan / evaluation.
- ☐ Significant changes from preop plan / evaluation.

RECOVERY

TIME IN PACU	CONDITION
1030	Stable

B/P	PULSE	RESP	O2 SAT
113/81	127	16	97

REMARKS

TEMP 98.8

REPORT TO: Murphy PARRS:

Tourniquet Time:

FLUIDS TOTALS

IN	OUT
Crystalloid: LR - 1000 cc	EBL 100
	Urine 100
	Gastric 0
Blood	

(b)(6)-2

MAC/CRNA

PATIENT'S IDENTIFICATION

(b)(6)-4

Iraqi National [illegible]

NAME: SURGEON: (b)(6)-2

Planned Surgery Date:

ANESTHESIA PREOPERATIVE EVALUATION

AGE	M / F	HEIGHT	WEIGHT
25	F		

PROPOSED OPERATION: Suprapubic cath

PREOPERATIVE VITAL SIGNS: B/P P R

PREVIOUS ANESTHESIA / OPERATIONS ☐ NEGATIVE

CURRENT MEDICATIONS ☐ NONE

FAMILY HISTORY OF ANESTHESIA COMPLICATIONS ☐ NEGATIVE

ALLERGIES ☐ NKDA

AIRWAY / TEETH / HEAD & NECK

SYSTEM				WN	COMMENTS	PERTINENT STUDY RESULTS	
RESPIRATORY				☐	Tobacco Use: ☐ No ☐ Yes ____ Pack/Day for ____ Years	Chest X-ray	Pulmonary Studies
Asthma	Bronchitis	COPD					
Dyspnea	Pneumonia	Productive Cough					
Recent cold	SOB	Tuberculosis					
CARDIOVASCULAR				☐		EKG	
Angina	Arrhythmia	CHF					
Exercise Tolerance	Hypertension	MI					
Murmur	MVP	Pacemaker					
Rheumatic fever							
HEPATO/GASTROINTESTINAL				☐	Ethanol Use: ☐ No ☐ Yes Frequency ____	LFTs	
Bowel obstruction	Cirrhosis	Hepatitis					
Hiatal Hernia	Jaundice	N&V					
Reflux/Heartburn	Ulcers						
NEURO/MUSCULOSKELETAL				☐			
Arthritis	Back problems	CVA/Stroke					
DJD	Headaches	Loss of consciousness					
Neuromuscular disease	Paralysis	Paresthesia					
Syncope	Seizures	TIAs					
Weakness							
RENAL/ENDOCRINE				☐		Urinalysis	Thyroid / FBS
Diabetes	Renal failure/Dialysis	Thyroid disease					
Urinary retention	Urinary tract infection	Weight loss/gain					
OTHER						Hgb / Hct / CBC	Lytes
Anemia	Bleeding tendancies	Hemophilia					
Pregnancy	Sickle cell trait	Transfusion history					

PROBLEM LIST / DIAGNOSES

ASA: 1, 2, 3, 4, 5, E

PREOPERATIVE MEDICATIONS ORDERED

COUNSELING STATEMENT

Anesthesia alternatives, benefits and risks from minor to death explained. All questions answered.
Patient / legal guardian voices understanding and gives consent for :
Local / MAC, SAB, Epidural, IVR, General Anes.
Other: ____
Appropriate alternative as backup.
NPO status explained.

PATIENT'S SIGNATURE ____ DATE ____

EVALUATOR(S) SIGNATURE (b)(6)-2 DATE 4 MAY 03

PHYSICIAN ____ DATE ____

POST ANESTHESIA VISITS

ANESTHESIA RECOVERY COMPLICATED BY THE FOLLOWING PROBLEMS: (IF NONE, SO STATE)

SIGNED: ____ DATE: ____ TIME: ____

MEDICAL RECORD - DOCTOR'S ORDERS

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

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

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
	POST ANESTHESIA CARE UNIT ORDERS		
1	OXYGEN: _____ litres via Mask /Prongs to maintain O2 Sats greater than 94%;		
	Wean to room air.		
2	IVF: LR @ 100 cc/hr, bolus _____ cc x 1		
3	MORPHINE: 2-4 mg IV q 5-10 minutes PRN pain. MAX dose of 20 mg		
4	DEMEROL: 50 mg IV q 5-10 minutes PRN pain. MAX dose of 100 mg		
5	ZOFRAN: Give 4 mg IV PRN nausea. May repeat after 10 minutes X 1		
6	DROPERIDOL: 0.625 mg (1/4 cc) OR 1.25 mg (1/2 cc) IV PRN Nausea X 1		
7	REGLAN: Give 10 mg IV PRN nausea X 1		
8	Release from "PACU" when Aldrete score is _____ or greater		
9	Call Anesthesia for any questions or concerns		
	Fentanyl 50 mcg IV prn pain max dose 200 mcg		
	(b)(6)-2		
	SIG		
	MAS/CRNA		

PATIENT IDENTIFICATION

(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.

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

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: 2 MAY 03 — TIME OF ORDER: 2205 HOURS — LIST TIME ORDER NOTED AND SIGN

1. Admit ICW #3 - Gen Surg (b)(6)-2
2. S/P GSW (R) neck, carotid dissection, CVA
3. Stable
4. VS per routine
5. NKDA
6. Regular Diet / Sustacal TID c̄ meals
7. IV → heplock

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER — TIME OF ORDER — HOURS

8. C-collar @ all times, may sit up
9. Foley → gravity
10. Have PT see patient in AM for ROM/strength evaluation & daily care
11. Vicadin ÷ PO q̄ 4-6° PRN pain
12. Colace 100 mg PO TID
13. Coumadin 2.5 mg PO QD

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER — TIME OF ORDER — HOURS

14. Tegretol 200 mg PO TID
15. Elavil 75 mg PO q̄ hs
16. MSO4 2-4 mg IV q̄ 1-2° PRN severe pain
17. Phenergan 25 mg IM/PO q̄ 6° PRN nausea
18. Benadryl 25 mg IM/IV q̄ 8° PRN pruritis

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER — TIME OF ORDER — HOURS

19. Dulcolax supp ÷ PR PRN for BM
20. Fleets enema ÷ PR q̄ 3-4 days PRN for no BM
21. Notify MD for T>101.5 P>120 <60 SBP>170 <100 sats <93%
22. AFO splints (R) LE

(b)(6)-2 MD

(b)(6)-2 MAJ, MC

Turn off MAJ (b)(6)-2 2 May 03 2355

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

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

MS04 @ 2230 4mg

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

DATE OF ORDER: 1052 TIME OF ORDER: 03 May 03 HOURS

LIST TIME ORDER NOTED AND SIGN

(b)(6)-2

1) NPO at midnight
2) @ midnight CR @ 125 cc/hr
3) Levoflox 500 mg po qHS
4) Reglan 10 mg po tid.

SSS

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

MD

PATIENT IDENTIFICATION

DATE OF ORDER: 1235 TIME OF ORDER: 3 MAY 03 HOURS

OB/GYN

1) Fentanyl 50 mg IV prn breakthrough pain; may repeat if RR>10, max dose 150 mg in 2 hrs
2) Zofran 4 mg IV prn N/V; may repeat x1 max dose 8 mg in 12 hrs.

(b)(6)-2

MAS/CRNA

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

MAS

PATIENT IDENTIFICATION

DATE OF ORDER: 04 May 03 TIME OF ORDER: 1010 HOURS

1) Post op Sp S-P catheter - resume previous order.
2) Levoflox 500 mg po QD F2 Daly
3) D5 1/2 NS c̄ 20 KCl/Dil @ 125 cc/hr

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

MD

PATIENT IDENTIFICATION

DATE OF ORDER: 04 May 03 TIME OF ORDER: 1030 HOURS

1) Advance diet as tol.

(b)(6)-2

Noted 4 May @ 1330

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

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

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 SHOWN.

PATIENT IDENTIFICATION

(b)(6)-4

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

5 MAY 03 _____ HOURS

1) Δ Levo Flox to Levofloxin 500 mg PO QD - stop on 11 May 03

2) on 6 May 03 - change foley catheter

3) change dressing on SP tube site QD

4) Can DIC to red crescent / red cross when able

(b)(6)-2

06 May 03 / 0430 hrs 24° chart check done

(b)(6)-2

- 24° chart check done 7 May 03 0600 -

(b)(6)-2

- 24° chart check done 8 May 03 / 0000

Noted 5 May 03 1400

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

8 MAY 03 0930 HOURS

(1) Transfer to 28th CSH

- See Transfer Summary from 455 comfort

(b)(6)-2

MD

MAJ, MC

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*

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

Mo. 05 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 2	3	4	5	6	7	8
2 May 03	(b)(6)-2	Vital Signs Per Routine	D	/	(b)(6)-2					
			E	/	(b)(6)-2					
			N	(b)(6)-2						
2 May 03	(b)(6)-2	Diet Regular & Sustacal	D	(b)(6)-2						
		TID & Meals	E	(b)(6)-2						
			N							
2 May 03	(b)(6)-2	Heplock IV	D	/	(b)(6)-2					
			E	/						
			N	(b)(6)-2						
2 May 03	(b)(6)-2	C-Collar at All Times	D	/	(b)(6)-2					
		(may sit up)	E	/						
			N	(b)(6)-2						
2 May 03	(b)(6)-2	Foley To Gravity	D	/	(b)(6)-2					
			E	/	(b)(6)-2					
			N	(b)(6)-2						
2 May 03	(b)(6)-2	MD Notification: Temp > 101.5°	D	/	(b)(6)-2					
		Pulse > 120 < 60 O2sat < 93%	E	/	(b)(6)-2					
		SBP > 170 < 100	N	(b)(6)-2						
		AFO Splints (B) LE	D	/	(b)(6)-2					
			E	/	(b)(6)-2					
			N	(b)(6)-2						
4 May 03	(b)(6)-2	Advance diet as	D	/	/	(b)(6)-2				
		tol.	E	/	/	(b)(6)-2				
			N	/	/		(b)(6)-2			
5 May 03	(b)(6)-2	Change dressing on	1600	/	/	/				
		SP Tube site Q.D.								

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: GSW (A) Neck, Carotid Dissection, CVA

ADDITIONAL PAGES IN USE ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION: (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

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo _____ Yr _____

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
2 May 03	(b)(6)-2	Admit FCW #3 General Surgery / (b)(6)-2	NOW	NOW	2315	(b)(6)-2
2 May 03		DX: s/p GSW (R) Neck, Carotid Dissection, CVA	NOW	NOW	2315	
2 May 03		Condition: Stable	NOW	NOW	2315	
2 May 03		Have PT See Patient in AM For ROM /	3 May 03	AM	done	
2 May 03		Strength evaluation And Daily Care	3 May 03	AM	done	
3 May 03		NPO at MIDNIGHT (PLAN	4 MAY 03	0001	done	
	-----	SUPRAPUBIC CATHETER INSERTION)	~~3 MAY 03~~	NOW	done	
4 May	(b)(6)-2	Post op SP catheter, resume	4 May 03	ASAP	1330	
	-----	previous orders.				
5 May	(b)(6)-2	on 6 May 03 - Change Foley	6 May 03	ASAP	—	
	-----	Catheter				
5 May 03	(b)(6)-2	Can D/C to red crescent /	ASAP			
	-----	red cross when able				
8 May	(b)(6)-2	Transfer to (b)(3)-1	8 May	ASAP		
	-----	See transfer Summary From				
	-----	(b)(6)-4				

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

CL... CAL RECOR... | TH...APEUTIC DOCUMENTATION ... PLAN ... EDICATIONS)

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

Mo. 05 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 2	3	4	5	6	7	8
2 May 03	(b)(6)-2	Colace 100mg PO TID	08	/	(b)(6)-2					
			16	/						
			23	/						
2 May 03	(b)(6)-2	Coumadin 2.5mg PO QD			(b)(6)-2					
2 May 03		Tegretol 200mg PO TID	09	/						
			07							
			14							
2 May 03	(b)(6)-2	Elavil 75mg PO q HS	22	(b)(6)-2						
			22							
3 May 03		REGLAN 10mg PO TID	06	/	(b)(6)-2					
			14	/	(b)(6)-2					
			22	/						
3 May 03	(b)(6)-2	LEVOFLOX 500mg PO q HS	22	/	(b)(6)-2					
3 May 03	(b)(6)-2	LR @ 125 cc/hr when NPO	07 15	/	/					
			15 23	/	/					
			23 07	/	(b)(6)-2					
4 May 03	(b)(6)-2	Levofloxin 500mg PO QD F - 2 days	22	/	/					
4 May 03		D5½ c̄ 20 KCL 1 liter @ 125 cc/hr	07 15	/	/					
			15 23	/	/					
			23 07	/	/					

D/C 4 May 03 New Order

D/C 4 May 03 New Order

5 May 03

ALLERGIES: ☐ YES ☐ NO

NKNA

PRIMARY DIAGNOSIS: GSW (R) Neck, Carotid Dissection, CVA

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

DA FORM 1 FEB 79 4678

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

MEDCOM - 4456

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. May 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															
2 May 03	(b)(6)-2	Vicodin 7 PO Q 4-6°	10 03 May	1 PO 1725	1 PO 0415													
		PRN Pain	(b)(6)-2															
2 May 03	(b)(6)-2	MS04 2-4mg IVq 1-2°	2251 2 May	0300 03 May	0835 3 May	3 May	4 May 1130	3 May	2200	4 May 0300	2400 3 May 4 May	0100 4 May 4 May	0200 4 May 4 May	0300 4 May 4 May	4 May 0715 4 May	4 May 1305 4 May	4 May 2100 4 May	
		PRN Severe Pain	(b)(6)-2				740	(b)(6)-2	3 May (b)(6)-2	(b)(6)-2	(b)(6)-2				(b)(6)-2			
2 May 03	(b)(6)-2	Phenergan 25mg IM/PO	3 May 1100	3 May 2130														
		Q6° PRN Nausea	(b)(6)-2															
2 May 03	(b)(6)-2	Benadryl 25mg IM/IV	3 May 2200	3 May 2330														
		Q8° PRN Pruritis	2330 (b)(6)-2	(b)(6)-2														
2 May 03	(b)(6)-2	Dulcolax Supp 7 PR																
		PRN - For BM																
2 May 03	(b)(6)-2	Fleets Enema 7 PR q																
		3-4 Days PRN for																
		No BM.																

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION (PLAN, MEDICATIONS)

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

Mo. MAY Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 5	6	7	8	9	10	11
5 May 03	(b)(6)-2	Δ Levo flox to Levofloxin 500mg po QD stop on 11 May 03	22	(b)(6)-2						

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS:

GSW ⓡ neck CVA, ~~[illegible]~~

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO. 2

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

DA FORM 1 FEB 79 4678

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. MAY Yr. 03

Verify by Initialing: 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
3 MAY 03	(b)(6)-2	FENTANYL 50 mcg IV PRN BREAKTHROUGH PAIN - MAY REPEAT IF RR>10 - MAX DOSE 150 mcg IN 2 HRS	3 MAY 50 mcg 1400; 3 May 50 mcg 1445; 4 May 0330 50 mcg; 4 May 50 mcg 1245; 5 May 1845 50 mcg; 5 May 50 mcg; 6/4/03 100 mcg 2115; 6/5/03 50 mcg 0245; 6/5/03 100 mcg 0030; 6/5/03 50 mcg 0100; 6/5/03 50 mcg 0300; 6/5/03 50 mcg 0340; 6/5/03 50 mcg 0830; 6/5/03 50 mcg 1130; 6/6 50 mcg w/ [illegible]
3 MAY 03	(b)(6)-2	ZOFRAN 4 mg IV PRN N/V MAY REPEAT X 1 MAX DOSE 8 mg IN 12 hrs.	3 May 4 mg 1354; 3 May 4 mg 2030; 4 May 0600 4 mg; 4 May 4 mg 2344; 5 May 4 mg 1725; 5 May 4 mg 1730; 6 May 4 mg 1442; 7 May 4 mg 1446; 7 May 4 mg; 8 May 4 mg 0100
4 May 03	(b)(6)-2	MSO4 2-4 mg IV q1-2° PRN Severe pain (transcribed from previous order)	5 May 0330 4 mg; 5 May 0400 4 mg P.C.; 5 May 1225 4 mg 1130; 5 May 1800 4 mg P.C.; 5 May 4 mg 1600; 6 May 4 mg 1025; 6 May 4 mg 2240; 6 May 0730 4 mg; 6 May 4 mg; 6 May 4 mg 1930; 6 May 4 mg 2330; 7 May 0130; 7 May 4 mg 0600; 7 May 4 mg; 7 May 4 mg 1800; 7 May 4 mg 1230 IV 4 mg
3 May	(b)(6)-2	Fentanyl 50 mcg IV PRN breakthrough pain, may repeat if RR >10 max dose 150 mcg in 2h	6 May 1310 50 mcg; 6 May 1700 50 mcg; 6 May 1800 50; 6 May 2330 50 mcg; 7 May 1442 50 mcg; 8 May 0100 50 mcg; 8 May 1400 50 mcg
7 MAY	(b)(6)-2	MSO4 2-4 mg IV q 1-2° PRN PRN SEVERE PAIN (transcribed from above)	7 MAY 1930 4 mg; 7 May 2030 4 mg; 8 May 0400 4 mg; 8 May 4 mg 1330
7 May	(b)(6)-2	MSO4 2-4 mg IV q1-2	7 May 2330 4 mg

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF (b)(3)-1 | MTF LOCATION (State or Country Code)

3. REGISTER NUMBER (b)(6)-4 | NAME (Last, First, Middle Initial) (b)(6)-4

4. PAY GRADE: 16 17 —

5. SEX: 18 F

6. DATE OF BIRTH (Y Y Y Y M M D D): 19 20 21 22 23 24 25 26 — 1 9 8 5 0 1 0 1

7. AGE AT ADMISSION: 27 28 29 — 1 8 Y

8. RACE: 30 X I

9. ETHNIC BACK-GROUND: 31 9

RELIGION

10. LENGTH OF SERVICE: 32 33 34 —

ETS

11. FMP: 35 36 — 9 9

12. SOCIAL SECURITY NUMBER: 37 38 39 40 41 42 43 44 45 (b)(6)-4

ORGANIZATION (Active Duty Only)

13. MARITAL STATUS: 46 Z

HOUR OF ADMISSION: 2008

BRANCH / CORPS

14. FLYING STATUS: 47 48 49 —

15. BENEFICIARY CATEGORY: 50 51 52 — K 9 1 K78

16. ZIP CODE OF RESIDENCE: 53 54 55 56 57 58 59 60 61 — Ø 9 3 3 Ø Ø Ø Ø Ø

17. UNIT LOCATION (State or Country Code): 62 63 —

18. MOS: 64 65 66 67 68 69 70 —

19. TRAUMA: 71 9 INS

PREV. ADMISSION: YEAR ☐ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 72 1 Direct

WARD: ICW3

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION: 73 74 — 2 1

22. MTF TRANSFERRED TO: 75 76 77 78 79 80 — A 1 1 D 1

23. DATE OF DISPOSITION (Y Y M M D D): 81 82 83 84 85 86 — 2ØØ3 Ø5Ø8

24. CLINIC SVC - ADMITTING: 87 88 89 90 — A B A A

25. MTF TRANSFERRED FROM: 91 92 93 94 95 96

26. DATE THIS ADMISSION (Y Y M M D D): 97 98 99 100 101 102 — 2ØØ3 Ø5 Ø2

27. LOCATION OF OCCURRENCE (Battle Casualty Only): 103 104 — I Z

28. MTF OF INITIAL ADMISSION: 105 106 107 108 109 110

29. DATE INITIAL ADMISSION (Y Y M M D D): 111 112 113 114 115 116

FOR LOCAL USE

DX: 0749
95205
90001
9001
44321
44320
34400
99639
[illegible]

S/P GSW (R) Neck, carotid dissection

TRAUMA 9

COI 599

ADMIT[illegible] (Signature, as req[illegible]) (b)(6)-2

DX: 5717
9763

SIGNATURE OF ADMITTING CLERK (b)(6)-2

DA [illegible]35, M[illegible]

EDITION OF MAY 79 IS[illegible]

MEDCOM - 4460

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	MTF LOCATION (State or Country Code)
1 2 3 4 5 6	7 8
(b)(3)-1	

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
9 10 11 12 13 14 15	(b)(6)-4	16 17	18
(b)(6)-4			F

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19 20 21 22 23 24 25 26	27 28 29	30	31	
		I		

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36	37 38 39 40 41 42 43 44 45
		9 9	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	2085	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52	53 54 55 56 57 58 59 60 61

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
62 63	64 65 66 67 68 69 70	71	YEAR ☐ NO
		INJ	

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72	ICW3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
Direct		
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
73 74	75 76 77 78 79 80	81 82 83 84 85 86
		0 3 0 5 0 8

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
87 88 89 90	91 92 93 94 95 96	97 98 99 100 101 102
A B A A		0 3 0 5 0 8

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110	111 112 113 114 115 116

FOR LOCAL USE

S/P GSW (R) Neck, carotid dissection

AD (b)(6)-2

SIGNATURE OF ADMITTING CLERK (b)(6)-2

EDITION OF MAY 79

MEDCOM - 4461

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER (b)(3)-1	2. NAME (Last, First MI) (b)(6)-2 (b)(6)-4			3. GRADE	ADMISSION REMARKS
4. SEX F	5. AGE	6. RACE I	7. RELIGION IRAQI	8. LENGTH OF SVC	9. ETS
10. PREVIOUS ADMISSION					
11. EMP 99	12. SSN (b)(6)-4	13. ORGANIZATION		14. WARD ICW1	
15. FLYING STATUS NO	16. RATING/DSG	17. DEPT./BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct			22. HOURS OF ADMISSION 2230	23. CLINIC SERVICE ABAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE		25. TYPE DISPOSITION TRANS		26. DATE OF DISPOSITION 10MAY03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)		27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION 2MAY03	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1 IRAQ				30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

S/P GSW to buttocks

~~E969~~

877.0
808.0
44320

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
8	8				8

36. Total Days All Facilites

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

(b)(6)-2 OFFICER MD (b)(6)-2 MAJ MC SIGN (b)(6)-2

EDITION OF 1 AUG 76 IS OBSOLETE

MEDCOM - 4462

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER (b)(3)-1	2. NAME (Last, First, MI) (b)(6)-4 (b)(6)-4			3. GRADE	ADMISSION REMARKS
4. SEX F	5. AGE	6. RACE I	7. IRAQI	10. PREVIOUS ADMISSION	
11. AGE 99	12. SSN (b)(6)-4	13. ORGANIZATION		14. WARD ICW1	
15. FLYING STATUS NO	16. RATING DSG	17. DEPT/BEN 1K78	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct

22. HOURS OF ADMISSION: 2230

23. CLINIC SERVICE: ABPM

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

25. TYPE DISPOSITION: TRANS

26. DATE OF DISPOSITION: 10MAY03

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

27b. TELEPHONE NO.

28. DATE OF THIS ADMISSION: 2MAY03

ADMITTING OFFICER

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1, IRAQ

30. DATE OF INITIAL ADMISSION

32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Back

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

S/P GSW to buttocks

~~E969~~

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
8	8				8

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING OFFICER (b)(6)-2 MD (b)(6)-2 MAT, MC

SIGNATURE OF (b)(6)-2

EDITION OF 1 AUG 76 IS OBSOLETE

MEDCOM - 4463

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
2 May 03 @	2315 hrs – Nursing Admission Note —
	Pt received from (b)(3)-1 this evening. Pt speaking Arabic, but understands some simple English words. Pt alert and appears oriented. UTA orientation due to language barrier. PERRLA 2mm brisk. MAEW Heart – NSR, ∅ m/r/g noted. ∅ edema, brisk cap refill. ∅ MIVF infusing, ∅ heplock. Lungs CTA (B), ↓ bases bilat. ∅ cough or SOB noted. Abdomen large, rounded, soft and tender near incision. Midline abdominal incision with dressing intact – ∅ drainage noted. LLQ colostomy with scant amount of soft stool in it. ∅ N+V noted. Pt has not voided since admission – UTA @ this time. (L) buttock c̄ dressing intact – ∅ drainage noted. All pulses palpable +2. Pt denies pain at this time. Uss. Will continue to monitor. (b)(6)-2 [redacted] PT, A
2345 HRS 2 MAY 03	VS7 BP 120/76 – P-109 – RR-20 – Temp 98.7(F) SPO2 95%. (b)(6)-2 [redacted]
3 MAY 03 ~~0300~~ 0350	Pt c/o (L) Hip pain, medicated c̄ #(2) Percocett PO as ordered. ∅ other complaints noted @ this time. (b)(6)-2 [redacted]
3 MAY 03 0600	Informed that pharmacy does not carry Impenien 500mg IVPB, Physician paged, dose Held @ this time for 0600 HRS. (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.

(b)(6)-4 [redacted]

PROGRESS NOTES
Medical Record

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

DATE	NOTES
3 May 03 0851	B/P-100/88 P-97 R-24 UT-97.7 D2-94 — SPC [redacted] (b)(6)-2

[redacted] (b)(6)-2

FPI LEX Printed on Recycled Paper

STANDARD FORM 509 (REV. 5-99) BACK

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	PT NOTE NOTES
5-3-03	(S) Pnt seen on ward per Dr. (b)(6)-2 Request for consult s/p GSW to (L) buttocks, (L) acetabular fx and diverting colostomy - No interpreter
	(O) NAD, Laying supine
	- (I) bed mobility → min assist x 1
	- Mod assist x 1 for transfers
	- Ambulates c̄ crutches - FWB (L) c̄ distress - dentatively c̄ SBA x 1
	(A) Functionally doing well - ambulates FWB c̄ Stand-by assist -
	(P) Nursing supervision/encouragement for ambulation TID → Ab Lib for LOS (b)(6)-2 VMPT, ATC
5-3-03	D/W Dr. (b)(6)-2 - Ortho about WB precautions for (L) Acetabular fx - Recommends TTWB (L) LE only - will initiate through interpreter this PM regarding TTWB and completion — (b)(6)-2 PT
3 May 03 1210	Pt seen by Surg this am for dig Δ to midline Abd, wnd. Δ'd Abx c̄ question on dosage ordered Δ'd by MD. Pt seen by PT for ~~ab~~ ambulation will require f/u c̄ translator for instruction c̄ CS tches. (b)(6)-2 SSG LPN

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

#(b)(6)-4

PROGRESS NOTES
Medical Record

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

DATE	NOTES
05-03-03	PT
1410	- Pt seen this PM and was able to Ambulate TTWD
	(L) LE ≈ 20 feet c̄ SBA. Cont TID ~ Ad Lib c̄
	Nursing supervision for LOS (b)(6)-2 [redacted] PT
3 MAY 03 1545	Pt c/o pain in buttocks area. Pt given two Vicodin. A+O x3. Reps even + unlabored. Skin W+d. BS x3. Colostomy in place. With small amt of stool. Picc line in (L) AC) place ∅ S+S of infection. Pt resting on (L) side. SGT (b)(6)-2 [redacted]
3 May 03 1600	130/88 (T) 98.3 (P) 109 - 18 SPO2 - 97% SGT (b)(6)-2 [redacted]
2300 03 MAY 03	VS> BP - 128/90 P 91 R 16 T - 97.8 SpO2 98
03 MAY 03 2345 HRS	Pt resting quietly s̄ complaints @ this time. AEO x3. LS CTA in upper lobes ↓ to bases bilat. O2 sats 97-98%. ∅ SOB noted. BS active x3, (b)(6)-2 [redacted] Ostomy bag to (L) side of ABD c̄ small amounts of Brown stool. Pt voiding s̄ difficulty. Picc line to (R) AC, single lumen. Good blood return noted to Picc line, Flushed c̄ NS prior to IV ABX. Midline ABD DRSG CDI @ this time. (L) Buttock c̄ DRSG intact. Pt able to ambulate c̄ crutches. (b)(6)-2 [redacted]
4 MAY 03 0400	Pt medicated c̄ 2 Vicodin PO for c/o (L) Hip/Buttocks pain. Pt now resting quietly. (b)(6)-2 [redacted]
4 Mar. 03 0814	B/P - 118/88 P - 103 R - 20 T - 97.7 O2 - 98 - SPO (b)(6)-2 [redacted]
1130	Pt A+O x3 Heart RRR Lungs CTA Dss moist + intakt. Colostomy bag c̄ >100cc of fecal material Pt c/o nausea c̄ food intake. Bowl sounds x4 (b)(6)-2 [redacted] SSG (b)(6)-2 [redacted]
04 May 03	Pt VS c̄ 103 PULSE AND 98 SPO2, BP 132/80, TEMP 98.7, AND [redacted] (b)(6)-2 [redacted]

FPI LEX Printed on Recycled Paper

STANDARD FORM 509 (REV. 5-99) BACK

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
04 May 03	1520 - c/o pain to ABD. & (L) posterior hip Medicated c̄ Percocet ii PO pain (b)(6)-2 [redacted]
	1630 - attempted to get OOB Pt. became weak & had to be put back to bed again. VSS assessed BP 130/76 - POX = 98% Pulse = 103. (b)(6)-2 [redacted]
	1700 - Drsg Δ to ABDomen. Assessment of ABD reveals: beefy red tissue c̄ deep opening & white necrotic edges - no unusual odor / no unusual drainage. Area irrigated c̄ NSS - Wet to dry packing @ NSS. Covered c̄ Dry gauze & secured c̄ tape. TX to (L) posterior buttock slow assessment of area reveals: clean wound c̄ beefy red tissue & white necrotic edges & depth. Wet to dry TX c̄ NSS. Applied / covered c̄ gauze & secured c̄ tape. Tol. well. Colostomy bag has soft formed green color Bri - Small amt. & Emptied. Pt. sad as interpreted by interpreter - misses "baby". Assured she'd be better once she heals & feels better & returns home. (b)(6)-2 [redacted]
	1800 - ate 25% supper & PO flds. encouraged (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.

(b)(6)-4 [redacted]

PROGRESS NOTES
Medical Record

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

DATE	NOTES
2400 04MAY03	VS> BP 122/82 P 113 R 20 T-99.4 SpO2 99%
05MAY03 0015	Pt AEOX3, Resting quietly @ this time. Medicated for pain @2315hrs denies pain @ this time. LS CTA in bilat ↑ lobes ↓ in lower lobes, O2 SATS 98-99% on RA. BS active X4, Colostomy bag in place c̄ small amounts of brown stool. Pt voiding s̄ difficulty. Single lumen Rec line to (R) AC flushing well c̄ good blood return. ABD DRSG CDI, (L) Buttocks DRSG CDI. Cap refill <3 Sec in ext X4. Pt has not been OOB this shift. (b)(6)-2
0800 5May03	VS> 116/78 P=105 R=17 T=96.4 SP 98 (b)(6)-2
0945	Pt A+OX3 Lungs CTA Heart RRR. Bowel sounds X4 Δ dsg middle Abd c̄ moist Kelex c̄ Dakins Wnd 10" long 2" deep c̄ deep sutures. Covered c̄ 4x4 & tape. Wnd (L) Buttock 2" wide 1" deep packed c̄ 4x4 moistened c̄ Dakins covered c̄ 4x4 & tape. Emptied colostomy & irrigated bag c̄ VS. (b)(6)-2 556 LPN
1500 5May03	VS> 110/77 P=98 R=23 T=97.7 SP 98 (b)(6)-2
5 May03	1515 — Facial grimmacing but denies pain per Interpreter. Asked interpreter to ask what can be done to make her comfortable She told interpreter "not much". Pt assisted up in bed. Remove blanket & applied sheet. Mouth care c̄ Lemon Swabs. Faced wiped c̄ baby wipes. (b)(6)-2
050503	1700 - Husband visited. Pt ate 100% meal. (b)(6)-2
2000 5MAY03	VS> BP 112/88 P 103 R 20 T 99.3 SpO2 95%

FPI LEX Printed on Recycled Paper

STANDARD FORM 509 (REV. 5-99) BACK

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
050503	at 2000 – Husband here. Drsg Δ to Abdomen. Area is clean, pink – no unusual drainage / odor. Has even edges. Area cleansed c̄ NSS. Apply NSS wet packing. Covered c̄ dry gauze + secured c̄ tape. (L) posterior buttocks drsg done. Area is clean, pink c̄ white necrotic, even Edges – no unusual drainage / odor. Tol. well. Cleansed area c̄ NSS, Applied wet drsg. Covered c̄ dry gauze + secured c̄ tape. Colostomy bag emptied – DK. greenish semi-formed BM mod. Amt. Peri-care done per pt. (b)(6)-2 [redacted] LTA
	2100 medicated for pain c̄ ⅡⅡ Percocet. Effective (b)(6)-2 [redacted] LTA
05 May 03 @ 2300	Received report from night shift. Pt resting c̄ husband @ BS. HRRR, clear breath sounds, ↓ bases, abdomen round, midline Drsg C/D/I. Single lumen PICC to (R) arm. Flushes well. Cap refill < 2sec. Pt denies pain. Colostomy to (L) side. Will continue to monitor – (b)(6)-2 [redacted] 91WMC
6 May 03 0800	VS> BP 122/90 P 105 R 19 T 96.4(Ax) SP 98 (b)(6)-2 [redacted] 91W

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

DATE	NOTES
6 May 03 0930	Pt resting in bed this am - Husband at bedside. Pt c̄ ¹ episode of emesis this am. no further c/o N/ at this time. Tol PO meds. Lungs CTA B/C - HRRR BS X4 Quads. Colostomy bag intact to LLQ draining semiformed brownish/yellow stool. ML ABD incision - open wound. DSG Δ'd at this time W-D c̄ ¼ % Dankins soln. Wound is beefy red - healthy tissue. Sutures in place at bottom of wound. DSG Δ'd to (L) buttock. Packed c̄ 2 4x4 gauze fluffs. Wound is fairly deep as ¹ gauze packed in wound. Pt tolerated dsg Δ s̄ c/o. PICC line to (R) AC patent. Pt not receiving IV ABX any longer. Pt encouraged to AMB. Will amb pt to BR when she has to urinate. Will cont to assess — (b)(6)-2 CPTAN
1030	DSG to (R) PICC line done. old dsg soiled & falling off. PICC entry site red & slightly swollen. Will notify MD's on rounds. Site clean c̄ Betadine under sterile tech. — (b)(6)-2 CPTAN
1315	pt amb to back vestibule to use BR. Pt urinated. Assisted in emptying colostomy bag. Pt began to perspire & felt faint. Pt assisted to vestibule floor. Pt's name called & opened eyes. Pt helped up to chair by myself & husband. Pt amb back to bed c̄ crutches. Pt sitting up in chair at this time. Will cont to assess — (b)(6)-2 CPTAN
1445	MD'S round on pt. ~~[illegible]~~ Removed ML dsg. DSG repacked W-D c̄ ¼ Dankins. PICC line removed - tip intact (b)(6)-2 CPT
06 May 03 @ 1950	Pt resting. Colostomy bag emptied, semiformed stool. Pt has DRSG to Abd CDI & buttocks CDI. No IV assess. HRRR, clear equal breaks sounds, good cap refill, A&Ox3, pain denies pain, c/o nausea 25m Meclizine given. Will continue to [illegible] (b)(6)-2

FPI LEX Printed on Recycled Paper STANDARD FORM 509 (REV. 5-99) BACK

MEDCOM - 4471

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
6 MAY 03	VS > BP 132/76 P 100 R 20 T 99.1 SpO2 99
07 May 03 @ 0500	Dx'd Drsg to buttocks. Area deepened. Pseudomonas of infection. (b)(6)-2 9/WM6 Dx'd colo. (b)(6)-2 Emptied colostomy bag. Soft brown stool. (b)(6)-2 9/WM6
7 May 03 0800	VS > BP = 124/78 P = 103 R = 18 T = 96.9 SP = 98 (b)(6)-2
7 May 03	Ate (w/o) breakfast. C/O pain in ABD. Medicated c̄ Percocet tabs ii PO. ABD/drsg intact at this time. Colostomy ⊼ drainage BM at this time (b)(6)-2
0800	Does not like MWI - Says it makes her feel sick (nauseated) (b)(6)-2
0915 -	Sitting in chair at BS. Tol well. (b)(6)-2
1030 -	Back to bed. Resting Quietly (b)(6)-2
1600 -	Husband present - Drsg Δ to ABD. Area is pink moist inside wound c̄ even edges, no unusual odor/drainage. Cleansed/irrigated c̄ NSS. Applied wet NSS packing. Covered c̄ ABD. Pad - Secured c̄ Tape. Tol. well. Δ'd Drsg to (L) posterior thigh, area has tunneling depth even edges - no unusual odor/drainage → (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

DATE	NOTES
07May03	1600 Cont'd. Cleansed c̄ NSS. Applied NSS Gauze packing covered c̄ dry gauze - Secured c̄ tape. Tol well. Δ'd Colostomy bag - Has mod - Amt semi formed fecal matter. Tol. well. (b)(6)-2
7 MAY 03 @ 2000	VS> BP 128/98 P 96 R 18 T 98.3 A SpO2 94% RA DRSG Δ to ABD. No unusual odor/drainage. Irrigated c̄ NSS Applied wet NSS packing. Covered c̄ ABD pad. Tolerated well. DRSG Δ to (L) post thigh. No unusual odor/drainage. Even edges on tunnel, moist & pink. Applied wet NSS packing, covered c̄ 4x4s. Tolerated well. Emptied colostomy bag - has semi-formed brown stool. Tol. well. (b)(6)-2 (b)(6)-2 91WM6
@ 2030	Pt resting c̄ husband @ bedside. c/o difficulty sleeping will medicate c̄ Benadryl. (b)(6)-2 91WM6
@ 2200	BP 120/78 (b)(6)-2 91WM6
8 May 03 0800	VS> BP - 118/74 P - 90 R - 18 T - 98.3 A SP - 96 O2 (b)(6)-2
8 May 03	0830 - Husband present. Am Care done by Pt & husband. Assessment reveals - Good mood - Smiling. Ate own food for breakfast & some of our food (about 10%). Denies pain at this time. Lungs clr c̄ No cough/congestion - BS + all Quads. Colostomy bag intact - (b)(6)-2
12N	Pt. Resting Quietly (b)(6)-2
1300	Ambulated to Bathr - urinated & colostomy bag emptied. (b)(6)-2
1600	Medicated for pain c̄ 2 percocet (b)(6)-2
1700	TX'S done to ABD, (2) Posterior hips - (b)(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
08 May 03 @ 1930	Received report from day shift. Pt resting c̄ husband @ bedside. Dd DRSG to ABD. Area is red c̄ ∅ infection. Dd DRSG to Buttock no signs of infection. Pt is taking care of colostomy care. HRRR, Clear equal bilat breath sounds. Stool from colostomy is semi-formed brown. Pt c/o pain, will coredicate c̄ Percocet. Also pt c/o of difficulty sleeping. 10mg of ambien given — (b)(6)-2 [redacted] 91 Wm 6
@ 2000	POR 98% HR 100 BP 128/70 HR 70 Temp 98.2
9 May 03 0800	VS> BP-120/72 P-100 R-18 T-97(Ax) SP-98 Drazo 91 W
9 May 03	medicated c̄ percocet ii PO for pain at ABDs & (L) buttocks. Resting Calmly at this time. Husband present. (b)(6)-2 [redacted]
9 May 03	1615 - Ambulating in Hall of NSG unit c̄ Husband. c/o "Leg cramping" which subsided. (b)(6)-2 [redacted]
9 May 03	1800 - No c/o's voiced. Lungs Sound CTA, No c/o's SOB. No warmth at Leg cramp site. Left lower leg. Continue to monitor & encourage pt. to walk as much as possible. (b)(6)-2 [redacted]
@ 2000	VS> BP 118/88 P 107 R 18 T 98.9 SpO_2 98

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

DATE	NOTES
09 May 03 @ 2030	Received report from day shift. Husband @ BS. Pt up walking w/ crutches & assistance from husband. HRRR, ¢E/B Breath sounds. Pt is proforming colostomy care, emptied this shift. Pt has ABD dressing to midline CDI, & to (D) buttocks, CDI. Will continue to monitor for pain & infection — (b)(6)-2 [redacted] SKWML
0820- 10 May 03	Pt AS0x3, resting in bed, (D) DS CTA, HRR, Ø edema, cap ref <3 sec, (P) DS xsquared, drag to midline abd CDI, drag to buttock inbet, colostomy inbet, pt is c/o dis w/ at @ this time will cont to monitor — (b)(6)-2 [redacted] LTAW
10 May 03 0800	VS7 BP-116/84 R-18 P-100 T-97.5 SP-98 (b)(6)-2 [redacted] SKW
10 May 1200-	Pt D/C/transferred to Ar Nisaiyah via Red Lisent, pt left floor ambulatory c̄ family - VSS, stabilized - proper supplies c̄ pt. — (b)(6)-2 [redacted] LTAW

PT # (b)(6)-4

(b)(6)-4

SPECIMEN/LAB RPT

HEMATOLOGY

URGENCY: [X] ROUTINE; TODAY [ ]; [ ] PRE-OP; STAT [ ]

PATIENT STATUS: [X] BED; [ ] AMB; OUTPATIENT [ ]; [ ] NP; [ ] DOM

SPECIMEN SOURCE: [X] VEIN; [ ] CAP; [ ] OTHER (Specify)

PATIENTS MED

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO (b)(6)-2

REQUESTING PHYSICIAN'S SIGNATURE: Dr (b)(6)-2

REPORTED BY: Sgt (b)(6)-2 (b)(6)-2 MD

DATE: 3 MAY 03

LAB. ID. NO.

REMARKS: 1+ Basophillic Stippling

CBC - 1+ Polychromasia

549-107

TEST(S)	SPECIMEN TAKEN DATE	TIME A.M. P.M.	REQUESTED (X)	RBC COUNT	HEMOGLOBIN	HEMATOCRIT	MCV	MCH	MCHC	WBC COUNT	IMMATURE	NEUTRO-BANDS	NEUTROSEGS	LYMPHS	EOSINOPHILS	BASOPHILS	MONOCYTES	PLATELETS	RBC	SED. RATE	PLATELET COUNT	RETICULOCYTE COUNT	CLOTTING TIME	BLEEDING TIME	CONTROL	PATIENT	CONTROL	PATIENT	% ACTIVITY	RATIO	SICKLING TEST		
			RESULTS	3.89	10.4	32.8	84.2	26.7	31.7	6.3									increased	hemarks	562											24.2	24.6 Ly#
																																1.5	

WBC DIFF AND BLOOD CELL MORPH

HEMATOLOGY STANDARD FORM 549 (Rev. 7-78) Prescribed by GSA/ICMR FIRMR (41-CFR) 201-45.505

PT # (b)(6)-4

(b)(6)-4

SPECIMEN/LAB. RPT. NO.

CHEM I

URGENCY: [X] ROUTINE; TODAY [ ]; [ ] PRE-OP; STAT [ ]

PATIENT STATUS: [X] BED; [ ] AMB; OUTPATIENT [ ]; [ ] NP; [ ] DOM

SPECIMEN SOURCE: [X] BLOOD; [ ] OTHER (Specify)

PATIENT'S MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE: Dr (b)(6)-2

REPORTED BY: Sgt (b)(6)-2 (b)(6)-2 MD

DATE: 3 MAY 03

LAB. ID. NO.

REMARKS: Chem 7

546-107

TEST(S)	SPECIMEN TAKEN DATE	TIME A.M. P.M.	REQUESTED (X)	GLUCOSE	UREA N.	CREATININE	URIC ACID	SODIUM	POTASSIUM	CHLORIDE	CO_2	PHOSPHATE	CALCIUM	TOTAL PROTEIN	ALBUMIN	GLOBULIN	ALKALINE PHOSPHATASE	ACID PHOSPHATASE	SGOT	LDH	CPK	BILIRUBIN (TOTAL)	BILIRUBIN (DIRECT)	CHOLESTEROL	TRIGLYCERIDES	AMYLASE	LIPASE	PROFILE (Specify)		
			RESULTS	92	9	1.2		136	3.1	97																			32	HCT
																													11	HOB

CHEMISTRY I STANDARD FORM 546 (Rev. 8-77) General Services Administration and Interagency Committee on Medical Records, FIRMR (41 CFR) 201-45.505

(b)(6)-4

SF 546

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

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW-1		5

DATE OF ORDER: 2 MAY 03 — TIME OF ORDER: 2210 HOURS — LIST TIME ORDER NOTED AND SIGN

1. ADMIT TO ICW1
2. DX: GSW (L BUTTOCKS ⊼ (L ACETABULAR FX
   DIVERTING COLOSTOMY
   C/B WOUND DEHISCENCE / NEC FASCIITIS
3. COND STABLE
4. VS PER ROUTINE
5. ACT: AD LIB - CRUTCHES @ BEDSIDE

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW-1		5

DATE OF ORDER: ↓ — TIME OF ORDER: ↓ HOURS

6. ALL: NKDA
7. DIET: REGULAR
8. IV (PICC LINE) HL - FLUSH PICC QID
9. LOVENOX, 30 MG SQ BID
10. IMIPENEM, 500 MG IVPB Q6'
11. ZANTAC 150 MG PO BID
12. MULTIVITAMIN T PO QD

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW-1		5

DATE OF ORDER: ↓ — TIME OF ORDER: ↓ HOURS

13. MECLIZINE, 25 MG PO BID PRN NAUSEA
14. VICODIN OR PERCOCET, 1-2 TAB PO
    Q4-6 HR PRN PAIN
15. MOTRIN, 800 MG PO TIDWM, PRN PAIN
16. CBC, CHEM 7 IN AM (b)(6)-2
17. CONSULT PT — MD

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW-1		5

DATE OF ORDER — TIME

noted. (b)(6)-2

CPT ADD
5/2/03 @ 2315 hrs

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 03 MAY 03 TIME OF ORDER: 0958 HOURS

LIST TIME ORDER NOTED AND SIGN

1) if Imipenem unavailable then: Timentin 750mg IV Q6°

2) 1/2 strength DAKINS solution to BEDSIDE

3) BID damp-to-dry dressing changes c̄ 1/2 strength DAKINS

4) Ambien 5-10mg PO QHS prn

(b)(6)-2

(b)(6)-2 MAS 3 May 03 1350

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 03 MAY 03 TIME OF ORDER: 1814 HOURS

1) Δ timentin to 3.1gm IV Q6H

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 4 MAY 03 TIME OF ORDER: 1300 HOURS

1) Transfer to (b)(3)-1

2) D/C Timentin

3) Rx on chart for D/C (no others)

Noted 4 May 03 1300

(b)(6)-2 UD

(b)(6)-2 MAJ, UC

(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.

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

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			6 May 03	1430 HOURS	
			(1) D/C PICC line		
			V.O. Dr. (b)(6)-2	(b)(6)-2 COTAN	
					(b)(6)-2
NURSING UNIT	ROOM NO.	BED NO.			

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

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

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

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

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

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. May Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 2	3	4	5	6	7	8	9	10	11	12	13	14	15
2May03	(b)(6)-2	VS @ Shift	08	(b)(6)-2													
			16														
			24														
2May03	(b)(6)-2	Activity: AD Lib c̄	08														
		Crutches @ bedside	16														
			24														
2May03	(b)(6)-2	Diet: Regular	08														
			16														
			24														
2May03	(b)(6)-2	IV: PICC LINE - Flush	06	(b)(6)-2													
		QID	12														
			18	(b)(6)-2													
			24	(b)(6)-2													

D/C'd 6 May 03

ALLERGIES: ☐ YES ☒ NO — NKDA

PRIMARY DIAGNOSIS: GSW to (L) buttocks c̄ (L) Acetabular fracture; Diverting Colostomy

ADDITIONAL PAGES IN USE: ☐ YES ☒ NO — PAGE NO: 1

PATIENT IDENTIFICATION: (b)(6)-4 (b)(6)-4 # (b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 1 OCT 78 4677 — EDITION OF 1 DEC 77 MAY BE USED.

MEDCOM - 4480

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)				Mo May Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
2 May	(b)(6)-2	Admit DCW-1	2May03	2210	2230	(b)(6)-2
2 May		Condition Stable	2May03			
2 May		Chem 7, CBC in AM	3May03	0600	0600	
2 May		PT Consult	3May03	1000		
4May03		Transfer to (b)(3)-1				
4May03		PX on chart for D/C Cno orders				

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

☆ U.S. GPO:1997-418-290/55267

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 May Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 2	3	4	5	6	7	8	9	10	11	12	13	14	15
2May03	(b)(6)-2	Lovenox 30mg SQ BID	08	(b)(6)-2													
	.....		20	(b)(6)-2													
2May03	(b)(6)-2	Imipenem 500mg IVPB Q6°	06	(b)(6)-2													
	.....		12														
	.....		18														
	.....		24														
2May03	(b)(6)-2	Zantac 150mg PO BID	08	(b)(6)-2													
	.....		20	(b)(6)-2													
2May03	(b)(6)-2	Multivitamin + tab PO QD	08	(b)(6)-2													
	.....																
	.....																
3M,03	(b)(6)-2	Timentin 3.1gm IV Q6°	06	(b)(6)-2													
	.....		12	(b)(6)-2													
	.....		18														
	.....		24														

D/c'd 1200 3May03

D/c'ed 4May03 (b)(6)-2

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: GSW (L) Buttocks c̄ (L) Acotabular fx; Diverting Colostomy

ADDITIONAL PAGES IN USE: ☐ YES ☒ NO

PAGE NO. 1

PATIENT IDENTIFICATION:

Bed #5

(b)(6)-4

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. May Yr. 2003

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
3 May	(b)(6)-2	½ strength DAKINS solution to BS	3 May	—		(b)(6)-2
6 May		DIC PICC line	6 May	done		

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
2 May	(b)(6)-2	Meclizine 25mg PO BID PRN - nausea	06 May 0315 (b)(6)-2	06 May 2000 2500 (b)(6)-2												
2 May		Vicodin 1-2 Tab PO @4-6 HR PRN-Pain	2 PO 0315	2 PO 1615	2 PO 2100 (b)(6)-2	4 May 0400	4 May 2015	5 May 0900	5 May 2100	06 May 0600	6 May 1600 (b)(6)-2	06 May 0200 (b)(6)-2	9 May 2345	10 May 0630 (b)(6)-2		
2 May		Percocet 1-2 Tab PO @4-6 HR PRN-Pain	3 May 0850	4 May 1530	5 May 2 PO (b)(6)-2		6 May 0315	6 May 1045	06 May 2100	07 May 0400 (b)(6)-2		07 May 0800	07 May 1930	07 May 2330		
2 May		Motrin 800mg PO TID ĉ meals PRN-Pain			(b)(6)-2		(b)(6)-2				(b)(6)-2					
3 May	(b)(6)-2	Ambien 5-10mg PO	08 May 2000	9 May 2345												
		QHS prn		10 May PO (b)(6)-2												
2 May	(b)(6)-2	Percocet 1-2 tabs	5 May 1630	6 May 0800												
		PO Q4-6 PRN Pain	11 PO (b)(6)-2	11 PM (b)(6)-2												

USAPA V1.00

(b)(6)-4

(b)(6)-4

MEDCOM - 4483

1. REPORTING MTF	MTF LOCATION (State or Country Code)	ADMIS. AND CODING INFORMATION
(b)(3)-1	IZ	For use of this form, see AR 40-400; proponent agency is OTSG

2. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
(b)(6)-4	(b)(6)-4		F

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

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
		99	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	2	2230	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K91 78	09330000

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
1 Direct	ICW1	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
(b)(3)-1	IRAQ	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
26 TRNS	(b)(3)-1	2003051 0

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
A B A D		2003052

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

FOR LOCAL USE

DX: 8081 GSW to buttocks
8771
86350
E0912

~~E869~~

Trauma 9 Inj 569

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK
(b)(6)-2 (b)(6)-2 MD KAJ, MC	(b)(6)-2

DA FORM 2985, MAR 89 EDITION OF MAY 79 IS OBSOLETE

7-06(

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF: (b)(3)-1

MTF LOCATION (State or Country Code): IQ

3. REGISTER NUMBER: (b)(6)-4

NAME (Last, First, Middle Initial): # (b)(6)-4 (b)(6)-4

4. PAY GRADE:

5. SEX: F

6. DATE OF BIRTH (Y Y Y Y M M D D):

7. AGE AT ADMISSION:

8. RACE: I

9. ETHNIC BACKGROUND:

RELIGION:

10. LENGTH OF SERVICE:

ETS:

11. FMP: 99

12. SOCIAL SECURITY NUMBER: (b)(6)-4

ORGANIZATION (Active Duty Only):

13. MARITAL STATUS:

HOUR OF ADMISSION: 2230

BRANCH / CORPS:

14. FLYING STATUS:

15. BENEFICIARY CATEGORY:

16. ZIP CODE OF RESIDENCE:

17. UNIT LOCATION (State or Country Code):

18. MOS:

19. TRAUMA: INJ

PREV. ADMISSION: YEAR ☐ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: Deroot

WARD: ICW1

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE:

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code):

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1 IRAQ

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE:

21. TYPE OF DISPOSITION: TRANS

22. MTF TRANSFERRED TO:

23. DATE OF DISPOSITION (Y Y M M D D): 030510

24. CLINIC SVC - ADMITTING: ABAD

25. MTF TRANSFERRED FROM:

26. DATE THIS ADMISSION (Y Y M M D D): 030502

27. LOCATION OF OCCURRENCE (Battle Casualty Only):

28. MTF OF INITIAL ADMISSION:

29. DATE INITIAL ADMISSION (Y Y M M D D):

FOR LOCAL USE

GSW to buttocks

~~E969~~

ADMITTING OFFICER (Signature, as required): (b)(6)-2 (b)(6)-2 MD MAJ, MC

SIGNATURE OF ADMITTING CLERK: (b)(6)-2

DA FORM 2985, MAR 89 EDITION OF MAY 79 IS OBSOLETE

INPATIENT TREATMENT RECORD CONTINUATION SHEET

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

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4 (b)(6)-4		3. GRADE	ADMISSION REMARKS
4. SEX F	5. AGE	6. RACE IRAQI	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION yes
11. FMP 99		12. SSN (b)(6)-4	13. ORGANIZATION			14. WARD ICW 1
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct				22. HOURS OF ADMISSION 2202	23. CLINIC SERVICE AEAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION		26. DATE OF DISPOSITION 03MAY03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)			27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION 02MAY03	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1					30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

R tibia fx - ~~$23.00~~

873.80

29405

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
1	1				1

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING PHYSICIAN (b)(6)-2

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER (b)(6)-2

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

MEDCOM - 4486

INPATIENT TREATMENT RECORD CO[illegible] SHEET

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

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4 (b)(6)-4			3. GRADE	ADMISSION REMARKS
4. SEX F	5. AGE	6. RACE IRAQI	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION yes	
11. FMP 99		12. SSN (b)(6)-4		13. ORGANIZATION		14. WARD ICW 1	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN		18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE INJ	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct				22. HOURS OF ADMISSION 2202	23. CLINIC SERVICE AEAA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION		26. DATE OF DISPOSITION 03MAY03		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)			27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION 02MAY03		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1					30. DATE OF INTIAL ADMISSION		32. UNITS OF WHOLE BLOOD COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

R tibia fx - ~~823.00~~

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
1	1				1

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER (b)(6)-2

SIGNATURE OF RAD OR MEDICAL RECORDS OFFICER (b)(6)-2

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

MEDCOM - 4487

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
2 May 03 Nursing.	@2400 - T-97.4 Ax, P 124 RR 24 BP 105/54, admitted from USNS Comfort, alert + appropriate, smiling, interactive c̄ staff + other patients, lungs clear bilaterally, HRR, S1S2, ⊕ edema noted, Abd soft, nontender, bowel sounds x 4 quads, MAE x4, cast to RLE - short leg, ⊕ toe movement, cap refill ↓ 2 sec, ⊕ IV access - [redacted] OLT, AN
3 May 03 Nsg.	@0600 - Quiet noc, slept, [illegible] from previous assessment - [redacted] OLT, AN
3 May 03 0806	B/P NO Baby B/P Cuff P-119 O_2-99 T-95.3 R 22 SPC [redacted] g/w —
3 May 03 1045	Pt AA and appropriate. Interacts well c̄ staff and other patients, very friendly. Cast to (R) leg intact. NO obvious discomfort. moves toes easily. ambulates c̄ steady gait. good appetite. diaper changed. — [redacted] MAJ
3 May 03 1230	Pt transferred to hosp (civilian) in stable condition — [redacted] MAJ

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
	(b)(3)-1 [redacted]	

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

(b)(6)-4 [redacted]

REGISTER NO.	WARD NO.
	KW 1

PROGRESS NOTES
Medical Record

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

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

NURSING UNIT	ROOM NO.	BED NO.
ICW1		12

DATE OF ORDER: 5/2/03 TIME OF ORDER: 2200 HOURS

LIST TIME ORDER NOTED AND SIGN

Admit to ICW2
Dr. (R) this fx.
stable
vs PR
Revise diet
X Ray (R) lep tenight done
WBAT on (R)

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: Noted (b)(6)-2 ~~OLF, Ann~~ 5/3/03 @ 0330

24° chart ✓ (b)(6)-2 ~~OLF, Ann~~ 5/3/03 @ 0330

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER _____ HOURS

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER _____ HOURS

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

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

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. 5 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 2	3	4	5	6	7	8
5/2/03	(b)(6)-2	VS per Routine	(b)(6)-2	/	(b)(6)-2					
			16	/						
			24	(b)(6)-2						
5/2/03.	(b)(6)-2	Regular diet	B	/	(b)(6)-2					
			L	/						
			D	/						
5/2/03	(b)(6)-2	WBAT (R) leg	07	/	(b)(6)-2					
			15	/						
			23	(b)(6)-2						

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (R) tibia fx (2yo)

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION: (b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 1 OCT 78 4677

EDITION OF 1 DEC 77 MAY BE USED.

MEDCOM - 4490

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)					Mo 5 Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
5/2/03	(b)(6)-2	admit ICU	5/2/03	2400	2400	(b)(6)-2	
5/2/03		stable	5/2/03	2400	2400		
5/2/03		xray (R) leg tonight	5/2/03	2400	2400		

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

☆ U.S. GPO:1997-418-290/55267

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF — MTF LOCATION (State or Country Code)
1 2 3 4 5 6 7 8
(b)(3)-1

3. REGISTER NUMBER
(b)(6)-4

NAME (Last, First, Middle Initial)
(b)(6)-4
(b)(6)-4

4. PAY GRADE
16 17

5. SEX
18
F

6. DATE OF BIRTH (Y Y Y Y M M D D)
19 20 21 22 23 24 25 26
2 0 0 1 0 1 0 1

7. AGE AT ADMISSION
27 28 29
0 2 Y

8. RACE
30
X

9. ETHNIC BACK-GROUND
31
9

RELIGION
2Y/0

10. LENGTH OF SERVICE
32 33 34

ETS

11. FMP
35 36
9 9

12. SOCIAL SECURITY NUMBER
37 38 39 40 41 42 43 44 45
(b)(6)-4

ORGANIZATION (Active Duty Only)

13. MARITAL STATUS
46
Z

HOUR OF ADMISSION
2200

BRANCH / CORPS

14. FLYING STATUS
47 48 49

15. BENEFICIARY CATEGORY
50 51 52
K 9 1

16. ZIP CODE OF RESIDENCE
53 54 55 56 57 58 59 60 61
Ø 9 3 3 Ø Ø Ø Ø Ø

17. UNIT LOCATION (State or Country Code)
62 63

18. MOS
64 65 66 67 68 69 70

19. TRAUMA
71
Inj

PREV. ADMISSION
YEAR
NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION
72
1
DIR

WARD
ICW1

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY
(b)(3)-1

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION
73 74
2 2

22. MTF TRANSFERRED TO
75 76 77 78 79 80
(b)(3)-1

23. DATE OF DISPOSITION (Y Y M M D D)
81 82 83 84 85 86
2 Ø Ø 3 Ø 5 Ø 3

24. CLINIC SVC - ADMITTING
87 88 89 90
A E A A

25. MTF TRANSFERRED FROM
91 92 93 94 95 96

26. DATE THIS ADMISSION (Y Y M M D D)
97 98 99 100 101 102
2 Ø Ø 3 Ø 5 Ø 2

27. LOCATION OF OCCURRENCE (Battle Casualty Only)
103 104
I Z

28. MTF OF INITIAL ADMISSION
105 106 107 108 109 110

29. DATE INITIAL ADMISSION (Y Y M M D D)
111 112 113 114 115 116

FOR LOCAL USE

Trauma 9 Inj 999

(R) tibia fx Dx 82380
E9889
Former # 115
Rx: 9353

ADMITTING OFFICER (Signature, as required)
(b)(6)-2

SIGNATURE OF ADMITTING CLERK
(b)(6)-2

DA FORM 2985, MAR 89

EDITION OF MAY 79 IS

MEDCOM - 4492

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF (1–8): (b)(3)-1
ITF LOCATION (State or Country Code)

3. REGISTER NUMBER (9–15): (b)(6)-4

NAME (Last, First, Middle Initial): (b)(6)-4 (b)(6)-4

4. PAY GRADE (16–17):

5. SEX (18): F

6. DATE OF BIRTH (Y Y Y Y M M D D) (19–26):

7. AGE AT ADMISSION (27–29):

8. RACE (30):

9. ETHNIC BACK-GROUND (31):

RELIGION:

10. LENGTH OF SERVICE (32–34):

ETS:

11. FMP (35–36):

12. SOCIAL SECURITY NUMBER (37–45): (b)(6)-4

ORGANIZATION (Active Duty Only):

13. MARITAL STATUS (46):

HOUR OF ADMISSION: 2200

BRANCH / CORPS:

14. FLYING STATUS (47–49):

15. BENEFICIARY CATEGORY (50–52):

16. ZIP CODE OF RESIDENCE (53–61):

17. UNIT LOCATION (State or Country Code) (62–63):

18. MOS (64–71):

19. TRAUMA:

PREV. ADMISSION: YEAR ☐ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72): DTR

WARD: ICW1

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE:

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code):

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE:

21. TYPE OF DISPOSITION (73–74):

22. MTF TRANSFERRED TO (75–80):

23. DATE OF DISPOSITION (Y Y M M D D) (81–86): 0 3 0 5 0 3

24. CLINIC SVC - ADMITTING (87–90): A E A A

25. MTF TRANSFERRED FROM (91–96):

26. DATE THIS ADMISSION (Y Y M M D D) (97–102): 0 3 0 5 0 2

27. LOCATION OF OCCURRENCE (Battle Casualty Only) (103–104):

28. MTF OF INITIAL ADMISSION (105–110):

29. DATE INITIAL ADMISSION (Y Y M M D D) (111–116):

FOR LOCAL USE

(R) fibia fx

Former # 115

ADMITTING OFFICER (Signature, as required): (b)(6)-2

SIGNATURE OF ADMITTING CLERK: (b)(6)-2

DA FORM 2985, MAR 89 EDITION OF MAY 79 IS OBSOLETE

INPATIENT TREATMENT RECORD C[illegible]R SHEET

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

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4		3. GRADE	ADMISSION REMARKS
4. SEX	5. AGE	6. RACE Iran			PREVIOUS ADMISSION	
11. FMP		12. SSN (b)(6)-4		13. ORGANIZATION	14. WARD ICW3	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN K78	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE Inj	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION				22. HOURS OF ADMISSION 2100	23. CLINIC SERVICE ABA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION Home		26. DATE OF DISPOSITION 03 May 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)			27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION 02 May 03	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1					30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Burns R arm, leg & Back
943 / 945 / 942.14

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

36. Total Days All Facilites

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

SIGNA (b)(6)-2 SIGNAT (b)(6)-2

INPATIENT TREATMENT RECORD CO . . . SHEET

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

1. REGISTER NUMBER (b)(6)-4	2. NAME (Last, First, MI) (b)(6)-4			3. GRADE	ADMISSION REMARKS
4. SEX	5. AGE	6. RACE Iraqi		PREVIOUS ADMISSION	
11. FMP 99	12. SSN (b)(6)-4	13. ORGANIZATION		14. WARD ICW 3	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT/ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct	22. HOURS OF ADMISSION: 2100	23. CLINIC SERVICE: ABA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION: Home	26. DATE OF DISPOSITION: 03 May 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION: 02 May 03	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: 86TH COMBAT SUPPORT HOSPITAL, LSA ADDER, IRAQ		30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Burns R arm, leg & Back

~~943 / 945 / 942.14~~

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
1	1			1	1

36. Total Days All Facilites

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

SIGNA (b)(6)-2 SIGNAT (b)(6)-2

MEDICAL RECORD	PROGRESS NOTES
DATE	
2May03/2355	Assumed pt care @ 2300hrs. VSS. T-96', R-26, P-119, 99% RA. Pt has burn to ® arm/leg, ® thigh, and ® flank area. Silvadine applied to all burnt areas. Pt ® flank covered c̄ burn pad. Administered 5cc elixir motrin. Pt c̄ father. Diaper x1 changed. Will continue to monitor pt throughout shift. [redacted] (b)(6)-2, LI, AN
3May/0300	Pt itching, father requested medication. 5cc elixir beradyl administered. [redacted] (b)(6)-2
3May 0800	VS - P-100, R-20, T-98.8, Sat-100% on RA. A&O x3, responds to commands in ~~Iraqui~~ Pc Arabic language age appropriate, Lungs CTA, BS (+) x4, (+) pedal pulses, will continue to monitor pt for changes. [redacted] (b)(6)-2 LPN
3May 0900	Pt had Ø problems throughout shift pt's father assisted c̄ care throughout shift, will continue to monitor for changes. [redacted] (b)(6)-2
3May 1100	Pt given discharge instructions waiting for transport to Red Crescent. [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.

WARD NO.

(b)(6)-4

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

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

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 5/2/03 TIME OF ORDER: 2200 HOURS

LIST TIME ORDER NOTED AND SIGN

admit to ICW 3

ortho service DR. (b)(6)-2

Condition Good

nx Burn @ arm Leg

Regular Diet

Routine VS

Parent here will no self care

(b)(6)-2

Noted 2345hrs 2 May 03

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

Proving

~~Motrin 100mg/5cc~~

Motrin 100mg/5cc 6cc Q8° PRN

Silvidene, Bacitracin o.D

Benadryl elixer 12.5mg/5cc

5cc q6h PRN

DC Pt to home in AM

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 1047 TIME OF ORDER: 03 May 03 HOURS

(1) D/c Home.

~~(2)~~ SHS

(2) No meds

(3) please give supplies dressings + silvidine

(b)(6)-2

4 mo

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

CLINICAL RECORD

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

Mo. ____ Yr. ____

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 2	3	4	5
2 May	(b)(6)-2	Regular Diet	07	/	(b)(6)-2		
			12	/			
			17	/			
2 May	(b)(6)-2	VS q Shift	D	/	(b)(6)-2		
			E	/			
			N	(b)(6)-2			

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Burn (R) arm/leg, back

ADDITIONAL PAGES IN USE ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION

(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 5 Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
5/2	(b)(6)-2	Admit ICU 3	5/2	ASAP	2300	(b)(6)-2
5/2		Ortho Service Dr Blum	5/2	ASAP	2300	
5/2		Condition Good	5/2	ASAP	2300	
5/2		Dx: Burn ® arm, leg	5/2	ASAP	2300	
5/2		Parent here will know self care	5/2	ASAP	2300	

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

USAPA V

Verify by Initialing		THERAPEUTIC DOCUMENTATI[illegible] [illegible]A[illegible]E PLAN (MEDICATIONS)				Mo. _____ Yr. _____
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																					
5/2	(b)(6)-2	Motrin 100mg/5cc -	D	3 May 03																				
		6cc Q8° PRN	T	2355 5cc	(b)(6)-2																			
			I	[illegible]																				
5/2	(b)(6)-2	Benadryl elixer																						
		12.5mg/5cc q6h	D	3 May 03	3 May 03																			
		PRN	T/I	0300 [illegible]	0330 P.C.																			
				(b)(6)-2																				

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

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

Mo.____ Yr.____

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED													
5/2	(b)(6)-2	Silvidene / Bactracin qD	(b)(6)-2	2	3	4	5										
				/	(b)(6)-2												

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Burn ® arm/leg

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

DA FORM 1 FEB 79 4678

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF (1 2 3 4 5 6 7 8) (b)(3)-1

2. MTF LOCATION (State or Country Code)

3. REGISTER NUMBER (b)(6)-4

NAME (Last, First, Middle Initial) (b)(6)-4 (b)(6)-4

4. PAY GRADE (16 17)

5. SEX (18) M

6. DATE OF BIRTH (Y Y Y Y M M D D) (19 20 21 22 23 24 25 26)

7. AGE AT ADMISSION (27 28 29)

8. RACE X Iraqi

9. ETHNIC BACK-GROUND 9

RELIGION

10. LENGTH OF SERVICE (32 33 34)

ETS

11. FMP (35 36) 9 9

12. SOCIAL SECURITY NUMBER (37 38 39 40 41 42 43 44 45) (b)(6)-4

ORGANIZATION (Active Duty Only)

13. MARITAL STATUS (46) Z

HOUR OF ADMISSION

BRANCH / CORPS

14. FLYING STATUS (47 48 49)

15. BENEFICIARY CATEGORY (50 51 52) K 9 1 91 ~~94~~

16. ZIP CODE OF RESIDENCE (53 54 55 56 57 58 59 60 61) Ø 9 3 3 Ø Ø Ø Ø Ø

17. UNIT LOCATION (State or Country Code) (62 63)

18. MOS (64 65 66 67 68 69 70)

19. TRAUMA (71) 9 Inj

PREV. ADMISSION YEAR ☐ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72) 1

WARD 1CN3

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

(b)(3)-1

21. TYPE OF DISPOSITION (73 74) Ø 5 Home

22. MTF TRANSFERRED TO (75 76 77 78 79 80)

23. DATE OF DISPOSITION (Y Y M M D D) (81 82 83 84 85 86) 2ØØ 3 Ø 5 Ø 3

24. CLINIC SVC - ADMITTING (87 88 89 90) A B A A

25. MTF TRANSFERRED FROM (91 92 93 94 95 96)

26. DATE THIS ADMISSION (Y Y M M D D) (97 98 99 100 101 102) 2ØØ 3 Ø 5 Ø 2

27. LOCATION OF OCCURRENCE (Battle Casualty Only) (103 104) I Z

28. MTF OF INITIAL ADMISSION (105 106 107 108 109 110)

29. DATE INITIAL ADMISSION (Y Y M M D D) (111 112 113 114 115 116)

FOR LOCAL USE

Burns R arm, leg & BK

Ox: 94310
94516
94213
94800
E9881

Trauma 9

Inj 999

ADMITTING OFFICER (Signature, as required) (b)(6)-2 (b)(6)-2

DA FORM 2985, MAR 89

EDITION OF MAY 79 IS OBSOLETE

MEDCOM - 4502

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF (1–8): (b)(3)-1

2. MTF LOCATION (State or Country Code)

3. REGISTER NUMBER (9–15): (b)(6)-4

NAME (Last, First, Middle Initial): (b)(6)-4

4. PAY GRADE (16–17)

5. SEX (18)

6. DATE OF BIRTH (Y Y Y Y M M D D) (19–26)

7. AGE AT ADMISSION (27–29)

8. RACE (30): Iraqi

9. ETHNIC BACKGROUND (31)

RELIGION

10. LENGTH OF SERVICE (32–34)

ETS

11. FMP (35–36): 9 9

12. SOCIAL SECURITY NUMBER (37–45): (b)(6)-4

ORGANIZATION (Active Duty Only)

13. MARITAL STATUS (46)

HOUR OF ADMISSION: 2100

BRANCH / CORPS

14. FLYING STATUS (47–49)

15. BENEFICIARY CATEGORY (50–52)

16. ZIP CODE OF RESIDENCE (53–61)

17. UNIT LOCATION (State or Country Code) (62–63)

18. MOS (64–70)

19. TRAUMA (71)

PREV. ADMISSION: YEAR ☐ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72): 0 OIR

WARD: ICW3

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION (73–74): HOME

22. MTF TRANSFERRED TO (75–80)

23. DATE OF DISPOSITION (Y Y M M D D) (81–86): 0 3 0 5 0 3

24. CLINIC SVC - ADMITTING (87–90): A B A A

25. MTF TRANSFERRED FROM (91–96)

26. DATE THIS ADMISSION (Y Y M M D D) (97–102): 0 3 0 5 0 2

27. LOCATION OF OCCURRENCE (Battle Casualty Only) (103–104)

28. MTF OF INITIAL ADMISSION (105–110)

29. DATE INITIAL ADMISSION (Y Y M M D D) (111–116)

FOR LOCAL USE

Burns R arm, leg & BK

ADMITTING OFFICER (Signature, as required): (b)(6)-2

(b)(6)-2

DA FORM 2985, MAR 89 EDITION OF MAY

INPATIENT TREATMENT RECORD COVER SHEET

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

REGISTER NUMBER (b)(6)-4	(b)(6)-4					3. GRADE	ADMISSION REMARKS
4.	6. RACE IRAQI	7. RELIGION	8. LENGTH OF SVC	9. ETS		10. PREVIOUS ADMISSION	
11. FMP	12. SSN (b)(6)-4		13. ORGANIZATION			14. WARD ICW2	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN 1L78	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION — Direct				22. HOURS OF ADMISSION 1101	23. CLINIC SERVICE AEAA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION		26. DATE OF DISPOSITION 4 MAY 03		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)			27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION 2 MAY 03		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1					30. DATE OF INTIAL ADMISSION		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Right Lower Ext (GSW) ~~S21.20~~

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
2	2				2

36. Total Days All Facilites

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

SIGNA (b)(6)-2 | SIGN (b)(6)-2 | S OFFICER

INPATIENT TREATMENT RECORD COVER SHEET

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

(b)(6)-4

1. REGISTER NUMBER (b)(6)-4				3. GRADE	ADMISSION REMARKS
4. SEX	5. AGE	6. RACE IRAQI		10. PREVIOUS ADMISSION	
11. FMP	12. SSN (b)(6)-4		13. ORGANIZATION	14. WARD ICW2	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION — Direct			22. HOURS OF ADMISSION 1301	23. CLINIC SERVICE AEAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE		25. TYPE DISPOSITION Home		26. DATE OF DISPOSITION 4 MAY 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)		27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION 2 MAY 03	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY 86TH COMBAT SUPPORT HOSPITAL, LSA ADDER, IRAQ				30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Right Lower Ext Fx ~~$21.20~~

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
2	2				2

36. Total Days All Facilites

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

SIGNAT (b)(6)-2 SIGNA (b)(6)-2 OFFICER

MEDICAL RECORD	PROGRESS NOTES
DATE	
18 April 03 16 40	22 y/o Iraqi male, 4-5 days s/p motorcycle accident, says he was driving at 120 km/hour, wrecked, no other vehicle. Denies L.O.C., had no helmet. Had surgery on his left femur. Since then is eating, little pain. No bowel movement.
	PMH - Gun shot wound to back + (R) axilla, 1997. Had 15 days of paralysis, no residual
	NKDA
	No Meds
	ROS - negative
	PE. - ENT - No injuries, PERRL, Neck not tender
	Chest - clear, not tender. Healed wound (R) axilla, Scapula.
	Heart - (no) (m) clear.
	Abd - benign
	Rectal - normal prostate
	Pelvis - stable.
	Ext - Neuro/vascular intact. Ext fix (L) femur. Multiple superficial abrasions flanks + thighs.
	Neuro - alert. (over)

(Continue on reverse side)

REGISTER NO. | WARD NO.

PATIENT'S IDENTIFICATION (For typed or written entries give: Name, grade; rank; rate; hospital or medical fac

(b)(6)-4

(b)(6)-4

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

PROGRESS NOTES

DATE

A: Femur fracture, (L) -
P: admit to ortho
CXR, Femur Xray, antibiotics.

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

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

4/18/03 Ortho Casrel:
22y/o Iraqi ♂ s/p motorcycle MVA, 5 helmet, 5 other vehicle. Sustained (L) closed femur fx, & underex fix on date of injury ~5 d ago. Medevaced to USNS Comfort for definitive care.
PMHx: GSW post upper T-spine 5 yr ago c̄ 2w of paraplegia p̄ inj; no permanent sequelae
PSHx
Meds
All:
PE p̄ in plane lat (L) femur.
Mid; good DP & PT pulses.
road rash c̄ bandage (R) anterolat pelvic brim
FC: (L) femur
A/P (1) Cleared by Gen Surg (2) Ortho, Neuro/Admit
(3) On 4/20/03 IM nail (4) DVT prophylaxis Lovenox.
(5) NPO c̄ meds p̄ MN of 4/19 for on 4/20 [redacted] (b)(6)-2

☆U.S. GOVERNMENT PRINTING OFFICE: 1990 262-081/20182

STANDARD

MEDICAL RECORD	PROGRESS NOTES
DATE	
April 19 '03	APRIL 18 . Hb 9.1 Hct 28.2.
10:25 hrs	Start FeSO4 T Tid
	MULTIVIT T QD
	folic acid 1mg T QD.
	131 | 98 | 10 — 78.
	4.5 | 26 | 0.7
	Q LOVEMAN 30mg RDD [illegible]
	(b)(6)-2 [redacted] (A. [illegible]).
19APR03	Medical Nutrition Tx:
1520	O: PerRN - ate lunch. Dx: (L) femur fx c external fixation.
	Wt. ≈ 60kg. Labs 18APR03 Hgb/Hct 9.1↓/28.2↓. Diet Rx: Regular
	A/P: Kcal needs = 30-35 kcal/kg/day = 1800-2100 kcal/day
	Protein needs: 1.5 g/kg/day = 90 g/day.
	Hgb/Hct↓ - will monitor c̄ FeSO4, MVI, Folic acid tx.
	PO intake fair - recommend continue encourage PO
	intake c̄ Regular diet + snacks / ENSURE TID.
	RD to flu c̄ 2-3 days. (b)(6)-2 [redacted] MPH, RD
	(b)(6)-2 [redacted] MPH, RD
	LT, MSC, USNR (b)(6)-2 [redacted]

(Continue on reverse side)

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

(b)(6)-4 [redacted]

REGISTER NO. | WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FPMR (41 CFR) 101-11.806-8
509-110

PROGRESS NOTES

DATE

4/20/03

ORTHO p̄p ✓
S/P (2) fem in nil
Pain well controlled
dry s̄ staining
NVID wiggly toes | (+)TA | (+)EHL | (+) pulses
A/P (1) ✓ AM labs.
(2) wound care
(3) PT for NWB LLE crutch ambul to begin Am 4/21.
(4) DVT prophylaxis
(5) 48° p̄p Abx.

(b)(6)-2

4/21/03

ORTHO POD#1 S/P (2) fem in [illegible]
Tm 102.8 immed p̄p; now 100.7 VSS
dressing c̄ minimal staining
NVID
Cultures sp̄t, NT
21 Apr labs

9.1	7.3	485	131	96	11	108
	22.5		4.1	30	.9	

B (x(P)
U (x(P)

prep.
20 Apr

8.4	8.0	377
	24.8	

A/P Clinically no fever source; pub p̄p attributions
2° Gen Anesth
(1) Xfuse for Hct of 22 initiated by WMO
(2) Follow (6) (3) OOB + crutch training ambul.
(4) wound care by MD.

(b)(6)-2

☆ U.S.GPO:1984-0-421-526/124

STANDARD FORM 509 BACK (Rev. 11-77)

MEDICAL RECORD	PROGRESS NOTES
DATE	
4/21/03	Hb 7.1 / 22.2.
09 05 hrs	
	Transfuse 2 units packed cells
	(b)(6)-2 [redacted]
23Apr 03	P.T. Note
	Pnt seen this Am. for crutch Trng. Required min Ⓐ x 1 supine ↔ sit and mod. Ⓐ x1 sit ↔ stand, upon standing c̄ crutches Pnt c/o feeling dizzy and pain in LLE. Will cont crutch Trng in the A.M. — (b)(6)-2 [redacted] HMC(FMF) P.T. Tech
26 Apr 03	on tho POD#2 S/P I&D ⓒ lat thy wnds
	AVSS x 48°. (b)(6)-2 [redacted]
	Tol pos
	⊕ up on crutch the AM, MWB/TTWB LLE
	wnds dsg Δ's by wnd tm c̄ 1% acetic acid soln
	A/P ① daily wnd care
	② PT [illegible]
	③ DVT [illegible]
	(b)(3)-1 [redacted] PT TECHNICIAN NSU-MH (b)(6)-2 [redacted]
	(b)(6)-2 [redacted]

(Continue on reverse side)

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

(b)(6)-4 [redacted]

REGISTER NO.	WARD NO.

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

PROGRESS NOTES

DATE

26APR03 P.T. NOTE

Pnt transfered from supine to EOB c̄ min assist x1, EOB to stand c̄ mod assist x1. Ambulated 8 feet c̄ crutches and CGAX2. Transfered back to bed c̄ mod assist x1. Pnt forth a good effort but not yet safe c̄ crutches. Cont P.T. QD. — [redacted]

HM - USN
PT TECHNICIAN
SSN: [redacted]

27APR03 P.T. NOTE

Pnt transfered from supine to EOB to stand c̄ min assist x1. Ambulated approx 100 feet c̄ crutches and SBAX1. Transfered back to EOB c̄ min assist x1. Pnt forth a good effort and tolerated session well. Pnt ind c̄ crutches and able to ambulate c̄ staff. Pnt discharged from P.T. — [redacted]

HM2 [redacted]

Apr 27 '03 Internal Med

Consulted re: culture of thigh wound done 4/23 has grown Pseudomonas + Acinetobacter, both few + both sens ticarcillin, cipro, as well as imipenem. Pt was referred to Acineto ward on 4/22 due to blue-stained wound dressing suspicious for P. fluorescens. Blood cx of 4/21 are ⊖. Afeb (<100 since 4/24 1200). Wounds reported to look good (Pin cx fix sites), but direct path to bone. Rec Add cipro, tx GUL total (dk Tiners on dk)

WBC
21 9.5
22 13.5
23 13.5
24 13.5

Timentin #5

☆ U.S.G.P.O.: 1986-491-248/20616

STANDARD FORM 509 BACK (Rev. 11-77)

MEDICAL RECORD	PROGRESS NOTES
DATE	
4/22/03	ONTHO POD#2 ...
	Tm 102 still ; 99+ now
	tvl pols.
	PE MMP
	wwmps - surgical incision for 4/20 - clean + dry
	- wwND from ex fix (proximal ex fix site + distal ex fix site → Blue staining
	IMP Empirical Tx for Pseudomonas Fluorescens
	p̄ D/W I.M. MP.
	Plan (1) Begin IV Tinentin
	(2) Xfer to isolation ward.
	(3) ↓ Labs
	(4) DVT prophylaxis
	(b)(6)-2 [redacted]
22APR03	Medical Nutrition Txs Flu:
1905	O: Accepted apple + 1 can ENSURE from RD. Diet Rx: Regular
	Labs 22 APR03: Hgb/Hct 8.6↓/25.5↓ MCV/MCH 73.2↓/24↓
	AVP: PO intake fair - recommend continue to encourage
	PO intake. Hgb/Hct ↓ MCV/MCH ↓.
	Recommend offer MVI + FeSO4 c̄ fruit juice to
	↑ absorption. RD to flu c̄ 2-3 days.
	(b)(6)-2 [redacted] MPH, RD

PATIENT'S IDENTIFICATION (For typed or grade; rank; rate; hospital or medical facility)

(b)(6)-4 [redacted]

(b)(6)-2 [redacted] LT, MSC, USNR (b)(6)-2 [redacted] MPH, RD

REGISTER NO. | WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FPMR (41 CFR) 101-11.806-8
509-110

PROGRESS NOTES

DATE 4/24/03

ORTHO

Narrative Summary.

22y/o Iraqi ♂ S/P Motorcycle MVA in Iraq on about 4/13/03. Pt had closed left femur fx, and had ex fix placed across fx on same date. Pt remained in Iraq, c̄ ? dsg D's at pin sites for 5 days. Brought to (b)(3)-1 [redacted] and had films done showing proximal diaphyseal oblique fx. Examination of pin sites showed long proximal pin incision communicated with fracture site, and therefore closed fracture was converted to open fracture by ex fix. On 4/20 pt underwent anterograde IM nail, I+D, and removal of ex fix; proximal nail interlocks were placed thru ex fix site incision, c̄ fascia closed over interlock screw heads, as there was no other option. On POD #2 (4/22) the ex fix site wards, which had been closed over drain, were noted to be draining serpentent drainage and blue staining, c/w Pseudomonas Fluorescens, was noted on dressing. Pt began immed on IV Timentin, c̄ subsequent ↓ Temps, ↓ drainage. Pt was then taken to on 4/23 for opening of ex fix wards, I+D, packing c̄ acetic acid solution for a planned period of 5d, to be followed by

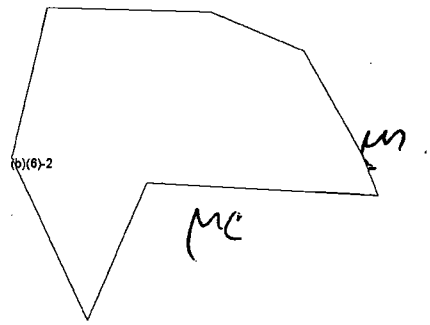
(b)(6)-4 [redacted]

STANDARD FORM 509 BACK (Rev. 11-77)

MEDCOM - 4513

(over)

wet → dry dsg Δ's until wound granulate closed.
Now getting Percocet, MVI, Folate, Fe sulfate,
Colace, and IV Timentin (to continue for 10-14d).
Pt needs these meds, and bid dsg Δ's.
P.O. meds Rx'd + dispensed. Pt is to remain
~~NPO~~ NWB LLE, until fx healed. Check fl at
2 mos $\bar{p}p$ prior to beginning WBAT. Can ambulate
on crutches, NWB LLE until fx healed.



MEDICAL RECORD	PROGRESS NOTES

DATE

25APR03 P.T. NOTE

Pnt transfered from supine to EOB, EOB to stand c̄ mod assist x1. Attempted crutch training but pnt c/o dizziness. Transfered back to supine c̄ mod assist x1. C/o pain (alem) LLE post session. Cont P.T. RD.

(b)(6)-2 [redacted]

ATT'L (b)(6)-2 [redacted]

25APR03 Medical Nutrition TX: F/U:

1510 O: Per RN - ate 75% Breakfast + Lunch. Eating apple.

Labs 24 APR03: Hgb/Hct 8.1↓/24.1↓ MCV/MCH 73.7↓/24.7↓

A/P: PO intake fair - good - recommend continue to encourage PO intake. Hgb/Hct/MCV/MCH ↓ - recommend offer FeSO4 + MVI c̄ fruit juice to ↑ absorption.

RD to f/u q̄ 2-3 days. (b)(6)-2 [redacted] MPH, RD

(b)(6)-2 [redacted] MPH, RD

LT, MSC, USNR (b)(6)-2 [redacted]

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

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

MEDICAL RECORD	PROGRESS NOTES

DATE

4/29/03 Inf Dis

0940 22 y/o s/p MVA (L) femur fx - fix

had infected pins from field hospital c̄

communication to the comminuted fx.

Pt underwent femoral nail 4/20/03. 3 d post op

had blue wounds - subsequently (+) for [illegible] monas.

Since then pt doing ok. Pt last febrile

24 Apr 02. c/o occ chills "big" pain (L) thigh + above knee

PMHx	Meds	All: NKDA
GSW '97	Ancef 4/18-22	
MVA '03 c̄ fem fx.	Timentin 4/22 →	
	Cipro 4/27 →	

O: WD♂ NAA

HEENT: Ø thrush

Heart: RRR c̄ (M)

Lungs: CTAB

Abd: (+) NABS

Ext: (L) thigh wounds x 2 - serosang d/c.

Ø odor Ø erythema, good granulation

4/28 8.3 / 6.5 / 25.7 / 974 4/24 8.1 / 13.3 / 24.1 / 810 16 / 93 / 08

Cx: Blood 4/18 - NG 4/21 Urine, blood - NG

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FPMR (41 CFR) 101-11.806-8
509-110

PROGRESS NOTES

DATE

4/23 wound: Acinetobacter Amik, Unasyn, Sulfa, cipro, Imp, CTZ, Timent.
Pseudo aeruginosa - Amik, CTZ, Cip, Gent, Imp
Timent (S)
CXR 4/18 (L) effusion vs Atalect.
femur - fx
Imp: 22 y/o s/p MVA. Now c̄ femoral rod in place. Had open fx c̄ pseudomonas + acinetobacter causing osteo.
Rec: 5 more weeks of cipro + 2nd agent.
Since Timentin is working would favor keeping H, however needs to be given q 4-6 hr + has high fluid burden. Both isolates (S) to ceftaz - it is tid dring. would Δ to CTZ + cipro + give 5 more weeks (35 d) more. consider picc for IV Atbx.

(b)(6)-2

(b)(6)-2
LCDR, MC, USNR (UMO/SS)
INFECTIOUS DISEASE
(b)(6)-2

29APR03 Put asked to be seen by P.T. this AM. Put JPT performed 10 reps of (L) ankle pumps and heel slides exercises c̄ assistance. Put tolerated session well and ind c̄ crutches. Will cont P.T. as per doctor's orders.

(b)(6)-2 (b)(6)-2
HM - USN
PT TECHNICIAN
(b)(6)-2 (b)(6)-2

☆U.S.GPO:1984-0-421-526/124

STANDARD FORM 509 BACK (Rev. 11-77)

MEDICAL RECORD	PROGRESS NOTES

DATE

4/28/03 ONTHO POD#8 S/P/M/N/L (R) femur. Cipro 500 pobid

POD#6 I+D Timentin 3.1g IVq8

Tolerates PO's ...

ambulates c̄ crutches

Duoderm on minor road rash - healing well

PE AUSS (x 4 d+ now)

wound (U) thigh granulating c̄ minimal fibrinous debris at base of wound.

A/P (1) Lovenox SQ continue

(2) will have ID enter note Re: Appropriate Abx Coverage per Dr Headrick

(3) Xfer care to Dr Headrick @ MN tonight.

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

28APR03 Medical Nutrition Tx's F/U's

1635 S: Per translator - 4/27 - Ate 3 meals + 1 apple + 1 orange.

4/28 - Ate Breakfast + lunch + 1 apple.

O: Diet Rx's Regular. Labs 4/28's Hgb/Hct 8.3↓/25.7↓

MCV/MCH 75.6↓/24.3↓. Meds's FeSO4

A/P's PO intake good. Recommend offer FeSO4 c̄ fruit, juice to ↑ absorption. RD to F/U q̄ 3-5 days.

(b)(6)-2 [redacted] MPH, RD

(b)(6)-2 (b)(6)-4 MPH, RD

LT, MSC, USNR (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)

(b)(6)-4 [redacted]

REGISTER NO.

WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FPMR (41 CFR) 101-11.806-8
509-110

MEDICAL RECORD	PROGRESS NOTES
DATE 4/29/03	ORTHO s/p IM Nail R femur 9d ago, 6d s/p I&D.
	Sleeping.
	Afebrile
	L femur - small amt. drainage from proximal incision
	able to DF ankle
	P: dr sg D. done.
	ID c/s appreciated. - CTZ, Cipro 5 more wk
	(b)(6)-2 mg
4/30/03	ORTHO R fem nail 10 d ago 7d s/p I&D.
	Comp.
	Afebrile
	P: Cont. present care. (b)(6)-2
4/30/03	ID
1015	Afebrile CPB walking on crutches
	Imp overall doing well pm' osteo c contiguity
ceftaz d8	to fx femur 3p MRA day 8/42
cipro d8	Rec: continue cipro/ceftaz until June 3rd
	will sign off - pts call 2 questions
	(b)(6)-2 LCDR, MC, USNR (UMBSS) INFECTIOUS DISEASE

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

(b)(6)-4

REGISTER NO. WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FPMR (41 CFR) 101-11.806-8
509-110

MEDICAL RECORD	PROGRESS NOTES
DATE	
5/1/03	I.P
0945	Afebrile VSS ESR 72
	doing well
	Exam unchanged
	Imp: Femoral osteo dx 9/42 cip/CTZ
	Rec: continue meds
	repeat CBC 7 days
	(b)(6)-2 LCDR, MC, USNR (UMO/SS) INFECTIOUS DISEASE (b)(6)-2
1MAY03	Medical Nutrition Tx: F/U:
1820	SS Per translator - ate 3 meals 4/30 + 5/1.
	O: Diet Rx: Regular. Labs 1MAY03: Hgb/Hct 9.5/29.36
	A/P: Hgb/Hct ↓, but improved since 25APR03.
	PO intake good. Recommend continue to encourage PO intake.
	RD to f/u ≈ 3-5 days. (b)(6)-2 (b)(6)-2 MPH, RD MPH, RD
	LT, MSC, USNR (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. | WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FPMR (41 CFR) 101-11.806-8
509-110

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
3May02 0250	Nsg Note: PT admitted from EMT @ approx 2315 ambulate c̄ crutches accompanied by staff. PT A&O: Ambulate, HC to (L) FA patient. IV Abx given. C/o pain to (L) hip pencoc 2 tabs given. Drsg to (L) hip c̄ reinforced c̄ d/t. Incision approx 4cm noted above drsg (L) hip c̄ sutures. Wound edges well approximated. ∅ drainage or odor noted. Will continue to monitor. (b)(6)-2
Addendum	NO. EXT Fracture or injury noted to (L) post. (b)(6)-2
3May03 1330	Client ī c/o pain. Client Lungs CTA, ⊕BS. Client c̄ drsg change to (O) thigh. Provided W-D drsg on 2 locations on outside of thigh. Wound bed pink c̄ scant amt of greenish exudate noted, c̄ small odor. Client D/C'ed IV when disconnecting IV piggyback from SL. (b)(6)-2 (b)(6)-2 CPT, AN
3 May 03 @1715	NSG Note - Medicated c̄ 2 percocet by CPT (b)(6)-2 for c/o pain ~~p~~ ambulating outside to Bathroom — SSG (b)(6)-2 91WM6
3 May 03 @1800	NSG Note - PRN Effective. Pt Sleeping — SSG (b)(6)-2 WM6
4May03 0900	Client D/C to LN hospital through red crescent. Client received W-D drsg to 2cm and son (O) hip. Client ī c/o pain. Client discharged c̄ SL in (O) FA to receive IV forta 2 ī gm Q8hr. (b)(6)-2 CPT

RELATIONSHIP TO SPO (b)(6)-2

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)

(b)(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
2135 18Apr03			Assumed pt @ 2200. Pt transported from casrec. Pt VSS, A=O×3 ∅ English speaking. Pt Perrla, lungs CTA (B), Abd soft NT, ND ∅ c/o N/V. Tolerating PO ∅ difficulty. Pt (L) Thigh FX c̄ external fixator in place. Pin care completed, gauze changed around pins. Pt neuro ✓ circ ✓ WNL (+) pulses (+) capillary refill <3 secs. Color pink. Pt given tylenol for pain and MSO4 - will continue to monitor.
			(b)(6)-2 [redacted] PENS/NC
19APR03			ASSUMED PT CARE @ 2300. PT LYING ON RACK SLEEPING. HAS EXT FIX ON (L) LE, ∅ DRAINAGE, CAP REFILL <3 SECS, (+) SENSATION, (+) PULSE, NO SWELLING, PT AOX3. ∅ c/o PAIN @ THIS TIME, VS STABLE, CLEAR LUNG SOUNDS. WILL CONTINUE TO MONITOR
			(b)(6)-2 [redacted]
19Apr03 @ 0235			Concur c̄ note as written
			(b)(6)-2 [redacted]
19Apr03			Assumed ~~by~~ pt care @ 1500. Pt ∅ complaints. A=O×3 c̄ little English speaking knowledge. Pt Perrla, lungs CTA (B). Abd soft NT, ND (+) BS ×4 quads. Pt urinating ∅ difficulty. Tolerating PO ∅ problems. Pt (L) leg c̄ external fixator in place. Pin care completed. Neuro/circ ✓ WNL. capillary refill <3 secs. Pt able to move leg ∅ problem.

*U.S. GOVERNMENT PRINTING OFFICE: 1985 0 - 461 -275 (20038)

(b)(6)-4 [redacted]

NURSING NOTES
Standard Form 510
(Reverse)

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
cont			Will continue to monitor.
			[redacted] EMS/NC
19/APR/03	0000		Assumed pt. care. pt. sleeping. very cooperative c̄ care. HR s's? present. All pulses strong & equal. Bowel sounds hyperactive. ABD. soft. Ø T&D noted. Pt. A&O x3. Pt. Has ext. Fix. no (LLE) Looks good pt. has Ø c/o pain. Neuro checks are very good. Motor skills are good. Lungs are clear bilat. V/S stable. Pt. in good ~~ste~~ cheer. Will continue to monitor pt. [redacted]
20APR03	0300		concur c̄ above note S. Carmack LPN
21APR03			Assumed pt care @ 2300. Pt Ø complaints A&O x3 c̄ English speaking ability. Pt VSS, lungs CTA (B), abd soft NT, ND Ø complaints N/V. Tolerating regular diet Ø difficulty. Pt (L) leg c̄ dressing drainage noted good/moderate amount sanguinous drainage to dressing. Pt neuro/circ WNL to (L) leg. all pulses (+) cap refill <3 sec. Pt medicated for pain will continue to monitor [redacted]
21APR03	1030		Pt temp @ 101.9. Gave 2 tylenol. I.S. [redacted]
	1800		PT TEMP @ 102°F. LARGE AMOUNT OF DRAINAGE ON DRESSING ON LOWER BACK. PT COMPLAINING PAIN ON (L) LE.

*U.S. GOVERNMENT PRINTING OFFICE: 1985 0 – 461 –275 (20038)

NURSING NOTES
Standard Form 510
(Reverse)

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/22	1000		Alert & Orientated X3 - Lungs clear BL, ⊘ Resp distress - Cardiovascularly infact. (+) BS x 4 quays, Tolerating Reg diet - Voiding Quantities sufficient. Frequent complaints of pain, Medicated as ordered - Controlled and Cooperative c̄ TX regimen [redacted]
4/22	1220		Transfer to 4 Ford Port at this time [redacted]
23Apr03	1630		Accepted pt. on ward. Given 5 mg MSO4 for pain. Ace to (L) leg clean, dry & intact [redacted]
22APR03		1620	ASSUMED PT CARE. PT HAS (L) FEMUR FX c̄ ACE WRAP TO (L) THIGH. PT HAS A FEVER OF 100.9. WILL CONTINUE TO MONITOR.
22APR		1800	Read + concur w/ above. Encouraged to use ICS q̄ 1°. Temp ↓ 99.6 ↑ cough + deep breathe. - Will continue to monitor. [redacted] LCDR, NC
		2200	Temp ↓ 98.6 (po). Medicated for c/o pain - No apparent distress noted. Pt [illegible]
23APR03	0140		Assumed pt care @ 2300. Vital signs WNL, pt resting comfortably. (L) femoral dsg CDI, dsg on (R) hip CDI. Slight temperature of 100.0°F, pt encouraged to use IS. c/o pain & medicated w/ 5 mg MSO4. Will continue to monitor. [redacted]
23APR	0800		NPO maintained for I+D of (L) LE wounds. PT instructed. Verbalized understanding. Speaks and understand some English. IV of D5 1/2 ws infusing at 75 cc/hr. Initial assessment noted and concur R [redacted]

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NURSING NOTES
Standard Form 510
(Reverse)

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
CONT			WILL CONTINUE MONITOR THROUGOUT THE SHIFT.
			(b)(6)-2 [redacted] HN
04/21/03		1600	Pt. resting most of shift. pt. had c/o pain to (LLE). Was medicated ~~c~~ LT. Nurse AWARE. Pt. had high temp of 102.0 pt. was medicated. Re-tock TEMP 101.5. Nurse notified. Pt. voiding without difficulty. Will continue to monitor Pt. closely.
			(b)(6)-2 [redacted]
0041 22APR03			Assumed pt care @ 2300. Pt ∅ complaints resting comfortably. Pt VSS stable c̄ elevated temperature noted and Mos aware. Pt Renal, lungs CTAB, abd soft NT, ND ⊕ BS x4 quad. ⊕ pulses x4 extremities capillary Refil <3 sec. Pt L femur wrapped c̄ guaze/silk tape c̄ drainage serosanginous marked on dressing. Will continue to monitor. ~~Ex~~ Left Extremity warm to touch, NEURO/CIRC ✓ WNL ∅ deficits. Pt to receive second unit PRBCS this shift will administer and monitor for side effects closely.
			(b)(6)-2 [redacted] EMS/NC

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(b)(6)-4 [redacted]

NURSING NOTES
Standard Form 510
(Reverse)

MEDCOM - 4525

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
24APR03	0830		Assumed care of pt. Pt AAO x3. BS (+) 4 quads. S1 & S2 c̄ RRR, PPP. VSS. & Lungs CTAB. Pt ate 50% breakfast. Resting @ this time. Will continue to monitor. [redacted] RN
24APR03		1620	Assumed pt care. VSS, minimal c/o pain. Temp slightly ↑, given pain meds. Pt has ace wrap to (L) thigh c̄ edema below the knee. Will continue to monitor. [redacted]
24APR03		1755	Concur c̄ above assessment [redacted]
25APR03	0230		ASSUMED PT CARE @ 2350. TEMP SLIGHTLY ↑, med given, I.S. ENCOURAGED c̄ PN NOTIFIED. BS (+) 4 QUADS. (L) THIGH c̄ ACE WRAP c̄ EDEMA. PT. ASLEEP @ THIS TIME. WILL CONTINUE TO MONITOR. [redacted] HN PT. IV (R) HAND 5 S/SX I/I. WILL CONTINUE TO MONITOR [redacted] HN
25APR	0600		Initial assessment noted and concur [redacted]
25APR03	0755		ASSUMED CARE OF PT AT THIS TIME. PT COMPLAINS OF PAIN. PT GIVEN 5mg of MSO4. PT EATING BREAKFAST. APPEARS TO BE DOING WELL. DRESSING ON (L) LEG APPEARS CLEAN DRY and intact. will continue to monitor pt. [redacted]
25APR03		1630	ASSUMED PT CARE PT IS SITTING UP IN WHEEL CHAIR. PT HAS ACE WRAP BANDAGE TO (L) THIGH WITH 2 J.P. DRAINS DRAINING WELL. PT HAS COMPLAINTS OF MILD PAIN, VSS, AND WILL CONTINUE TO MONITOR. [redacted]

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CLINICAL RECORD	NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
23Apr03 HLN ~~073~~	0737		Assumed care of pt A & OX3 RRR Cl & Bl Lung sounds, ⊖ Tp to abdominal area ⊖ distention ⊕ bowel sounds to all 4 quads ⊕ neurochecks ⊕ cap refill. Pt has dressings to (R) & (L) hips (small) large dressings to (L) leg femoral area, dry and intact. IV site in (L) anacub, good. [redacted] HN
1019			Pt Departed for O/R [redacted] HN
1417			Pt returned from O/R [redacted] HN
23APR03		1745	ASSUMED PT CARE. PT HAS (L) FEMUR FX IN ACE WRAP. PT HAS Ø COMPLAINTS OF PAIN. VSS WILL CONTINUE TO MONITOR. [redacted]
24APR03	0600		Assumed PT care. PT c̄ dressing to (L) thigh ~~CDI~~ c̄ moderate amount of serosanguinous drainage noted. Small dressing to (R) hip CDI. Neurochecks within normal limits. Will continue to monitor. — [redacted], HN
24APR03	0600		Initial assessment noted and cover. Resting quietly. Postop [redacted] am.

Continue on reverse side

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

REGISTER NO. | WARD NO.

NURSING NOTES
Standard Form 510
General Services Administration and Interagency Committee on Medical Records
FPMR 101-11.806-8—October 1975
510-109

CLINICAL RECORD	NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
25APR03		1630	ASSUMED PT CARE. PT IS AWAKE & ALERT LYING IN BED. PT HAS ACE WRAP BANDAGE TO (L) THIGH. NUERO CHECKS WNL PT HAS Ø COMPLAINTS OF PAIN & VSS. WILL CONTINUE TO MONITOR PT. (b)(6)-2
25APR		0130	DRESSING ON ~~##~~ (L) THIGH C/D/I; AREA COVERED C̄ ABD & TAPE. (+) CMS TO AFFECTED EXTREMITY. NO NEEDS @ THIS TIME — (b)(6)-2
26APR03	0745		ASSUME CARE OF PT @ THIS TIME. PT COMPLAINS OF PAIN IN (L) LE ALONG WOUND. PT DRESSING TO INJURY are clean dry and intact. PT DOES NOT WISH TO GET UP @ THIS TIME FOR AM CARE. WISHES TO SLEEP INSTEAD. WILL continue to monitor PT. will wake for AM CARE. IN 2hrs. (b)(6)-2
26APR03		1747	ASSUMED PT CARE @ 1530 PT AXO X 3. (L) LE DRESSING C/D/I (+) NUERO (+) CIRC CHECKS PT RESTING NOT C/O PAIN @ THIS TIME — (b)(6)-2
26Apr03		2350	Assumed Pt Care @ this time pt AOX3 Pts Ace wrap to LLE CDI nuero Vs WNL capretil +3 No C/os @ this time Will Continue to Monitor @ this time (b)(6)-2

Continue on reverse side

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

REGISTER NO.	WARD NO.

NURSING NOTES
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General Services Administration and Interagency Committee on Medical Records
FPMR 101-11.806-8—October 1975
510-109

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/27/03		0038	CONCUR c̄ ABOVE ASSESSMENT (b)(6)-2
~~4/27/03~~	~~0803~~		~~Assumed care of pt at 0700. Pt resting comfortably. No c/o RF RVS WNL pt has dressing from Mid thigh to foot c̄ splint on the foot. No apparent drainage. heploc to (R) forearm.~~ (b)(6)-2
4/27/03	0803		Assumed care of pt @ 0700 pt resting comfortably c̄ eyes closed. Pt c/o pn to (L) thigh. Dressing on (L) thigh c̄ No apparent drainage, stitches to outer hip and duoderm to (L) hip joint. Pt VS WNL. Pt requests to take a shower and put on pants and shirt (b)(6)-2 HN
4/27/03		1030	Agree c̄ above assessment. Pt. ambulate c̄ crutches + up to shower. Will cont to monitor (b)(6)-2
27APR03		1530	Assumed pt care. VSS. pt has drsg to (L) thigh/knee CDI. pt c/o minimal pain. drsg. W-D c̄ gauze, Kerlix's ace wrap. Will cont. to monitor (b)(6)-2
27APR03		1850	pt asked for crutches, went to RR & walked around ward x3. Pt had ∅ c/o pain - (b)(6)-2

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NURSING NOTES
Standard Form 510
(Reverse)

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
28APR03		1900	Assumed Pt care VSS Pt w/ complaints of pain. Pt A&O x3 will continue to monitore Pt Resp Pain — (b)(6)-2 [redacted]
29APR03	0910		Pt lying in bed @ this time. (L) leg dsg Δ by wound team this AM. Dsg 4x4 gauze/tape to left lateral thigh and knee. Dsg C/D/I. No drainage. N/V WNL. Pt c/o pain in (L) leg. 5mg MSO4 IVP given (b)(6)-2 [redacted]
29APR03		1300	ASSUMED CARE @ 0700. VSS. (+) HR, RR, BS. Ø c/o OF PAIN. WILL CONTINUE TO MONITOR. — (b)(6)-2 [redacted]
29Apr03		2205	Assumed care of Pt @ 1900. VSS, medicated for pain. Pt ambulated at side of bed. Will continue to monitor — (b)(6)-2 [redacted]
30APR		1000	ASSUMED CARE @ 0700. VSS. PT AMBULATING WELL c̄ CRUTCHES. NEURO CHECKS WNL. (L) LEG HAS GAUZE + TAPE. DSG Δ'd BY WOUND CARE TEAM. WILL CONTINUE TO MONITOR. — (b)(6)-2 [redacted]
30Apr03		2032	Assumed care of Pt @ 1900, VSS, Neuro checks WNL, Pt medicated for pain. Dressing Δ'd by wound care team. Will continue to monitor — (b)(6)-2 [redacted]
1MAY03			ST PT c̄ LLE FX c̄ PIN DSG C/D/I c/o mild pain to LLE neuro ✓ WNL V/S ~~[illegible]~~ WNL mild edema to LLE ⊖S/S infection cap Refill < 2sec L-CTA ABD-NT/ND HORRG — (b)(6)-2 [redacted]

☆ U.S. GOVERNMENT PRINTING OFFICE : 1983 O - 421-526 (9201)

(b)(6)-4 [redacted]

NURSING NOTES
Standard Form 510
(Reverse)

CLINICAL RECORD	NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
28Apr03	0400		Assumed pt CARE 2300. VS WNL. Neuro checks WNL. (L) hip stictched. (L)+(R) side c̄ patch. (L) leg swollen able to move. ace wrap 11E reinforced top of wrap c̄ drsg pt partial wound exposed. pt resting at this time. Will continue to monitor — (b)(6)-2 [redacted] HN/VSN
28Apr	0830		Above noted and concur ~ (b)(6)-2 [redacted]
~~28APR03~~	~~0815~~		~~Pt sitting on side of bed. No c/o pain. Pt has arch braces in mouth. Pt tolerating soft diet. Dsg to (L) cheek Δ'd by MO. Small rectangler area to (L) cheek approx quarter size. Area irrigated and dsg Δ'ed W/D Dsg c̄ 1% acetic acid. Area pink c̄ small amount of sangious drainage. Will cont to monitor — (b)(6)-2 [redacted] JTJ MC~~
28APR03	0830		Pt ~~has~~ lying in bed @ this time. No c/o pain. (L) leg wrapped with kerlex and ace bandage. N/V checks WNL. Pt ambulating NWB c̄ crutches. — (b)(6)-2 [redacted] JTJ MC

Error as wrong pt.

Continue on reverse side

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

(b)(6)-4 [redacted]

REGISTER NO. | WARD NO.

NURSING NOTES
Standard Form 510
General Services Administration and Interagency Committee on Medical Records
FPMR 101-11.806-8—October 1975
510-109

CLINICAL RECORD	NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
5/1/03	13	00	Concur c̄ HM3 Disalvo's assessment, AM care done. Ambulating well on crutches. Dsgs to (L) upper thigh Δ'd. Dsg #1 on top of thigh approx 2in. in length + 1/2 in deep. Packed c̄ sterile gauze. Draining moderate amt of sanginous fluid. Dsg #2 (near knee) approx 1in in length. Packed c̄ sterile gauze. Pt. doing well. Minimal to pain. WTH cont to monitor. (b)(6)-2 [redacted]
1 May 03		2020	Assumed care of Pt @ 1900, VSS, A+O x3, medicated for pain. Pt is ambulating well w/ crutches. Will continue to monitor. (b)(6)-2 [redacted] HMS
2 MAY 03		0100	Patient with dressing BLE, CDI., changed. See ENS Sinder's note for details on dressings. will monitor. Pt to leave in am. Supplies at bedside, meds at nurses station. (b)(6)-2 [redacted] ENS, NC
2 May 03		1050	Assumed care of pt. @ 0200. Pt. showered + awaiting discharge. Dsg's Δ'd. Dsg. #1 c̄ less drainage today than 1 MAY 03. Pt. sleeping @ this time. Will cont. to monitor (b)(6)-2 [redacted]

Continue on reverse side

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

REGISTER NO.

WARD NO.

(b)(6)-4 [redacted]

NURSING NOTES
Standard Form 510
General Services Administration and Interagency Committee on Medical Records
FPMR 101-11.806-8—October 1975
510-109

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
2 May 03	1650 Z/1950 L		(b)(3)-1 [redacted]. Pt. enplaned via litter $\bar{s}$ incident. Pt. ⊕ CSM to bilat. L.E's., moves L.E's on own. Skin warm, brown, dry. ⊕ pedal pulses, strong, regular. Pt. resting comfortably on litter. No complaints at this time. ∅ English speaking. — TSGT (b)(6)-2 [redacted] MSTER note: unable to visualize dressings to L.E's. — (b)(6)-2 [redacted]

☆ U.S. GOVERNMENT PRINTING OFFICE : 1983 O - 421-526 (9201)

NURSING NOTES
Standard Form 510
(Reverse)

516-108

NSN 7540-00-634-4156

MEDICAL RECORD | **OPERATION REPORT**

PREOPERATIVE DIAGNOSIS

(L) Femur Fx, closed

SURGEON (b)(6)-2 Dr [redacted]	FIRST ASSISTANT Dr (b)(6)-2 [redacted]	SECOND ASSISTANT	
ANESTHETIST LCDR (b)(6)-2 [redacted]	ANESTHETIC Gen CTT b-6-2		TIME BEGAN: 0955
CIRCULATING LT (b)(6)-2 [redacted] / LT (b)(6)-2 [redacted]	SCRUB NURSE Hm3 [redacted]	TIME OPERATION BEGAN 1105	TIME ENDED: 1443
OPERATING ...			TIME OPERATION COMPLETED 1425

(L) Femur fx, open → proximal external fixator pin incision communicated with fracture.

DRAINS (Kind and number)

1/2 Penrose to each of tt pin site incisions/lat.

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

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION

Ø

OPERATION PERFORMED

(L) ANTEGRADE FEMORAL IM NAIL

DESCRIPTION OF OPERATION (Type(s) of suture used, gross findings, etc.)

PROSTHETIC DEVICES (Lot no.) SEE BELOW

DATE OF OPERATION 20 April 03

VOP: 550
EBL: 350
IV FLUIDS: 3600

(1) Cannulated Femoral Nail
12 mm x 380 mm
MCN: 4525012
Exp: 03/2012

(2) 4.9 mm x 38 (459.38)
(3) 4.9 x 58 (459.58)
(4) 4.9 x 48 (459.48)
(5) 4.9 x 64 (459.64)

Surge McLoughlin
Asst Gentchos
post supine on fx table
Chestn General
incision at over posterolat (L) buttock.
tt stab portals for distal interlocks
prox interlocks placed thru prior pin site incision lat fem.
closure 0-vicryl, 2-vicryl, 3-vicryl skin
drain 1/2 of penrose to each of tt pin site prior wounds.
Skin Ø stable & awake to PACU.

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

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

...written entries give: ... hospital or medical faci... (b)(6)-2 [redacted]

DATE 4/20/03

STER/I.D. NO.

WARD NO.

OPERATION REPORT
Medical Record

*U.S. GOVERNMENT PRINTING OFFICE: 1990-259-301

MEDCOM - 4534

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

MEDICAL RECORD

PREOPERATIVE DIAGNOSIS

No infx of (L) thigh wounds from ex fix

SURGEON

DR (b)(6)-2

ANESTH

LCDR

CIRCULATING NURSE

LT (b)(6)-2

HM3 (b)(6)-2

OPERATIV

FIRST ASSIST

N/A

ANESTHETIC

GENERAL VIA ETT

SCRUB NURSE

HM3 (b)(6)-2

N/A

TIME

1300

TIME ENDED: 1225

TIME OPERATION COMPLETED: 1342

Same as above..

DRAINS (Kind and number)

NONE

SPONGE

1 + SHARPS

2 Correct Kettles & Tyrone

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION

(1) AEROBIC C+S

(2) ANAEROBIC C+S

(L) PROXIMAL THIGH WOUND

OPERATION PERFORMED

I+D LLE WOUNDS

DESCRIPTION OF OPERATION (Type(s) of suture used, gross findings, etc.)

Surgeon (b)(6)-2

Asst ∅

incision open of prior (L) lat thigh ~~incision~~ fine wounds from ex fix sites; prior surgical incisions clean and not opened.

Anesth GEN/ET

Closure # 0-prolene retention sutures.

dressing: plain sterile gauze c̄ 1% Acetic acid

drains ∅ cultures ⊤ from prox pin site (+ aerobic + anaerobic)

Counts correct.

Stable to pacu

Tourniquet ∅ used

PROSTHETIC DEVICES (Ref no.)

NONE

DATE OF OPERATION

23 APR 03

UOP: NM

EBL: MIN

IV FLUIDS: ~~1400~~ 450 KW

SIGNATURE OF SURGEON (b)(6)-2

PATIENT'S IDENTIFICATION

(b)(6)-2

(b)(6)-4

DATE

4/23/02

511–119

NSN 7540–00–634–4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY															
POST-	DAY														
MONTH-YEAR	DAY	2MAY03		3May03		4May03									
19	HOUR	2320		06	1600										
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															
RESPIRATION RECORD		98													
BLOOD PRESSURE		115/57			114/64										
		85			85										
		985			982										
HEIGHT:	WEIGHT →														

(Centigrade Equivalents, for Reference only)

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

(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

518–124

NSN 7540–00–634–4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

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

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

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

DIAGNOSIS OR OPERATIVE PROCEDURE: (L) Femur Fx

DATE REQUESTED: 4/21/03

DATE AND HOUR REQUIRED: ASAP

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

VOLUME REQUESTED *(If applicable)*: 1 Unit ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

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

REMARKS: HIH ~~4~~ ABN 7/22.4

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

DATE VERIFIED: 21 APR 03

TIME VERIFIED: 1020 Hrs

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6)-4 [redacted]

TRANSFUSION NO.: 4

PATIENT NO.:

TEST INTERPRETATION

ANTIBODY SCREEN: neg

CROSSMATCH: comp

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [x] NO RECORD

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

DONOR

ABO: O

Rh: POS

RECIPIENT

ABO: O

Rh: POS

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONE

DATE: 21APR03

REMARKS: EXP. 03MAY03

SECTION III – RECORD OF TRANSFUSION

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

AT *(Hour)*: 2120 ON *(Date)*: 4-21-03

IDENTIFICATION

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

1st VERIFIER *(Signature)*

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

LCDR

PRE-TRANSFUSION

TEMP. 101.3 PULSE 104 BP 126/60

DATE OF TRANSFUSION: 4/21/03

TIME STARTED: 2145

POST-TRANSFUSION DATA

AMOUNT GIVEN: 1 unit ML

TIME/DATE COMPLETED/INTERRUPTED: 21 APR 03 2255

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

- [x] NONE
- [x] SUSPECTED

TEMPERATURE: 100.9 PULSE: 106 BLOOD PRESSURE: 120/78

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

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

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

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

(b)(6)-2 [redacted]

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility)

(b)(6)-4 [redacted]

SEX: M

WARD: 4WD

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

MEDCOM - 4537

Medical Record Copy

518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)* 1 unit ML

REMARKS: H/H 7/22.4

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

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED 4/21/03

DATE AND HOUR REQUIRED ASN (b)(6)-2

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE (L) femur fx

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

(b)(6)-2

DATE VERIFIED 21 APR 03

TIME VERIFIED 1020

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6)-4

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
Neg	Comp

- [ ] CROSSMATCH NOT REQUIRED FOR THE COM

REMARKS: EXP. 03 MAY 03

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [x] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST (b)(6)-2

(b)(6)-2

DATE 21 APR 03

DONOR	RECIPIENT
ABO O	ABO O
Rh POS	Rh POS

SECTION III – RECORD OF TRANSFUSION

(b)(6)-2

IN DATA

AT *(Hour)* 2345 ON *(Date)* 4-21-03

IDENTIFICATION

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

1st VERIFIER *(Signature)*

(b)(6)-2 ENS/NC

(b)(6)-2 ENS, NC

TEMP. 100.9 PULSE 107 BP 122/68

DATE OF TRANSFUSION 22APR03 TIME STARTED 0010

POST-TRANSFUSION DATA

AMOUNT GIVEN	TIME/DATE COMPLETED/INTERRUPTED
1 unit ML	22APR03 0205

REACTION	TEMPERATURE	PULSE	BLOOD PRESSURE
[x] NONE [ ] SUSPECTED	100.2	96	118/64

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

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

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

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

(b)(6)-2 ENS/NC

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility)

(b)(6)-4

SEX M

WARD 4 FWD

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

MEDCOM - 4538

Medical Record Copy

MEDICAL RECORD			DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
18 April 03 1700			1) Admit to Orthopedics, Dr [redacted]	B6-2	(b)(6)-2
			2) Condition Stable		
			3) Dx - (L) femur fracture with external fixation.		
			4) NKDA		
			5) Diet - regular		
			6) I+O Q 8H		
			7) Lab - a) male trauma panel (done in CASREC)		(b)(6)-2
			b) Blood cultures (done in CASREC)		
			8) Radiology - CXR - Portable AP (L) femur c hip + knee } done in CAS		
			9) Meds - Ancef 1 gm IVPB Q 8H		(b)(6)-2
			10) IV - LR @ 75 cc/hour.		
			11) Pain meds		
			a) Morphine 2-5 mg IV push PRN severe pain		(b)(6)-2
			b) Tylenol #3, 1 or 11 PO Q 4H PRN pain		
			c) Tylenol 325 mg, 11 PO Q 4H PRN mild pain		(b)(6)-2
			12) Other meds		
			a) Ambien 5 mg PO Q HS KKP sleep -		(b)(6)-2
			b) Milk of Magnesia 30 cc PO when arrive on Ward, then Q day PRN constipation		(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. CAPT (b)(6)-2

18 April 03 1715, Lovenox 30 mg SQ Q12 [redacted] MLUG

(b)(6)-4

DOCTOR'S ORDERS (b)(6)-2

(b)(6)-2 MD B6-2

STANDARD FORM 508 (R
Prescribed by GSA and ICMR
FPMR 101-11. 806-8
508-110

18 APR 03 NCTCCI ENS (b)(6)-2

MEDCOM - 4539

MEDICAL RECORD | **DOCTOR'S ORDERS** *(Sign all orders)*

DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
19APR03@0210			VERIFIED	(b)(6)-2	(b)(6)-2
April 19 03			fe sou T tid		(b)(6)-2
10 30 hrs			MULTIVIT T OD	(b)(6)-2	(b)(6)-2
			folic acid 1mg T OD		
			CBC Tomorrow		
4/19/03			1200	(b)(6)-2	
4/20/03	0300		chart verified	(b)(6)-2	
4/20/03	245 pm.		pt gr orders	(b)(6)-2	
			Admit PACW → GPW ward		
			Sippmnail (L) femur.		
			Stable, routine vitals		
			NKMA ; Bedrest 4/20		
			OOB → chair + NWB ambul RLE		
			c̄ PT. for crutch training		
			to begin 4/21.		
			I/O's + record. ; D/C Foley AM 4/21		
			Straight cath if no spont u/o at 8hrs		
			after Foley out.	(b)(6)-2	
			TED to RLE.		
			D5 1/2NS IV @ 100 cc/hr ; H/L wheat pw.		
			MSO4 2-6mg IV/SQ/IM q 2° pm	(b)(6)-2	
			Tyl 650mg po/pr q 4° pm		

Faxed + Received 4/20/03 1510

noted 4/20/03 2100

(Continue on reverse side)

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

REGISTE

WARD NO. 4 FWD STARBOARD

(b)(6)-4

Faxed 2100 4/20/03

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45-505
508-112

06-111

NSN 7540-00-634-4121

MEDICAL RECORD

DOCTOR'S ORD

(Sign all orders)

DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
4/20/03 1450			**ANESTHESIA PACU ORDERS**		(b)(6)-2
		1.	Admit to PACU.		
		2.	Allergies: Ø		
		3.	Vital signs per PACU protocol.		
		4.	O2: X FM @ ~~10~~ 5 LPM, ___ ___% Blowby, ___ NP @ ___ LPM.		
		5.	IVF: LR at 100 cc/hr		
		6.	On ward: 02 @ 2-3 LPM via NC: YES NO		
		7.	Pain medication:		
			Ketorolac ___ mg IV x1 dose (adults 30 mg max; peds consider 0.2-0.4 mg/kg)		
			MSO4 2-5 mg IV q 5 min prn; max dose 30 mg		
			Fentanyl ___ mcg IV q ___ min prn; max dose ___ mcg		
			Percocet ___ tab(s) p.o. with sip of water		
			Other: ___		
		8.	Antiemetics:		
			Ondansetron 4 mg IVP, may repeat x1 in 15 min (0.1mg/kg; max 4 mg)		
			Metoclopramide ___ mg IV x1 (0.15 mg/kg; max 10 mg)		
			Droperidol ___ mg IV x 1 dose (0.01 mg/kg; max 0.625 mg) Must have baseline ECG available before administration.		
			Other ___		
		9.	Clear liquids as tolerated: YES NO		
		10.	Notify Anesthesia (pager ~~1506~~ 178) for airway issues, pain, nausea/vomiting not responsive to above orders or other patient problems/concerns per PACU protocol.		
			(rev 3/2002)	(OVER)	

(Continue on reverse side)

ATIENT'S IDENTIFICATION (For typed or written entries give: Nan ... ade; rank; rate; hospital or n

(b)(6)-4

(b)(6)-2

REGISTER NO.

(b)(6)-2

WARD NO.

1455 4/20/03

DOCTOR'S ORDERS

Medical Record

STANDARD FORM 508 (Rev. 3-94)
Prescribed by GSA/ICMR FIRMR (41 CFR) 201-9.202-1

MEDCOM - 4541

MEDICAL RECORD

DOCTOR'S ORDERS
(Sign all orders)

DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE

ANESTHESIA PACU ORDERS -- CONTINUED

11. Discharge patient from PACU per protocol: YES NO

12. When epidural/spinal patients meet discharge criteria per PACU protocol, discharge to ward. On ward: bedrest pending full recovery of sensory and motor function; progress to ambulation with assistance.

FOR PACU KEEP PATIENTS ONLY

13. Release patient from anesthesia care to KEEP status when patient meets anesthesia discharge criteria: YES NO

14. Notify anesthesia (1506) for airway management and: (circle if applicable)
    a. Pain management
    b. Fluid management
    c. Other _____

15. TOW patient to ward in a.m. if patient meets discharge criteria:
    YES NO

Signature _____ Beeper

(b)(6)-2

(b)(6)-2

(b)(6)-2

LEDR

4/20/03

STANDARD FORM 508 (Rev. 3-94) BACI

MEDCOM - 4542

MEDICAL RECORD | **DOCTOR'S ORDERS** *(Sign all orders)*

DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
			P'p orders Continued		
4/20/03	245p		Ancef 1 gm IV q8° x 48° pp	(b)(6)-2 [redacted]	
			Lovenox 30mg sq q/L c̄		
			first dose tonight (pm of 4/20)		
			AM labs 4/21 CBC, Chem 7		
			Fe gluconate 325mg po tid		
			Colace 100mg po bid		
			MVI 1 po qD	(b)(6)-2 [redacted]	
			Folate 1mg po qD		
			Faxed & Revised	(b)(6)-2 [redacted]	
			Faxed 4/20/03 2100 4/20/03	(b)(6)-2 [redacted]	4/20/03 2100
21APR03			V.O. Per DR (b)(6)-2 [redacted] ENS (b)(6)-2 [redacted]		(b)(6)-2 [redacted]
			① Bld cx x2		
			② UA / urine cx		
			③ CBC		
			④ Tylenol 650mg PO X1 Now		
			(for Fever workup)		
			X		
21APR03			Noted By ENS (b)(6)-2 [redacted]		
21APR03			24 Chart Very Scratch By ENS (b)(6)-2 [redacted]		

(Continue on reverse side)

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

(b)(6)-4 [redacted]

REGISTER NO.

WARD NO. 4 FWD. Starboard

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45-505
508-112

MEDICAL RECORD	DOCTOR'S ORDERS (Sign all orders)

DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
April 21 03			TYPE + X MATCH 2 units	(b)(6)-2 [redacted]	
0900hrs			packed cells + transfuse when ready (APOTTS)		
			CBC April 22 '03.		
4/21/03					
~~0054~~ 22 Apr 03			24° chart verification By ENS		
4/22/03	0930		TIMENTIN 3.1 gm IV q 8°	(b)(6)-2 [redacted]	
			Xfer to isolation (Contact iso)		
			· ward for GPWs		
			D/C Anuf		
				(b)(6)-2 [redacted]	
					22 Apr 03 1325
4/22/03			NPO p̄ MN	(b)(6)-2 [redacted]	
			D5 1/2 NS @ 75cc/hr		
			V/O Dr.	(b)(6)-2 [redacted]	
4/23/03	0400		24° chart verification	(b)(6)-2 [redacted]	
4/24/03	0330		24° chart verification - no further orders noted	(b)(6)-2 [redacted]	

(Continue on reverse side)

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

4 Forward port

REGISTER NO.

WARD NO.

(b)(6)-4 [redacted]

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45-505
508-112

508-111

NSN 7540-00-634-4121

MEDICAL RECORD — **DOCTOR'S ORDERS** (Sign all orders)

DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
23 Apr 03			**ANESTHESIA PACU ORDERS**		
1330		1.	Admit to PACU.		
		2.	Allergies: NKA	(b)(6)-2	
		3.	Vital signs per PACU protocol.		
		4.	O2: ___FM @ 10LPM, ____% Blowby, ___NP @ 2-4 LPM.		
		5.	IVF: LR at LVO cc/hr		
		6.	On ward: 02 @ 2-3 LPM via NC: (YES) NO		
		7.	Pain medication:	(b)(6)-2	
			Ketorolac ____mg IV x1 dose (adults 30 mg max; peds consider 0.2-0.4 mg/kg)		
			MSO_4 1-2 mg IV q 2-4 min prn; max dose 20 mg		
			Fentanyl _____mcg IV q ____ min prn; max dose _____mcg		
			Percocet _____ tab(s) p.o. with sip of water		
			Other: _____	(b)(6)-4	
		8.	Antiemetics:		
			Ondansetron _____ mg IVP, may repeat x1 in 15 min (0.1mg/kg; max 4 mg)		
			Metoclopramide 10 mg IV x1 (0.15 mg/kg; max 10 mg)		
			~~Droperidol _____mg IV x 1 dose (0.01 mg/kg; max 0.625 mg) Must have baseline ECG available before administration.~~		
			Other _____	(b)(6)-2	
		9.	Clear liquids as tolerated: (YES) NO		
		10.	Notify Anesthesia (~~pager 1506~~) for airway issues, pain, nausea/vomiting not responsive to above orders or other patient problems/concerns per PACU protocol.		
			(rev 3/2002)		

(OVER)

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: N middle; grade; rank; rate; hospital/o

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

WARD NO.

No Cod

LCDR/MC

4/23/03 @ 1355

DOCTOR'S ORDERS
Medical Record

MEDICAL RECORD			DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE

ANESTHESIA PACU ORDERS -- CONTINUED

11. Discharge patient from PACU per protocol: YES NO

12. When epidural/spinal patients meet discharge criteria per PACU protocol, discharge to ward. On ward: bedrest pending full recovery of sensory and motor function; progress to ambulation with assistance.

FOR PACU KEEP PATIENTS ONLY

13. Release patient from anesthesia care to KEEP status when patient [illegible] anesthesia discharge criteria: YES NO

14. Notify anesthesia (1506) for airway management and: (circle if applicable)
    a. Pain management
    b. Fluid management
    c. Other _____

15. TOW patient to ward in a.m. if patient meets discharge criteria: YES NO

(b)(6)-2 [redacted]

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

LCDR NC NSN

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

Noted (b)(6)-2 [redacted] LCDR/NC

STANDARD FORM 508 (Rev. 3-94) BACK

MEDICAL RECORD			DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
4-24-03		1.	Turn, Cough & deep breath q2h		
	1005 an		Turn towards unaffected side	(b)(6)-2 [redacted]	ENPC
			~~VO CDR 1/1~~		
4/24/01			VO CDR (b)(6)-2 [redacted] / (b)(6)-2 [redacted]		ca
			continue Lovenox		
			FeSO4, colace, Folate, MVI		
			(b)(6)-2 [redacted]	CDR	
				1100 4-24-03	
4/28/03			24hr chart ver freshen (b)(6)-2 [redacted]	@ 0130	
4/26/03	0235		chart verified	mkharper	
4-26-03	1055	1.	Percocet 1-2 q4-6hr pm pain. Cd (b)(6)-2 [redacted]		
			(b)(6)-2 [redacted]		ca
				1000 4-26-03	
4/27/03	0037		chart verified	(b)(6)-2 [redacted]	

(Continue on reverse side)

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

(b)(6)-4 [redacted]

REGISTER NO.

WARD NO.

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505
508-111
☆U.S. GPO: 1988—201-760/80076

MEDICAL RECORD			DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
4/23/03			P̄ orders		(b)(6)-2 [redacted]
			PAW → ward / ontitis / Mcloughe		
			S/P (L) lat thigh ex fix site		
			wounds.		
			Stable		
			routine vitals		
			NKMA		
			OOB to w/c today		
			PT - crutch ambulation training		
			NWB LLE on 4/24.		
			I/O's + record.		
			reinforce dsgs prn.		
			Begin W→D packing of (L) lat		
Invited @ 1710			thigh wounds c̄ 1%		
			→ acetic acid solution		
			on 4/24, bid		
			Reg diet + snacks + insure tid		
			Lovenox 30 mg Sq q 12°		
			TED to RLE		
			Thrombin 3.1 gm IV q 8° given @ 1400		
			MSO4 2-6 mg IV/SQ q 2° prn		
			Tylol 650 mg PO/PR q 4° prn		

(Continue on reverse side)

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

(b)(6)-4 [redacted]

REGI[redacted]

(b)(6)-2 [redacted]

(b)(6)-2 [redacted]

ORDERS

STANDARD FORM 508 (Rev. 10-76)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505
508-111
☆U.S. GPO: 1988—201-760/80076

1100

4 FWD PORT

WDR/RC

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

NURSING UNIT	ROOM NO.	BED NO.

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

1. admit ortho ICW-2
2. sip R LE Ex Fix
   now c pseudomonas
   and [illegible] 33
3. vitals q [illegible]
4. Regular diet
5. Notify [illegible] T7101

Not 5/3/0

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

P7110 RR 724
BP 7160/110 BP C 160/40

(b)(6)-2

6. PT consult
7. Fortaz T gm IVPB
   q 8hrs
8. ciprofloxacin 500mg po BID
9. Regular diet

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

10. ~~Ext~~ Percocet 1-2 tab
    po q 4-6 hrs p.r.n.
11. BID dressing Δ
12. Naprosyn 500mg po BID
13. Red crescent
    ~~[illegible]~~

SSS (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

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

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

Standard Form 508

CLINICAL RECORD			DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME START	STOP	Rx	DRUG ORDERS (Another brand of a generically equivalent product, identical in dosage form and content of active ingredient(s), may be administered UNLESS checked here)	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
Apr 27 '03		1	Cipro 500 mg po BID	(b)(6)-2 [redacted]	
1217		3	CBC in AM		
			GLUSTAD	(b)(6)-2 [redacted]	(b)(6)-2 [redacted]
April 28/03			24 chart verification @ 0400	(b)(6)-2 [redacted]	
4/28/03			B6-2 Consult Dr [redacted] of infection disease for appropriate Abx Coverage given recent Cx results (per Dr (b)(6)-2 [redacted])	(b)(6)-2 [redacted]	
4/28/03			B6-2 Xfer Care to Dr [redacted] at midnight tonight please. Please pick up outpatient meds for Xfer; Adding outpatient Cipro 500 po bid.	(b)(6)-2 [redacted]	
			24° chart ✓ 29APR2003 0230	(b)(6)-2 [redacted]	
4/29/03		1	D/C Timentin		
1000		2	Ceftaz 1 gm IVPB 48 hrs x 35 days		
			B6-2 29APR03 15 unpted Ca [redacted]	(b)(6)-2 [redacted]	

PATIENT'S IDENTIFICATION ... grade; date; hospital or medical fa... ...tries give: Name—last, first, middle: 30APR2003 0230

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

LCDR, MC, USNR (UMO/SS) ...TIOUS DISEASE

...ARD NO.

...R'S ORDERS

...ard Form 508
508-109

General Services Administration and Interagency Committee on Medical Records
FPMR 101-11.806-8
October 1975

Standard Form 508

CLINICAL RECORD

DOCTOR'S ORDERS
(Sign all orders)

DATE AND TIME START	DATE AND TIME STOP	Rx	DRUG ORDERS (Another brand of a generically equivalent product, identical in dosage form and content of active ingredient(s); may be administered UNLESS checked here)	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
4/30/03		①	CBC ESR } in A.M. SMA-7	(b)(6)-2	
			QHD	(b)(6)-2	
			called 4/30	(b)(6)-2	
24° chart ✓ 01 may 2003 0200				(b)(6)-2	ENS/RC
24° chart ✓ 02 may 2003 0100				(b)(6)-2	ENS/RC 0 new orders

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

DOCTOR'S ORDERS
Standard Form 508
508-109

General Services Administration and
Interagency Committee on Medical Records
FPMR 101-11.806-8
October 1975

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
2May 03	(b)(6)-2	Fortaz 1gm IVPS Q 8hrs	24	
			08	
			16	
			18	
2May		Cipro 500mg PO BID	08	
			20	
2May		Naprosin 500mg	08	
			20	
2May		Diet: Reg	7	
			12	
			17	
2May		Vitals Q 8°	7	
		Notify MD T>101	15 ✓	
		P>110, R>24 BP>101-4	23	
2May		BID Drag A	10	
			20	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P (R) LE EXT Fix

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

(b)(6)-4

ICW

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

USAPA V1.00

MEDCOM - 4552

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
2 May	(b)(6)-2	Admit ortho 5GW #2	2 May 2	done		(b)(6)-2
		SP (R) LE EX FIX Now in pseudomonas				
		and				
2 May		Red Cresent				
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED		
2 May	(b)(6)-2	Percocet 1-2 tabs	3 May 0100	3 May 1715	3 May 2355
.....	.....	PO Q4°-6° PRN	2 tabs [redacted]	⁂ MLWB	⁂ QB
.....	.....		(b)(6)-2		
.....	.....				
.....	.....				
.....	.....				
.....	.....				
.....	.....				
.....	.....				
.....	.....				
.....	.....				
.....	.....				
.....	.....				

USAPA V1.00

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF: (b)(3)-1

2. MTF LOCATION (State or Country Code.)

3. REGISTER NUMBER: (b)(6)-4

NAME (Last, First, Middle Initial): (b)(6)-4 (b)(6)-4

4. PAY GRADE: —

5. SEX: M

6. DATE OF BIRTH (YYYYMMDD): 19810107

AGE AT ADMISSION: 22Y

8. RACE: X

9. ETHNIC BACKGROUND: 9

RELIGION:

10. LENGTH OF SERVICE: —

ETS:

11. FMP: 99

12. SOCIAL SECURITY NUMBER: (b)(6)-4

ORGANIZATION (Active Duty Only):

13. MARITAL STATUS: 3

HOUR OF ADMISSION: 1751

BRANCH / CORPS:

14. FLYING STATUS: —

15. BENEFICIARY CATEGORY: R9178

16. ZIP CODE OF RESIDENCE: 09330000

17. UNIT LOCATION (State or Country Code): —

18. MOS: —

19. TRAUMA:

PREV. ADMISSION: YEAR / NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 1 Direct

WARD: ICW2

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE:

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code):

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE:

21. TYPE OF DISPOSITION: 22

22. MTF TRANSFERRED TO: (b)(3)-1

23. DATE OF DISPOSITION (YYYYMMDD): 20030504

24. CLINIC SVC - ADMITTING: AEAA

25. MTF TRANSFERRED FROM:

26. DATE THIS ADMISSION (YYYYMMDD): 20030502

27. LOCATION OF OCCURRENCE (Battle Casualty Only): IZ

28. MTF OF INITIAL ADMISSION:

29. DATE INITIAL ADMISSION (YYYYMMDD):

FOR LOCAL USE

DX: 82100
99667
S/P R LE Exs Fx
0417
E8122
E8784
Px: 7815
8622
7865
7865

Trauma 9

Inj 126

ADMITTING: (b)(6)-2

SIGNATURE OF ADMITTING CLERK: (b)(6)-2

DA FORM 2996, MAR 2000

MEDCOM - 4554

USAPA V1.00

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF (1–6): (b)(3)-1
2. MTF LOCATION (7–8) (State or Country Code.)
3. REGISTER NUMBER (9–15): (b)(6)-4
NAME (Last, First, Middle Initial): (b)(6)-4
4. PAY GRADE (16–17)
5. SEX (18)
6. DATE OF BIRTH (Y Y Y Y M M D D) (19–26)
DATE OF ADMISSION (27–29)
8. RACE (30)
9. ETHNIC BACKGROUND (31)
RELIGION
10. LENGTH OF SERVICE (32–34)
ETS
11. FMP (35–36): 9 9
12. SOCIAL SECURITY NUMBER (37–45): (b)(6)-4
ORGANIZATION (Active Duty Only)
13. MARITAL STATUS (46)
HOUR OF ADMISSION: 1707
BRANCH / CORPS
14. FLYING STATUS (47–49)
15. BENEFICIARY CATEGORY (50–52)
16. ZIP CODE OF RESIDENCE (53–61)
17. UNIT LOCATION (State or Country Code) (62–63)
18. MOS (64–70)
19. TRAUMA (71)
PREV. ADMISSION: YEAR / NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72): Direct
WARD: ICW2
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF [illegible]: (b)(3)-1
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
21. TYPE OF DISPOSITION (73–74): ~~TRANS~~ Home
22. MTF TRANSFERRED TO (75–80)
23. DATE OF DISPOSITION (Y Y Y Y M M D D) (81–88): 2 0 0 3 0 5 0 4
24. CLINIC SVC - ADMITTING (89–92): A E A A
25. MTF TRANSFERRED FROM (93–98)
26. DATE THIS ADMISSION (Y Y Y Y M M D D) (99–106): 2 0 0 3 0 5 0 2
27. LOCATION OF OCCURRENCE (Battle Casualty Only) (107–108)
28. MTF OF INITIAL ADMISSION (109–114)
29. DATE INITIAL ADMISSION (Y Y Y Y M M D D) (115–122)

FOR LOCAL USE

S/P R LE EXS FX

ADMITTING: (b)(6)-2 (b)(6)-2

DA FOR [illegible]

EDITION OF MAR 89 IS OBSOLETE

MEDCOM - 4555

USAPA V1.00

MEDICAL TREATMENT FACILITY
USNS COMFORT (T-AH 20)
LIFT OF OPPORTUNITY

NAME (LAST, FIRST, MIDDLE) (b)(6)-4					SOCIAL SECURITY NUMBER
RANK/RATE	OFFICERS ONLY DESIG NOBC	ENLISTED NEC	BIRTH DATE	SEX	
BRANCH OF SERVICE	NAMED AND ADDRESS OF PARENT MILITARY COMMAND				SHIP HOMEPORT
UIC	BLOOD TYPE	RELIGIOUS PREFERENCE	MARITAL STATUS	IS SPOUSE ACTIVE DUTY	NUMBER OF DEPENDENTS
NAME OF NEXT OF KIN (NOK)					RELATIONSHIP OF NOK
ADDRESS OF NOK					PHONE NUMBER OF NOK

PRINTED NAME OF PATIENT RECEIVING FLIGHT TRAINING

SIGNATURE OF PATIENT

PRINTED NAME OF MEDHOLD COORDINATOR

(b)(6)-2

(b)(6)-2

LD COORDINATOR

PRINTED NAME OF ATTENDING PHYISICIAN

ING PHYSICIAN

Name: [redacted] (b)(6)-4

NURSING [redacted] SHEET
MEDTREFAC-65[redacted] Temp Form

Date: 1 MAY 03 [redacted]

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
180																								
160																								
140																								
120																								
100																								
80																								
60																								
40																								
RR		18												00										
TEMP		97.2												97.4										
SAO2																								
MAP																								
O2 Mode																								
														104/60										
														96										

DRIP/DOSE

MEDCOM - 4557

Name: [redacted] (b)(6)-4

[redacted] SHEET
[redacted] Form

Date: 30 APR

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
180																								
160																								
140																								
120																								
100																								
80																								
60																								
40																								
RR	16					18	~~18~~							20										
TEMP	97.3					98.4	~~98.9~~							98.2										
SAO2																								
MAP																								
O2 Mode																								
BP	104/56					116/62								98/76										
HR	80					77								84										

DRIP DOSE

MEDCOM - 4558

FREQ. V[illegible]

TIME																	
BP																	
HR																	
RR																	
TEMP																	
SAO_2																	

otes:

INPUT/OUTPUT

IN	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
PO																										
IVPB																										

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
FOLEY																										
UOP													500													
BM																										

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

MEDCOM - 4559

(b)(3)-1

(b)(6)-4

Date Admission: 4/18/2003
Date of Transfer:
Age: Gender: M

History:
22 y/o Iraqi male s/p motorcycle MVA approx 5 days prior to admission; had ex fix placed to L femur fx same day. Mild road rash.

Hospital Course:
begin crutch training, NWB LLE on 4/21

Diagnoses:
R closed proximal diaphyseal femur fracture which was converted to open by proximal ex fix pins which communicated with
fracture site., ,

4/27 - Cultures have grown out a few colonies only of both pseudomonas and Acinetobacter; sensitive to Ticarcillin (Timentin) according to USNS Comfort Lab. Continue IV Abx on Comfort + until clinically stable to return to Iraq. (b)(6)-2

Surgeries/Treatment:
ex fix in field on date of injury; 4/20 removal of ex fix and anterograde IM femoral nail; I&D of ex fix wounds on 4/23 and packed with acetic acid packing., ,

Recommendations:
IM nail done; to begin crutch training NWB LLE on 4/21; needs packing changed with acetic acid through 4/28, then change to wet to dry packing for ex fix wounds only.

Special Needs:
requires packing change qd and wound checks qd; will need staples removed.

Prognosis: Good

Physician: (b)(6)-2 LCDR Dept of Orthopedics

4/24/2003

Name (b)(6)-4

NURSING [redacted] SHEET
MEDTREFAC [redacted] Form

Date: 29 APR

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
	22					20						18				20						16		
MP	97.3					97.0						98.0				98.9						97.9		
O2																								
AP																								
de																								
BP	118/66					108/68						118/56				104/78						102/68		
HR	70					84						88				84						84		

DRIP DOSE

FREQ. VITAL SIGNS

TIME															
BP															
HR															
RR															
TEMP															
SAO_2															

Notes:

INPUT/OUTPUT

IN	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	T
PO																										
IVPB																										

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06
FOLEY																									
UOP			475cc			480		600								450									
BM																									

PREVIOUS 24 HOUR INPUT _____

PRESENT 24 HOUR INPUT _____

PREVIOUS 24 HOUR OUTPUT _____

PRESENT 24 HOUR OUTPUT _____

PREVIOUS WEIGHT _____

PRESENT WEIGHT _____

MEDCOM - 4562

(b)(6)-4

NURSING [redacted] SHEET
MEDTREFAC-65[redacted] Temp Form

Date: 28-29 Apr 03

T	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
2																								
1																								
140																								
120																								
100																								
80																								
60																								
MP		180			98.1				98.1				98.6											
O2																								
AP																								
de																								
					112/84				112/84				122/64											
DRIP/DOSE																								

(b)(6)-4

NURSING [redacted] SHEET

MEDTREFAC-65[redacted]emp Form

Date: 28, 29 Apr 03

T	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
2																								
140																								
120																								
100																								
80																								
60 80																								
MP		18 98.0			20 98.1				20 98.7				20 98.6											
O2																								
AP																								
de																								
					110 68 84				112 64 84				122 64											

DRIP DOSE

FREQ. VITAL SIGNS

TIME																
BP																
HR																
RR																
TEMP																
SAO_2																

Notes:

INPUT/OUTPUT

IN	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	T
PO																										
IVPB																										

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06
FOLEY																									
UOP			475cc			480		600								450									
BM																									

PREVIOUS 24 HOUR INPUT_____

PRESENT 24 HOUR INPUT_____

PREVIOUS 24 HOUR OUTPUT_____

PRESENT 24 HOUR OUTPUT_____

PREVIOUS WEIGHT_____

PRESENT WEIGHT_____

MEDCOM - 4565

Name: [redacted] (b)(6)-4

NURSING [redacted] SHEET
MEDTREFAC-6[redacted]/Temp Form

Date: 27 APR 03

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
180																								
160																								
140																								
120																								
100						V			V															
80																		V						
60						A			A															
40																		A						
RR	12					12			12									16						
TEMP	97.2					98.1			97.7									99.0						
SAO2						98			99%									97						
MAP																								
O2 Mode																								
	126/89					90		Rise	83									92/62						
	59																	83						

DRIP DOSE

FREQ. VITAL SIGNS

IM																
P																
R																
R																
EM																
AO																

otes

INPUT/OUTPUT

	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
PB																										

UT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
OLE																										
OP						400	500																			
M																1300									375	

PREVIOUS 24 HOUR INPUT _____ PREVIOUS 24 HOUR OUTPUT _____ PREVIOUS WEIGHT _____

PRESENT 24 HOUR INPUT _____ PRESENT 24 HOUR OUTPUT _____ PRESENT WEIGHT _____

MEDCOM - 4567

Name: (b)(6)-4

NURSING [redacted] SHEET
MEDTREFAC-65[redacted]/Temp Form

Date: 26 APR 03

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
180																								
160																								
140																								
120																								
100																								
80																								
60																								
40																								
RR	12									14				16			18							
TEMP	98.9									97.6				98.4			99.0							
SAO2										98%				98%										
MAP																								
O2 Mode																								
	90/64									116/48				108/54			110/70							
	116																							

DRIP/DOSE

FREQ. VITAL SIGNS

INPUT/OUTPUT

07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL

07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
								540														475			

US 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

T.24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

MEDCOM - 4569

Name: [redacted] (b)(6)-4

NURSING [redacted] SHEET
MEDTREFAC-65[redacted]/Temp Form

Date: [redacted]

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
180																								
160																								
140																								
120																								
100																								
80																								
60																								
40																								
RR	18																20					18		
TEMP	98.6																98.6					97.9		
SAO2																	98%					78		
MAP																								
O2 Mode																								
	98/52 118																98/68					102/64		

DRIP/DOSE

FREQ. VITAL SIGNS

INPUT/OUTPUT

07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL

07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
					275																				
									275																

RI US 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

RI T.24 JR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

MEDCOM - 4571

Name: [redacted] (b)(6)-4

NURSING [redacted] SHEET

MEDTREFAC 65[redacted]/Temp Form

Date: [illegible]

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
180																								
160																								
140																								
120																								
100																								
80																								
60																								
40																								
RR		[illegible]	17			15				16								18					18	
TEMP			99.6			100.3				99.3								99.9	99.4				98.7	
SAO2																		97					98	
MAP																								
O2 Mode																		RA					RA	