b(2)-2

Admission and Coding Information

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

1. Reporting MTF 0580 - [redacted]	2. MTF Loc. IZ			
3. Register Number [redacted] b(6)-4	Name (Last; First, MI) [redacted]		4. Pay Grade FGN	5. Sex M
6. DoB (YYYYMMDD)	7. Age at Admission	8. Race Z	9. Ethnicity 9	Religion
10. Length of Service	ETS	11. FMP 99	12. Social Security Number [redacted] b(6)-4	
Organization (Active Duty Only)		13. Marital Status Z	Hour of Admission 20:23	Branch / Corps:
14. Flying Status	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES		16. Zip Code of Residence:	
17. Unit Location	18. MOS	19. Trauma DIS	Prev. Admission NO	
20. Source of Admission Direct from ER	Ward: ICW1	Name / Relationship of Emergency Addressee Address of Emergency Addressee		
Name and Location of Medical Treatment Facility: 0580 - 28th CSH - Iraq; No Install Provided		Telephone Number of Emergency Addressee		
21. Type of Disposition TRF-OTH	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2003-10-19		
24. Clinic Svc - Admitting AEA - ORTHOPEDICS	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-10-16		
27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission 2003-10-16		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: RIGHT ANKLE SPRAIN

Procedure Narrative(s):

Cause of Injury Narrative:

Dx 84500
E9289
Trauma 9
Inj 999

b(6)-2 [redacted]

Admitting Officer (Signature, as required) [redacted] [redacted] of Admitting Clerk

Automated Facsimile - DA FORM 2985, MAR 2000

Automated Facsimile

INP. .ENT TREATMENT RECORD CO. . . SHEET

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

b(6)-4

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

4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm
M	15Y	X				NO

11. FMP	12. SSN	13. Organization	14. Ward
99	[redacted] b(6)-4		ICW1

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

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	20:36	AEA - ORTHOPEDICS

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	TRF-OTH	2003-11-02

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-10-19	[redacted]

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
0580[redacted] b(2)-2	2003-10-19	

31. Selected Administrative Data

Marital Status: DoB: 1988-03-01

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

S/P L FEMUR X-FIX

820.31
792.1
E991.2

19 Oct 03 { 78.15, 79.65, 48.23

22 Oct 03
86.28
86.59

b(6)-4

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	16	16

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	[redacted]	0	0	16	16

Signature of A[redacted]fficer	Signature of PAD or Medical Records Officer
[redacted]	.MAJ [redacted]

Automated Facsimile - DA FORM 3647, May 79

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

16yo Iraqi male EPW by GSW buttock (L), exit (L) hip. Occurred at 1300 today. BIB EMT 2030 for CM. Pt c/o (L) hip pain.

Denies other pain.

[illegible]

PHYSICAL EXAMINATION

[illegible] HN WD T = [illegible]
NAD. Cooperative
Neck Veins
Chest CTA anteriorly
Abd soft NT/ND. [illegible]
Ext: (L) hip deform. (L) DP/PT 2+ [illegible]
Pelvis: [illegible], [illegible] by exam, but [illegible] (L) [illegible]

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

A/ GSW (L) hip [illegible]

P/ [illegible]
Pro to

b(6)-4

SI[redacted]	ATE	IDENTIFICATION NO.	ORGANIZATION

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

REGISTER NO.	WARD NO.

[redacted] b(6)-2

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

b(2)-2

AUTHORIZED FOR LOCAL REPRODUCTION

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

[redacted] APO AE 09234 OPERATION IRAQI FREEDOM BAGHDAD, IRAQ

19 OCT 2003 — REASON FOR VISIT

TIME 1945 — S 16 yr old M IRAQI shot in (L) hip — by RPG, entrance wound anterior, exit wound posterior, Initial assessment possible Socket fracture & dislocation

T

HR 130

RR

BP

O2 SAT

Brought in by 2/3 for assessment / XR

(L) thigh & soft dressing DNVI

Lungs CTAB

PMHx — CV S,S,RRR tachy

ABD soft bladder distended

PSHx — Rectal wl tone (+) BRB

MEDICATIONS — Toradol, Ancef

ALLERGIES

App 1640 or EPW with (L) hip GSW, possible fracture

- Foley catheter placed
- Requires evac to CSH for surgical eval

TOBACCO

[redacted] b(6)-2

b(6)-4

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

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

NAME [redacted]

SSN DOB UNIT

[redacted]

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

USAPA V2.00

MEDICAL RECORD	PROGRESS NOTES	AUTHORIZED FOR LOCAL REPRODUCTION

DATE	NOTES
190503 2356	Orthro Op Note
	Pre Op Dx - (1) GSW with open (L) femur fx (2) ? Rectal injury
	Post Op Dx - (1) GSW with open (L) femur with fracture
	Procedure - (1) Proctoscopy (2) I+D (L) femur (3) Application of opening x-fix (L) femur
	Surgeon: [illegible] / Bratumoto Anesthesia: [illegible]
	Findings: EBL - <50 Fluids 2000 cc LR, 1000 cc NS
	Proctoscopy WNL. No evidence of rectal injury. Comminuted soft tissue - intraarticular fracture. I+D done, 6 liters. Opening x-fix from ankle crest to femur. Good reduction under fluoroscopy.
	Plan: Repeat I+D in 48-72 hours. DVT PPX

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

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

REGISTER NO.	WARD NO.

[redacted] b(6)-4

b(6)-2

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
20 ~~Oct~~ 03 0100	Pt admitted to ICW1 from [redacted] ICU-3 via litter in stable condition; All VSS, pt alert but drowsy & responds accordingly; Ⓓ c/o pain @ this time; Ⓐ CMS to LE, +2 PP, brisk cap Ref; Ext Fix in place; dsg intact, dsg reinforced d/t sanguinous drainage; S.S2, LS CTA Ⓑ, equal & unlabored; Ⓐ BS x4, [redacted] S/L [redacted] to Ⓛ FA patent, PIV to Ⓡ FA patent, infusing LR @ 125cc/hr S/Sx infection/infiltration; Restraints in place, Ⓐ circ, Ⓐ skin break, cont to monitor. [redacted] b(6)-2
20 Oct 03	0945 - Assumed care of pt @ 0100. VSS - A+O. PERRLA, LS CTA Ⓑ, Resp. even, unlabored, abd. soft, non-tender. BS x4. Foley to gravity, intact draining clear yellow urine. Ext. fix in place to Ⓛ hip + LE. Dr'sng saturated c̄ blood re-enforced x 2 c̄ hemex. Pt. c/o pain. medicated c̄ TI Percs Ⓐ Results. Pt. OOB → chair @ this time. Ⓐ CMS to Ⓛ LE, Ⓐ Pedal pulses, pt. has no c/o pain @ this time. HL Ⓛ Bicep IV @ 125cc/hr LR in Ⓡ FA. CDI c̄ Ⓐ S/Sx inf. Will cont. to monitor pt. [redacted]
1400	Re-enforced dr'sng. applied compact bandages + wrapped Kerlex around [redacted] Will cont. to monitor. [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			
	LAST	FIRST	M	(SSN or Other)
		b(6)-2		

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	

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

REGISTER NO.	WARD NO.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1)
USAPA V1.0

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
1800	- Pt. c/o pain. 5mg MSO4 given [redacted]
20 OCT03	Pt received @ 0600 hours VSS LS CTA (B), S_1, S_2
2200	present (+) BS x4 quads. Pt FTG Draining (YO). (D) LE c̄ Ex fix and bulk gauze Drsg. Drsg has Sero Sang Shadowing. No increase since start of shift. Pt c/o pain controlled c̄ percocet p̄ MSO4. Will [redacted] to monitor. b(6)-2 [redacted] 91WM6
21OCT03	(1535) Assumed care of pt @ [redacted] p̄ report from night shift. Pt alert, speaking Arabic. VSS. Ø c/o pain. Pt OOB to chair - tol. well. Drsg to LLE Δd. Penrose drain intact draining mod. amount sero sang drainage. Pin care done. Ex fix in place. Pt able to move LLE. Skin warm to touch. Cap refill <3secs. (+) pedal pulse equal bilat. SL in (D) forearm flushes well s̄ S/Sx infection/infiltration. Tol. reg diet well. Foley draining quantity sufficient clear yellow urine. 2-point restraints in place s̄ S/Sx ~~infection~~ [redacted] complications. Will continue to monitor. b(6)-2 [redacted] UJA
21OCT03 @	Pt laying in bed. c/o (D) leg pain. Medicated c̄ 5mg MSO4.
2053	Pt (+) ~~cont~~ c/o pain. Pt temp @ 1840 102°. Medic ~~@~~ 650mg Tylenol. Rechecked temp @ 2050 101.2. DSG to (D) leg CDI. (+) foley draining clear yellow urine. Lung sounds clear through all lobes (+) bowel sounds. [redacted] b(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
22 OCT 03	Arthro Op Note
1001	
	Pre-Op Dx: Open (L) fracture foot
	Post-Op Dx: Same
	Procedure: I&D (L) foot, fasciotomy, DPC wound
	Surgeon [redacted]
	GAS w/ MIV
	Findings – Devitalized & fibrotic. Wound closed in layers over penrose
	Plan: IV ABX, pain rx, [redacted] CDL OK
	b(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
22 OCT 03@0900	Pt. sitting up in bed, A&O×3. DRSNG to (L) thigh CDI. Pin care done. Temp=100.9°F, HR=120 BPS. Other V.S.S. Pt. has no C/O pain at this time. All other assessments WNL. Will continue to monitor temps & pain. Pt. is to go to OR this AM. EPW protocol in use for restraints. Ø signs of skin breakdown. — b(6)-2 [redacted] 2LT, AN
22 OCT 03@1000	Pt. to OR via stretcher. — [redacted] 2LT, AN
22 OCT 03@1800	Assumed care of pt. Pt denies C/O pain percocets 2 tab P.O given. (R) FA IV intact and patent infusing LR @ 100 cc/hr. Will keep pt NPO dinner. Lungs clear bilateral. BS(+) x4 quad. Abd soft non-distended. (L) LE ↑ on folded blankets. Pedal pulses +2 & capillary refill <3 sec to toes. (L) LE Ex fix pin sites without crusting or drainage. Will continue care as planned. — b(6)-2 [redacted] 2LT AN
23 OCT 03@1500	Pt. OOB in chair & (L) leg elevated. Pin care done. V.S.S. Ø C/O pain at this time. DRSNG to (L) thigh CDI. All other assessments WNL. Foley draining clear yellow, good output. EPW restraint protocol in use, Ø signs of skin breakdown. P.T. consult tomorrow. — b(6)-2 [redacted] 2LT, 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.
[redacted] b(6)-4		CWA

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
			[redacted]

DATE	NOTES
(2000) 23OCT03	Pt lying in bed, VSS, Ø c/o pain, (L) thigh ex-fix intact, pin care done. Pt able to move extr. (+) pedal pulses, cap refill <3 sec. skin: warm & pink. Foley draining ayu. QS. 2 pt restraints on ∃ compromise to skin or circulation. Will cont to monitor b(6)-2 [redacted] 91WM6.
24OCT03 @1100	Pt. OOB → chair, legs elevated, Pt. taught to do own pin care. DRNG to (L) thigh CDI, Pain controlled ∃ PRN percocet. Foley D/C'd, clear amber urine. New IVSL to (R) AC. V.S.S. Ø c/o pain @ this time. All other assessments WNL, Will continue to monitor. b(6)-2 [redacted] RLT, RN.
(2100)	Pt awake, speaking arabic, pain controlled ∃ Percocet. (L) thigh ex-fix intact, pin care done drsg. reinforced due to saturation. OOB to chair x1. (+) pedal pulses (+) movement to digits, brisk cap refill. IV HL'd to (R) AC. Ancef cont per MD orders. 2 pt restraints on ∃ compromise to skin or circulation. monitoring [redacted] 91WM6
(2200)	Pt voided 1100 cc med. yellow urine [redacted] 91WM6
25OCT03	(1515) Assumed care of pt. @ 0000 ∃ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled ∃ Percs. Ex fix in place on UE. Pin care done. Pt OOB to chair-tol. well. SL in (R) ac flushes well ∃ s/sx infection/infiltration. Drsg to (L) thigh ∆d-sutures intact. 2-point restraints in place ∃ s/sx complication will cont. to monitor. [redacted] 91WM6 b(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

[redacted] b(6)-4

b(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
25 OCT 03 0130	Assumed pt care @ 1900 hrs. A&O VSS Denies Pain [redacted] @ this time. Pt refuses to eat. LLE Ex fix in place. Pin care Done. SL in R AC flushes and patent. [redacted] continue to monitor. [redacted] Spc. 91WM0
26 OCT 03	(1455) Assumed care of pt @ 0000 ~~p~~ report from night shift. Pt alert, speaking Arabic. VSS. 0 c/o pain. Pt OOB to chair c̄ min. assist. from staff. Tol well. Pin care done to ex. fix on LLE. Pt able to move toes on LLE. ⊕ pedal pulse equal bilat. IV in R ac dkd d/t infiltration. 20g IV started in L forearm flushes well s̄ sx infiltration. Drsg to LLE ad - sutures to wound intact c̄ scant amount of sero-sang drainage. 2 point restraints in place s̄ sx complications. Will cont. to monitor [redacted]
27 OCT @ 0315	Pt laying bed. Pin care to ex-fix completed. ⊖ s/sx of infe. sutures to wound well approximated & intact. Med c̄ 2 perc 2° c/o pain. Will continue to monitor. Tole regular diet voiding s̄ difficulty, Pt able to move toes, ⊕ pedal pulse, ⊖ excess Refill. [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)
		b(6)-2		

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.
# [redacted] b(6)-4		ICW #1

PROGRESS NOTES
Medical Record

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

b(6)-4

LAST NAME	NAME	M	ALIEN NUMBER
EPW [redacted]			

DATE	NOTES
~~27OCT03~~ [redacted] b(6)-2	
27OCT@ 1600	Pt. resting quietly in bed, A&O x3, V.S.S. Pt. C/O pain to stomach, ⊕BS all 4 quads, abdomen soft, non-distended. Ø C/O pain to (L) LE. DRSNG to (L) femur ex. fix. CDI. Pt. performed own pin care. All other assessments WNL. Pt. in 2 point restraints, Ø signs of skin breakdown. b(6)-2 [redacted] 2LT, AN
28OCT03 0200	[redacted] Assumed care of Pt @ 1800 hrs. A&O speaking Arabic. VSS LLE Ex Fix in place c̄ Kerlix Dresg on pins and under Ex fix. Dresg CDI. Pt completed pin care. Pain controlled c̄ percocet. Will cont. to Monitor. b(6)-2 [redacted] Spc 91WM6
28OCT03	(1615) Assumed care @ 0000. Pt alert, speaking Arabic. VSS. Ø C/O pain. Pt amb to BR c̄ walker well. OOB to chair. Tol. well. Sutures intact to lac. on LLE. Pin care done to ex fix. 2 point restraints in place s̄ s/sx complications. SL in (L) forearm flushes well s̄ s/sx infection/infiltration. Will cont. to monitor. b(6)-2 [redacted] 2LT AN
28OCT03@0240	Assumed care @ 1800; All VSS, pt A&O speaking arabic, ⊕ CMS, brisk cap ref, +2PP, NV intact to (L) LE; pt OOBTC for 2 hours, TOI well; pin care provided c̄ Kerlix wrapped to pins, pain controlled c̄ perCet; Restraints in place, ⊕ circ, ⊖ skin break ↓, cont to monitor [redacted] b(6)-2
29 OCT03@1600	Assumed care of pt. @ 0600. Pt. performed own pin care in AM. V.S.S. A&O. Ø C/O pain this shift. Pt. ambulated c̄ crutches during P.T. consult for first time since admission. Dressing to (L) thigh CDI. Pt. in 2-point restraints, Ø signs of skin breakdown. All other assessments WNL. Now IVSL to (L) AC, flushes well. [redacted] 2LT, AN

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

b(6)-2

b(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
29OCT03 2200	Assumed care of Pt @ 1800. Pain controlled c̄ percs. Ancef ran @ 2000. Pt completed ~~of~~ self pin care @ 2200hr. VSS HL on (L) FA Flushed & Patent. Will continue to monitor. — [redacted] RC 91WM6
30OCT03 @ 1800	Assumed care of pt. @ 0600, V.S.S., A&O, Ø c/o pain. DRSNG TO (L) thigh CDI, pt. performed own pin site care. Pt. ambulated c̄ crutches into hallway c̄ PHYS. THER. Pt. in 2-point restraints Ø signs of breakdown to skin. All other assessments WNL. Will cont. to monitor. — b(6)-2 [redacted] RC AW
30OCT03 2200	Assumed care of Pt @ 1800. A&O. Pt Denies pain. Pt reading qS c̄ ill & difficulty WBE Ex Fix in place [redacted] 2 pulse skin warm & Dry to palpation. Drsg CDI. Pt [redacted] pleted self pin care. Will continue to monitor. — [redacted] RC 91WM6
31Oct03 1630	Assume care of Pt @ 0600. A&OX3, VSS Ø c/o pain. Acad drsg to (L) leg. pin care done as well. Ambulated up and down hall. Drsg CDI. In 2 pt restraint Ø Skin irritation. Will cont. to monitor. — [redacted]

b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

EPW Pt [redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

USAPA V1.00

LAST NAME	NAME	MI	ID NUMBER

DATE	NOTES
1 NOV @ 0020	VSS. A/O. c/o pain. Med c̄ 2 perc. Will continue to monitor. Pin care completed. Pins ~~from~~ proximal to torso has sm amount of yellow purlent drainage. Cleaned site + ~~covered~~ wrapped pins c̄ gauze. Sutures ⊖ s/sx of infection, well-approximated. Pt cont IV Abx. Urinating c̄ difficulty. [redacted] b(6)-2 4/AW
1 Nov 03 @ 1750	Assumed care @ 0600, All VSS, pt A&O speaking arabic; ⊘ c/o pain or discomfort @ this time; pin care completed by pt c̄ assistance from staff; pt verbalized understanding on how to perform & the importance of pin care; ⊖ drainage noted; pins wrapped c̄ sterile 4x4; sutures c/d/I, well approximated, ⊖ s/sx infection; s/t patent, easily flushes, pt tol Reg diet well; cont c̄ IV abx; Restraints in place ⊖ c/c, ⊖ skin breakdown, cont to monitor [redacted] b(6)-2
1 NOV 03 1900	Assumed care of pt @ 1800. A&O. (R) FA IV Saline lock patent and intact. Consumed Regular diet for dinner. Pin sites to (L) LE without drainage or crustate. Sutures to (L) LE intact with incision edges well approximated. Urinary clear yellow urine. Will continue care as planned. [redacted] b(6)-2
2 nov 1100	Pt a/o, VSS, medicated c̄ percocet for pain. (L) thigh ex-fix intact, pin care done. ⊘ drainage noted. Sutures to (L) LE intact & well approximated. (R) FA IV patent. IV Abx cont. ⊕ pulses, equal bil. awaiting Tx to 21st CSH. 2 pt restraints on while in bed ⊖ compromise to skin / circulation. Will monitor. [redacted] AWME

STANDARD FORM [illegible] (REV. 5/1999) BACK
USAPA V1.00

[redacted] b(6)-2

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)* | TIME

TRANSPORTATION TO FACILITY

SEX: M

DUTY/LOCAL PHONE: AREA CODE | NUMBER

HOME PHONE: AREA CODE | NUMBER

AGE: 15

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: PO Dones

ALLERGIES: PO Dones

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: Pain to Lt Hip

CATEGORY OF TREATMENT

☐ EMERGENT

☒ URGENT

☐ NON-URGENT

TIME: 2041

INITIALS: CLT

VITAL SIGNS

TIME	2042	2100			
BP	145/42	113/42			
PULSE	101	104			
RESP	14	14			
TEMP	100.3	100.3			
WT					

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

☒ PULSE OX — 96 RA

☐ MONITOR

☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
2100	UA		[redacted]		b(6)-2
2100	CBC, chem 12, PT, PTT				

DISPOSITION: ☐ HOME ☐ FULL DUTY

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

MODIFIED DUTY UNTIL

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ | TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

[redacted] b(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

NSN 7540-01-075-3786

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

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

16 yo Iraqi EPW ♂ s/p GSW to (L) femur. Pt stabilized in field + brought here. Currently c̄ pain @ (L) Superior femur.

PE: USS, gen AAO x 3 — Fast c̄ ? Fluid in (L) Pelvis/ow/kg -
CV: RRR ⊘ VM — abd: soft, flat, NTP, (+) BS, ND
lys: CTA (B) — Neuro: ⊘ focal deficits. gwoc (D) (+) Stad on card, ⊘ frank blood
ext: (L) femur/upper leg c̄ GSW through lat thigh, no obvious exit wound, (+) area on (L) buttocks of small wound, under if exit wound, N-V intact.

Last Meal 0800

CONSULT WITH	TIME	ACTION
Ortho	2115	

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

b(6)-2

PROVIDER SIGNATURE AND [redacted]

DIAGNOSIS

GSW (L) leg - Proximal femur

CODE

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

[redacted] b(6)-7

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

MEDICAL RECORD	PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT FOR Use this form. See AR 40-407: the Proponent agency is The Office of the Surgeon General.
1. AGE 15 HEIGHT: WEIGHT: 115	2. KNOWN ALLERGIC SENSITIVITIES (e.g.. Iodin, Tape, Medication) [X] NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD REACTION: 3. PREVIOUS SURGERY [X] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE: T&S
Proctoscopy
I&D U. Femur Application of Ex Fix Guiac +

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition ____
Tobacco Ø ppd X ___ vrs Body Piercing ____ Diabetes (Y) (N) ROM ____ ASA/Motrin W 72hrs (Y) (N)
ETOH Ø Implants ____ Respiratory Disease (Asthma COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures ____ Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL Y potential for anxiety related to: X 1) Surgical Procedure& Operating Room Environment ___ 2) Separation Anxiety (Child) X 3) Surgical Outcomes	Ø Pt. verbalizes any specific anxiety. Ø Pt. Exhibits relaxed body posture.	Ø. Allow pt. to verbalize freely. Ø. Explain Or environment and answer questions regarding surgery. Ø. Offer comfort measures. (e.g. warm blanket. touch). Ø. Explain all nursing procedures before they are done. Ø. Remain with pt. Whenever possible. Ø. Maintain family interface. Parents to stay with pt.
B. AERATION X Potential for respiratory dysfunction due to: X 1) Positioning X 2) Effects of Anesthesia ___ 3) Medical/Smoking History	Ø Pt. will be able to breath without difficulty during immediate intraoperative phase.	Ø. Offer to elevate head of litter or offer pillow. Ø. Observe pt. While awaiting surgery for signs of distress. Ø. Assist anesthesia during intubatior and extubation.
C. INTEGUMENT X Potential Impairment of Skin Integrity due to: X 1) Intraoperative Immobility X 2) ESU Pad Placement X 3) Positional Aids ___ 4) Prosthesis X 5) Pooling of Prep Solutions	Ø Pt. will exhibit signs of impairment of skin integrity (e.g., reddened areas).	Ø. Utilize pressure preventing devices on OR table and accessories. Ø. Check for proper positioning and support to maintain good body alignment. Ø. Pad pressure points. Ø. Place ESU ground pad on non compromised skin surface area. Ø. Keep prep fluids form pooling.

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

H[redacted] 1540 ♂ 6(6)-4

[redacted]

GSW to (L) thigh

VERIFICATIONS AT HOLDING AREA:

! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since____ ! Jewelry Removed
! UHCG/LMP ! Body Pierce Removed
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact precautions (Y) (N)
! Family/Friend:____

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION X Potential for inadequate tissue perfusion due to: X 1) Intraoperative Mobility X 2) Positioning 3) Existing Disease X 4) Safety Devices X 5) Hypothermia	Ø. Pt. will exhibit signs of adequate tissue perfusion (e.g. color, warmth. pedal pulse.	O Check foe support stocking or ace warps. if none, check with doctors. Ø Check that safety straps are correctly applied. Ø Offer pillow for under knees. O Place and take down legs from stirrups with slow bilateral motion. Ø Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.I. X Potential Impairment of Mobility due to: X 1) Pain X 2) Intra operative Hazzards X 3) prosthesis X 4) Positioning X 5) Transfer pt. To/form OR table E.2. X Potential Discomfort Due to: X 1) Length of Surgery X 2) Positioning 3) Arthritis	Ø pt. will be transferred to OR table without difficultly. Ø pt. will be not experience unnecessary physical discomfort.	Ø Have sufficient people available for transfer. Ø Insure proper body alignment. Ø Allow patient to lie in position of comfort while waiting for surgery. Ø Offer support (i,e..pillows. Bath towel. etc) for positioning.
F. Special Senses F.I. X Diminished visual perception due to being: X 1) pre-medicated 2) W O GLASSES F.2. X Potential for Decreased Communication due to: X 1) Diminished Hearing X 2) Language Barrier F.3. Potential Injury due to Dentures: 1) Upper 4) Caps 2) Lower 5) Crowns 3) Bridges	Ø pt. will be made aware of surroundings prior to anesthesia induction. Ø pt. will be transferred safely to OR table. Ø pt. will be able to understand instructions. Ø Minimize danger of injury during intraop period.	Ø Introduce self. keep pt informed as to where he. she is and what is happening. Ø Inform pt. in which direction to move and assist if necessary. Speak clearly and slowly. O Address pt. from Either side. Ø Validate pt.'s understanding of verbal communication. O Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS OR Continuation of Above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS OR continuation of above interventions.

b(6)-2

10. OR NURSING INTERVENTION COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTIONS NOTED.

[redacted] CPT/AN 19 Oct 03 DATE

11. POSTOPERATIVE EVALUATION : SKIN INTEGRITY: Bovie Pad Site: ☒ Clean and Dry ☐ Red ☐ N/A DRESSING DRY & INTACT: (Y)(N)

LEVEL OF CONSCIOUSNESS: ☐ A&O ☒ Drowsy ☐ Sleepy ☐ Intubated BREATHING EASY: (Y)(N)

LEVEL OF ACTIVITY: ☒ MOVES ALL EXTREMITIES ☐ Moves Upper Extremities ☐ Transferred to Litter With roller due to spinal

12. PREOPERATIVE EVALUATION PREPARED BY (Signature/Title) [redacted] CPT/AN DATE: 19 Oct 03 TIME: 2115

13. PREOPERATIVE EVALUATION PREPARED BY (Signature/Title) [redacted] CPT/AN DATE: 19 Oct 03 TIME: 0010

REVERS OF FORM 5179, JUN 91 USAPA V1.0

b(6)-2

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING R[illegible]
VIA Litter BY anesthesia

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

3. DATE 19 Oct 03 TIME PATIENT ARRIVED IN SUITE 2200

4. PATIENT IN ROOM [illegible] TIME 2200 NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Unable to speak or understand English

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

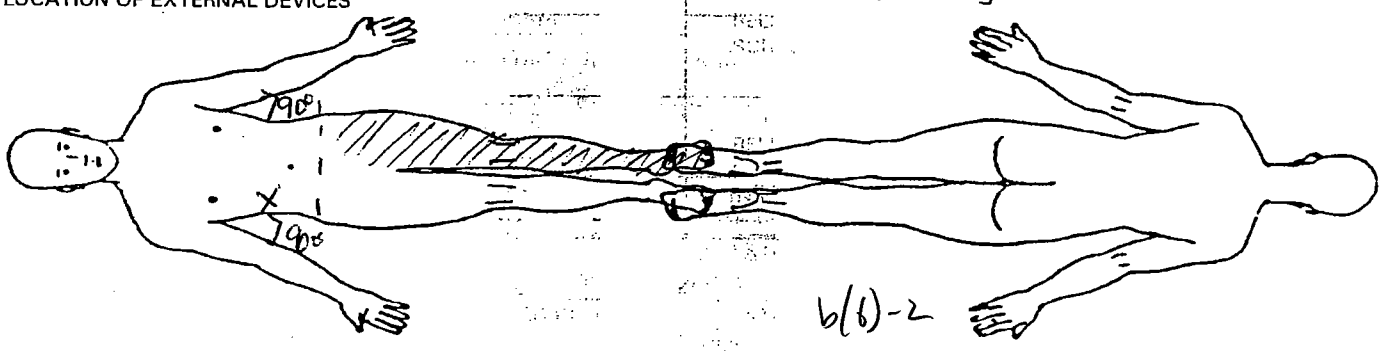
COMMENTS: Proper body alignment maintained. Bump under Lt. hip

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine scrub/sol'n
SITE: Rt. leg BY WHOM: Meyer
SITE: BY WHOM:
COMMENTS: No pooling of fluids

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect Initial C [redacted]

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

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

[redacted] b(6)-4
15 yo ♂
Luay Qusay Qasim
GSW to (L) thigh

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

☒ ESU NO: Force 40 RBE 10530S 40/40
GROUND PAD: BRAND Valleylab REM
LOT NO: 68245

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

13. PROSTHESIS, IMPLANTS ☒ YES ☐ NO IF YES NAME: ID NUMB NUFACTURER

#50186180 pins X6

Hoffman II Lead # 0629201

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY
None		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☒

TYPE/SIZE	1. 3/8 Penrose	2.	3.
SITE	1. Lt. Femur	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs
Kerlix
Abd

19. ADDITIONAL INFORMATION

Surg: [redacted] Anesth: ~~Stas~~ CRNA Anesth. Type: General

Observer [redacted] (MP)

b(6)-2

Foley in place RTA

20. OPERATION(S) PERFORMED

1. Proctoscopy
2. I & D Lt. Femur
3. Application of Ex Fix

21. PATIENT TRANSFERRED TO PACU b(6)-2 TIME 0007 METHOD Litter

22. [redacted] CPT/AN

MEDCOM - 21660

REVERSE OF DA FORM 5418 * OCT 87

USAPA V1.00

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING [illegible]
VIA Litter BY Anesthesia

2. PATIENT IDENTIFIE[illegible] REVIEWED AND PROCEDURE VERIFIED BY ILT [redacted]

3. DATE 22 OCT 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM [redacted] TIME 1015 NUMBER ~~2-2~~ 1-4 #2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: ∅ concerns voiced

b(6)-2

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: correct body alignment maintained, arms on padded armboards at less than 90°, position approved by anesthesia + surgeon

8. SKIN PREPARATION

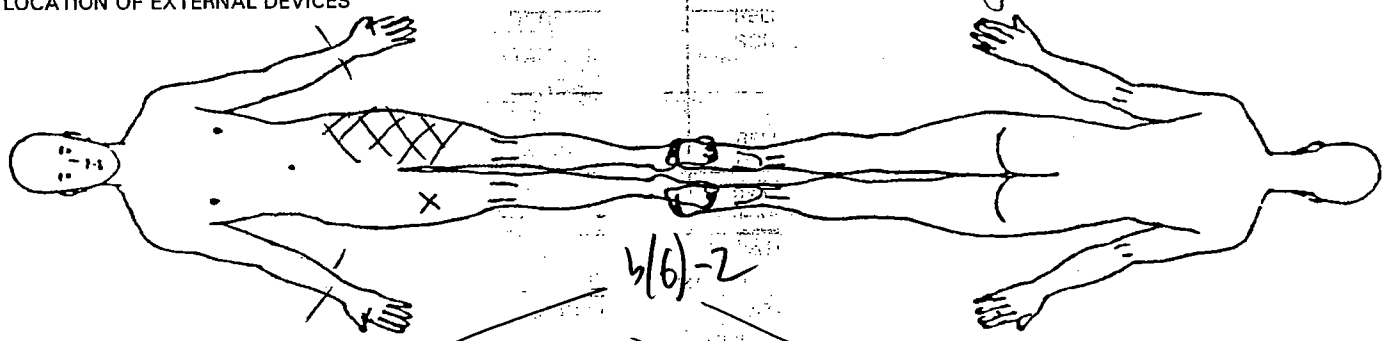
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine / Betadine
SITE (L) Leg (thigh, hip) BY WHOM: Humphrey
SITE: BY WHOM:

COMMENTS: no pooling or skin Δ's noted

9. LOCATION OF EXTERNAL DEVICES



b(6)-2

LEGEND X Ground Pad [redacted] -- Safety Strap [redacted] = = = Tourniquet ☒ prep area

INITIAL [redacted] C = Correct I = Incorrect

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

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

[redacted] b(6)-4

[redacted] b(2)-2

22 OCT 03

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

☐ ESU NO: Valleylab Force 40
GROUND PAD: BRAND 68245-2005-02
LOT NO: VL Rem Polyhesive II

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

13. PROSTHESIS, IMPLANTS ☐ ☒ NO IF YES NAME: ID NUMBE NUFACTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY
none		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 3/8 in Penrose	2.	3.
SITE	1. (L) Femur	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs
~~Kerlix~~
Tape

19. ADDITIONAL INFORMATION
Surgeon: [redacted] b(6)-2
Anesthesia: [redacted]
-5179 on chart, Ø 4's noted

-DA 5179 in Chart ✓

20. OPERATION(S) PERFORMED
I+D (L) Femur
b(6)-2

21. PATIENT TRANSFERRED TO PACU TIME See DA 7389 METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] CPT ATN

MEDCOM - 21662

REVERSE OF DA FORM 5179 [redacted] OCT 87 USAPA V1.00

NSN 7540-00-63

-119

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY

19 HOUR

PULSE (0) | TEMP. F (•) | TEMP. C

105° 104° 103° 102° 101° 100° 99° 98.6° 98° 97° 96° 95°

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

40.6° 40.0° 39.4° 38.9° 38.3° 37.8° 37.2° 37.0° 36.7° 36.1° 35.6° 35.0°

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

O2

O2 Source

20 Oct	20 Oct		21		22		23	24	24		25	
166/61	134/90	135/80		122/72	135/71		113/77	129/74	120/78		124/64	116/69
		116			144							91
		100										98.3°
		97%			96%			99%				
98% RA	100% RA	RA	99% (RA)		98% RA	98% RA	95% RA		98% (RA)		98% (RA)	97% RA
							97% (RA)					

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

REGISTER NO.

WARD NO.

[redacted]

b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY: 26, 27, 28, 29, 30, 31, 1/2 NOV

19 HOUR

PULSE (O) — TEMP. F (°) — TEMP. C

105° 40.6°

180 104° 40.0°

170 103° 39.4°

160 102° 38.9°

150 101° 38.3°

140 100° 37.8°

130 99° 37.2°

98.6° 37.0°

120 98° 36.7°

110 97° 36.1°

100 96° 35.6°

90 95° 35.0°

80

70

60

50

40

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

	26		27		28		29		30		31		1/2 NOV	
Blood pressure	127/74	130/62		135/62	113/71			114/52			102/6	114/63		116/70
		97		99		120/68		103			98.7	97.6	124/74	
		98.9		97.9				98.8			97	92		
				98%				99%						97%
	99% (RA)	99%	98% RA		99% (RA)	99% LA	99% RA		99% RA		98%	97%	98%	(RA)

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

[redacted] b(6)-4

REGISTER NO.

WARD NO.

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

b(6)-4 b(6)-2 b(6)-4

Ward/Section: EMT | REQUESTING PHYSICIAN: Dr. [redacted]

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

LAST, FIRST MI: [redacted] | DATE: 19 Oct 03 | TIME: 0109 | SSN/PSEUDO-SSN: [redacted]

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10³
R		
H		
H		
M		
Pl		
L		
S		
B		
L		
Atyp		Imm
RBC Morpl		
Spun Hemat		
Sed Ra		
Other		
TES		
PT		
APTT		
D dim		
FDP		
REM		
REPC		

[redacted]

			Patient	Limits
WBC	12.1 H	x10^3/uL	4.5	10.5
RBC	3.56 L	x10^6/uL	4.00	6.00
Hgb	9.3 L	g/dL	11.0	18.0
Hct	29.9 L	%	35.0	60.0
MCV	84.0	fL	80.0	99.9
MCH	26.1 L	pg	27.0	31.0
MCHC	31.1 L	g/dL	33.0	37.0
Plt	317.	x10^3/uL	150.	450.
LYM	15.4 *L	%	20.5	51.1
LYM	1.9 *	x10^3/uL	1.2	3.4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/19/03 21:41

Patient ID [redacted] b(6)-4
Test Name :PT
Test Result:= 13.4 sec
Ratio = 1.1
Calculated INR = 1.16
Sample Type:citrated wh. blood
Test Date :10/19/03
Test Time :21:39
Card Lot [redacted]
Operator [redacted] b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/19/03 21:45

Patient ID [redacted] b(6)-2
Test Name :APTT
Test Result:= 29.9 sec.
Sample Type:citrated wh. blood
Test Date :10/19/03
Test Time :21:43
Card Lot [redacted]
Operator [redacted] b(6)-2

Urinalysis

TEST	RESULT	REF. RANGE
Color	Straw	N/A
Appr	Clear	N/A
Glu	Neg	Negative
Bili	Neg	Negative
Ket	Trace	Negative
SG	1.010	N/A
Bld	Trace	Negative
pH	6.5	N/A
Prot	Neg	Negative
Urob	0.2	0.2-1.0
Nit	Neg	Negative
Leuk		Negative
		Negative

CSF

		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

rbc -0-5

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

TYPE	CROSSMATCH

LAB ID NO.:

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

(I-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

b(6)-2

=======[redacted]======

19/10/03 21:16

REFERENCE RANGE: MALE

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

GENERAL CHEMISTRY 12

DISC LOT #: [redacted]

OPER #: [redacted] DR #: 000

SERIAL #: b(6)-2 [redacted]

ALB	3.8	3.3-5.5	G/DL
ALP	195*	26-84	U/L
ALT	22	10-47	U/L
AMY	29	14-97	U/L
AST	39*	11-38	U/L
TBIL	0.6	0.2-1.6	MG/DL
BUN	5*	7-22	MG/DL
CA++	8.8	8.0-10.3	MG/DL
CHOL	78*	100-200	MG/DL
CRE	0.7	0.6-1.2	MG/DL
GLU	123*	73-118	MG/DL
TP	6.7	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK

HEM 1+, LIP 0 , ICT 0

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^+	137	128-145 mmol/l
K^+	4.4	3.3-4.7 mmol/l
CL^-	103	98-108 mmol/l
tCO_2	23	18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)														
FENTANYL	(mcg)	100	100	50	60	25	50	25	25	25	50				
MSO4	(mg)			10											
PROPOFOL	(mg)	160													
SUX	(mg)	100													
	( )														
	( )														
VOLAT AGENT	SEVO % del	3.0	2.5	3.0	2.0	2.0	2.0	1.0	0						
	% e.t.														
AIR	L/Min														
N2O	L/Min														
O2	L/Min	8/2	2	2	2	2	2	2	7/8						

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

TOTALS	TOTAL EBL
500	450
10	TOTAL URINE
	1000

FLUIDS - SUMMARY

CRYSTALLOID- 2000

COLLOID- Ø

BLOOD- Ø

FLUIDS

LINE site														
LR 18 (L)	☐ Warmed		1000-#2				1500		1700					
LR 18 (R)	☐ Warmed		500-#2				1000		1500					
	☐ Warmed													

LOSSES — EST BLOOD LOSS / URINE -

REMARKS

Code drugs with numbers, events with letters

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: 60 (KG) LB

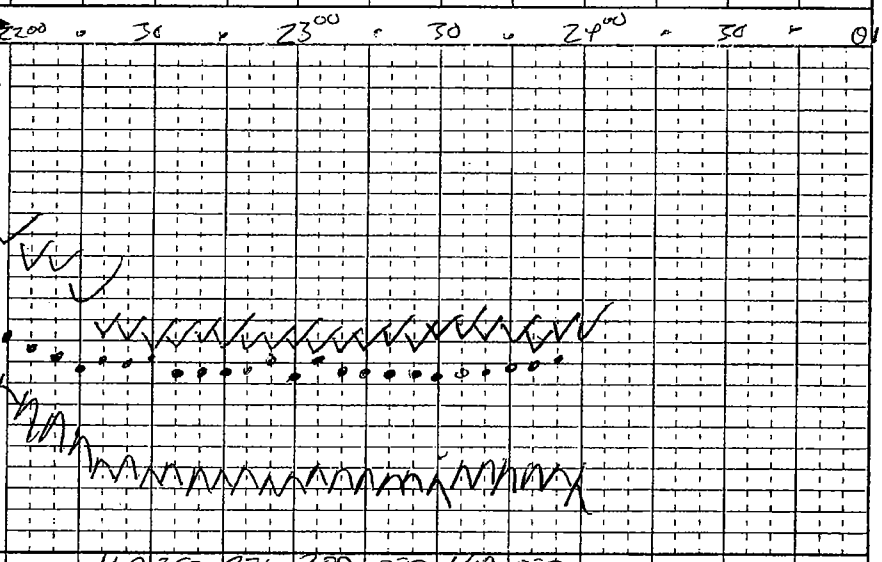
HEMATOCRIT:

INITIAL DATA: BP- 149, 86 HR- 86

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? yes TIME- 2005

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



VENTIL

VT - ml		160	250	370	380	570	640	520
f - breaths/min	16	14	12	6	7	6	7	10
Peak inf pres / PEEP								
MODE - S(pon), A(ssist), C(on)	S/A	S	S	S	S	S	S	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	(+)	61	59	61	61	59	54	61
BP/oth	FIO2 (Frac or %)	.74	.74	.75	.77	.77	.78	.78	.79
ART line	SpO2 (%)	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site	AVAILABLE							
	N-M Block (T/4)	4/4	4/4	4/4	sustained	tetany			
Warming blkt									
Conv warmer									

Mark with letters & symbols, explain under REMARKS EVENTS *Position* → O-1

RECOVERY AT 0010

PACU ICU _____ (Specify)

OTHER _____

CONDITION:

RESP- SpO2-

BP- HR-

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	2145	2200	0020
	Ready	Begin	End
PROC	2210	2130	2400

PROCEDURES and CPT Codes:

(L) Femur Fx

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GETA

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

#[redacted] b(6)-4

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

PRIVOX - Sim. 14 Fr, Rt 2 cricoid pressure, DLXT intact Grade I view, 7.0 ETT, 22cm @ lips (+) BBS (+) ETCO2

SURGEONS: [redacted]

b(6)-2

ANESTHESIOLOGIST: [redacted] CPT, AN, CRNA

PROCEDURE LOCATION: OR 1

DATE: 19 OCT 03

PAGE 1 OF 1

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

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 15 DAYS MOS (YRS) Sex (✓) MALE ( ) FEMALE

Physical State 1 2 3 4 5 (E)

WT: 60 (KG) LB HT: ____ IN.

ALLERGIES: NKDA

PROPOSED PROCEDURE: ____

SURGICAL SERVICE: ____

NPO SINCE: ____

HABITS:

TOBACCO: Ø

ETOH: Ø

DRUGS: Ø

CURRENT MEDICATIONS:

( ) = ordered as premed

( ) Ø

( )

( )

( )

( )

( )

PREMEDICATIONS:

None Yes (@ ____ Hrs) /CC

~~Ign~~ Anet ____ mg IV IM PO

~~Pelamin~~ ____ mg IV IM PO

____ . ____ mg IV IM PO

LABORATORY STUDIES:

HB/HCT: pending

U/A: pending

OTHER: Ø

12.1 / 9.3 / 29.9 / 317

T&S (+)

Guiac (+)

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

Pulmonary System:
- Asthma N Y
- Bronchitis/URI N Y
- COPD N Y
- Other N Y

Renal System:
- Acute/Chronic RF N Y

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

Endocrine System:
- Diabetes N Y
- Steriods N Y
- Thyroid N Y

Neurological:
- Seizures N Y
- Neuropathy N Y
- Other N Y

Gynecological :
- Pregnancy N Y N/A

Other Significant Hx:
- N Y
- N Y

Familial HX N Y

Joining an RPG @ US forces

ASSESSMENT

PAST SURGICAL/ANESTHETIC

Ø

PHYSICAL EXAMINATION

BP 113/78 HR 117 R ____ T ____ 99%

Pain Scale 0-10 ____

HEENT - Teeth intact

Trachea midline

TMJ/Neck FROM

Oropharnyx MP2

Nares

CHEST: CTA (B) =

CARDIAC: RRR (-) R

EXTREMITIES:

IV Access: 18G RA

Ulnar Filling: ____

BACK: ____

OTHER: ____

NPO Since ____

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

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

The patient/[redacted] guardian seems to understand and agrees. Questions answered.

Signed: [redacted] CRNA/MAJ Date: 19 Oct 03 Time: 2126 Hrs

POST-A[redacted]A EVALUATION AND NO[redacted]ON ASU)

{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

b(6)-2

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

SEDATION KEY:

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

NPO
NKDA

MEDICAL RECORD - ANESTHESIA

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

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

DRUG (Units)															
Fentanyl (mcg)	<150>														
MSO4 (mg)		2	2	2	1										
Lidocaine (mg)	70														
Propofol (mg)	200														
Sux (mg)	Ø														
( )															
VOLAT AGENT: Iso % del / % e.t.	1.0	1.8	1.3	0.2	X										
AIR L/Min															
N2O L/Min															
O2 L/Min	10	2	2	2	2	10									
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS →															

TOTALS	TOTAL EBL
150	MINIMAL
7	
70	TOTAL URINE
200	Ø 50

FLUIDS - SUMMARY

CRYSTALLOID- 200

COLLOID- Ø

BLOOD- Ø

FLUIDS

LINE site															
18G (L) A ☐ Warmed	LR #1														
☐ Warmed															
☐ Warmed															
☐ Warmed															

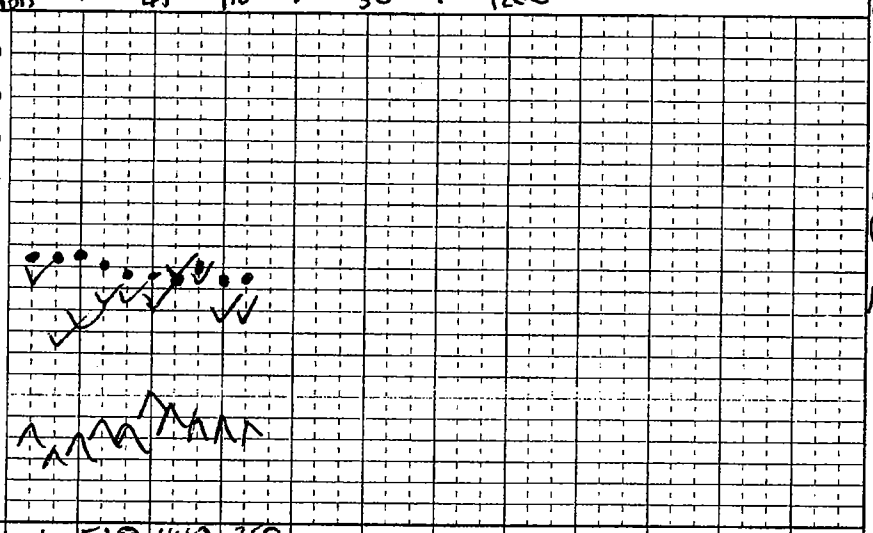
LOSSES															
EST BLOOD LOSS				150											
URINE -				50											

REMARKS

Code drugs with numbers, events with letters

(1) Pre-op assessment Lungs CTA (B) = HRR (E) Lite
(2) OR, O_2 induced eyelids taped closed
(3) SV > 8 + < 30 BPM TV > 4 ml/kg LMA removed w/o complications
(4) To PACU Report to nurse 18G (R) AC placed

PHYS STATUS	TIME → 1015 · 45 · 1100 · 30 · 1200
(A) 1 2 3 4 5 E	
BODY WEIGHT: 60 (KG) LB	SYMBOLS: BP by cuff V ∧; Heart rate ●; Resp rate; BR (transduced) ‡; TOURNIQUET T—⊥; ANES- X-X; PROC- ⊙-Ø
HEMATOCRIT: 29.9	
INITIAL DATA:	
BP- 113/47	
HR- 136	
EQUIP CHECK	
OK?- (Y) N	
PATIENT RECHECK	
OK for PROCEDURE? JA	
TIME- 1030	



VENTIL				
VT - ml	+	510	440	350
f - breaths/min	+	8	14	10
Peak inf pres / PEEP	—	16	—	—
MODE - S(pon), A(ssist), C(on)	S~C	C	S	S

MONITORS/ACCESSORIES					
✓ BP/Auto Cuff	✓ ET CO2 (torr)	—	39	47	51
✓ BP/oth	✓ FIO2 (Frac or %)	0.56	0.56	0.56	0.56
✓ ART line	✓ SpO2 (%)	100	100	100	100
✓ Steth- PC/ES	✓ ECG	ST	ST	ST	ST
✓ Gas analyzer	✓ TEMP-site axilla				
	N-M Block (T/4)				
	BS	+			
✓ Warming blkt	x1 blanket				
Conv warmer					

Mark with letters & symbols, explain under REMARKS — EVENTS → Position (1) (2)

RECOVERY AT	1105
PACU ICU ____ (Specify)	
OTHER	T-99.4
CONDITION:	Stable
RESP- 20	SpO2 98
BP- 137/88	HR- 138

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1000	1015	1115
	Ready	Begin	End
PROC	1025	1030	1100

PROCEDURES and CPT Codes: I+D (L) femur

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GLMA

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

#4 LMA seated PPV sust ETCO2 + BBS

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

[redacted] [redacted]

b(6)-4

[redacted] b(6)-2

[redacted] CRNA

PROCEDURE LOCATION: 1

DATE: 22 Oct 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 — [redacted] HESIA PROVIDER — USAPA V1.00

MEDCOM - 21669

MEDICAL RECORD - DOCTOR'S ORDERS

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

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

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
	POST ANESTHESIA ORDERS (circled Items)		
1	VS q 5 min X 15 min, then q 15 min until discharge.		
2	Supplemental oxygen.		
3	Morphine / ~~Meperidine~~ 2 mg IV now and 2 mg q 3-5 min prn pain for a		
	max dose of 10 mg.		
4	Zofran 4 mg IV prn N/V q 15 min, may repeat x ____.		
5	Metoclopramide____mg IV prn N/V x 1.		
6	Droperidol____mg IV prn N/V x 1.		
7	Phenergan____mg IV prn N/V x 1.		
8	Benadryl 25-50mg IVP q1 hr prn, itching while in PACU.		
9	IV[redacted]____@ 150 cc/hr.		
10	[redacted]om recovery status when PACU discharge criteria met.		
	[redacted] b(6)-2		

PATIENT IDENTIFICATION

[redacted] b(6)-4

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

Diagnosis: _____

Height: _____ Weight: _____ Diet: _____

Allergies: _____

Nursing Unit	Room No.	Bed No.	Page No.
[redacted]			1 of 1

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

b(2)-2

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
Oct 22, 2003 1047	POST ANESTHESIA ORDERS (circled Items)		
1	VS q 5 min X 15 min, then q 15 min until discharge.		
2	Supplemental oxygen. PRN SaO2 <95%		
3	Morphine / Meperidine 2 mg IV now and 2 mg q 3-5 min prn pain for a		
	max dose of 10 mg.		
4	Zofran 4 mg IV prn N/V q 15 min, ~~may repeat x ____~~.		
5	Metoclopramide 10 mg IV prn N/V x 1.		
~~6~~	Droperidol ____ mg IV prn N/V x 1.		
7	Phenergan 25 mg IV prn N/V x 1.		
~~8~~	Benadryl 25-50mg IVP q1 hr prn, itching while in PACU.		
9	IVF: LR @ TKO cc/hr.		
10	Discharge from recovery status when PACU discharge criteria met.		
	[redacted] CRNA/MAJ		
	b(6)-2		

PATIENT IDENTIFICATION

[redacted] b(6)-4

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

Diagnosis: _____

Height: _____ Weight: _____ Diet: _____

Allergies: _____

Nursing Unit	Room No.	Bed No.	Page No.
[redacted]			1 of 1

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

b(2)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4 [redacted]

b(6)-2 [redacted]

Noted 20 Oct 03 0125

NURSING UNIT	ROOM NO.	BED NO.
ICW1		

↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	19 OCT 03	2357 HOURS	
1	TO ICW		
2	S/P (L) FEMUR X-FIX		
3	CONDITION - STABLE		
4	VS - Q SHIFT		
5	BED REST, OOB TO COMMODE		TID
6	REGULAR DIET		

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

↓	DATE OF ORDER	TIME OF ORDER	
7	IV-LR AT 125 cc/HR	HOURS	HEP LOCK
	WHEN TAKING PO, WEAR		
8	CBC IN AM.		
9	PERCOCET 1-2 P.O. Q 4-6 HRS		PRN
10	TYLENOL 650 mg P.O. Q 4 HRS		PRN
11	MSO4, 2-6 mg IVP Q 1 HR		PRN
12	MILOPS + ZOFRAN IVPB Q 8 HRS		04 12 20
13	GENTAMYCIN 350 mg IVPB Q DAY.		

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

↓	DATE OF ORDER	TIME OF ORDER	
14	PIN SITE CARE BID BEGINNING	HOURS	21 OCT 03
	10 AM		
	20 OCT @ 0200	DR [redacted]	
	24° ✓		
	20 OCT @ 0200	[redacted]	
	24° ✓		
		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.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] b(6)-4	[redacted] b(6)-2			22 OCT 03	1110 HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
FCW7	24			(1) Reserve previous orders (2) LR @ 100 cc/hr. Hep Lock when taking P.O. when (3) Regular diet Pin care BID. [redacted] 24 OCT [redacted]		
PATIENT IDENTIFICATION					TIME OF ORDER	
b(6)-4 [redacted]	b(6)-2 [redacted]			[redacted] b(6)-2	HOURS	
NURSING UNIT	ROOM NO.	BED NO.		1 NOV 03	2250	
				RESTART TO [redacted] b(2)-2 [redacted]		
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER b(6)-2 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 ICH 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. 11 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 02	03	04	05	06	07	08	09	10	11	12	13	14
19 OCT 03	[redacted]	VS q shift	08 18	[redacted]												
			18 06	[redacted]												
19	[redacted]	BR, OOB to chair	06 18	[redacted]												
		TID	18 06	[redacted]												
19	[redacted]	Regular diet	06 18	[redacted]												
			18 06	[redacted]												
19	[redacted]	in site care BID	06 18	[redacted]												
		(begin 21 OCT 03)	18 06													
		b(6)-2														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/p @ Femur X. Fix

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO: 2

PATIENT IDENTIFICATION:

[redacted] b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 19	20	21	22	23	24	25	26	27	28	29	30	31	1
19OCT	[redacted]	VS QShift	06 18	X	[redacted]												
			8 66	[redacted]													
19Oct	[redacted]	Bedrest, OOB to	06 18	X	[redacted]												
		Chair TID	18 06	[redacted]													
19Oct	[redacted]	Regular Diet	06 18	X	[redacted]												
			18 06	[redacted]													
19Oct	[redacted]	Pin site care BID	10	X	X	[redacted]											
		Begin 21Oct03	22	X	X	[redacted]											
		b(6)-2															

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P (L) Femur X-Fix

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted] b(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo OCT Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
19Oct	[redacted]	Condition Stable	19Oct	—	0130	[redacted]
19Oct	[redacted]	CBC IN AM	20Oct	0500	0545	[redacted]
2NOV	[redacted]	Transfer to 21st CSH	2NOV			

	-----	b(6)-2				

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 (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo OCT Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 19	20	21	22	23	24	25	26	27	28	29	30	31	NOV 01
19OCT	[redacted]	IV LR @ ~~125~~ 100cc/hr	06 18	/	[redacted]												
	-----	Heplock when	18 06	[redacted]													
	-----	Taking P.O well	X														
19OCT	[redacted]	Ancef 1 gm IVPB	04	/	[redacted]												
	-----	Q8 hrs	12	/													
	-----		20	/													
19 OCT	[redacted]	Gentemycin 350mg	10	/	[redacted]												[redacted]
	-----	IVPB QD															
19OCT	[redacted]	Ancef 1gm IVPB	08													/	[redacted]
	-----	Q8hrs	16													/	
	-----		24														[redacted]
	-----	b(6)-2															

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P (L) Femur X-fix

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted] b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)					Mo. 10 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials	

b(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
19Oct	[redacted]	Percocet 1-2 po Q4-6 hrs prn	D/T	20Oct 0815	21Oct 0100	22Oct 1245	22Oct 1730	23Oct 0448	24Oct 1700	25Oct 0300	25Oct 1100	24 1900	25 0545	25Oct 1245	26Oct 2140	26Oct 1010
			D/I	2	[redacted]											
			E/I													
19Oct	[redacted]	Tylenol 650 mg PO. Q4 hrs prn	D/T	21Oct 1900												
			D/I	[redacted]												
			E/I													
19Oct	[redacted]	MSO4 2-6 mg IVP Q 1 hr prn	D/T	20Oct 5mg	20Oct 6mg	21Oct 5mg	21Oct 5mg	23Oct 4mg								
			D/I	1900	[redacted]		2130	[redacted]								
			E/I													
RGWF	[redacted]	Percocet 1-2 PO Q4-6 hrs PRN	D/T	27 1940	28Oct 2115	29Oct 0235	31Oct 1911									
			D/I	2			2									
			E/I	[redacted]												

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

CLINICAL RECORD

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

Mo. 11 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 02	03	04	05	06	07	08	09	10	11	12	13	14	15
19 Ø3	- [redacted]	HL. flush q shift	06 18	[redacted]													
	-----		18 06														
19	- [redacted]	Gentamycin 350mg	10	[redacted]													
	-----	IVPB QD															
19	- [redacted]	Ancef 1 gm IVPB q	08	[redacted]													
	-----	8°	16														
	-----		24														

	-----	b(6)-2															

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P ⓒ FEMUR K-FIX

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted] b(6)-4

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 11 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
		b(6)-2				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
02NOV	[redacted]	Percocet 1-2 po q4-6° pm	D/T	2NOV 1115 #											
			D/I	[redacted]											
19OCT03	[redacted]	Tylenol 650mg po q4° pm	D/T												
			D/I												
19	[redacted]	MSO4 2-6mg IVP q10° pm	D/T												
			D/I												

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

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

OTSG APPROVED (Date)

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

Date: 20 OCT 03
Time In: 0010
Allergies: NKDA
Pre-op V/S: 149/86 86
Procedures: Ex fix L femur

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 2500 Colloid
OR Output: UOP 1000 EBL
Meds/Times: MSO4, fentanyl

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

Pre Op Meds / History

Time	0010	0015	0020	0025
SaO2	102	100	99	97
FiO2	/	/	/	/
Methods	RA	RA	RA	RA
240				
220				
200				
180				
160				V
	V	V		
140			V	
120				
100				
		^	^	^
80	^			
60				
40				
20				
RR	20	22	21	19
T	96.8			

Time	
Pain (0-10)	
LOS	

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused
	LR	325			

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

PREPARED BY (Signature & Title): SGT [redacted] LPN

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 20OCT03

PATIENT'S IDEN[redacted] written entries give: Name – last, first, middle; grade; date; hospital or medical facility)

[redacted] EPW

b(6)-2

b(6)-4

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(L) femur	limited	+	P	B	W	Pk
15'	(L) femur	limited	+	P	B	W	Pk
30'	(L) femur	limited	+	P	B	W	Pk
45'							
60'							
90'							
D/C	(L) femur	limited	+	P	B	W	Pk

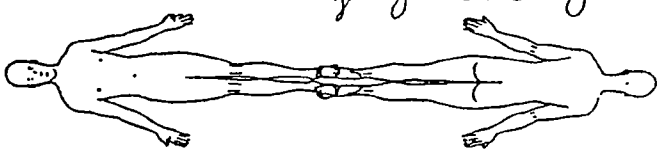
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) femur	gauze	serosanguous
30'	(L) femur	gauze	serosanguous
60'			
D/C	(L) femur	gauze	serosanguous



PACU OUTPUT

Time	Source	Color/Appearance	Amount
0045	FTG	Clear yellow	100cc

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0035	TSR	NO	NO

WAMC OP 173-E

NURSING NOTES

0010 20OCT03 Recv'd pt via litter from OR. Pt fully awake and able to move ext x4. Gauze to (L) femur weeping serosanguous fluid. Pt maintaining own airway. — SGT [redacted]
0020 pt helped to sitting position. SGT [redacted]
0150 Report given to ICW1. Dressing [redacted] reinforced on (L) femur & kenlex. [redacted] LPN

b(6)-2

Discharge Criteria:
Date: 20OCT03 Time: 0160 PARS: 10
BP: 114/99 T: 95.3 HR: 102 RR: 19 Sa02: 98
Pain Level at D/C (0-10):
Intake: 325 Output: 100
Additional Data:
Transferred To: ICW1
Report Given To: SGT [redacted]
Transferred Via: W/C (Litter) Gurney Ambul[redacted]
Transferred By: SGT [redacted]
Cleared IAW Recovery Room SOP B.3 [redacted]
Charge Nurse Signature [redacted]

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

OTSG APPROVED (Date)

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

Date: 22 Oct 03
Time In: 1114
Allergies: 113/47 134 5
Pre-op V/S: NKDA
Procedures: I+D L thigh

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 200 Colloid
OR Output: UOP 50 EBL MIN
Meds/Times: 150mcg Fent · 7mg MSO4

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

Pre Op Meds History

Time	1114	1119	1124	1129
SaO2	99	99	98	99
FiO2				
Methods	RA	RA	RA	RA
240				
220				
200				
180				
160				
140				
120				
100				
80				
60				
40				
20				
RR	24	10	10	13
T	97			

Time	
Pain (0-10)	
LOS	

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

V/S
X = A-line BP
˙ = Cuff BP
= Pulse

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

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

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

(Continue on reverse)

PREPARED BY [redacted]

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 22Oct03

PA[redacted]ries give: Name – last, first, middle; grade; date; hospital or medical facility)

[redacted] b(6)-2

[redacted] b(6)-4

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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1144		2mg MSO4	IV			[redacted]
1148		2mg MSO4	IV			
1154		2mg MSO4	IV			

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	L leg	limited	+	P	B	WM	PK
15'	L leg	limited	+	P	B	WM	PK
30'	L leg	limited	+	P	B	WM	PK
45'							
60'							
90'							
D/C	L leg	limited	+	P	B	WM	PK

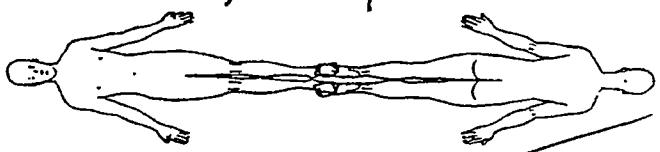
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 1114	L leg	exfin, Kerlex	0
30' 1144	L leg	ex fix, Kerlex	0
60'			
D/C NSS	L leg	exfix, Kerlex	0



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1114	TSR	0	0

WAMC OP 173-E

NURSING NOTES

Pt received from OR s/p I+D L Femur. Pt SpO2 99% RA. No c/o pain. Arousable to verbal. Pt awake c/o pain 2mg MSO4 given. Pt still c/o pain 2 more mg MSO4 given. Will continue to monitor. 2mg MSO4 given. Report given to Lt Berohneyer. — Sgt [redacted]

b(6)-2

Discharge Criteria:
Date: 22 Oct 03 **Time:** 1155 **PARS:** 10
BP: 133/81 **T:** 99.4 **HR:** 128 **RR:** 17 **Sa02:** 99
Pain Level at D/C (0-10):
Intake: — **Output:** —
Additional Data: —
Transferred To: ICW
Report Given To: [redacted]
Transferred Via: W/C [redacted] Gurney Ambulance
Transferred By: Sgt [redacted]
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:

1. LAST NAME, FI[illegible]E / NOM ET PRÉNOM	RANK / GRADE	☒ MALE / HOMME ☐ FEMALE / FEMM
SSN / NUMÉRO	SPECIALTY CODE / GPM	RELIGION / RELIG

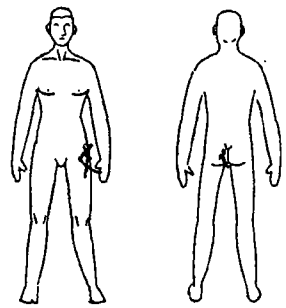
2. UNIT / UNITÉ

FORCE / ÉLÉMENT				NATIONALITY / NATIONALITÉ
A/T	AF/A	N/M	MC/M	Iraqi National (hostile)

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)

Left Hip

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE

- ☒ ALERT / ALERTE
- ☐ VERBAL RESPONSE / RÉPONSE VERBALE
- ☐ PAIN RESPONSE / RÉPONSE À LA DOULEUR
- ☐ UNRESPONSIVE / SANS RÉPONSE

5. PULSE / POULS	TIME / HEURE	6. TOURNIQUET / GARROT	TIME / HEURE
		☒ NO / NON ☐ YES / OUI	

7. MORPHINE / MORPHINE	DOSE / DOSE	TIME / HEURE	8. IV / IV	TIME / HEURE
☒ NO / NON ☐ YES / OUI			2000mL	1430

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

EBL 500mL

140/80 BP 2000mL LR

Ancef 1 gram via I.V. 1445

Possible Socket Fx of L hip

Splint 80mg IM of Toradol 1545 10 OCT

10. DISPOSITION / DISPOSITION		TIME / HEURE
	☐ RETURNED TO DUTY / RETOUR À L'UNITÉ	
	☒ EVACUATED / EVACUÉ	
	☐ DECEASED / DÉCÉDÉ	

11. PROVIDER / UNIT / OFFICIER MÉDICALE / UNITÉ	DATE/DATE (YYMMDD)

DD Form 1380, DEC 91

This form replaces previous editions of DD Form 1380 and DD Form 1380 (TEST), which are obsolete.

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

MEDCOM - 21685

12. REASSESSMENT / RÉASSESSMENT

DATE / DATE (YYMMDD)	TIME OF ARRIVAL / HEURE D'ARRIVÉE

TIME / HEURE	1545	1605		
BP / PS	142/92	144/84		
PULSE / POULS	100SR	110		
RESP / RESP	16 DR	21		

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

15. PROVIDER / OFFICIER MÉDICALE

DATE/DATE (YYMMDD)

16. DISPOSITION / DISPOSITION

- RETURNED TO DUTY / RETOUR À L'UNITÉ
- EVACUATED / EVACUÉ
- DECEASED / DÉCÉDÉ

TIME / HEURE

17. RELIGIOUS SERVICES / SERVICES RE

- BAPTISM / BAPTISÉ
- ANOINTING / ONCTION
- CONFESSION / CONFESSION
- PRAYER / PRIÈRE
- COMMUNION / COMMUNION
- OTHER / AUTRE

CHAPLAIN / CH

DD Form 1380, DEC 91 (Back)

MEDCOM - 21686

Admission Coding Information

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

1. Reporting MTF	2. MTF Loc	3. Register Number	Name (Last, First, MI)	4. Pay Grade	5. Sex
0580 [redacted] b(2)-2	IZ	[redacted]	[redacted]	FGN	M

6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
1988-03-01	b(6)-4 15Y	X	9	

10. Length of Service	ETS	11. FMP	12. Social Security Number
		99	[redacted]

Organization (Active Duty Only)	13. Marital Status	Hour of Admission	Branch / Corps:
		20:36	

14. Flying Status	15. Beneficiary Category	16. Zip Code of Residence:
	K78-PRISONER OF WAR/INTERNEES	

17. Unit Location	18. MOS	19. Trauma	Prev. Admission
		DIS	NO

20. Source of Admission	Ward:	Name / Relationship of Emergency Addressee
Direct from ER b(2)-2	ICW1	Address of Emergency Addressee

Name and Location of Medical Treatment Facility:	Telephone Number of Emergency Addressee
0580 [redacted]; No Install Provided	

21. Type of Disposition	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD)
TRF-OTH		2003-11-02

24. Clinic Svc - Admitting	25. MTF Transferred From	26. Date this Admission (YYYYMMDD)
AEA - ORTHOPEDICS		2003-10-19

27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission
		2003-10-19

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: S/P L FEMUR X-FIX

Dx 82110 Trauma 9
8770 Inj 569

Procedure Narrative(s):

Proc 7815
8604 x2
4823 BGK

Cause of Injury Narrative:

b(6)-2

Admitting Office [redacted] quired)	Signature of Admitting Clerk
[redacted]	[redacted]

Automated Facsimile - DA FORM 2985, MAR 2000

b(6)-4

Automated Facsimile

PATIENT TREATMENT RECORD COVER SHEET

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

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

4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm
M	22Y	X				NO

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

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

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	20:36	ABA - GENERAL SURGERY

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	TRF-OTH	2003-11-09

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-10-19	[redacted]

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
0580 [redacted] b(2)-2	2003-10-19	

31. Selected Administrative Data

Marital Status: DoB [redacted]

In/Out Patient: Inpatient MOS:

b(6)-2

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

SOFT TISSUE WND

823.92
458.3
E 991.2 / 79.16
77.17

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	21	21

35. Total Days This Facility

Absent Sick Days	Other Days	Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
[redacted]	[redacted]	0	[redacted]	[redacted]	21

Signature [redacted] Medical Officer [redacted] Records Officer

DAVIS

MEDCOM - 21688

Automated Facsimile FORM 3647, May 79

MEDICAL RECORD

19 OCT 03

2. CHIEF COMPLAINT, PERTINENT HISTORY, AND PERTINENT SYSTEM REVIEW

(R) LEG PAIN S/P GSW TO (R) THIGH, [illegible] SHORTS RPG, [illegible] ≈ 1330 TODAY.

WLOB PMH - HAD CHOLECYSTECTOMY FOR MEMORIALIZE S/P [illegible]

3. PHYSICAL EXAMINATION *(Including pertinent positives and negatives)*

INTWW
HEENT - NT/NC
CHEST - [illegible]
EXT - SMALL [illegible] WOUND, NO EXIT.
PULSES 2+ (=)

4. IMPRESSION *(Enter admission note with plan on progress notes)*

X-RAYS: (R) TIB-FIB FX

PLAN: FOL 1 TO TODAY

b(6)-2

5. ADMITTING OFFICER

a. SIGNATURE	b. DATE SIGNED *(YYYYMMDD)*
[redacted]	

6. DISCHARGE [redacted]urse, diagnoses, procedures, condition on discharge, pertinent discharge information (including medications, diet, activity limitations, follow-up instructions).)

7. DISCHARGE DATE *(YYYYMMDD)*

b(6)-4

8. DISCHARGING OFFICER

a. NAME *(Last, First, Middle Initial)*	b. GRADE	c. TITLE	d. SIGNATURE

9. PATIENT IDENTIFICATION *(For typed or written entries: Name (last, first, middle), grade, SSN, date of birth, hospital or medical facility, ward number, and register number)*

[redacted]

10. OUTPATIENT/HEALTH RECORD MAINTAINED AT:

11. COPY PLACED IN OUTPATIENT RECORD *(X when done)*

DD FORM 2770, APR 1998 (EG) USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
19Oct03 0200	Received from EMT alert & oriented. VS 97-71-98 126/72 O2 SAT 98% on RA. (L) FA 18 gauge IV patent & intact infusing LR @ 125 cc/hr. Lungs clear. Bilateral. Abd soft - non-distended. BS (+) x4 quad. Foley to gravity draining clear yellow urine. NPO → OR tonight. Pt informed per interpreter (R) LE with splint/dry intact & dry. Will continue to monitor [redacted] 24/7 Pt.
20 Oct 03 0530	Ortho Op Note b(6)-2 Pre Op Dx: Open Grade I II (R) Tib-Fib fracture s/p GSW Post Op Dx: same Procedure: I+D (R) Tib-Fib with ORIF Fluids: 2000 UR UOP 300 Findings: Anatomic reduction of comminuted Tibia fx fixed with 3 long screws. Fibular fx, not stable by rough fixed with 7 hole DCP plate with compression

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other) [redacted]
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT b(6)-2		
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)		REGISTER NO.		WARD NO.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	Foot wound closed primarily. Calcaneus wound had grafts placed. Splint applied. b(6)-2 [redacted]
20 Oct03 1422	Assume care of Pt @ 0600. VSS, slept most of the day due to surgery. Has splint on (R) leg. C/O Ø pain. Foley to gravity, clear yellow urine. Given fluids while in OR. No skin breakdown at apt. restraint sites. Will cont. to monitor. [redacted]
21oct03@0300	Assumed care @ 1800; temp: 101.5°, accompanied c̄ pain to (R) LE, 1 percs given c̄ good relief; temp retaken, 99.5°, cont to monitor; pt A&O speaking arabic; (+) CMS, +2 PP, brisk cap RF, NV intact; slight edema to (R) LE, splint in place; FTG draining QS, clear yellow urine; Restraints in place, (+) circ, (-) skin breakdown; cont to monitor [redacted] b(6)-2
21oct03@0530	Foley D/C'd per MD; pt DTV NLT 1330 [redacted]
21 oct 03 0700	- Assumed care of pt. AAO x3. VSS. Lungs clear HRRR Active BS x4 tolerated 15% of breakfast. Foley dc'd this am due to void by 1330 urinal @ bedside PIV to (R) FA patent IR @ 150 IV abx to. Afebrile RLE soft splint cast Ø c/o pain or discomfort @ this time Will monitor [redacted]
21 Oct 1120	- Void 250 cc per urinal dark yellow urine. 6 hrs post foley removal [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	(Continued) NOTES
22 Oct 03 2000	Abd soft non distended. Voiding amber clear urine. (R) FA Saline lock patent and intact. Will continue care as planned — b(6)-2 [redacted] 2LT
23 OCT 03	(1330) Assumed care of pt w/ report from night shift. Pt alert, speaking Arabic. VSS. ↑ 4o pain w/ this time. Pt OOB to chair this am — tol. well. Splint/drsg to RLE CDI - elevated. SL in (R) forearm flushes well ∑ S/Sx infection/infiltration. Tol. reg diet well. Voiding ∑ difficulty. 2 point restraints in place ∑ S/Sx complications. Will cont. to monitor. b(6)-2 [redacted] RN
23 OCT 03 2000	VSS Alert & oriented. (R) FA IV Saline lock patent & intact. (R) LE Tan folded blankets. Peripheral pulses palpable ↑2. Bilateral Toes ∈ capillary refill < 3sec. Lungs clear. BS(+) x4 quad. Abd soft non-distended. Voiding clear amber urine. Will continue care as planned. b(6)-2 [redacted] 2LT RN
24 OCT 03 0500	VSS. AO. OOB/C @ 0525. Ambulated to BR ∈ moderate assistance. (+) pulse to RLE ∈ CR ≤ 2 seconds. Pt c/o pain to RLE and provided 2 percocet. Oral care performed and d'd bedding. No S/S skin breakdown or infectious complications. Voiding light amber, BS ∑ difficulty. b(6)-2 [redacted] RN

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
21 Oct 03 1900	VSS. Alert & Oriented. Lungs clear Bilaterally. Abd soft non-distended. (R) lower Extremity ↑ on ~~pto~~ folded blankets. Voiding clear amber urine. (L) FA Saline lock patent & intact. BS(D) x4 guard. Ø c/o pain voiced or noted @ this time. Resting with eyes closed. Will continue to monitor. b(6)-2 [redacted] 2CTM
22 Oct 03	(0820) Assumed care of pt @ 0800 p report from night shift. Pt alert, speaking Arabic. VSS. Ø c/o pain. Drsg/splint to RLE CDI. Pt able to move toes. Skin warm/dry to touch. SL in @ forearm flushes well ~~s~~ sisx infection/infiltration. Personal hygiene done by pt this am c̄ min. assist from staff. Tol. reg diet well. voiding ~~s~~ difficulty. 2-point restraints in place ~~s~~ sisx complications. Will cont. to monitor [redacted] (1240) Pt COB to chair. Tol. well. SL in @ forearm clled d/t infiltration. 18g IV started in @ forearm b(6)-2 flushes well ~~s~~ sisx infiltration. monitoring [redacted]
22 Oct 03 2000	VSS alert. Ø c/o pain voiced or noted. (R) LE ↑ on folded blankets. Pedal pulses palpable +2. Capillary refill to toes <3sec. Lungs clear BS (D) x4 guard.

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			NUMBER
	LAST	FIRST b(6)-2	MI [redacted]	2CTM

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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b(6)-2

LAST NAME	NAME	ID NUMBER

DATE	NOTES
27OCT@0055	Pt has (R) ft elevated. Pt able to move toes (+) Cap refill. Pt ambulated c̄ walker to BR. Med c̄ 2 perc for pain. VSS. Urinates c̄ difficulty. All assessments @ WNL. Tol. Reg diet. Pt 2pt restraints c̄ S/Sx of infection. [redacted] MTP
27OCT@1400	Pt. resting quietly in bed c̄ (R) LE elevated. V.S.S. A&O. Pt. requested to ambulate to BR c̄ walker. Pt. ambulated c̄ walker into hallway then began c/o severe pain to (R) LE. Pt. assisted back to bed and given ii Percocet. No c/o pain at this time. Cap. refill to (R) LE 2 sec. All other assessments WNL. IVSL to (R) AC, flushes well. Pt. in 2 point. restraints. (-) signs of skin breakdown. Will continue to monitor. b(6)-2 [redacted] 2CT AN
27OCT@0220	Pt crying 2° pain. Med c̄ 2 perc. Will continue to monitor. Pt able to move toes, (+) cap Refill, (+) Pedal pulse. ~~Uses walk~~ Amb c̄ walker. Tol diet, urinates in urinal c̄ difficulty. Cont IV ABX. b(6)-2 [redacted] MTP/AN
28 OCT 03 0700	Assumed care of pt. A+O x3. VSS (-) c/o pain or discomfort @ this time. ~~(-) c/o pain or disco~~ (R) LE cast CDI on call for surgery today. Lungs clear HRRR Active BS Tolerates P.O. PIV (R) AC HL IV ABX Treatment cont Will cont to monitor b(6)-2 [redacted]

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b(6)-4

[redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
24OCT@2100	Pt laying in bed. ⊖ C/O pain. Lung sounds clear. ⊕ bowel sounds. Urinating ⅋ difficulty. Ⓡ leg drag CDI. Pt able to wiggle toes. ⊕ pedal pulse to Ⓡ foot. Ⓡ foot warm ⅋ ⊕ cap refill [redacted]
25OCT1200	VSS. AO. OOB ambulate for 15 min and then placed in b(6)-2 chair for 15 min. Returned to bed for IV placement. Performed self care in BR. IV placed in BUE. ⊕ pulse & CNS intact to RLE. Splint and DSG intact. b(6)-2 [redacted]
25OCT@1900	Pt laying in bed ⅋ Ⓡ ft elevated. Pt C/O pain. Medicated ⅋ 1/1 percocet. Will continue to monitor. VSS. Lung sounds clear through lobes. S.S. audible. ⊕ bowel sounds. Ⓡ ~~le~~ foot has ⊕ 2 b(6)-2 ⊕ capillary refill. Pt able to wiggle toes. toes warm to touch [redacted]
26OCT03:0915	Pt. resting in bed. A&O. V.S.S. Ate 25% of breakfast. NSR, lungs clear bilat., ⊕ bowel sounds, ⊕ pedal pulse 1-2 sec. cap. refill. ⊘ C/O pain. IVSC Δ'd from Ⓛ AC to Ⓡ AC. DRSNG to Ⓡ LE CDI. Pt. in 2 point restraints, ⊘ signs of skin breakdown. — [redacted] ZCT, AN
26OCT03:1400	Pt. OOB to chair & BR. Ambulates ⅋ walker [redacted] ZCT, AN b(6)-2

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

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

REGISTER NO. | WARD NO.

PT [redacted] b(6)-4

PROGRESS NOTES
Medical Record

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
28OCT03 1900	VSS. PT Alert & Oriented. Received report from previous shift of H/S to RLE results and that previous shift informed Dr [redacted]. Informed pt of Bedrest status until further notice. (R) LE in soft cast. Pt moves toes freely to (R) foot (R) Toes c̄ brisk capillary refill. (R) FA Saline lock patent & intact. Tolerating Regular diet. No c/o pain voiced or noted. Will continue care as planned. b(6)-2 [redacted] LCPN
28OCT03 0050	Dr [redacted] ordered Lovenox 60m SQ BID. first dose given now. Will continue to monitor b(6)-2 [redacted] LCPN
29 OCT03 0700	- Assumed care of pt sleeping yet easily arousable. Lungs clear HRRR Active BS x 4 quads. Voiding as per urinal & c/o pain @ this time (R) LE soft cast intact. Remaining Acetrile IV ABx Tx cont. Bedrest positive (R) DVT. NWB to (R) LE will cont to monitor b(6)-2 [redacted] Guarnera
29OCT03 2000	VSS Alert & Oriented. (R) LE c̄ +2 palpable pulse (R) Toes c̄ brisk capillary refill. Move (R) toes freely. Saline lock ⊿ to (L) FA as previous shift. Saline lock to (L) FA patent & intact [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	b(6)-2

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	NAME	MI	ID NUMBER

b(6)-2

DATE	NOTES
30 OCT 03 0200	Assumed care of pt. A+O x 3. Denies pain. (R) LE soft cast applied CDI - Positive DVT to (R) Leg NWB bedrest. Lungs clear HRRR Active BS. Urinates per urinal QS. Will cont to monitor. [redacted]
30 OCT 03 2000	Pt A+O x3, VSS, Ø c/o pain @ this time, dsg (R) LE CDI, LS CTA (B), (+) BS x4, voiding ≅ diff cyu to urinal, peripheral pulses +2 equal (B), 2 point restraint in place ≅ s/sx of complications. [redacted] I concur with above assessment [redacted]
31 OCT 03 1235	VSS. AO. OOB to BR for BMX1 and returned to bed ≅ difficulty. Continued ≅ BRest. (+) pulse to RLE & CR ≅ Dsn HRR. Voiding but urine wine, QS. (-) c/o pain @ this time. ~~Skin intact.~~ [redacted]
31 OCT 03 1900	Pt A+O x3, VSS, dsg RLE CDI, OOB → BR ≅ walker, voiding ≅ difficulties, LS CTA (B), (+) BS x4, IV intact, Ø s/sx of infex, 2 point restraint ≅ complications. [redacted]
1905	Pedal pulses equal (B), cap re[redacted] sec [redacted]
1 NOV 03 0600	Pt. resting quietly in bed, Ø c/o pain, V.S.S., A&O x3, (R) LE elevated, IVSL to (L) AC flushes well. Voided @ bedside, clear yellow urine. Pt. on Coumadin therapy, PT = 14.9s, INR = 1.38. Pt. ambulated to BR ≅ elbow crutches x2, (+) BM x2. Pt. slightly unsteady on crutches. Pt in 2 point restraints, Ø signs of skin breakdown. All other assessments WNL. [redacted]

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[redacted] b(6)-4

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MEDICAL RECORD | **PROGRESS NOTES**

b(6)-2

DATE	NOTES
1 NOV. 03 1900	Pt resting in bed, A+Ox3, VSS, RLE elevated, dsg CDI, LS CTA (B), (+) BS x4, Ø c/o pain, SL IV (L) AC flushes well, Ø s/sx of infex, d/c Lovenox tomorrow, voiding ī complications c/u per urinal, pt on 2 point restraint ī s/sx of complications. [redacted] gw
2 NOV 03 @ 1500	Pt. resting quietly in bed, V.S.S., A+O×3, Ø c/o pain. (R) LE elevated, DRSNG CDI, Nero IV SL to (R) FA, flushes well. Pt. on coumadin therapy, PT this AM = 18.4 sec, Pt. ambulates to BR ē elbow crutches, some assistance given for balance. Pt. took shower, (R) LE wrapped ē plastic bag. Pt. performed oral care. (+) BM. Pt. in 2-point restraints Ø signs of skin breakdown. All other assessments WNL. [redacted] 2LT, AN
2 NOV. 03 1930	Pt A+Ox3, VSS, OOB → BR ē crutches, Ø assistance needed, IV SL (R) FA intact, Ø s/sx of infex, dsg + ace wrap to (R) LE CDI, peripheral pulses equal (B), 2 point restrant, Ø complications, voiding ī diff. [redacted] gw I concur with above assessment [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.

E # [redacted] b(6)-4

PROGRESS NOTES
Medical Record

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b(6)-2

LAST NAME	NAME	MI	ID NUMBER

DATE	NOTES
3 NOV 03 1530	VSS, AO. ⊕ pulse to RLE. Cast on Coumadin Tx. Up ad libs and ambulated to BR and back for 15 min. Performed self care ē difficulty, but ē AB Tx. Pleasantly confused in bed. Mild c/o pain to RLE, but tolerable to patient. [redacted]
3 NOV 03 2000	Pt A+O×3, VSS, cast to RLE CDI, ambulates ē elbow crutches x1, ∅ c/o pain, LS CTA (B), ⊕ BS x4, cap refill <3 sec, peripheral pulses +2 equal (B), ate most of diet, voiding ē difficulties, 2 point restraint ē any complications. IV SL (R) FA intact, ∅ s/sx of infex [redacted] 9W
4 NOV 03 1620	VSS. AO. Ambulated x2 for 30 min each this AM & afternoon. ⊕ pulse & CMS to RLE. BS (A) x4 Voiding light amber urine QS. ē difficulty. Cast ē AB TP and skin intact, remains intact. [redacted] Also performed self bathing & oral care [redacted]
4 NOV 03 2200	VSS Alert & Oriented. (R) FA Same lock patent & intact. (R) LE ē cast. (R) Pedal pulse palpable. (R) Toes with capillary refill brisk. Denies pain, numbness or tingling to (R) LE per interpreter. OOB ē crutches to BR. Consumed 80% of regular diet for dinner. No c/o pain, vocal or moted. Will continue plan of care [redacted]

STANDARD F[redacted]/1999) BACK
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E# [redacted] b(6)-4

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
5 NOV 03 1145	VSS AO. Ambulated x1 this AM c̄ crutches to shower to perform self care. Tolerated well. ⊕ pulse & CNS intact to RLE. ⊖ c/o pain @ this time. Voiding light amber urine, BS c̄ use of BR. Tolerated PO well this AM. Cast c̄ AB tx. [redacted]
5 NOV 03	PT/PTT = 3.2 b(6)-2 D COVERSION PO 2 MG DAILY Q 6 WK WILL WATCH WBC SERIOUSLY [redacted]
5 NOV 03 2000	VSS Alert & Oriented Consumed 60% of Regular diet dinner. OOB c̄ crutches to BR (R) Pedal pulses palpable +2. (R) Toes c̄ brisk capillary refill. Moves toes on (R) foot freely ⊖ c/o pain numbness or tingling since IV site to (R) FA without active pt bleeding noted. Denies bleeding from gums or urine. Will continue care as planned. [redacted]
06 NOV 03	(1010) Assumed care @ 0600. Pt alert, speaking Arabic. VSS. ⊖ c/o pain. Amb to BR for personal hygiene c̄ crutches s̄ difficulty. Cast to RLE CDI. Pt able to

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

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E # [redacted]

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
06NOV03	(cont.) move toes on RLE. Skin warm/dry to touch. Elevated while in bed. Pt OOB in chair @ this time. SL in (R) forearm dlcd d/t infiltration - catheter intact. 18g IV started in (L) forearm - Ø S/Sx infiltration. Ø unusual S/Sx bleeding noted. Tol. reg. diet well. Voiding ī difficulty. 2 point restraints in place while in bed ī S/Sx complications. Will cont. to monitor. b(6)-2 [redacted]
06NOV03 2030	VSS Alert & Oriented. OOB ⇒ BR c crutches & NWB to (R) LE. Peripheral pulses palpable +2. Move toes to (R) foot freely. Denies pain, numbness or tingling to (R) LE per interp. (L) FA Saline lock patent & intact. Ø active bleeding noted from IV site. Ø noted bleeding from gums. Voiding clear yellow urine. Will continue care as planned. b(6)-2 [redacted] 2270
7NOV03 1125	VSS. AO. OOB to ambulate to BR c crutches ī difficulty. (-) c/o pain to RLE. (+) pulses to all extremities. CNS intact to RLE c CR ≤ 2 seconds. BS (+)x4. LS CTAB. RRRA. Voiding clear yellow urine ī difficulty, QS. [redacted]
7NOV03 2300	VSS A&O OOB to BR c crutches. Denies pain RLE CNS intact. Will continue to monitor. [redacted] b(6)-2 [redacted] 91W/M
8NOV03 1005	VSS. AO. OOB to ambulate to BR. Ø c/o pain @ this time. Ø placed to (R) AC region. Performed oral care this AM. Cont. to RLE CRI (+) CNS, pulses. [redacted] RN-

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	On the Transfer Note: [redacted] b(2)-2
8 NOV 03 1245	DXs: (1) (R) open tib-fib fracture s/p ESW (2) (R) superficial femoral and popliteal DVTs.
	22 yo Iraqi male shot by US forces after he shot RPG at us. Admitted 19 October with grade I open tibia + fibula fracture. Treated with long screw in tibia and plate on fibula. Did well post-op, then developed increased pain. Ultrasound showed DVTs as above. Began coumadin on 28 OCT 03. Placed in short leg cast.
	PLAN: (1) Cast x 6-8 weeks, weight bearing as tolerated (2) Coumadin 2 mg P.O. Q D27. (3) Follow up in 3-4 weeks. [redacted] b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

E# [redacted] b(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
8 NOV03 1800	PA Pt A&O Denies pain. cont AnBx via 18G IV Cath in (R) FA. LS CTA (B), BS x4 quads, HRRR. [redacted] Cast on RLE. Toes [redacted] Warm & Dry to Palpation. Cap refill ≤3 sec. Will cont to monitor. [redacted] Spc 9 WMB
	b(6)-2

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[redacted] b(6)-4

b(2)-2

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

[redacted] PO AE 09234 OPERATION IRAQI FREEDOM BAGHDAD, IRAQ

19 OCT 2003

TIME 2000

T

HR 63

RR

BP 117/51

O2 SAT

PMHx

PSHx

MEDICATIONS

ALLERGIES

TOBACCO

REASON FOR VISIT

S 22 y/o Iraqi male GSW to dist [redacted] b(6)-2
x 3 hrs PE seen @ 2/3 by PA determined
fx of tibia open Transported due by
origin assest. sent @ by splinted

GW Alert, no Litter, no NAD
Lungs CTAB
W/O S, S2 RRR Sem 11/VL
Abd soft c̄ Bladder distention
Ext (R) LE ankle splint DNVI

Foley cath placed

A/P (R) tibia GSW c̄ probable open fx
requires evac to CSH
For surgical management

[redacted] b(6)-2

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

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

REGISTER NO.

WARD NO.

NAME [redacted] RANK b(6)-4

SSN DOB [redacted] UNIT

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

USAPA V2.00

NSN 7540-01-075-3786

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

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS: EPW

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 190403 | TIME: 2037

TRANSPORTATION TO FACILITY

SEX: M

AGE: 22

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: Ø

ALLERGIES: Ø

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: GSW R. Leverley GSWRH

CATEGORY OF TREATMENT

☐ EMERGENT

☒ URGENT

☐ NON-URGENT

TIME: 2037

INITIALS: [redacted] b(6)-2

VITAL SIGNS

TIME	2037					
BP	137/59					
PULSE	89					
RESP	21					
TEMP	99.3					
WT						

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

☒ PULSE OX 97% ☐ MONITOR b(6)-2 ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
2022	Penicillin 1000mg IVP	[redacted]	[redacted]	TM	
2100	1 L NS Fluid IV			TM	
2100	.5 Tetanus IM			2100 TM	
2125	Penicillin 500mg IV			2125 TM	

DISPOSITION: ☐ HOME ☐ FULL DUTY

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

MODIFIED DUTY UNTIL

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ | TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

EPW [redacted] b(6)-4

[redacted]

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

NSN 7540-01-075-3786

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

TEST RESULTS

CBC		SMAC	ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
WBC			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

22 yr old male brought in by ground ambulance, GSW to R. lower leg. PPP foley in place before arrival, pt. alert + oriented, no other injuries noted at this time [redacted] 20 X

Last Meal 0800

b(6)-2

PMH/PSH

1CH s/p a fall-1997
s/p Craniotomy.

Meds
Ø

All
NKDA

non-smoker.

22 yo s/p GSW to (R) ankle/Distal Fibia. Pt c̄ pain @ Lower leg. O/W no complaints.

PE: LSS, gen NAD
CV: RRR 4/VI Sem LUSB
Lys: CTA (B)

abd: soft, ND, (+)BS, NTP.
ext: (R) ~~ankle c̄ GSW~~
~ Distal fib/tib c̄ obvious Deformity, Vascular intact, neuro-states Ø sensation, Ø moving toes.

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

b(6)-2

PROVIDER SIGNATURE AND STAMP

[redacted]

DIAGNOSIS

(R) distal leg c̄ GSW c̄ tib/Fib fx, shattered. w/md. Bullet inattly.

CODE

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

#[redacted] b(6)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

MEDICAL RECORD	PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT FOR Use this form. See AR 40-407: the Proponent agency is The Office of the Surgeon General.
1. AGE 22 HEIGHT: WEIGHT: 135	2. KNOWN ALLERGIC SENSITIVITIES (e.g.. Iodin, Tape, Medication) [X] NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD REACTION: 3. PREVIOUS SURGERY [X] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE:

ORIF Rt. Tib/Fib ICH 1997

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition ____

Tobacco Ø ppd X ___ yrs Body Piercing Ø Diabetes (Y)(N) ROM ____ ASA/Motrin W 72hrs (Y)(N)
ETOH Ø Implants ____ Respiratory Disease (Asthma COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y)(N) Dentures Ø Hypertension (Y)(N) Herbal Medicines (Y)(N) MEDS:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL X potential for anxiety related to: X 1) Surgical Procedure& Operating Room Environment ___ 2) Separation Anxiety (Child) X 3) Surgical Outcomes	Ø Pt. verbalizes any specific anxiety. Ø Pt. Exhibits relaxed body posture.	Ø. Allow pt. to verbalize freely. Ø. Explain Or environment and answer questions regarding surgery. Ø. Offer comfort measures. (e.g. warm blanket. touch). Ø. Explain all nursing procedures before they are done. Ø. Remain with pt. Whenever possible. Ø. Maintain family interface. Parents to stay with pt.
B. AERATION X Potential for respiratory dysfunction due to: X 1) Positioning X 2) Effects of Anesthesia ___ 3) Medical/Smoking History	Ø Pt. will be able to breath without difficulty during immediate intraoperative phase.	Ø. Offer to elevate head of litter or offer pillow. Ø. Observe pt. While awaiting surgery for signs of distress. Ø. Assist anesthesia during intubatior and extubation.
C. INTEGUMENT X Potential Impairment of Skin Integrity due to: X 1) Intraoperative Immobility X 2) ESU Pad Placement X 3) Positional Aids X 4) Prosthesis X 5) Pooling of Prep Solutions	Ø Pt. will exhibit signs of impairment of skin integrity (e.g., reddened areas).	Ø. Utilize pressure preventing devices on OR table and accessories. Ø. Check for proper positioning and support to maintain good body alignment. Ø. Pad pressure points. Ø. Place ESU ground pad on non compromised skin surface area. Ø. Keep prep fluids form pooling.

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

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

22-yo ♂

GSW Rt. Ankle

VERIFICATIONS AT HOLDING AREA:

! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since ____ ! Jewelry Removed
! UHCG/LMP ! Body Pierce Removed
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact precautions (Y) (N)
! Family/Friend: ____

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION X Potential for inadequate tissue perfusion due to: X 1) Intraoperative Mobility X 2) Positioning 3) Existing Disease X 4) Safety Devices X 5) Hypothermia	Ø. Pt. will exhibit signs of adequate tissue perfusion (e.g. color, warmth. pedal pulse.	O Check foe support stocking or ace warps. if none, check with doctors. Ø Check that safety straps are correctly applied. Ø Offer pillow for under knees. O Place and take down legs from stirrups with slow bilateral motion. Ø Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.I. X Potential Impairment of Mobility due to: X 1) Pain X 2) Intra operative Hazzards X 3) prosthesis X 4) Positioning X 5) Transfer pt. To/form OR table E.2. X Potential Discomfort Due to: X 1) Length of Surgery X 2) Positioning 3) Arthritis	Ø pt. will be transferred to OR table without difficultly. Ø pt. will be not experience unnecessary physical discomfort.	Ø Have sufficient people available for transfer. Ø Insure proper body alignment. Ø Allow patient to lie in position of comfort while waiting for surgery. Ø Offer support (i,e..pillows. Bath towel. etc) for positioning.
F. Special Senses F.I. X Diminished visual perception due to being: X 1) pre-medicated 2) W O GLASSES F.2. X Potential for Decreased Communication due to: X 1) Diminished Hearing X 2) Language Barrier F.3. Potential Injury due to Dentures: 1) Upper 4) Caps 2) Lower 5) Crowns 3) Bridges	Ø pt. will be made aware of surroundings prior to anesthesia induction. Ø pt. will be transferred safely to OR table. Ø pt. will be able to understand instructions. Ø Minimize danger of injury during intraop period.	Ø Introduce self. keep pt informed as to where he. she is and what is happening. Ø Inform pt. in which direction to move and assist if necessary. Speak clearly and slowly. Ø Address pt. from Either side. Ø Validate pt.'s understanding of verbal communication. O Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS OR Continuation of Above problems/needs. b6)-2	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS OR continuation of above interventions.

10. OR NURSING INTERVENTION COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTIONS NOTED.

[redacted] CPT/AN 19Oct 03 DATE

11. POSTOPERATIVE EVALUATION : SKIN INTEGRITY: Bovie Pad Site: ☒ Clean and Dry ☐ Red ☐ N/A DRESSING DRY & INTACT: (Y) (N)

LEVEL OF CONSCIOUSNESS: ☐ A&O ☐ Drowsy ☒ Sleepy ☐ Intubated BREATHING EASY: (Y) (N)

LEVEL OF ACTIVITY: ☐ MOVES ALL EXTREMITIES ☐ Moves Upper Extremities ☐ Transferred to Litter With roller due to spinal

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] CPT/AN

DATE: 19Oct03 TIME: 2130

13. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title)

DATE: 19 Oct03 TIME: 0535

MEDCOM - 21708

REVERS OF FORM 5179, JUN 91

USAPA V1.0

b(6)-2

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPER IN M
VIA Litter BY anesthesia

2. PATIENT IDENTI CORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] CPT/AN

3. DATE 20 Oct 03 TIME PATIENT ARRIVED IN SUITE 0238

4. PATIENT IN [redacted] TIME NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: unable to speak or understand English

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Proper body alignment maintained Lg bump under Rt. hip

8. SKIN PREPARATION

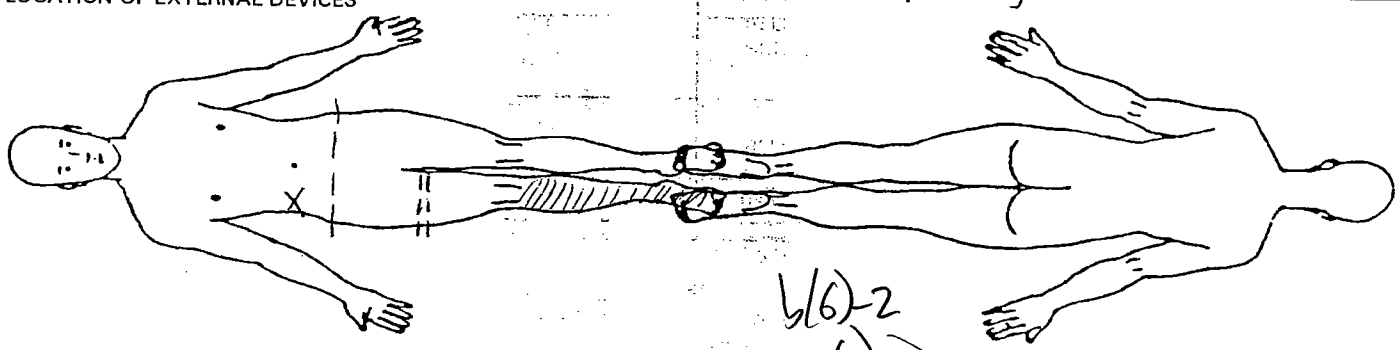
HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP

COMMENTS: Skin intact

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

COMMENTS: No pooling of fluids

9. LOCATION OF EXTERNAL DEVICES



b(6)-2

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

C = Correct I = Incorrect Initial C [redacted]

10. COUNTS

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

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

[redacted] b(6)-4
22-40 ♂

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

☒ ESU NO: Force 40 R8E105308 30/30
GROUND PAD: BRAND Valleylab REM
LOT NO: 68245

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

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

4.5 cortical 214.028 X 3 .5 Fully Threaded Cortical 16mm X 3 14mm X 3 hole plate 241.07

ASIF Screw Load #0526602 Small Frag Load # 0529201

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY
None		
[redacted] b(6)-2		

PHYSICIAN'S SIGNATURE [redacted]

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

YES ☒ NO ☐ C-Arm Rt. Lower Leg

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☒

	1.	2.	3.
TYPE/SIZE	3/8 Penrose		
SITE	Rt. lower leg		

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs
Kerlix
Webril
Plaster splint ACE

19. ADDITIONAL INFORMATION

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

Observer: SGT [redacted] b(6)-2

Tourniquet # 3996
275mmHg
↑0318 ↓0510
Total time 114min

Foley in place PTA

20. OPERATION(S) PERFORMED

1. ORIF Rt. Tib/Fib
2. I & D Rt. Lower Leg

b(6)-2

21. PATIENT TRANSFERRED TO	TIME	METHOD
PACU	0535	Litter

22. REGISTERED NURSE SIGNATURE

[redacted] CPT/AN

VITAL SIGNS RECORD

CAL RECORD

HOSPITAL DAY

DAY

AR Oct 03 | DAY | 20 | 21 Oct | 21 OCT | 22 | 23 | 24 | 25 OCT 03

19 | HOUR | 0700

PULSE (O) | TEMP. F (•) | TEMP. C

105° | 40.6°

104° | 180 | 40.0°

103° | 170 | 39.4°

102° | 160 | 38.9°

101° | 150 | 38.3°

100° | 140 | 37.8°

99° | 130 | 37.2°

98.6° | 37.0°

98° | 120 | 36.7°

97° | 110 | 36.1°

96° | 100 | 35.6°

95° | 90 | 35.0°

80

70

60

50

40

(Centigrade Equivalents, for Reference only)

PIRATION RECORD

BLOOD PRESSURE

	107/52		111/53		109/54	116/61	116/64	119/69	106/55	107/56	114/63
	T 98.0	112/58	H 78	112/56						85	75
	H 67		T 98°							97°	98°
			96%			97%		98%	98%	98%	99%
HEIGHT:	WEIGHT →		RA		96% (RA)	98					
	RA	81% 95%			97%						

Record special data only when [illegible]

REGISTER NO.

WARD NO.

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

STANDARD FORM 511 (REV. 7–95) BACK

[redacted]

b(6)-4

511-119

MEDICAL RECORD

VITAL SIGNS RECORD

NSN 7540-00-634-4124

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY | 19 | HOUR

DAY	27	28	29	29 OCT	30	31 OCT
HOUR	1900	0200	1200	2200	2000	2000

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

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

RESPIRATION RECORD

	27	28	29	29 OCT	30	31 OCT
	103/77					
	16					
	86					
	98.7					
	97%					

BLOOD PRESSURE

	27	28	29	29 OCT	30	31 OCT
	103/53	122/64	107/63	120/64	113/57	114/67
	97°	111/53	114/70	116/67	114/67	
	98%	116/62	17	74	67	84
	89	T 97°	98°	99	573	99%
		98%	98%	98%	551	98%
	98%	RA 98%	RA	RA		
	RA					

HEIGHT: | WEIGHT →

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)

b(6)-4

[redacted]

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM

VITAL SIGNS RECORD

ICAL RECORD

HOSPITAL DAY

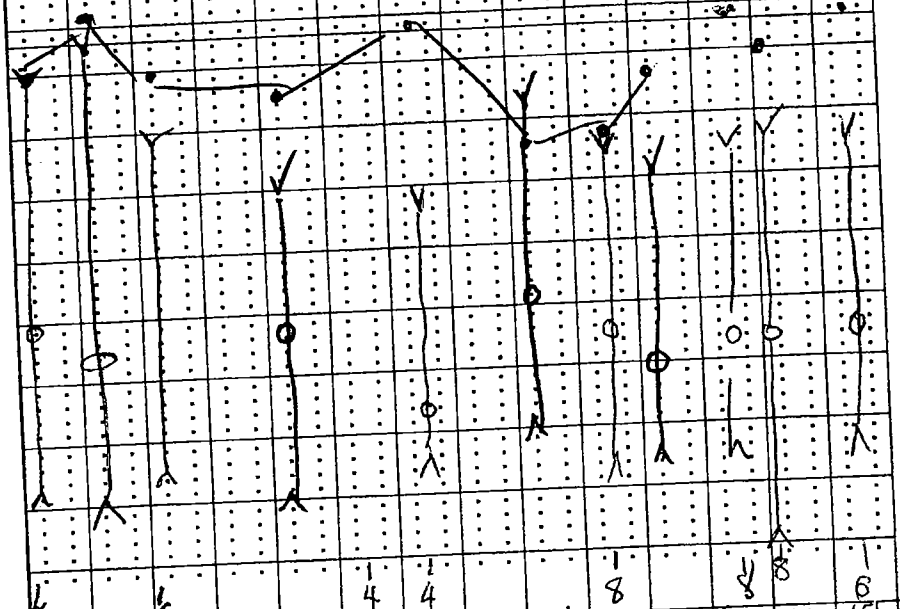
DAY

EAR	DAY	1 NOV		2 NOV		3 NOV 03		3 NOV		4 NOV 03		5 NOV 03		06	
19	HOUR	0	20	1		0	1	1		0	1	0	1	0	2
PULSE (O)	TEMP. F (•)	9		3		7	8	8		7	2	7	0	8	0
		8		0		5	2	2		3	0	4	9	0	8
		7		8		0	5	5		0		0		8	

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

(Centigrade Equivalents, for Reference only)

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



								4	4		8		8	8	6
PIRATION RECORD															
BLOOD PRESSURE		124/81	100/51		100/51			97/56		113/61	105/56	102/53	100/52		105/58
		74	78		78			63		81	74	70			76
		90/2	97		97	98.7	98.7	98.7		96	96.8	97.9			98.7
			98%		98%			97%		97%	98%	99%			
HEIGHT: WEIGHT →		96%	98%	98%									99% (RA)	98%	
		RA		RA						RA		RA			

Record special data only when [illegible]

REGISTER NO.

WARD NO.

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

EPW [redacted] b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST-DAY

MONTH-YEAR | DAY | HOUR

19

PULSE (0)	TEMP. F (°)	TEMP. C (Centigrade Equivalents, for Reference only)
	105°	
180	104°	40.6°
170	103°	40.0°
160	102°	39.4°
150	101°	38.9°
140	100°	38.3°
130	99° / 98.6°	37.8°
120	98°	37.2° / 37.0°
110	97°	36.7°
100	96°	36.1°
90	95°	35.6°
80		35.0°
70		
60		
50		
40		

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

TEMP.

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] b(6)-4

STANDARD FORM 511 (REV. 7-95) BACK

KW, b(6)-4 [redacted]

(Subject to the Privacy Act of 1974)

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
[redacted] b(6)-2	1NOV03	0600	

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

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

Coagulation Studies

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

REMARKS:

REPORTED BY:

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/01/03 06:08

Patient ID: [redacted] b(6)-4
Test Name :PT
Test Result:= 14.9 sec.
Ratio = 1.2
Calculated INR = 1.38
Sample Type:citrated wh. blood
Test Date :11/01/03
Test Time :06:04
Card Lot [redacted] b(6)-4
Operator : [redacted] b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/01/03 06:08

Patient ID [redacted] b(6)-4
Test Name :APTT
Test Result:= 31.5 sec.
Sample Type:citrated wh. blood
Test Date :11/01/03
Test Time :06:06
Card Lot
Operator

ood Bank

IT SF 518 WITH
T REQUESTED

IT OF BLOOD

CROSSMATCH

b(6)-4 b(6)-2 b(6)-4

Ward/Section: ICW	REQUESTIN[redacted]	LAB[redacted]ATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI [redacted]	DATE 2NOV	TIME 0445	SSN/PSEUDO SSN: [redacted]

(Hematology) CBC			Urinalysis			[redacted]Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV		[illegible]	Ket		Negative	Gram Stain		
			SG		N/A	Occ Bld		Negative
			Bld		Negative	H. pylori		Negative
			pH		N/A	Micro Parasites		
			Prot		Negative	Malaria		
			Urob		0.2-1.0	O & P		
			Nit		Negative	Other		
			Leuk		Negative	**Microscopic Urinalysis**		
			HCG		Negative			

CSF			Blood Bank	
Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED	
Directigen		Negative	ABO/Rh	

RAPIDPOINT [illegible]
SERIAL #0[illegible]

Patient ID: [redacted] b(6)-4
Test Name :PT
Test Result:= 18.4 sec.
Ratio = 1.5
~~Calculated INR = 1.85~~
Sample Type:citrated wh. blood
Test Date :11/02/03
Test Time :05:10
Card Lot [redacted]
Operator [redacted] b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 11/02/03 05:17

Patient ID: [redacted] b(6)-4
Test Name :APTT
Test Result:= 34.1 sec.
Sample Type:citrated wh. blood
Test Date :11/02/03
Test Time [redacted] b(6)-4
Card Lot
Operator [illegible]

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

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

2NOV03

b(6)-4 b(6)-2 b(6)-4

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

LAST, FIRST, MI: [redacted]		DATE: 03NOV	TIME: 0400	SSN/PSEUDO SSN: [redacted]

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
					N/A	Occ Bld		Negative
					Negative	H. pylori		Negative
					N/A	Micro Parasites		
					Negative	Malaria		
					0.2-1.0	O & P		
					Negative	Other		
					Negative	**Microscopic Urinalysis**		
					Negative			

RAPIDPOINT [illegible] ANALYZER V4.54
SERIAL [redacted] [illegible] 03:54

Patient ID: [redacted] b(6)-4
Test Name: [illegible]
Test Result:= 26.1 sec.
RESULT OUT OF RANGE
Ratio = 2.3
Calculated INR = 3.86
Sample Type:citrated wh. blood
Test Date :11/03/03
Test Time :03:54 b(6)-4
Card Lot [redacted]
Operator [redacted] b(6)-2

RAPIDPOINT [illegible] ANALYZER V4.54
SERIAL [redacted] 11/03/03 03:56

Patient ID: 1050 b(6)-4
Test Name :APTT
Test Result:= 41.5 sec.
Sample Type:citrated wh. blood
Test Date :11/03/03
Test Time :03:54
Card Lot [redacted] b(6)-2
Operator [redacted]

CSF			Blood Bank	
			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED	
gen		Negative	ABO/Rh	

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

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

b(6)-4

Ward/Section: ICW 1	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)		
LAST, FIRST, MI. EPW [redacted]		DATE 7NOV	TIME 0420	SSN/PSEUDO SSN:

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App		N/A	Mono		Negative
					Negative	**Microbiology**		
					Negative	Source		
					Negative	Gram Stain		
					N/A	Occ Bld		Negative
					Negative	H. pylori		Negative
					N/A	Micro Parasites		
					Negative	Malaria		
					0.2-1.0	O & P		
					Negative	Other		
					Negative	**Microscopic Urinalysis**		
					Negative			
			CSF			**Blood Bank**		
			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED		
			Directigen		Negative	ABO/Rh		

RAPIDPOINT [illegible]
SERIAL [redacted] [illegible]

b(6)-4

Patient ID: [redacted]
Test Name :PT
Test Result:= 42.0 sec.
RESULT OUT OF RANGE
Ratio = 3.4
Calculated INR = 7.41
Sample Type:citrated wh. blood
Test Date :11/07/03
Test Time :05:06
Card Lot [redacted]
Operator [redacted]

b(6)-4
b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 11/07/03 05:12

b(6)-4

Patient ID: [redacted]
Test Name :APTT
Test Result:= 81.3 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :11/07/03
Test Time :05:08
Card Lot [redacted]
Operator [redacted]

b(6)-4
b(6)-2

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

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

b(6)-4

Ward/Section: FCW1	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted]	DATE: 11/5 TIME: 0430	SSN/PSEUDO SSN:

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb		14-18 g/dl (M)	Glu		Negative	**Microbiology**		
					Negative	Source		
					Negative	Gram Stain		
					N/A	Occ Bld		Negative
					Negative	H. pylori		Negative
					N/A	Micro Parasites		
					Negative	Malaria		
			b		0.2-1.0	O & P		
					Negative	Other		
			k		Negative	**Microscopic Urinalysis**		
			G		Negative			

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 11/05/03 05:39
Patient ID: [redacted] b(6)-4
Test Name :PT
Test Result:= 38.8 sec.
RESULT OUT OF RANGE
Ratio = 3.2
Calculated INR = 6.52
Sample Type:citrated wh. blood
Test Date :11/05/03
Test Time :05:36
Card Lot [redacted] b(6)-4
Operator [redacted] b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 11/05/03 05:42
Patient ID: [redacted] b(6)-4
Test Name :APTT
Test Result:= 55.2 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :11/05/03
Test Time :05:39
Card Lot [redacted] b(6)-4
Operator [redacted] b(6)-2

CSF			Blood Bank	
ll unt			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED	
rectigen		Negative	ABO/Rh	

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

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

b(6)-4

Ward/Section: FCW 1	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: EPW [redacted]	DATE: 6 NOV	TIME: 0440
		SSN/PSEUDO SSN:

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb		[illegible]	Glu		Negative	**Microbiology**		
			Bili		Negative	Source		
			Ket		Negative	Gram Stain		
			SG		N/A	Occ Bld		Negative
			Bld		Negative	H. pylori		Negative
			pH		N/A	Micro Parasites		
			Prot		Negative	Malaria		
			Urob		0.2-1.0	O & P		
			Nit		Negative	Other		
			Leuk		Negative	**Microscopic Urinalysis**		
			HCG		Negative			

RAPIDPOINT [illegible]
SERIAL [redacted] [illegible]

Patient ID: [redacted] b(6)-4
Test Name :PT
Test Result:= 41.3 sec.
RESULT OUT OF RANGE
Ratio = 3.4
Calculated INR = 7.21
Sample Type:citrated wh. blood
Test Date :11/06/03 b(6)-4
Test Time :05:29
Card Lot [redacted]
Operator : [redacted] b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 11/06/03 05:37

Patient ID: [redacted] b(6)-4
Test Name :APTT
Test Result:= 67.7 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :11/06/03
Test Time :05:34
Card Lot [redacted] b(6)-2
Operator

CSF			Blood Bank
Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED
Protein		Negative	ABO/Rh

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

MEDICAL RECORD - ANESTHESIA

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

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

DRUG (Units)												
FENTANYL (mcg)	100, 100, 50, 100								50, 50			
MSO4 (mg)	6	4							4			
Propofol (mg)	200											
SUX (mg)	100											
NMB (mg)	100											
( )												
VOLAT AGENT — 5% MAC % del	3.0	1.5	2.0	3.0	3.0	3.0	3.0	3.0	2.0	1.0	(0)	
% e.t.												
AIR L/Min												
N2O L/Min												
O2 L/Min	3/2	2	2	2	2	2	2	2	2	2	4	

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

TOTALS	TOTAL EBL
500	
20	minl
	TOTAL URINE
	300

FLUIDS - SUMMARY
CRYSTALLOID- 2000
COLLOID-
BLOOD-

FLUIDS

LINE site												
LR 18 (L)	☐ Warmed	300 (#2)							1350		2000	
	☐ Warmed											
	☐ Warmed											
	☐ Warmed											

LOSSES

EST BLOOD LOSS												
URINE -											300	

REMARKS
Code drugs with numbers, events with letters

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 60 KG LB

HEMATOCRIT:

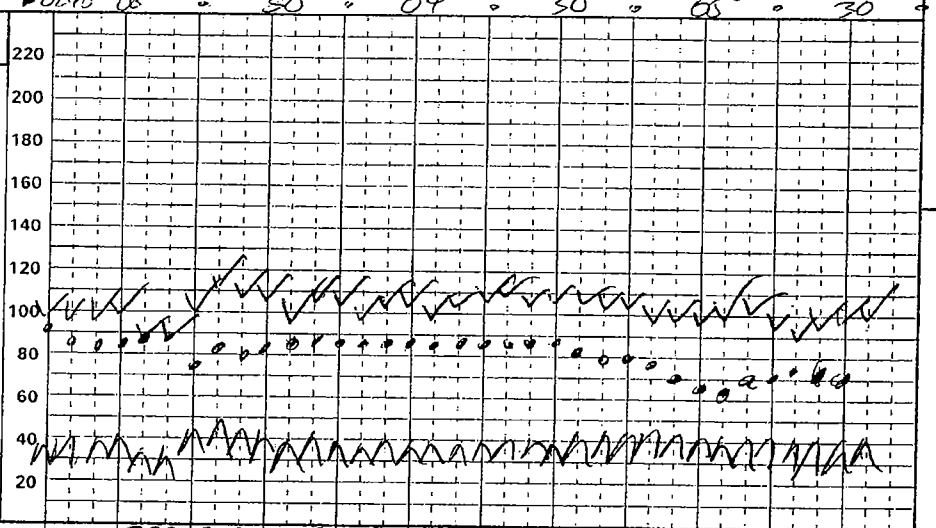
INITIAL DATA:
BP- 98, 34
HR- 100

EQUIP CHECK
OK?- Y N

PATIENT RECHECK
OK for PROCEDURE? yes
TIME-

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

TIME → 0245 0300 30 0400 30 0500 30



JJT-114

VENTIL

VT - ml		290	300	400	380	360	300	300	300	390	490
f - breaths/min		11	10	15	15	15	13	14	16	8	10
Peak inf pres / PEEP											
MODE - S(pon), A(ssist), C(on)	S/A	S	S	S	S	S	S	S	S	S	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	(+)	65	57	57	54	54	54	54	57	58	52
BP/oth	FIO2 (Frac or %)	.80	.80	.80	.80	.77	.77	.76	.76	.76	.77	.77
ART line	SpO2 (%)	97	97	98	97	98	98	99	99	99	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site	AXIL →										
	N-M Block (T/4)											
Warming blkt												
Conv warmer												

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

RECOVERY AT 0530
PACU ICU _____ (Specify)
OTHER _____
CONDITION:
RESP- 10 SpO2-
BP- HR- 78

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0230	0245	0490
	Ready	Begin	End
PROC	0285	0310	0530

PROCEDURES and CPT Codes:
(R) ANKLE OPEN

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
GATA

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

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
RRA-OT 8.0 ETT FO2 RSI Pt X2 MAC 4 Grade I View, 8.0 ETT Placed 25 cm @ lip (+) BBS (+) ET CO2

SURGEONS:
[redacted] b(6)-2
[redacted] CPT, MC, CRNA

PROCEDURE LOCATION: OR1
DATE: 20 OCT 03
PAGE 1 OF 7

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

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 22 DAYS MOS YRS Sex (✓) MALE ( ) FEMALE

PROPOSED PROCEDURE: Fx L ankle
SURGICAL SERVICE: ORTHO
NPO SINCE: 0800

ASA Physical State 1 2 3 4 5 E
WT: 60 KG/LB HT: ___ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: ___
ETOH: ___
DRUGS: ___

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) ___
( ) ___
( ) ___
( ) ___
( ) ___
( ) ___

PREMEDICATIONS:
None Yes (@ ___ Hrs) /CC
1gm Ancef mg IV IM PO
150mg Ferm mg IV IM PO
Tetanus mg IV IM PO

LABORATORY STUDIES:

HB/HCT: ___/___
U/A: ___
OTHER: ___

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

Pulmonary System:
- Asthma N Y
- Bronchitis/URI N Y
- COPD N Y
- Other N Y

Renal System:
- Acute/Chronic RF N Y

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

Endocrine System:
- Diabetes N Y
- Steriods N Y
- Thyroid N Y

Neurological:
- Seizures N Y JCH 1997
- Neuropathy N Y
- Other N Y ∅ problems

Gynecological :
- Pregnancy N Y

Other Significant Hx:
- N Y
- N Y
- Familial HX N Y

ASSESSMENT
PAST SURGICAL/ANESTHETIC

∅

PHYSICAL EXAMINATION
BP 138/64 HR 63 R 12 T ___ 100% SaO2
Pain Scale 0-10 ___
HEENT - Teeth intact
Trachea midline
TMJ/Neck FROM
Oropharnyx MPZ
Nares ___
CHEST: CTA(B) =
CARDIAC: RRR (-) ⊖
EXTREMITIES: ___
IV Access: 18G (L) A / 20G (R) A
Ulnar Filling: ___
BACK: ___
OTHER: ___

NPO Since ___

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

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

The patie[redacted]rdian [redacted] and agrees. Questions answered.
Signed: [redacted] CRNA MAJ Date: 10-19-03 Time: 2124 Hrs

POST-A[redacted]HESIA EVALUATION AND NOTE ([redacted]SU)
{ } NO [redacted]RENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ___ Date: ___ Time: ___ Hrs

b(6)-2

Patient Identification: (Ward) ___

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

SEDATION KEY:

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

NSN 7540-01-165-7294

519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN	WARD/CLINIC	REGISTER NO.
U/S RLE		M	[redacted]	ICW#1	
	FILM NO. [redacted] b(6)-4				PREGNANT ☐ YES ☒ NO
	REQUESTED BY (Print) [redacted]				TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR b(6)-2				DATE REQUESTED 28OCT03

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

28OCT03 R/O DVT

DATE OF EXAMINATION *(Month, day, year)* 1748 | DATE OF REPORT *(Month, day, year)* [redacted] | TRANSCRIPTION *(Month, day, year)*

RADIOLOGIC REPORT

Please notify Dr. [redacted] on Surgeon on-call ASAP.

1) (+) (R) DVT involving entire Superficial Femoral Vein and Popliteal Vein Based on Color Doppler and Compressibility US.

2) (R) CFV and (R) CFV/DFV bifurcation normal.

[redacted] b(2)-2

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

[redacted] Rm 2 Bed A

b(6)-4

LOCATION [redacted]

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

MEDCOM - 21723 ATION

1 — MEDICAL RECORD

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

b(6)-4

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]

Noted 19 Oct 03 2200 [redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW1		

DATE OF ORDER: 19 OCT 03 TIME OF ORDER: 2115 HOURS

LIST TIME ORDER NOTED AND SIGN

1. admit to ICW-1
2. Dx: OPEN (R) TIB-FIB s/p GSW
3. Continue strict
4. NS - routine
5. NPO
6. IVF - LR at 125 cc/hr.
7. Cancel ↑ chem NPB Q 8 HRS
8. MSO4 2-8 mg IVP Q 1-2 HRS PRN
9. to OR tomorrow

b(6)-2

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.
24° ✓	20	Oct

20 Oct 03 [redacted] 20 Oct AM

PATIENT IDENTIFICATION

DATE OF ORDER: 20 OCT 03 TIME OF ORDER: 0630 HOURS

1. Resume previous orders
2. Regular diet
3. NS LR at 150 cc/hr, keep tph when taking P.O. fluids
4. Cleaf ↑ chem NPB Q 8 HRS
5. Gentamycin 500 mg IVPB Q 8 HRS
6. Tylenol 1-2 P.O. Q 4-6 HRS PRN

NURSING UNIT	ROOM NO.	BED NO.
[redacted]		

PATIENT IDENTIFICATION [redacted]

DATE OF ORDER: TIME OF ORDER:

7. Percocet 1-2 P.O. Q 4-6 HRS PRN
8. MSO4 2-8 mg IVP Q 1 HR PRN
9. ~~Pt~~ OK to LIO, cast NWB on (R)
10. ODB to cylin TID
11. D/C Foley at 1200.
12. Elevate (R) LEG

NURSING UNIT	ROOM NO.	BED NO.
ICW1	24 ✓	21 Oct 03 @ 023 [redacted]

DA FORM 1 APR 79 4256 REPLACES [redacted] OF 1 JUL 77, WHICH MAY BE USE[redacted]

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b(6)-4

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
	24	1

DATE OF ORDER 31 DEC 03 TIME OF ORDER 1620 HOURS

LIST TIME ORDER NOTED AND SIGN

1. UA to LAB with CULTURE
2. COUMADIN 5mg P.O. Q DAY
3. D/C LOVENOX on 2 NOV 03
4. PT, PTT Q DAY x 7 days to [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER [redacted] HOURS

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.

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

#[redacted]

NURSING UNIT	ROOM NO.	BED NO.

↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	5 NOV 03	1620 HOURS	[redacted]
1	Δ COD MEDIN TO 2 MG Q DAY.		[redacted] 5 NOV 03 1630
			[redacted]

PATIENT IDENTIFICATION

b(6)-4

#[redacted]

Noted [redacted]

NURSING UNIT	ROOM	BED NO.
2d0/0300 [redacted]		

↓	DATE OF ORDER	TIME OF ORDER	
	6 NOV 03	1600 HOURS	b(6)-2
1	40000 COD MEDIN VOL 1L Q MW 03.		
			[redacted] b(6)-2

PATIENT IDENTI[redacted]

b(6)-2

NURSING UNIT	ROOM NO.	BED NO.

↓	DATE OF ORDER	TIME OF ORDER
		HOURS

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

↓	DATE OF ORDER	TIME OF ORDER
		HOURS

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted]			↓	8 NOV 03	1228 HOURS	
			1	DISCHARGED TO CPW CAMP		
			2	COUMADIN ~~2 MG~~ P.O. QDAY		0830
				V.O. 2.5		
				Col. [redacted]		
NURSING UNIT	ROOM NO.	BED NO.				
24C	0210	9 NOV 03 [redacted]				

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

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

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

b(6)-4

b(6)-2

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

CLINICAL RECORD

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

Mo. 10 Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 19	20	21	22	23	24	25	26	27	28	29	30	31	1
19Oct	[redacted]	~~VS Routine~~	06	/	[redacted]												
			18														
			00														
19Oct	[redacted]	NPO	06	/	[redacted]												
			18														
			06	B													
20Oct	[redacted]	VS routine	6	/	/	[redacted]											
			18	/													
20Oct	[redacted]	Regular diet	6	/													
			18	/													
20Oct	[redacted]	Upad lib, crutches	6														
		NWB on (R)	18	/													
20Oct	[redacted]	OOBTC TID	8	/													
			16	/													
			22	/													
20Oct	[redacted]	Elevate RLE	6	/													
			18	/													
31 Oct	[redacted]	PT, PTT QDAY x 7 days	4														
		to begin Am 1 Nov 03															
		b(6)-2															

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: OPEN (R) Tib/fib S/P GSW

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted] b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo _____ Yr 2003

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
19Oct	[redacted]	Admit to ICW 5	19 Oct	—	2200	[redacted]
19Oct	[redacted]	Condition Stable	19 Oct	—	2200	[redacted]
19 Oct	[redacted]	TO OR Tonight	19 OCT	To night		
20	[redacted]	D/C FOLEY @ 1200	20 OCT	1200	21 Oct 0530	[redacted]
28 OCT03	[redacted]	U/S @ LE R/O DVT	[redacted]			

	-----					

b(6)-2

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

USAPA V1.00

Recopied 2NOV03

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 11 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 2	3	4	5	6	7	8	9	10
20OCT	[redacted]	VS routine	6	[redacted]								
			18									
20OCT	[redacted]	Regular Diet	6									
			18									
20OCT	[redacted]	up ad lib, crutches	6									
		NWB on (R)	18									
20OCT	[redacted]	Elevate RLE	6									
			18									
31OCT	[redacted]	PT/PTT QD x 7 days	04	[redacted]								
		(Start INOV)	X									
		b(6)-2										

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: open (R) tib/fib (SPG/SW)

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

MEDCOM - 21730

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

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*				Mo NOV Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
8 NOV 1230	[redacted]	D/C to IPW Camp	9 NOV			
		b(b)-2				

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 (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 10 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 19	20	21	22	23	24	25	26	27	28	29	30	31	1
19 Oct	[redacted]	IV LR @ 125cc/hr	06	[redacted]													
	-----		18														
			06														
19 Oct	[redacted]	Ancef 1gm IVPB	08														
	-----	Q8°	16														
	-----		24														
20 Oct	[redacted]	LR @ 150cc/hr	6														
	-----	HL when taking po well	18														
20 Oct	[redacted]	Ancef 1gm IVPB Q8°	08														
	-----		16														
	-----		24														
20 Oct	[redacted]	Gentamycin 500mg	10														
	-----	IVPB QD	X														
29 Oct	[redacted]	Lovenox 60mg SQ	10														
	-----	BID	20														
	[redacted]																
31 Oct	[redacted]	Coumadin 5mg QD PO	10														

PREOP

[redacted]

b(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: OPEN (R) Tib/Fib S/P GSW

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted] b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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
3/oct	[redacted]	D/C Lovenox on 2-10-03	2-10-03			
		b(6)-2				

b(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED														
19oct	[redacted]	MSO4 2-8 mg	D/I	19oct 2237 5M	20oct 0030 4M												
		IVP Q1-2 hrs	D/I	[redacted]							PREOP						
		PRN	I/E	[redacted]													
20	[redacted]	Tylenol 625mg 1-2po Q4-6° PRN	D/T														
			D/I														
20	[redacted]	Percocet 1-2po Q4-6° PRN	D/T	20oct 0530	20oct 1400	20oct 0110	20oct 1705	21oct 0150	21oct 2220	26oct 0430	25oct 1820	26oct 1155	26oct 1615	27oct 0500	27oct 1015	27oct 1800	
			D/I	[redacted]													
20	[redacted]	MSO4 2-8mg IVP Q1° PRN	D/T														
			D/I														
20	[redacted]	Percocet 1-2 PO	D/T	29 oct 1200	30 oct 1136												
		Q4-6° PRN	D/T	[redacted]													

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

REWRITTEN 2ND VOB

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. N Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 2	3	4	5	6	7	8	9	10	11	12
20 OCT	[redacted]	LR @ 150 cc/0	6	[redacted]										
	[redacted]	th when tol po.	18											
20 OCT	[redacted]	Ancef + gm IVPB q8°	8											
	-----		16											
	[redacted]		24											
20 OCT	[redacted]	Gentamycin 500mg	10											
	-----	IVPB QD	X											
31 OCT	[redacted]	Coumadin 5mg po QD	10	[redacted]								5 NOV 03	[redacted]	
5 NOV	[redacted]	change to 2MG po QD	10					[redacted]	ON HOLD until 9 NOV					
8 NOV	[redacted]	Coumadin 2MG po QD	10							[redacted]				
	-----	x 30 days												

	-----	b(6)-2												

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: open (R) tib/fib (S/P ORSW

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

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

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				Mo. 11 Yr. 03
Order Date	**Clerk/ Nurse**	**SINGLE ORDER, PRE-OPERATIVES**	**Date to be Given**	**Time to be Given**	**Time Given**	**Initials**
06 NOV03	[redacted]	Hold coumadin until 09NOV03				
		b(6)-2				

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

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

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

DTSG APPROVED (Date)

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

Date: 20 OCT 03
Time In: 0535
Allergies: NKDA
Pre-op V/S: 95/34 100
Procedures: (2) ankle ORIF

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 2000 Colloid 0
OR Output: UOP 300 EBL mn
Meds/Times: Fentanyl, MSO4

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

Airway: ~~Nasal~~, Oral, ETT, Trach, Other

History

Pre Op Meds

Time	0535	0545	0555	0605
SaO2	99	100	99	100
FiO2	21	28L	6L	6L
Methods	RA	RA	RA	RA

240, 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20

RR: 7 7 8 8 8

T: 96.9

Time
Pain (0-10)
LOS

Pacu Intake

Time	Solution	Amount	Site	By	Infused
	LR				

X-rays:

Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	0	0	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	1	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	1
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	6	6	9

Codes:
AIRWAY: A = Ambu, BB = Blow-by, M = Mask, FT = Face Tent, RA = RoomAir, NC = Nasal Cannula
V/S: X = A-line BP, " = Cuff BP, = Pulse
TEMP: S = Skin, O = Oral, A = Axillary, T = Tympanic, R = Rectal
LOS: C = Cervical, T = Thoracic, L = Lumbar, S = Sacral

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

(Continue on reverse)

PREPARED BY (Signature): [redacted] LPN

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 20 OCT 03

PATIENT'S IDENTI[redacted] written entries give: (first, middle; grade; date; hospital or medical facility) Name – last.

b(6)-2

[redacted] b(6)-4

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	Rank	UTA	UTA	P	B	C	PK
15'	Rank	UTA	UTA	P	B	C	PK
30'	Rank	UTA	UTA	P	B	C	PK
45'							
60'							
90'							
D/C	R ankle	+	P	B	C	PK	

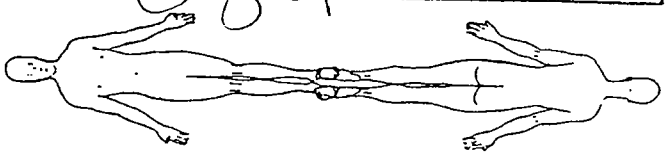
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	Rank	Soft cast	Ø
30'	Rank	Soft cast	Ø
60'			
D/C	R leg	Soft cast	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0600	NSR	NO	NO

NURSING NOTES

0535 Rec'd pt via litter from OR. Pt has oral airway. pt connected to monitor. SpO2 88%, pt put on 8L O2 via FM. SpO2 now 100%. — SGT [redacted]
Pt continues to be [redacted] Allergy: VS [redacted] b/b. — [redacted]

b(6)-2

b(6)-2

Discharge Criteria:
Date: 200703 Time: 0610 PARS: 9
BP: 103/53 T: 96.9 HR: 62 RR: 12 Sa02: 94
Pain Level at D/C (0-10):
Intake: 600 Output: 600
Additional Data:
Transferred To: [redacted]
Report Given To: [redacted]
Transferred Via: [redacted] Ambulance
Transferred By: [redacted]
Cleared IAW Recovery [redacted]
Charge Nurse Signature: [redacted]

b(6)-4

[redacted] I'll Hold

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

YELLOW FIELDS MUST BE FILLED IN, IF APPLICABLE, UPON APPREHENSION

Offense against Civilian(s) [check one] If "Other" then describe:

- [ ] Arson (I.P.C. 342)
- [ ] Solicitation of Fornication/Prostitution (I.P.C. 399)
- [ ] Rape/Indecent/Sexual Assaults/Acts (I.P.C. 393-98, 402)
- [ ] Murder (I.P.C. 405)
- [ ] Aggravated Assault/Assault With Intent To Kill (I.P.C. 410)
- [ ] Maiming (I.P.C. 412)
- [ ] Simple Assault (I.P.C. 415)
- [ ] Kidnapping (I.P.C. 421)
- [ ] Burglary or Housebreaking (I.P.C. 428)
- [ ] Extortion/Communicating Threats (I.P.C. 430)
- [ ] Theft (I.P.C. 439)
- [ ] Destruction of Property (I.P.C. 477)
- [ ] Obstructing a Public Highway/Place (I.P.C. 487)
- [ ] Discharging Firearm/ Explosive in City/Town/Village (I.P.C. 495)
- [ ] Riot or Breach of Peace (I.P.C. 495(3))
- [ ] Other

Offense against Coalition Forces [check one] If "Other" then describe: RPG-7 Attack

- [ ] Violation of Curfew
- [ ] Illegal Possession of Weapon
- [x] Assault/Attack on Coalition Forces
- [ ] Theft of Coalition Force Property
- [ ] Trespass on Military Installation or Facility
- [ ] Photographing/Surveilling Military Installation or Facility
- [ ] Obstructing Performance of Military Mission
- [ ] Other

b(6)-2

Apprehending Unit: 2-3 FA	Location Grid: MB 401 914

Date of Incident: (D/M/Y)	Time of Incident:	Date of Report: (D/M/Y)	Time of Report:
19 / 10 / 03 to / /	1100Z hrs to hrs	/ /	hrs

Detainee #_____	Key Connected Person: [ ] Victim [ ] Witness
Last Name: [redacted] 22 yrs old	Last Name:
First Name: [redacted] Given Name:	First Name: Given Name:
Hair Color: B / Scars/Tattoos/Deformities:	Hair Color: / Scars/Tattoos/Deformities:
Eye-Color: / Weight: lb / Height: in	Eye-Color: / Weight: lb / Height: in
Address: 60th Street 03 314 house 162	Address:
Place of Birth:	Place of Birth:
Ethn/Tribe/ Sect: / Sex: [x] M [ ] F / Phone#: / DOB D/M/Y: / [ ] Mobile [ ] Regular	Ethn/Tribe/ Sect: / Sex: [ ] M [ ] F / Phone#: / DOB D/M/Y: / [ ] Mobile [ ] Regular
[ ] Passport [ ] Dr. license [ ] Other (specify) Document #:	[ ] Passport [ ] Dr. license [ ] Other (specify) Document #:

Total Number of Persons Involved _____(list names/identifying info on reverse under "Additional Helpful Information")

[ ] Vehicle Information	Vehicle Number _____ of _____ Vehicle(s)		Owner:
Make:	Color:	VIN: N/A	
Model:	Type:	Plate No.:	Number of People in Vehicle:
Year:	Names of People in Vehicle:		
Contraband/Weapons in Vehicle:			

[ ] Property/Contraband	[ ] Weapon	Photo Taken of Suspect with Weapon/Contraband: Yes/ No	
Type:		Model:	Color/Caliber:
Serial No.:	Quantity:	Make:	Receipt Provided to Owner: Yes/ No
Other Details:		Where Found:	Owner:

Name of Assisting Interpreter: [redacted] b(6)-2 b(6)-2 Email, Phone, or Contact Info:

Detaining Soldier's Name (Print): [redacted]	Supervising Officer's Name (Print): [redacted]
Signature: [redacted]	Signature: [redacted]
Email: [redacted]	Email:
Unit Phone: [redacted] Date: 19 / 10 / 03	Unit Phone: Date: / /

MEDCOM - 21738

[redacted] b(6)-4

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

Why was this person detained? was the person Responsible for firing a RPG-7 at the 2-3 FA Palace Complex. He was implicated as the shooter and was trained local to do this

Who witnessed this person being detained or the reason for detention? Give names, contact numbers, addresses.

How was this person traveling (car, bus, on foot)?

Who was with this person?

What weapons was this person carrying?

What contraband was this person carrying?

What other weapons were seized?

What other information did you get from this person?

Additional Helpful Information:

[redacted] b(6)-2

SWORN STATEMENT

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

LOCATION	DATE	TIME	FILE NUMBER
2-3 FA, BAGHDAD, IRAQ	[redacted]	1741	
LAST NAME, FIRST NAME, MIDDLE NAME	SOCIAL SECURITY NUMBER		GRADE/STATUS
[redacted] b(6)-2			SFC/AD
ORGANIZATION OR ADDRESS			
FOB 51, BAGHDAD, IRAQ			

I, [redacted], WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

191100Z OCT 03 TWO (2) INDIVIDUALS FIRED AN RPG-7 AP ROUND FROM 38S MB 401914 AND IMPACTED AT GRID 38S MB 405916, ZONE 18. THE ROUND FLEW OVER OUR POSITION AND IMPACTED IN THE 2-3 FA MOTOR POOL. THE LAUNCH WAS 150 M FROM OUR POSITION. WE SHOT AND WOUNDED THE TWO (2) IRAQI'S IN THE LEGS AT THE LAUNCH SITE. [redacted] (THE ACCOMPLICE), AGE 16, FROM AL AZHAMIYA AND [redacted] (THE SHOOTER) AGE 22, FROM AL AZAMIYA. THE TWO (2) IRAQI'S WERE THEN TAKEN TO 2-3 [redacted] ATION FOR MEDICAL TREATMENT WHERE THEY WERE STABALIZED AND QUESTIONED. [redacted] CONFESSED THA[redacted] AD FIRED THE RPG AT THE 2-3 FA FOB. THEY GOT T[redacted] , ALSO OF AL AZAMIYA, THEN TOOK A TAXI WITH THE RPG IN A BOX. [redacted] N[redacted] THE SHOOTER) FIRED THE RPG FROM UNDERNEITH THE AL AZAMIYA BRIDGE NEXT TO THE RIVER. AFTER LOOKING AT THE SPENT WAREHEAD IT WAS DETERMINED THAT IT WAS AN RPG AP ROUND. THE ROUND LANDED UNDER THE FRONT AXLE OF A PLS AND CAUSED ONLY SLIGHT DAMAGE. [redacted] LKED FREELY, GIVING US THE INFORMATION CONCERNING THIS INCIDENT. HE SAID THAT [redacted] (THE SHOOTER) WOULD EVENTUALLY TALK AND ADMITT HIS GUILT. [redacted] THE SHOOTER) DENIED ANY KNOWLEDGE OF THE INCIDENT AND INSISTED THAT HE DIDN'T SEE ANYTHING. SWORN STATEMENTS WERE GIVEN TO 2-3 FA TO ACCOMPANY THE DETAINEES TO 1 BCT, 1AD. -----NOTHING FOLLOWS-------

b(6)-4

b(6)-2

EXHIBIT	INITIALS OF PERSO[redacted]	PAGE 1 OF _____ PAGES
	[redacted] 19 Oct 03	

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT OF _____ TAKEN AT _____ DATED _____ CONTINUED." THE BOTTOM OF EACH ADDITIONAL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEMENT AND BE INITIALED AS "PAGE _____ OF _____ PAGES." WHEN ADDITIONAL PAGES ARE UTILIZED, THE BACK OF PAGE 1 WILL BE LINED OUT, AND THE STATEMENT WILL BE CONCLUDED ON THE REVERSE SIDE OF ANOTHER COPY OF THIS FORM.

STATEMENT *(Continued)*

b(6)-2

AFFIDAVIT

I, [redacted], HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT WHICH BEGINS ON PAGE 1 AND ENDS ON PAGE _____. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING T[redacted]EMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNL[redacted] OR UNLAWFUL INDUCEMENT.

[redacted] *(Signature of Person Ma[redacted]tatement)*

WITNESSES:

_____

_____

_____

ORGANIZATION OR ADDRESS

_____

_____

_____

ORGANIZATION OR ADDRESS

Subscribed and sworn to before me, a person authorized by law to administer oaths, this _____ day of _____, 19 _____

at _____

_____

(Signature of Person Administering Oath)

_____

(Typed Name of Person Administering Oath)

_____

(Authority To Administer Oaths)

INITIALS OF PERSON MAKING STATEMENT

PAGE OF PAGES

USAPPC V2.00

b(6)-2

SWORN STATEMENT

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

LOCATION	DATE	TIME	FILE NUMBER
2-3 FA, BAGHDAD, IRAQ	19 OCT [redacted]	174[redacted]	
LAST NAME, FIRST NAME, MIDDLE NAME	SOCIAL SECURITY NUMBER		GRADE/STATUS
[redacted]			SFC/AD
ORGANIZATION OR ADDRESS			
FOB 51, BAGHDAD, IRAQ			

I, [redacted], WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

191100Z OCT 03 TWO (2) INDIVIDUALS FIRED AN RPG-7 AP ROUND FROM 38S MB 401914 AND IMPACTED AT GRID 38S MB 405916, ZONE 18. THE ROUND FLEW OVER OUR POSITION AND IMPACTED IN THE 2-3 FA MOTOR POOL. THE LAUNCH WAS 150 M FROM OUR POSITION. WE SHOT AND WOUNDED THE TWO (2) IRAQI'S IN THE LEGS AT THE LAUNCH SITE. [redacted] (THE ACCOMPLICE), AGE 16, FROM AL AZHAMIYA AND [redacted] (THE SHOOTER) AGE 22, FROM AL AZAMIYA. THE TWO (2) IRAQI'S WERE THEN TAKEN TO 2-3 FA MEDSTATION FOR MEDICAL TREATMENT WHERE THEY WERE STABALIZED AND QUESTIONED. [redacted] CONFESSED THAT [redacted] HAD FIRED THE RPG AT THE 2-3 FA FOB. THEY GOT THE RPG FROM [redacted], ALSO OF AL AZAMIYA, THEN TOOK A TAXI WITH THE RPG IN A BOX. [redacted] AND [redacted] (THE SHOOTER) FIRED THE RPG FROM UNDERNEITH THE AL AZAMIYA BRIDGE NEXT TO THE RIVER. AFTER LOOKING AT THE SPENT WAREHEAD IT WAS DETERMINED THAT IT WAS AN RPG AP ROUND. THE ROUND LANDED UNDER THE FRONT AXLE OF A PLS AND CAUSED ONLY SLIGHT DAMAGE. [redacted] TALKED FREELY, GIVING US THE INFORMATION CONCERNING THIS INCIDENT. HE SAID THAT [redacted] (THE SHOOTER) WOULD EVENTUALLY TALK AND ADMITT HIS GUILT. [redacted] (THE SHOOTER) DENIED ANY KNOWLEDGE OF THE INCIDENT AND INSISTED THAT HE DIDN'T SEE ANYTHING. SWORN STATEMENTS WERE GIVEN TO 2-3 FA TO ACCOMPANY THE DETAINEES TO 1 BCT, 1AD.

b(6)-4

b(6)-2

EXHIBIT	INITIALS OF PERSON MAKING STATEMENT	PAGE 1 OF 1 PAGES
	[redacted]	

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT OF [redacted] _____ TAKEN AT _____ DATED _____ CONTINUED." THE BOTTOM OF EACH ADDITIONAL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEMENT AND BE INITIALED AS "PAGE _____ OF _____ PAGES." WHEN ADDITIONAL PAGES ARE UTILIZED, THE BACK OF PAGE 1 WILL BE LINED OUT, AND THE STATEMENT WILL BE CONCLUDED ON THE REVERSE SIDE OF ANOTHER COPY OF THIS FORM.

STATEMENT *(Continued)*

b(6)-2

AFFIDAVIT

I, _____ [redacted] _____, HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT WHICH BEGINS ON PAGE [redacted] ___/___. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFLUENCE, OR UNLAWFUL INDUCEMENT.

[redacted]

(Signature of Person Making Statement)

WITNESSES:

_____

_____

_____

ORGANIZATION OR ADDRESS

_____

_____

_____

ORGANIZATION OR ADDRESS

Subscribed and sworn to before me, a person authorized by law to administer oaths, this _____ day of _____, 19 _____

at _____

_____

(Signature of Person Administering Oath)

_____

(Typed Name of Person Administering Oath)

_____

(Authority To Administer Oaths)

INITIALS OF PERSON MAKING STATEMENT [redacted]

PAGE 1 OF 1 PAGES

USAPPC V2.00

MEDCOM 21743

[redacted] b(6)-2

SWORN STATEMENT

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

LOCATION	DATE	TIME	FILE NUMBER
2-3 FA, BAGHDAD, IRAQ	19 OCT 03	1741	

LAST NAME, FIRST NAME, MIDDLE NAME	SOCIAL SECURITY NUMBER	GRADE/STATUS
[redacted] b(6)-2		CW1/AD

ORGANIZATION OR ADDRESS
FOB 51, BAGHDAD, IRAQ

I, [redacted], WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

191100Z OCT 03 TWO (2) INDIVIDUALS FIRED AN RPG-7 AP ROUND FROM 38S MB 401914 AND IMPACTED AT GRID 38S MB 405916, ZONE 18. THE ROUND FLEW OVER OUR POSITION AND IMPACTED IN THE 2-3 FA MOTOR POOL. THE LAUNCH WAS 150 M FROM OUR POSITION. WE SHOT AND WOUNDED THE TWO (2) IRAQI'S IN THE LEGS AT THE LAUNCH SITE. [redacted] (THE ACCOMPLICE), AGE 16, FROM AL AZHAMIYA AND [redacted] (THE SHOOTER) AGE 22, FROM AL AZAMIYA. THE TWO (2) IRAQI'S WERE THEN TAKEN TO 2-3 FA MEDITATION FOR MEDICAL TREATMENT WHERE THEY WERE STABALIZED AND QUESTIONED. [redacted] CONFESSED THA[redacted] HAD FIRED THE RPG AT THE 2-3 FA FOB. THEY GOT THE RPG FROM [redacted], ALSO OF AL AZAMIYA, THEN TOOK A TAXI WITH THE RPG IN A BOX. [redacted] ND [redacted] (THE SHOOTER) FIRED THE RPG FROM UNDERNEITH THE AL AZAMIYA BRIDGE NEXT TO THE RIVER. AFTER LOOKING AT THE SPENT WAREHEAD IT WAS DETERMINED THAT IT WAS AN RPG AP ROUND. THE ROUND LANDED UNDER THE FRONT AXLE OF A PLS AND CAUSED ONLY SLIGHT DAMAGE. [redacted] ALKED FREELY, GIVING US THE INFORMATION CONCERNING THIS INCIDENT. HE SAID THAT [redacted] THE SHOOTER) WOULD EVENTUALLY TALK AND ADMITT HIS GUILT. [redacted] THE SHOOTER) DENIED ANY KNOWLEDGE OF THE INCIDENT AND INSISTED THAT HE DIDN'T SEE ANYTHING. SWORN STATEMENTS WERE GIVEN TO 2-3 FA TO ACCOMPANY THE DETAINEES TO 1 BCT, 1AD. -----NOTHING FOLLOWS-------

b(6)-4

Nothing Follows

b(6)-2

EXHIBIT	INITIALS OF PERSON M[redacted]MENT	PAGE 1 OF 2 PAGES

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT OF [redacted] TAKEN AT _____ DATED _____ CONTINUED." THE BOTTOM OF EACH ADDITIONAL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEMENT AND BE INITIALED AS "PAGE _____ OF _____ PAGES." WHEN ADDITIONAL PAGES ARE UTILIZED, THE BACK OF PAGE 1 WILL BE LINED OUT, AND THE STATEMENT WILL BE CONCLUDED ON THE REVERSE SIDE OF ANOTHER COPY OF THIS FORM.

STATEMENT *(Continued)*

b(6)-2

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_____
(Making Statement)

WITNESSES:

_____

_____

_____
ORGANIZATION OR ADDRESS

_____

_____

_____
ORGANIZATION OR ADDRESS

Subscribed and sworn before me, a person authorized by law to administer oaths, this _____ day of _____, 19 _____
at _____

_____
(Signature of Person Administering Oath)

_____
(Typed Name of Person Administering Oath)

_____
(Authority To Administer Oaths)

INITIALS OF PERSON MAKING STATEMENT

USAPPC V2.00

b(6)-2

[redacted]

SWORN STATEMENT

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

LOCATION	DATE	TIME	FILE NUMBER
2-3 FA, BAGHDAD, IRAQ	19 OCT 03	1741	

LAST NAME, FIRST NAME, MIDDLE NAME	SOCIAL SECURITY NUMBER	GRADE/STATUS
[redacted]	[redacted]	SSG/AD

ORGANIZATION OR ADDRESS
FOB 51, BAGHDAD, IRAQ

I, [redacted], WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

191100Z OCT 03 TWO (2) INDIVIDUALS FIRED AN RPG-7 AP ROUND FROM 38S MB 401914 AND IMPACTED AT GRID 38S MB 405916, ZONE 18. THE ROUND FLEW OVER OUR POSITION AND IMPACTED IN THE 2-3 FA MOTOR POOL. THE LAUNCH WAS 150 M FROM OUR POSITION. WE SHOT AND WOUNDED THE TWO (2) IRAQI'S IN THE LEGS. AT THE LAUNCH SITE, [redacted] (THE ACCOMPLICE), AGE 16, FROM AL AZHAMIYA AND [redacted] (THE SHOOTER) AGE 22, FROM AL AZAMIYA. THE TWO (2) IRAQI'S WERE THEN TAKEN TO 2-3 FA MEDSTATION FOR MEDICAL TREATMENT WHERE THEY WERE STABALIZED AND QUESTIONED. [redacted] CONFESSED THAT [redacted] HAD FIRED THE RPG AT THE 2-3 FA FOB. THEY GOT THE RPG FROM [redacted], ALSO OF AL AZAMIYA, THEN TOOK A TAXI WITH THE RPG IN A BOX. [redacted] AND [redacted] (THE SHOOTER) FIRED THE RPG FROM UNDERNEITH THE AL AZAMIYA BRIDGE NEXT TO THE RIVER. AFTER LOOKING AT THE SPENT WAREHEAD IT WAS DETERMINED THAT IT WAS AN RPG AP ROUND. THE ROUND LANDED UNDER THE FRONT AXLE OF A PLS AND CAUSED ONLY SLIGHT DAMAGE. [redacted] TALKED FREELY, GIVING US THE INFORMATION CONCERNING THIS INCIDENT. HE SAID THAT [redacted] (THE SHOOTER) WOULD EVENTUALLY TALK AND ADMITT HIS GUILT. [redacted] (THE SHOOTER) DENIED ANY KNOWLEDGE OF THE INCIDENT AND INSISTED THAT HE DIDN'T SEE ANYTHING. SWORN STATEMENTS WERE GIVEN TO 2-3 FA TO ACCOMPANY THE DETAINEES TO 1 BCT, 1AD. -----NOTHING FOLLOWS-------

b(6)-4

b(6)-4

EXHIBIT	INITIALS OF PERSON MAKING STATEMENT	PAGE 1 OF 2 PAGES
	[redacted]	

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STATEMENT *(Continued)*

b(6)-2

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[redacted]
(Signature of Person Making Statement)

WITNESSES:

ORGANIZATION OR ADDRESS

ORGANIZATION OR ADDRESS

Subscribed and sworn to before me, a person authorized by law to administer oaths, this _____ day of _____, 19 _____

at _____

(Signature of Person Administering Oath)

(Typed Name of Person Administering Oath)

(Authority To Administer Oaths)

INITIALS OF PERSON MAKING STATEMENT

PAGE OF PAGES

USAPPC V2.00

b(2)-2

Admission and Coding Information

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

1. Reporting MTF 0580 [redacted]	2. MTF L[redacted] b(6)-4			
3. Register Number [redacted]	Name (Last, First, MI) [redacted]		4. Pay Grade FGN	5. Sex M
6. DoB (YYYYMMDD) [redacted]	7. Age at Admission 22Y	8. Race X	9. Ethnicity 9	Religion
10. Length of Service	ETS	11. FMP 99	12. Social Security Number [redacted]	
Organization (Active Duty Only)		13. Marital Status	Hour of Admission 20:36	Branch / Corps:
14. Flying Status	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES		16. Zip Code of Residence:	
17. Unit Location	18. MOS	19. Trauma DIS	Prev. Admission NO	
20. Source of Admission Direct from ER	Ward:	Name / Relationship of Emergency Addressee Address of Emergency Addressee		
Name and Location of Medical Treatment Facility: 0580 - 28th CSH - Iraq; No Install Provided		Telephone Number of Emergency Addressee		
21. Type of Disposition TRF-OTH	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2003-11-09		
24. Clinic Svc - Admitting ABA - GENERAL SURGERY	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-10-19		
27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission 2003-10-19		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: SOFT TISSUE WND

Procedure Narrative(s):

Cause of Injury Narrative:

Dx 82392
9972 E9912
4538
Proc 7936
7966
7817
Trauma 9
Inj 569 [redacted]

b(6)-2

Admitting Officer (Signature, as requ[redacted] ature of Admitting Clerk

[redacted]

Automated Facsimile - DA FORM 2985, MAR 2000

MEDCOM - 21748

Automated Facsimile b(6)-4

..NPATIENT TREATMENT RECORD COVER SHEET

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

1. Register Nbr	2. Name					3. Grade	Admission Remarks
[redacted]	[redacted]					FGN	
4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm	
M	17Y	X				NO	
11. FMP	12. SSN	13. Organization				14. Ward	
99	[redacted]					ICW1	
15. FlyStatus	17. Dept / Ben	18. BranchCorps	19. UIC / ZIP	20. Type Case			
	K78-PRISONER OF WAR/INTER			DIS			
21. Source of Admission	22. Hour Of Adm:	23. Clinic Service					
Direct from ER	01:15	AEA - ORTHOPEDICS					
24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp					
	TRF-OTH	2003-10-27					
27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:				
		2003-10-21	[redacted]				
29. ReportingMTF		30. Date Init Adm	32. Units Blood Components				
0580 [redacted] b(2)-2		2003-10-21					

31. Selected Administrative Data

Marital Status: DoB: [redacted] b(6)-4 b(6)-4

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

GSW R UE

b(6)-2

35. Total Days This Facility					
Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	7	7

35. Total Days This Facility					
Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	7	7

Signature of Attending Medical Officer	Signature of PAD or Medical Records C[redacted]
[redacted]	[redacted]

Automated Facsimile - DA FORM 3647, May 79

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

~ 30 yo Iraqi detainee GSW (R) Arm / Forearm

Otherwise healthy by report.

PHYSICAL EXAMINATION

RUE. pulse radial pulse.
open fx humerus / Radius (GSW)
Radial nerve appears out.

XRAYS - (R) humerus, (R) radius fx.

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

- OR for I/D + ORIF
- Kefzol
- b(6)-2

SIGNATURE	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted]	21 OCT 2003		

PATIENT IDENTIFICATION *(For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)*	REGISTER NO.	WARD NO.

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
21 oct 03 0800	- Assumed care of pt transfer from AACU USS transported per litter, self transferred from litter to bed s difficulty. Lungs clear HRRR tachy 105-115 range. PIV x 2 (L) upper Arm and (L) FA patent. Foley to gravity clear yellow urine. Active BS x 4 quads. AM care given. Sleep yet easily arousable & c/o pain or discomfort. DO (R) UE BSW IV ABX TK arm in a sling. Will cont to monitor — [redacted]
21 OCT 2003	ORDERS Pain c/o sleep APPLS Radial IV out (same as prep) Stable ✓ xrays ✓ check in cast days [redacted]

b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

#[redacted] b(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
			b(6)-2

DATE	NOTES
21Oct03 1930	VSS alert & oriented. Lungs clear bilateral. Abd soft non-distended. BS (+) x4 quad. Peripheral pulses +2. OOB + BR ambulated. c̄ [redacted] (R) arm in sling. Voiding clear yellow urine per foley. HOB ↑ 30°. Resting c̄ eye closed. Ø c/o pain voiced or noted. Will continue to monitor [redacted] 2670
22OCT03	(0830) Assumed care of pt @ 0800 p̄ report from night shift. Pt alert, speaking Arabic. VSS. Ø c/o pain. Drsg to RUE intact. (R) hand swollen. Pt able to move fingers. Skin warm to touch. Personal hygiene done this am c̄ assist of staff. Tol. reg diet well. Foley draining quantity sufficient deep yellow urine. SL in (L) forearm flushes well s̄ S/Sx infection/infiltration. 2 point restraints in place s̄ S/Sx complications. Will continue to monitor. b(6)-2 [redacted] (WA)
	(1245) Pt OOB to chair s̄ difficulty. Amb in hallway c̄ steady gait. Will cont. to monitor. [redacted] (WA)
22OCT03 1530	VSS alert. Lungs clear Bilateral. Abd soft non-distended. BS (+) x4 quad. Drsg to (R) UE dry & intact. (R) radial pulse +2. (R) toes capillary refill < 3sec. (R) hand c̄ swelling, non-pitting. Moves fingers to (R) hand freely. (L) FA saline lock patent & intact. Foley to gravity draining clear yellow urine. Will continue care as planned [redacted] 670

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS N**

DATE	NOTES
23OCT03	(1440) Assumed care of pt @ 0000 ~~p~~ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs. Drsg to RUE ~~Δd~~ - staples intact c̄ sm. amount sero-sang drainage. Wet→dry drsg applied to upper GSW entrance. Amb in hallway s̄ difficulty. SL in @ forearm flushes well s̄ s/sx infection/infiltration. Tol. reg diet well. Foley draining quantity sufficient clear yellow urine. 2 point restraints in place s̄ s/sx complications. Will continue to monitor. [redacted] (1655) Foley dlcd. Pt aware he is DTV by 2215, into urinal. ~~monitoring~~. [redacted] IV in @ forearm dlcd d/t infiltration. 18g IV started in @ forearm flushes well s̄ s/sx infiltration. monitoring [redacted]
23OCT03 2200	Alert & oriented. Temp @ beginning of shift 101.2. Tylenol 650mg PO given. Temp rev @ 2200 99. Lungs clear. BS ⊕ x4 quadrants. Abd soft non distended. Peripheral pulses palpable +2. RUE c̄ staples intact to incision. Posterior RUE entrance wound c̄ pink moist tissue. Old dry soiled c̄ serosanguin drainage. LFA R Hand swollen but non pitting. RUE ↑

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SP[redacted]ER /S[redacted]
	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted]

b(6)-4

REGISTER NO.

WARD NO. KW#1

b(6)-2

PROGRESS NOTES
Medical Record

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

LAST NAME	NAME	MIDDLE	ID NUMBER

DATE	NOTES
	(Continued)
23 Oct 03 2200	on pillow. (L) FA saline lock patent & intact. Very clear yellow urine — will continue care as planned. [redacted] 2LTA
24 Oct 03 0931	VSS. AO. (+) 2 pulses to RUE. Placed on bilbert = chop and elevated as ordered. c/o pain to RUE and provided 2 percocet. (+) 3 smooth to touch. CBK = some assistance. DSG to wound & staples CDI. Voiding light yellow urine, QS. [redacted]
24 Oct 03 @ 2100	VSS. Pt has Temp of 101°. Medicated w/ 650mg Tylenol. Will continue to monitor. (R) arm elevated w/ 2 blankets. (R) hand swollen. (+) pulse + (+) capillary refill. Pt able to move fingers. DSG to (R) arm CDI. [redacted] TAA
24 Oct 03	POST-OP STAFF Increase density. [redacted] - Cont down exercise. b(6)-2 S/C to E/W comp soon.
25 Oct 03 1200	VSS. AO. (+) 2 pulse to RUE and CNS intact [redacted] RUE. Ambulated for 1° on ward w/ difficulty. Tolerated PO well this AM. DSG d'd to RUE. Moved bien. [redacted]
25 Oct @ 1900	Pt. laying in bed. (R) arm elevated. DSG has small amount of serous sang drainage. (R) hand swollen. (+) pulse, (+) capillary refill. Pt. able to move fingers. Lung sounds clear through all lobes. $S_1 S_2$ audible. (+) bowel sounds. [redacted]

[redacted]

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
26OCT03@0910	Pt. sitting up in bed, A&O. (R) UE elevated on two blankets +3 pitting edema to (R) hand. DRSNG to (R) arm Δ'd c̄ dry Kerlex sponges & wrap. Moderate amount of serous fluid drainage to old dressing. Staples to (R) UE intact, edges well approximated. Ø c/o pain at this time. All other assessments WNL. Pt. ambulated to BR and walked in hallway for 5 min. c̄ difficulty. Pt. in 2-point restraints. Ø signs of breakdown. [redacted] 2LT, AN.
27OCT@0050	Pt. has (R) arm elevated. (+) 2 edema. Staples open to air. Staples (-) S/Sx of infection. Wound well approximated. Tolerating regular diet. (+) pulse in (R) arm. Pt able to move fingers. (+) capillary refill. [redacted] 2LT, AN
27OCT@1330	Pt. A&O×3. V.S.S. (R) arm DRSNG Δ'd, CDT, Staples intact. (R) arm elevated on two blankets while in bed. 1-2+ edema to (R) FA & hand. Pt. now in MP custody. D/C to EPW camp, ambulatory c̄ (R) UE in sling. All other assessments WNL. [redacted] 2LT, AN

b(6)-2

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

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

REGISTER NO. | WARD NO.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10/27/03	D/C Summary 30 y/o Iraqi male post ORIF of humerus and proximal radius fracture. Patient has permanent radial nerve palsy. Remove staples from Right arm in one week. Sling for immobilization for comfort. Range of motion by patient as tolerated. Follow up in 6 weeks for repeat x-rays. [redacted] b(6)-2 b(6)-4

[redacted]

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

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 CPT [redacted] CPT [redacted]

2. PATIENT IDENTIFICATION RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted]

3. DATE 01 Oct 2003 TIME PATIENT ARRIVED IN SUITE 0240

4. PATIENT IN ROOM TIME 0240 NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: b(6)-2

6. NURSING PERSONNEL

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

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

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

COMMENTS: Dr Wugate placed a lois u-drape pre-prep to isolate the prep field.

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

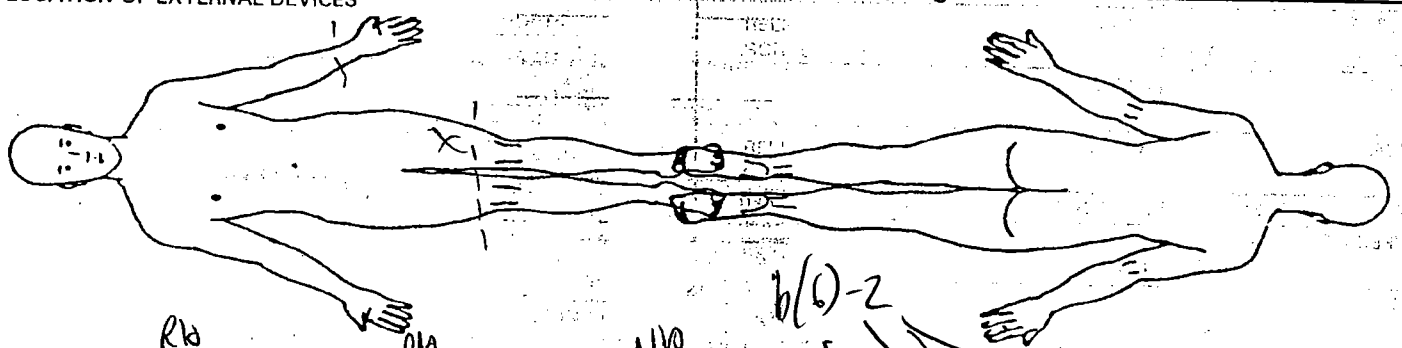
PREP SOLUTION *(Specify)* Betadine scrub/paint

SITE: Right Arm, Axilla, distal BY WHOM: CPT [redacted]

SITE: part of shoulder BY WHOM:

COMMENTS: no pooling noted

9. LOCATION OF EXTERNAL DEVICES



b(6)-2

LEGEND X Ground Pad (RD) -- Safety Strap (RD) = = = Tourniquet (NO)

10. COUNTS

C = Correct I = Incorrect

Initial count - SPC [redacted] CPT [redacted]

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No		C	C		
Needle Sharp	☒ Yes	☐ No		C	C		
Instrument	☐ Yes	☒ No		/	/		
Other	☐ Yes	☒ No					

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

[redacted] b(6)-4

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

☒ ESU NO: R8E 105365

GROUND PAD: BRAND Valleylab

LOT NO: 70011

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

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

Synthes DCP plates Lot# 0528602
8 hole plate 226.08x1
Synthes ASIF Screws set Lot# 062 9201
cortical 4.5 screws
214.034x1 214.028x2 214.036x1
214.026x1 214.030x2
Smith Frag set Lot# 0529301
3.5 cortex screws
204.20x4 204.16x1
204.18x4 8 hole plate → 248.08 x1

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 3/8" Penrose	2.	3.
SITE	1. (R) Arm	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Kerlix, ABD, 4x4, Kerlex, ACE

19. ADDITIONAL INFORMATION

Surgeon D[redacted]
Anesthesia - CP[redacted] CRNA

b(6)-2

20. OPERATION(S) PERFORMED

I&D & ORIF Right Radius & Right Humerus

b(6)-2

21. PATIENT TRANSFERRED TO [redacted] (ICW) TIME 0623 METHOD Litter

22. REGISTERED NURSE SIGNAT[redacted] CPT/AN

Ankeb ER

MEDICAL RECORD	PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT For use of this form, see AR 40-66; the proponent agency is The Office of the Surgeon General.
1. AGE: 17yo EPW HEIGHT: ? WEIGHT: ?	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): unknown 3. PREVIOUS SURGERY [X] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE:

ORIF & I/D Rgt Radius / Ulna

5. ADDITIONAL INFORMATION: Last PO: Medical Hx: None Implants: ∅ Medications:
Jewelry removed: yes/no Family waiting: yes/no

Unable to assess due to Emergency Nature of situation

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

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

#[redacted] EPW

b(6)-4

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

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

[redacted] OPT/N 21oct03 DATE

11. POSTOPERATIVE EVALUATION:

Goals met b(6)-2

b(6)-2

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title) [redacted] OPT/N

DATE: 21 oct 03 TIME: 0240 b(6)-2

13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title) [redacted] OPT/N

DATE: 21 OCT 03 TIME: 0620

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.01

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
0630		12.5mg Demerol	IV			[illegible]

NEUROVASCULAR

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

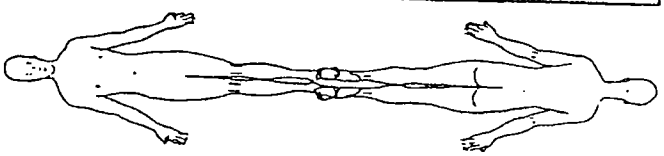
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	R Arm	Ace wrap	c/d/i
30'	R Arm	ace wrap	c/d/i
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
0630	Foley	clear yellow	140

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1630	TSR	Ø	Ø

NURSING NOTES

Pt received from OR s/p ORIF of R humerous + radius. Pt SpO_2 98% Pt moving around a lot. Pt gt 12.5 Demerol for shivering. No c/o pain Report given to Spc [redacted]. MP's notified that she is coming down. Pt VSS No c/o pain — [redacted]

b(6)-2

b(6)-2

Discharge Criteria:
Date: 21 Oct 03 Time: 1653 PARS: 9
BP: 138/62 T: 97.4 HR: 118 RR: 16 Sa02: 98%
Pain Level at D/C (0-10):
Intake: Ø Output: 160cc urine
Additional Data: None
Transferred To: ICW
Report Given To: Sp[redacted]
Transferred Via: W/C [redacted] Gurney Ambulance
Transferred By: Sgt [redacted]
Cleared IAW Recovery Room [redacted] R 3
Charge Nurse Signature: [redacted]

WAMC OP 173-E

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY																
POST- DAY		1														
MONTH-YEAR OCT	DAY	21 oct		22		23		24		25 OCT		26 OCT				
~~19~~ 2003	HOUR	0800	1	8	1	0	1	0	1	0		0800				

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

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

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

RESPIRATION RECORD

		20	18	18	14	20		16	12	1		100/88				
Record special data only when so ordered	BLOOD PRESSURE	114/65		112/57		108/60		110/62	110/57	102/69		98.0°				
		H 105	110/66							97		101				
		T 98°								98.1 F						
	HEIGHT: WEIGHT →	97%	98			96%		98%	94%	96%		96%				
		RA		98%(RA)	98											

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

REGISTER NO.

WARD NO.

#[redacted] b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

b(6)-4 b(6)-2 b(6)-4

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

LAST, FIRST, MI. # Eqw [redacted] | DATE 21 Oct | TIME 110 | SUPPRESSED SSN: [redacted]

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10³
F		
H		
H		
N		
P		
L		
S		
E		
L		
A		
RBC Morph		
Spun Hematocrit		42-4 37-4
Sed Rate		
Other		

ID: [redacted] 21-10-03 01:22

			Patient Limits	
WBC	18.8 H	x10^3/uL	4.5	10.5
RBC	5.11	x10^6/uL	4.00	6.00
Hgb	14.2	g/dL	11.0	18.0
Hct	44.8	%	35.0	60.0
MCV	87.6	fL	80.0	99.9
MCH	27.7	pg	27.0	31.0
MCHC	31.6 L	g/dL	33.0	37.0
PLT	317.	x10^3/uL	150.	450.
LY%	17.4	%	20.5	51.1
LY#	3.3	x10^3/uL	1.2	3.4

Urinalysis

TEST	RESULT	REF. RANGE
Color	yel	N/A
App	clr	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	sm	Negative
SG	1.025	N/A
Bld	neg	Negative
pH	6.0	N/A
Prot	n	Negative
Urob	n	0.2-1.0
Nit	n	Negative
Leuk	n	Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

acetest-small

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

it Crossmatch
H EVERY UNIT OF BLOOD
STED)

	CROSSMATCH

Coagulation Stud

TEST	RESULT	REF.
PT		9.8-13
APTT		21-34
D dimer		<20 ug
FDP		<10 ug

REMARKS:

REPORTED BY:

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/21/03 01:37

Patient ID: [redacted] b(6)-4
Test Name :PT
Test Result:= 13.7 sec.
Ratio = 1.1
Calculated INR = 1.21
Sample Type:citrated wh. blood
Test Date :10/21/03
Test Time :01:36
Card Lot [redacted]
Operator : [redacted] b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/21/03 01:39

Patient ID [redacted] b(6)-4
Test Name :APTT
Test Result:= 35.4 sec.
Sample Type:citrated wh. blood
Test Date :10/21/03
Test Time :01:37
Card Lot [redacted]
Operator [redacted] b(6)-2

b(6)-4 b(6)-2 b(6)-4

Ward/Section: ER

REQUESTING PHYSICIAN: [redacted]

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

LAST, FIRST, MI. # [redacted]

DATE 21/10/03 TIME

SSN/PSEUDO SSN: # [redacted]

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANG
Troponin-I		
Drug of Abuse		

======= PICCOLO =======
21/10/03 01:25
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: [redacted]
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	141*	73-118	MG/DL
BUN	12	7-22	MG/DL
CRE	1.0	0.6-1.2	MG/DL
CK	595*	39-380	U/L
NA+	135	128-145	MMOL/L
K+	4.2	3.3-4.7	MMOL/L
CL-	102	98-108	MMOL/L
tCO2	22	18-33	MMOL/L

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

b(6)-2

(Piccolo) M[illegible]el

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3 mg/dl

PICCOLO
21/10/03 01:24
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: [redacted]
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	4.2	3.3-5.5	G/DL
ALP	109*	26-84	U/L
ALT	21	10-47	U/L
AMY	46	14-97	U/L
AST	32	11-38	U/L
TBIL	1.5	0.2-1.6	MG/DL
BUN	12	7-22	MG/DL
CA++	9.1	8.0-10.3	MG/DL
CHOL	141	100-200	MG/DL
CRE	1.0	0.6-1.2	MG/DL
GLU	141*	73-118	MG/DL
TP	7.5	6.4-8.1	G/DL

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

REMARKS:

REPORTED BY: DATE: LAB ID NO.:

b(6)-4 CBC b(6)-2 b(6)-4

Ward/Section: OR	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted]	DATE 21 OCT 03	TIME 0430	SSN/PS[redacted]

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10³	Color		N/A	RPR		Negative
RBC		4.7-6.1 x 10⁶	App		N/A	Mono		Negative
H			Glu		Negative	**Microbiology**		
H			Bili		Negative	Source		
M			Ket		Negative	Gram Stain		
Pl			SG		N/A	Occ Bld		Negative
Ly			Bld		Negative	H. pylori		Negative
			pH		N/A	Micro Parasites		
Ge			Prot		Negative	Malaria		
Ba			Urob		0.2-1.0	O & P		
Ly			Nit		Negative	Other		
At			Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			

b(6)-4

[redacted] 21-10-03 04:35

				Patient Limits	
WBC	9.4		x10^3/uL	4.5	10.5
RBC	3.00	L	x10^6/uL	4.00	6.00
Hgb	8.5	L	g/dL	11.0	18.0
Hct	26.4	L	%	35.0	60.0
MCV	87.8		fL	80.0	99.9
MCH	28.4		pg	27.0	31.0
MCHC	32.3	L	g/dL	33.0	37.0
Plt	192.		x10^3/uL	150.	450.
LY%	23.4	*	%	20.5	51.1
LY#	2.2	*	x10^3/uL	1.2	3.4

			CSF			Blood Bank
Spun Hematocrit		42-52% (M) 37-47% (F)				
Sed Rate			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED
Other			Directigen		Negative	ABO/Rh

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

P1 TREND 10/21/03

TIME	HR/PR	SpO2	SYS / DIA - MEAN			RR
HH:MM	BPM	%	mmHg			RPM
02:04	183	56	OFF	OFF	OFF	80
02:02	208	83	OFF	OFF	OFF	59
02:00	109	97	OFF	OFF	OFF	20
01:58	109	99	OFF	OFF	OFF	17
01:56	108	100	OFF	OFF	OFF	15
01:54	116	100	OFF	OFF	OFF	19
01:52	209	95	OFF	OFF	OFF	65
01:50	191	74	OFF	OFF	OFF	68
01:48	111	99	OFF	OFF	OFF	29
01:46	133	SRCH	OFF	OFF	OFF	98
01:44	127	SRCH	OFF	OFF	OFF	36
01:42	248	SRCH	OFF	OFF	OFF	60
01:40	97	SRCH	OFF	OFF	OFF	41
01:38	97	79	OFF	OFF	OFF	92
01:36	95	100	OFF	OFF	OFF	63
01:34	100	99	OFF	OFF	OFF	0
01:32	101	63	OFF	OFF	OFF	11
01:30	102	65	OFF	OFF	OFF	30
01:28	107	44	OFF	OFF	OFF	33
01:26	123	55	OFF	OFF	OFF	42
01:24	106	91	OFF	OFF	OFF	23
01:22	115	56	OFF	OFF	OFF	36
01:20	109	91	OFF	OFF	OFF	51
01:18	110	95	OFF	OFF	OFF	37
01:16	114	79	OFF	OFF	OFF	67
01:14	104	96	OFF	OFF	OFF	24
01:12	110	SRCH	OFF	OFF	OFF	46
01:10	114	100	OFF	OFF	OFF	30
01:08	107	SRCH	OFF	OFF	OFF	24
01:06	110	SRCH	OFF	OFF	OFF	28
01:04	107	SRCH	OFF	OFF	OFF	62
01:02	OFF	STBY	OFF	OFF	OFF	OFF

ADULT

PROTOCOL® SYSTEMS, INC.

NIBP TREND 10/21/03

TIME	HR/PR	SpO2	SYS / DIA - MEAN			RR
HH:MM	BPM	%	mmHg			RPM
02:01	110	SRCH	153 / 47		87	27
01:56	107	100	128 / 50		86	17
01:52	122	93	ERR# 15			19
01:48	110	98	136 / 63		111	27
01:46	131	SRCH	ERR# 15			108
01:41	200	SRCH	92 / 79		84	40
01:36	95	100	143 / 48		83	61
01:31	106	55	133 / 52		89	23
01:25	171	62	ERR# 15			30
01:20	97	100	ERR# 15			45
01:15	117	89	114 / 67		87	44
01:11	102	SRCH	ERR# 15			26
01:04	107	SRCH	125 / 75		96	48

ADULT

PROTOCOL® SYSTEMS, INC.

P1 TREND 10/21/03

TIME	HR/PR	SpO2	SYS / DIA - MEAN			RR
HH:MM	BPM	%	mmHg			RPM
01:54	116	100	OFF	OFF	OFF	19
01:52	209	95	OFF	OFF	OFF	65
01:50	191	74	OFF	OFF	OFF	68
01:48	111	99	OFF	OFF	OFF	29
01:46	133	SRCH	OFF	OFF	OFF	98
01:44	127	SRCH	OFF	OFF	OFF	36
01:42	248	SRCH	OFF	OFF	OFF	60
01:40	97	SRCH	OFF	OFF	OFF	41
01:38	97	79	OFF	OFF	OFF	92
01:36	95	100	OFF	OFF	OFF	63
01:34	100	99	OFF	OFF	OFF	0
01:32	101	63	OFF	OFF	OFF	11
01:30	102	65	OFF	OFF	OFF	30
01:28	107	44	OFF	OFF	OFF	33
01:26	123	55	OFF	OFF	OFF	42
01:24	106	91	OFF	OFF	OFF	23
01:22	115	56	OFF	OFF	OFF	36
01:20	109	91	OFF	OFF	OFF	51
01:18	110	95	OFF	OFF	OFF	37
01:16	114	79	OFF	OFF	OFF	67
01:14	104	96	OFF	OFF	OFF	24
01:12	110	SRCH	OFF	OFF	OFF	46
01:10	114	100	OFF	OFF	OFF	30
01:08	107	SRCH	OFF	OFF	OFF	24
01:06	110	SRCH	OFF	OFF	OFF	28
01:04	107	SRCH	OFF	OFF	OFF	62
01:02	OFF	STBY	OFF	OFF	OFF	OFF

ADULT

PROTOCOL® SYSTEMS, INC.

NIBP TREND 10/21/03

TIME	HR/PR	SpO2	SYS / DIA - MEAN	RR
HH:MM	BPM	%	mmHg	RPM
01:52	122	93	ERR# 15	19
01:48	110	98	136 / 63 111	27
01:46	131	SRCH	ERR# 15	108
01:41	200	SRCH	92 / 79 84	40
01:36	95	100	143 / 48 83	61
01:31	106	55	133 / 52 89	23
01:25	171	62	ERR# 15	30
01:20	97	100	ERR# 15	45
01:15	117	89	114 / 67 - 87	44
01:11	102	SRCH	ERR# 15	26
01:04	107	SRCH	125 / 75 96	45

ADULT

PROTOCOL® SYSTEMS, INC.

APNEA TICKET (RR) 10/21/03

TIME	HR/PR	SpO2
H:MIN:S	BPM	%
LAST BREATH:		
01:33:36	101	94
RESUMED BREATHING:		
01:34:09	98	97
ELAPSED TIME:		
00:00:33		

ADULT

PROTOCOL® SYSTEMS, INC.

APNEA TICKET (RR) 10/21/03

TIME	HR/PR	SpO2
H:MIN:S	BPM	%
LAST BREATH:		
01:31:45	103	57
RESUMED BREATHING:		
01:32:07	102	68
ELAPSED TIME:		
00:00:22		

ADULT

PROTOCOL® SYSTEMS, INC.

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)												
Fentanyl	(mcg)	100											
Propofol	(mg)	150											
SUX / VEC	(mg)	100 / 10						5					
Nitroglycerin	(mg)	100/100											
	( )												
	( )												
VOLAT AGENT 150	% del	1.0	.8	1.5	2.0	1.5	1.5	1.4	1.0	1.0	1.0	1.0	1.0
	% e.t.												
AIR	L/Min												
N2O	L/Min												
O2	L/Min	8/2	2	1	1	1	1	1	1	1	1	1	1

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

TOTALS	TOTAL EBL
	600
	TOTAL URINE
	1000

FLUIDS - SUMMARY
CRYSTALLOID- 3200
COLLOID- Ø
BLOOD- Ø

REMARKS
Code drugs with numbers, events with lettters

FLUIDS

LINE site													
18G (R)	☐ Warmed	500	800 (#2)			1000 (#3)							2000
18G (L)	☐ Warmed	200	400				600 (#2)						1000
	☐ Warmed												

LOSSES													
EST BLOOD LOSS				200	+100	— 100		100			100		
URINE -			120	100/220		200/400		200/620			220/840	100/940	

PHYS STATUS: 1 2 3 4 5 (E)

BODY WEIGHT: 60 (KG) LB

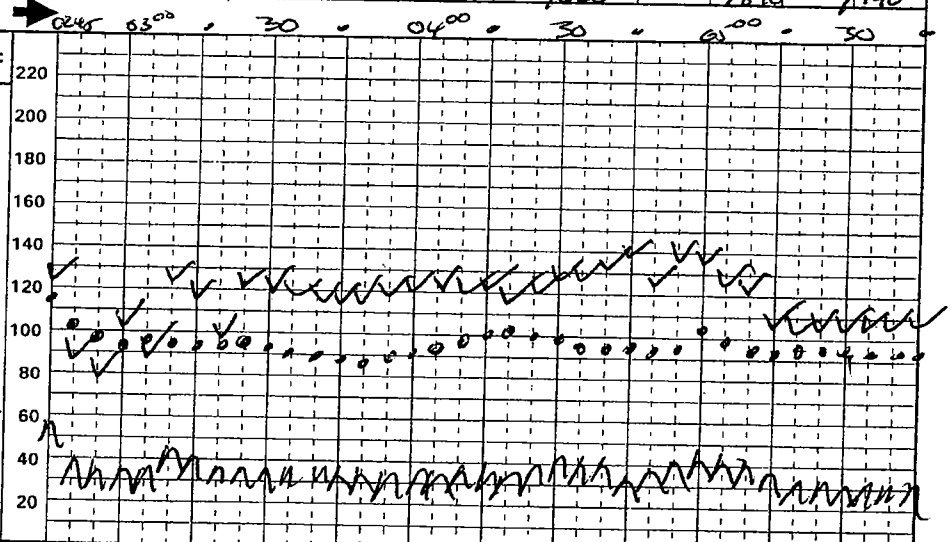
HEMATOCRIT:

INITIAL DATA:
BP- 122 156
HR- 117

EQUIP CHECK
OK?- (Y) N

PATIENT RECHECK
OK for PROCEDURE? yes
TIME- 0245

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



VENTIL

VT - ml	770	840	540	620	600	590	560	590	560	610	580	560
f - breaths/min	18	10	12	10	9	9	9	9	9	8	8	8
Peak inf pres / PEEP	26	26	20	21	22	21	22	23	24	24	24	24
MODE - S(pon), A(ssist), C(on)	S/C	C	C	C	C	C	C	C	C	C	C	C

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	41	36	35	35	35	35	35	34	35	33	35	35
BP/oth	FIO2 (Frac or %)	.87	.87	.86	.86	.85	.87	.88	.89	.85	.89	.89	.89
ART line	SpO2 (%)	100	99	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site	AXILLA											
	N-M Block (T/4)	4/4	0/4	0/4	0/4	0/4	1/4	0/4	0/4	0/4			
Warming blkt													
Conv warmer													

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

RECOVERY AT
PACU ICU _____ (Specify)
OTHER _____
CONDITION:
RESP- SpO2-
BP- HR-

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0220	0240	
	Ready	Begin	End
PROC	0250	0306	0615

PROCEDURES and CPT Codes:
ORIF (R) Humerus / Radius

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

[redacted] b(6)-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
PRE-OX 5min 80% FIO2, RSI c cricoid, OLXT MAC3 Grade I view, 7.0 ETT Placed 23cm @ lips (+) BBS (+) ET CO2 (+) cuff

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

ANESTHETISTS: STAC [redacted]

PROCEDURE LOCATION: OR 1
DATE: 21 OCT 03
PAGE 1 OF 2

DA FORM 7389, FEB 1998 — MEDCOM - 217 [redacted] - ANESTHESIA PROVIDER — USAPA V1.00

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)	
Fentanyl	(mcg)	100, 50
Neostigmine	(mg)	5
Glycopyrrolate	(mg)	
	( )	
	( )	
VOLAT AGENT 150	% del	1.0
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	2

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

FLUIDS

LINE site		
NS (R) 1000	☐ Warmed	1000
D5W (R) 1000	☐ Warmed	200
	☐ Warmed	
	☐ Warmed	

LOSSES

EST BLOOD LOSS	600
URINE -	1000

TOTALS	TOTAL EBL
	TOTAL URINE

FLUIDS - SUMMARY

CRYSTALLOID-

COLLOID-

BLOOD-

REMARKS

Code drugs with numbers, events with lettters

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: KG / LB

HEMATOCRIT:

INITIAL DATA: BP- HR-

EQUIP CHECK OK?- Y N

PATIENT RECHECK

OK for PROCEDURE? TIME-

TIME → 0545, 0600, 30, 0700, 30, 0800, 30

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

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

VENTIL

VT - ml	450	600
f - breaths/min	8	8
Peak inf pres / PEEP		
MODE - S(pon), A(ssist), C(on)	S	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	48	40
BP/oth	FIO2 (Frac or %)	100	100
ART line	SpO2 (%)	100	100
Steth- PC/ES	ECG	SR	SR
Gas analyzer	TEMP-site		
	N-M Block (T/4)	4/4	Tumulac left
Warming blkt			
Conv warmer			

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

RECOVERY AT

PACU ICU _____ (Specify)

OTHER

CONDITION:

RESP- SpO2

BP- HR

ANESTHESIA / PROCEDURE TIMES

ANES	Start	Room	End
PROC	Ready	Begin	End

PROCEDURES and CPT Codes: ORIF (R) Humerus/Radius.

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

#[redacted] b(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

PG II

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

SURGEONS: [redacted] b(6)-2

ANESTHETISTS: [redacted]

PROCEDURE LOCATION: OR1

DATE: 21 OCT 03

PAGE 2 OF 2

MEDICAL RECORD - DOCTOR'S ORDE

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

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

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

PATIENT IDENTIFICATION

#[redacted] b(6)-4

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

Diagnosis: _____

Height: _____ Weight: _____ Diet: _____

Allergies: _____

Nursing Unit	Room No.	Bed No.	Page No.
PACU,[redacted]			1 of 1

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

b(2)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

21OCT2003 0610

NURSING UNIT | ROOM NO. | BED NO.

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

ICW 1 / Hygate
GSW (R) UE
Stall
vitals q shift x 2 days, Hem q day.
I/Os x 2 days,
NKDA
NWB (R) UE

PATIENT IDENTIFICATION: b(6)-2

Noted [redacted] 21OCT2003 0810

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER ____ HOURS

~~NPO~~ Reg diet
LR @ 100 cc/h. Heparin when tol po.
MSO4 1-3 mg iv q30 min prn.
Phenergan 1 IV q4h prn.
Tylenol 650 mg po/pr q6h prn
Colace 1 po bid

PATIENT IDENTIFICATION

Noted [redacted] 21OCT2003 1600

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER ____ HOURS

Keytal 1 g IV q8 - next in RR.
HCT in LR Please [redacted]
[redacted] b(6)-2
AP/LAT (R) humerus
AP/LAT (R) forearm

PATIENT IDENTIFICATION

Noted [redacted] 21OCT2003 1615

038

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER 10-23-03 1600 HOURS

D/C Foley
[redacted]

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

Noted on [redacted] 2003 [redacted]

b(6)-2

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 10/27/03 TIME OF ORDER 1840 HOURS

LIST TIME ORDER NOTED AND SIGN

D/C to EPW camp

[redacted]

b(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER _____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER _____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER _____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 10 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 21	22	23	24	25	26	27
21 OCT 03	[redacted]	Vitals q shift X2days	[redacted]							
21	[redacted]	Vitals q day	[redacted]							
21	[redacted]	I/Os X 2 days	[redacted]							
21	[redacted]	NWB RUE	[redacted]							
21	[redacted]	Reg diet	[redacted]							

b(6)-2

ALLERGIES: ☐ YES ☒ NO	PRIMARY DIAGNOSIS:	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
NKDA	GSW RUE	PAGE NO:

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 10 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
21 OCT03	[redacted]	ICW! Hugate - stable	21 OCT03	—		[redacted]
21	[redacted]	HCT in RR please	21	—	0430	[redacted]
21	[redacted]	AP/LAT @ humerus/@forearm	21	—		[redacted]
23 OCT03	[redacted]	D/C foley	23 OCT03	—	1615	[redacted]
27 OCT03	[redacted]	D/C to EPW camp				

	-----					

b(6)-2

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

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. 10 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 21	22	23	24	25	26	27	28	29	30	31
21 OCT03	[redacted]	LR @ 100cc/° (+heplock	06 18	[redacted]										
	-----	when tol po)	18 06	[redacted]										
21	[redacted]	Codeine 1 po bid	06	[redacted]										
	-----		22	[redacted]										
21	[redacted]	Kefzol 1gm IV q8°	06	[redacted]										
	-----	(next in RR)	16	[redacted]										
	-----		24	[redacted]										

	-----	b(6)-2												

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: GSW @ UE

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

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

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 10 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials

b(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED														
210CT03	[redacted]	MSO4 1-3mg IV 930 min prn	D/T														
			D/I														
21	[redacted]	Percocet 1-II po 94° prn	D/T	21 1130	21 1730	22 0500	22 1325	22 2200	23 0705	24 0705	24 2210	25 1820	26 0460	26 1615			
			D/I	[redacted]													
21	[redacted]	Tylenol 650mg po/pr q 6° prn	D/T	23 0720	23 1930	24 2224											
			D/I	[redacted]													

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

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED *(Date)*: QI Appr 11 Jun 97

EMS REPORT

TIME:_____ ETA:_____ UNIT:_____

MED COM: [Y] [N]

17yo ♂ EPW GSW

ARRIVAL STATUS

TIME 105 ☒ IV x 1 ☐ O_2 none 1/min ☐ C-Spine Immob

Meds: ☐ UKN ☒ None ☐ Yes:_____

Allergies: ☒ UKN ☐ None ☐ Yes:_____

Tetanus: ☒ UKN ☐ Current Last Meal/Fluid Intake _____hrs

LMP:_____ ☐ NS LAC

Ø-PMHx Ø-PSHx

PRIMARY SURVEY

AIRWAY

☒ Natural Patient [☒ N]

☐ ETT_____ ☐ _____

☐ Secretions_____

BREATHING

☐ Labored ☒ Unlabored ☐ Absent

TRACHEA: ☒ Midline ☐ Deviated [L] [R]

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

CIRCULATION

PULSE: ☒ Present ☐ Absent

BLEEDING: [☒ N]

HEART TONES: ☒ Clear ☐ Muffled

SKIN: ☒ Warn ☐ Cool ☐ Hot

☒ Pink ☐ Pale ☐ Cyanotic ☐_____

☒ Dry ☐ Moist ☐ Diaphoretic

SECONDARY SURVEY

DISABILITY

GCS: E_____

V_____

M_____

SPHINCTER TONE:
☐ WNL
☐ None

HEAD

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

TM: ☐ Clear ☐ Blood [L] [R]

NECK

C-Spine Tenderness: [Y] [N]

Pain @_____

JVD: [Y] [N]

HEART

RHYTHM: ☐ Regular ☐_____

PULSES: ☐ Central ☐ Peripheral

LUNGS

BREATH SOUNDS: ☐ Bilat ☐ Equal ☐ Clear

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

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

ABDOMEN

☐ Soft ☐ Rigid ☐ Non-Tender

☐ Tender:

PELVIS

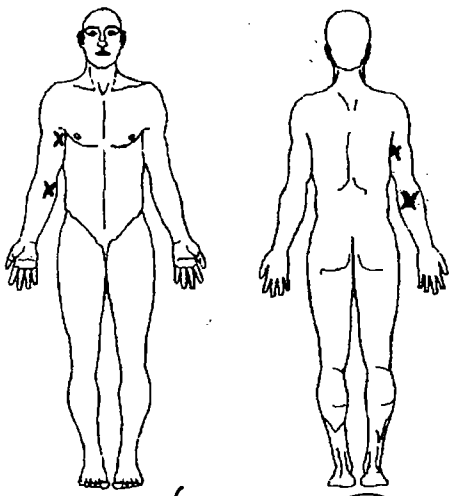
☐ Stable ☐ Unstable ☐_____

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

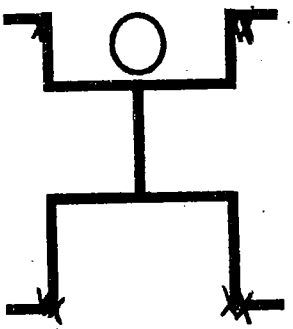
Heme + / - Prostate: ☐ WNL ☐ Abnl

USE DIAGRAM TO DOCUMENT INJURIES AND PAIN

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



VASCULAR ASSESSMENT



++ Strong	+ Palpable	D Dopler

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

PHYSICIAN: Dr. [redacted]

(Continue on reverse)

PREPARED BY *(Signature [redacted])*

DEPARTMENT/SERVICE/CLINIC: ER

DATE: 210803

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

[redacted] b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

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

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

REQUIREMENT OF PRIVACY ACT OF 1974 IS COVERED BY DD FORM 2005.
PREVIOUS EDITION IS OBSOLETE.

EAMC OP 503, 1 Dec 98

TIME	PROCEDURE	SIZE	SITE	BY	RESULTS
	ET Intubation		☐ Oral ☐ Nasal Teeth		☐ $ETCO_2$ Change ☐ BBS Post Int ☐ Post CXR
	Gastric Tube		☐ Oral ☐ Nasal		☐ Air ☐ Contents ☐ Verified_____ Suction: Y N
0128	Urinary	16	☒ Meatus ☐ Supra-Public	[redacted]	☐ Return_____cc ☐ Heme Dip: + - ☐ Secured
	DPL		☐ Opened ☐ Closed	1(6)-2	☐ Grossly: + - Cell count Sent@_____
	Chest Tube #1		L R		☐ Air ☐ Blood ☐ Pleuravac____cm ☐ Autotransfuser
	Chest Tube #2		L R		☐ Air ☐ Blood ☐ Pleuravac____cm ☐ Autotransfuser
	12 Lead	Rhythm:		Comments	

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

LABS

TIME	LABS
	☐ D-stick_____ ☐ SHct_____
	☐ D-stick_____ ☐ SHct_____
	☒ CBC ☒ Chem ☒ PT/PTT
	☐ ETOH ☒ T&S ☐ T&C x_____
	☐ Tox Screen
	☒ UA ☐ HCG
	☐ OTHER Met 8, Elect.
	☐ OTHER

X-RAYS

TIME	LABS
	☒ Chest Initial
	☐ Chest Post ET
	☐ Chest Post CT
	☐ C-Spine
	☐ Pelvis
	☒ (R) Humerus
	☒ (R) forearm
	☐

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

IV ACCESS & FLUIDS

TIME	#	GA	IAW SOP		SITE	IVF TYPE	AMT UP	AMT IN
110		18	(Y)	N	LFA	NS		
			Y	N				
			Y	N				
			Y	N				

MEDICATIONS

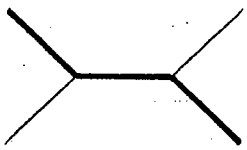
MEDICATION	TIME	DOSE	RTE	TIME	DOSE	RTE	TIME	DOSE	RTE
Ancef Ribar	112	1gr	IV						
Tet. Ribar	111	.5	IM						
Morph Haese	112	5	IV						
Morph Haese	129	5	IV						

BLOOD PRODUCTS

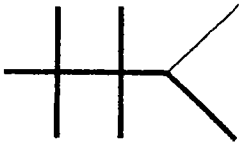
START	#	TYPE	UNIT#	AMT UP	AMT IN	END	INIT

LAB RESULTS

CBC:



Chem:



INTAKE & OUTPUT

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

TRAUMA TEAM ARRIVAL

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

VALUABLES & CLOTHING

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

DISPOSITION

☐ Home ☐ _____

Admitted to_____

Report Called to_____

Time Transferred_____

Accompanied By_____

Via: ☐ Stretcher ☐ Wheelchair

As per ACLS Precautions: ☐ Yes ☐ No

VITAL SIGNS

Oral ~~Rectal~~ Temp: 100.0 GCS:

TIME	BP	HR	RHY	RR	SAO_2	FIO_2	MODE	E	V	M	T
107	135/75	112		22	100						
0132	NC Nasal cannula @ 2 liters.										
0136	133/52	100		18	100						
0141	92/79	112		20	99						
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GLASGOW COMA SCALE

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

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

NOTES

Neg. fast exam.
D/C LAC IV - restart 18G @ bicep

☆U.S.GOVERNMENT PRINTING OFFICE 1997-571-7000

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

DTSG APPROVED (Date)

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

Date: 21 Oct 03
Time In: 600
Allergies: NKDA
Pre-op V/S: 122/56 117
Procedures: open reduction internal fix / humerus & radial

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 3200 Colloid
OR Output: UOP 1000 EBL 400
Meds/Times: 250mcg Fent

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds

History

Time	0630	0700	0830	0845
SaO2	98	97	97	98
FiO2				
Methods	RA	RA	RA	RA
240				
220				
200				
180				
160				
140	✓	•	✓	✓
120	•		•	•
100				
80				
60	^	^	^	^
40				
20				
RR	15	17	19	16
T	97			
Time				
Pain (0-10)				
LOS				

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays:

Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

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

(Continue on reverse)

PR[redacted] Signature & Tit[redacted] b(6)-2

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 21 Oct 03

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

[redacted] b(6)-4

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

P7 [redacted]

b(6)-4

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

YELLOW FIELDS MUST BE FILLED IN, IF APPLICABLE, UPON APPREHENSION

☐ Offense against Civilian(s) [check one] If "Other" then describe:

- ☐ Arson (I.P.C. 342)
- ☐ Solicitation of Fornication/Prostitution (I.P.C. 399)
- ☐ Rape/Indecent/Sexual Assaults/Acts (I.P.C. 393-98, 402)
- ☐ Murder (I.P.C. 405)
- ☐ Aggravated Assault/Assault With Intent To Kill (I.P.C. 410)
- ☐ Maiming (I.P.C. 412)
- ☐ Simple Assault (I.P.C. 415)
- ☐ Kidnapping (I.P.C. 421)
- ☐ Burglary or Housebreaking (I.P.C. 428)
- ☐ Extortion/Communicating Threats (I.P.C. 430)
- ☐ Theft (I.P.C. 439)
- ☐ Destruction of Property (I.P.C. 477)
- ☐ Obstructing a Public Highway/Place (I.P.C. 487)
- ☐ Discharging Firearm/ Explosive in City/Town/Village (I.P.C. 495)
- ☐ Riot or Breach of Peace (I.P.C. 485(3))
- ☐ Other

☒ Offense against Coalition Forces [check one] If "Other" then describe: See ATTACHED Statements

- ☐ Violation of Curfew
- ☐ Illegal Possession of Weapon
- ☐ Assault/Attack on Coalition Forces
- ☐ Theft of Coalition Force Property
- ☐ Trespass on Military Installation or Facility
- ☐ Photographing/Surveilling Military Installation or Facility
- ☐ Obstructing Performance of Military Mission
- ☐ Other

Apprehending Unit: 4/27 FA		Location Grid:	
Date of Incident (D/M/Y): 21/10/03 to / /	Time of Incident: hrs to hrs	Date of Report: (D/M/Y) / /	Time of Report: hrs

Detainee #:			Key Connected Person: ☐ Victim ☐ Witness		
Last Name: [redacted] b(6)-2			Last Name:		
First Name: [redacted]	Given Name:		First Name:	Given Name:	
Hair Color:	Scars/Tattoos/Deformities:		Hair Color:	Scars/Tattoos/Deformities:	
Eye-Color:	Weight: lb	Height: in	Eye-Color:	Weight: lb	Height: in
Address:			Address:		
Place of Birth:			Place of Birth:		
Ethn/Tribe/ Sect:	Sex: ☒ M ☐ F	Phone#: DOB D/M/Y: ☐ Mobile ☐ Regular	Ethn/Tribe/ Sect:	Sex: ☐ M ☐ F	Phone#: DOB D/M/Y: ☐ Mobile ☐ Regular
☐ Passport ☐ Dr. license ☐ Other (specify) Document #:			☐ Passport ☐ Dr. license ☐ Other (specify) Document #:		

Total Number of Persons Involved ____ (list names/identifying info on reverse under "Additional Helpful Information")

☐ Vehicle Information	Vehicle Number ____ of ____ Vehicle(s)		Owner:
Make:	Color:	VIN:	
Model:	Type:	Plate No.:	Number of People in Vehicle:
Year:	Names of People in Vehicle:		
Contraband/Weapons in Vehicle:			

☐ Property/Contraband	☐ Weapon	Photo Taken of Suspect with Weapon/Contraband: Yes/ No	
Type:		Model:	Color/Caliber:
Serial No.:	Quantity:	Make:	Receipt Provided to Owner: Yes/ No
Other Details:		Where Found:	Owner:

Name of Assisting Interpreter: b(6)-2 Email, Phone, or Contact Info:

Detaining Soldier's Name (Print): LT [redacted] Last, First MI	Supervising Officer's Name (Print): Last, First MI
Signature:	Signature:
Email:	Email:
Unit Phone: 551-0162 Date: / /	Unit Phone: Date: / /

2230
2231

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

Why was this person detained?

Who witnessed this person being detained or the reason for detention? Give names, contact numbers, addresses.

How was this person traveling (car, bus, on foot)?

Who was with this person?

What weapons was this person carrying?

What contraband was this person carrying?

What other weapons were seized?

What other information did you get from this person?

Additional Helpful Information:

b(2)-2

Admission [illegible] Coding Information

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

1. Reporting MTF 0580 - [redacted]	2. MTF [illegible] IZ			
3. Register Number [redacted]	Name (Last, First, MI) [redacted]		4. Pay Grade FGN	5. Sex M
6. DoB (YYYYMMDD) 1986-01-01	7. Age at Admission 17Y	8. Race X	9. Ethnicity 9	Religion
10. Length of Service	ETS	11. FMP 99	12. Social Security Number [redacted]	
Organization (Active Duty Only)		13. Marital Status	Hour of Admission 01:15	Branch / Corps:
14. Flying Status	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES		16. Zip Code of Residence:	
17. Unit Location	18. MOS	19. Trauma DIS	Prev. Admission NO	
20. Source of Admission Direct from ER	Ward: ICW1	Name / Relationship of Emergency Addressee Address of Emergency Addressee		
Name and Location of Medical Treatment Facility: 0580 - 28th CSH - Iraq; No Install Provided		Telephone Number of Emergency Addressee		
21. Type of Disposition TRF-OTH	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2003-10-27		
24. Clinic Svc - Admitting AEA - ORTHOPEDICS	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-10-21		
27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission 2003-10-21		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: GSW R UE

Dx: 81230
81315
3543
E9854

PR: 7931
7932

Trauma
9
Inj
569

Procedure Narrative(s):

Cause of Injury Narrative:

b(6)-2

Admitting Officer (Signature, as required) [redacted]	Signature of Admitting Clerk [redacted]

b(6)-4

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

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

1. Register Nbr	2. Name					3. Grade FGN	Admission Remarks
[redacted]	[redacted]						
4. Sex M	5. Age 27Y	6. Race X	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm NO	
11. FMP 99	12. SSN [redacted]	13. Organization				14. Ward	
15. FlyStatus	17. Dept / Ben K78-PRISONER OF WAR/INTER		18. BranchCorps	19. UIC / ZIP		20. Type Case BC	
21. Source of Admission Direct from ER			22. Hour Of Adm: 01:15	23. Clinic Service ABA - GENERAL SURGERY			
24. Name/Relation of Emergency Addressee			25. Type Disp TRF-OTH	26. Date of Disp 2003-11-04			
27a. Address of Emergency Addressee			27b. Telephone No	28. Date This Adm: 2003-10-21		AdmittingOfficer: [redacted]	
29. ReportingMTF 0580 [redacted] b(2)-2				30. Date Init Adm 2003-10-21		32. Units Blood Components	

31. Selected Administrative Data

Marital Status: DoB: [redacted] b(6)-4 b(6)-2

In/Out Patient: Inpatient MOS:

33. Cause Of Injury: GSW

34. Diagnosis / Operations and Special Procedures:

BRACHIAL ARTERY INJURY

Dx: 903.1, 884.0, 890.0, 991.2

Px: 39.50, 86.28, 86.89, 86.69

Trauma 9 Injury 549

b(6)-2

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
Ø	Ø	Ø	Ø	15	15

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
Ø	Ø	Ø	Ø	15	15

Signature of Attending Me[redacted] Signature of PAD or Medical Records Officer [redacted] MAJ[redacted]

Automated Facsimile - DA Form 3647, May 79

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

26yo IM shot while doing a drive by shooting

PMH ⊖ meds ∅
PSH ⊖ allergies ⊖

PHYSICAL EXAMINATION

VSS

Lungs clear
Heart - RR
Abd ⊖

Ext. L arm - ⊖ pulse
in + out upper arm
R arm - 1s soft tissue inj
NV ok
L leg ⊖
R leg thigh wound

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

Imp - 1) Multiple GSW
2) (L) brachial artery injury

Plan - OR

b(6)-2

SIGNAT[redacted]	DATE 27 Oct 03	IDENTIFICATION NO.	ORGANIZATION

PATIE[redacted]TION (*For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility*)	REGISTER NO.	WARD NO.

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

539-106

117

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10/21	Op Note
	Repair L brachial artery
	Debride R arm & leg
	[redacted]
	b(6)-2

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

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

REGISTER NO.	WARD NO.

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
21 oct 03 0600	Received report + assumed care of Pt. VSS, 130/40, 93, 19, 100% on 6L via simple mask, 97.1°. Dressing to (R) Arm saturated c̄ blood + blood on bulky pad under arm. +1 pulse to radial sites bilat. Able to move BUE c̄ + sensation to all fingers. Blood to (R) Leg dressing c̄ blood on sheet under leg. +1 pulses to bilat ~~dorsal~~ dorsal sites. Able to move BLE c̄ + sensation to all toes. Brisk cap refill to all extremeties. Will continue to monitor. — [redacted] 9/6/M6
0700	N/V check performed c̄ Ø Ntd Δ's. — [redacted] 9/6/M6
0725	Pt complaining of (L) Arm pain, medicated c̄ 4mg MSO4 per PRN order. Will monitor. — [redacted] 9/6/M6
0800	N/V check performed c̄ Ø Ntd Δ's. — [redacted] 9/6/M6
0810	Pt vomited large amount of clear liquid shortly after consumption of 700cc of water. — [redacted] 9/6/M6
0830	Pt complaining of (L) arm pain, medicated c̄ 6mg MSO4 per PRN order. Will monitor. — [redacted] 9/6/M6
0900	N/V check performed c̄ Ø Ntd Δ's. Will continue to monitor. — [redacted] 9/6/M6
1000	N/V check performed c̄ Ø Ntd Δ's. LR started @ 125cc/hr via cordis + sling applied to (L) Arm. VSS, will continue to monitor. [redacted] 9/6/M6

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO. IR U-1

[redacted] b(6)-4

b(6)-2

PROGRESS NOTES
Medical Record

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

b(6)-2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
1100	N/V check performed c̄ Ø Ntd Δ's. VSS, Pt lying in bed c̄ Ø Ntd signs of distress. Will monitor. — [redacted]
1120	PT's Abd + (R) arm cleaned c̄ peroxide + Normal saline. — [redacted] 9/WMG
1200	A-Line D/C'd [redacted] (R) [redacted]. Direct pressure [redacted] held for 5 min + then dressing secured c̄ tape. N/V check performed @ this time c̄ Ø Ntd changes. Will continue to monitor. — [redacted]
1300	N/V check done @ this time c̄ Ø Ntd changes. (R) Arm dressing changed. W/T/D c̄ Kerlex Fluffs + Abd Pad. Pt tolerated well c̄ Ø complications. VSS, will continue to monitor. — [redacted] 9/WMG
1400	N/V chek done c̄ Ø Ntd Δ's. — [redacted] 9/WMG
1415	Pt complaining of (R) Leg pain, medicated c̄ 2mg MSO4 per PRN order. VSS, Ø Ntd signs of distress. Will monitor. — [redacted] 9/WMG
1500	N/V check done c̄ Ø Ntd Δ's, Will continue to monitor. — [redacted] 9/WMG
1600	N/V check done c̄ Ø Ntd Δ's, will continue to monitor. — [redacted] 9/WMG
1700	N/V check done c̄ Ø Ntd Δ's, Will continue to monitor. — [redacted] 9/WMG
1800	N/V check done c̄ Ø Ntd Δ's. — [redacted] 9/WMG
1805	Report given to night shift. — [redacted] 9/WMG
2@1800 Oct 03	Assumed pt care. — [redacted]
2@1900 Oct 03	Neurovascular status unchanged from 1830 assessment. (R) LE cleared slightly (L) LE is slightly [redacted]
2@2000 Oct 03	Neurovascularly intact. ROM limited to (R) LE c̄ slight pain. (R) LE & LE ROM limited c̄ pain. — [redacted]
2@2100 Oct 03	Neurovascularly intact. Pulse 2+ to all extremities. ROM ↓ changes. — [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES b(6)-2
DATE	NOTES
212200 Oct 03	Neurovascularly intact. Pulses 2+ to all extremities. Mod swelling bilateral. MD informed RE: purulent eye drainage. Ordered Erygin TID. Drsg Δ completed to (R) elbow. Ø purulent drng noted to wound or old drsg. NS soaked - gauze reapplied to body red wound & two smaller, body red wounds. * Drsg Δ completed to (R) thigh; body red wound bed c̄, Ø purulent drng to wound bed or gauze. NS soaked gauze applied to wound or small wound to superior large thigh wound. Pt rolled to (R) side. — [redacted]
212300 Oct 03	Neurovascularly intact. Ø changes in pulses or swelling. Urine output [redacted] over last hour. Will monitor x 1 hr. If persists, will contact MD. — [redacted]
212400 Oct 03	Neurovascularly intact. Ø changes in pulses or swelling. Urine output [redacted] Ø MD notification needed. — [redacted]
220100 Oct 03	Neurovascularly intact. Ø changes in pulses or swelling. — [redacted]
220200 Oct 03	Pt sleeping through night c̄ c/o pain. Ø neurovascular changes noted. [redacted]
220300 Oct 03	Pt sleeping c̄ c/o pain. Ø neurovascular changes. — [redacted]
220400 Oct 03	Pt awake, c/o moderate pain. 4mg MSO4 given IV. Good relief. Neurovascularly intact, all extremities. Pt returned from (R) side to back. — [redacted]
220500 Oct 03	Pt resting c̄ c/o pain. Neurovascularly intact. IVF continue @ 125 cc/hr. — [redacted]
220100 Oct 03	LATE ENTRY: Urine has become ~~amber color~~ tea-colored. — [redacted]
220600 Oct 03	Pt resting c̄ c/o pain. Tx. UOP is again a light yellow. Neurovascularly intact. Slig inflam. Drsg to (R) elbow has moderate shadowing to drsg. (R) thigh wound has no apparent shadowing. — [redacted]
220605 Oct 03	Report given to day shift. Pt tolerated 1500 Regular Diet. — [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.

E [redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
22 oct 03 @0625	Pt Report recieved From Lt [redacted] VSS No C/O N/V @ present pt resting in bed c̄ eyes closed. pt has No S/s of acute distress @ this time will continue to monitor — [redacted] PFC Simms
22 oct 03 0830	Surgery wounds clean + pile to floor [redacted] b(6)-2
22 oct 03 @ 0845	pt dressing change complete tolerated well No S/s of infection dressing CDI to (R) Arm & LEG (L) Arm & chest VSS Assessment complete see Flow-sheet for details pt recieved 4mg MSO4 for dressing Δ pt resting in bed @ this time will continue to monitor for S/s of acute distress — [redacted] PFC Simms
22 oct 03 @ 0945	pt Neck lines D/C'd peripheral IV in (R) hand patent CDI Flushes well will give report to ICW 1 and transfer when ready [redacted] PFC Simms

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
22 OCT 03 1130	Assumed care of pt transfer from ICU #1 USS Dx GSWs bilateral upper extremities (R) LE. Wet → dry dsg change per MD. Wound to (L) axillary 2 in 2x2 Wet → dry gauze. (L) UE sling off. Incision 12 in staples in place CDI 4x4 Kerlix wrapped. (R) thigh GSW wet → dry muscle exposed kerlix wrapped minimal active bleeding. Ø evidence of skin break down. Decreased mobility at risk will cont to monitor [redacted] Gerrace.
22OCT03 @ 2200	Pt. laying in bed. Denies any pain. (L) Arm DSG CDI, (R) ARM DSG CDI. (R) Leg DSG CDI. Pt ⊕2 nailbed blood return. Lung sounds clear through all lobes ⊕ foley draining clear, yellow urine. [redacted]
23 Oct 03	Surgery + [redacted] b(6)-2
23 OCT 03 @ 1300	Pt. sitting up in bed, eating lunch. Ø c/o pain @ this time. W → D dressings to chest, (R) FA, & (R) leg. Dry DRSNG to (L) upper arm. Mild amount of purulent drainage to bd DRSNG's. Abrasion to (R) knee scabbing over. Fluids D/C'd, IVSL. Pt. instructed to Δ body position to prevent skin breakdown on sacrum. Pt. verbalized understanding. All other assessments WNL. EPW restraint protocol in use. Ø signs of skin breakdown. [redacted] PCT, AMC

[redacted] b(6)-4

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

LAST NAME	NAME	T	ID NUMBER
			b(6)-2

DATE	NOTES
24 oct 03 0700	-Assumed care of pt. A+O x3. VSS ↑BP lungs clear HRRR Active BS x4 quads Urinating per Foley to gravity AS dark amber color urine. C/O pain when moves arms bilat GSW upper extremities Q1° neuro checks intact AER Warm to touch, palpable radial pulse, pt able to wiggle fingers and pain tol stimuli. (R) lateral thigh GSW wet + dry intact Will cont to monitor [redacted] rma.
(2030)	Pt awake, speaking arabic, VS: see SF 511. pre-medicated c 5mg MSO4 for drsg Δ's. Drsg to (R) arm, (R) thigh + (L) chest wall CDI. Pt can wiggle fingers + move arms slightly. Q1° NV Vs. (+) pulses equal bil, brisk cap refill. ice packs applied for elevated temp. Will recheck. Ancef cont per MD orders. 2 pt restraints on ↓ compromise to skin or circulation. Will monitor ([redacted] 91WM6,
UOP)*	UOP this shift c 1400cc dwu. input c 1000cc. via foley [redacted] 91WM6.
25 oct 03 0700	- Assumed care of pt. A+O x3. VSS Lungs CTA HRRR Active BS x4 quads [redacted] Remains NPO o/c for surgery this am. foley to gravity AS dark amber urine. Neuro check intact Wound assessment: (L) UE surgical incision c/staples intact. (L) chest wall axillary area ASW 2x2 wet → dry. (R) UE GSW wet + dry dsg CDI open wound (R) LE thigh GSW wet to dry dsg change CDI. IV ABX cont Remains Afebrile Will cont to monitor [redacted] 91WM6.

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
(2100) 23OCT03	Pt lying in bed, VSS, C/O mild pain to (B) arms & (R) leg. drsg c̄ Kerlix intact to (L) UE. (R) arm drsg Δ'd, (R) thigh drsg Δ'd. small amt yellow drainage to (B) drsgs. Pt pre-medicated c̄ 6mg morf. Abrasion to (R) side of forehead & (R) knee scabbing over. Pt can wiggle fingers, brisk cap refill to (B) hands, limited ROM due to pain. Skin: warm & dry. (R) leg warm & dry, (+) pedal pulses, brisk cap refill. pt able to wiggle toes & lift (R) leg slightly. neuro√'s Q1° con't. 2 pt restraints on ≅ compromise
24OCT03 (0300)	to skin or circulation. Will monitor [redacted] pt voiding QS amber urine c̄ blood noted. [redacted]
24Oct03	Surgery doing well OR 10/25 [redacted] b(6)-2

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

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

REGISTER NO. | WARD NO.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
25Oct03	Op Note
	Closure of leg wound.
	Debridement of arm wound
	[redacted]
	b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

EPW [redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

26OCT03 0236 [redacted] Assumed care of Pt @ 1800. Pt A&O VSS. Drsg To (B) UE CDI. Drsg to (L) LE CDI. Drsg to (L) UE Δ'd. Pain controlled c̄ percocet. [redacted] SL & Wrist flushed + Patent. Will cont. to Monitor. — [redacted] Spc 9/HMC

26OCT03 Surgery + pulse wounds clean b(6)-2 STSG next week [redacted]

26 OCT 03 0700 - Assumed care of pt. Sleep yet easily arousable A+O x 3 VSS ∅ c/o pain or discomfort @ this time. Lungs clear HCRR Active BS x4 quads. ∅ evidence of skin breakdown noted. Wound assessment: (L) UE GSW surgical incision closed staples. (R) axilla region GSW healing wet + dry 2x2 dsg applied. (R) UE GSW open wound wet + dry 4x4 dsg kerlix wrapped. (R) LE GSW to thigh wound closed c̄ sutures penrose drains 4x4 dry dressings kerlix wrapped ∅ s/s of infection Will cont to monitor — [redacted] Spc

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] b(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/19)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)
USAP

LAST NAME	ME	MI	ID NUMBER

DATE	NOTES
27 OCT 03 0200	Assumed care of Pt @ 1800 hrs. A&O VSS unknown if B/P is accurate due to B/P cuff size to Large for Thigh. Unable to use B/P on Brachial artery due to bUE wounds. RUE Dsg CDI. LUE Dsg CDI. RLE Dsg CDI. LLE Dsg Ad. Pt Denied Bin. Last Dose of ancef administered. Will continue to monitor. [redacted] Spc 91WM
27Oct03	Surgery wounds clean [redacted] b(6)-2
27Oct03 1450	Assume care of PT @0600. AOx3 VSS Ø C/O pain. In 2pt restraints without any skin irritation. Acd dsg's on (R) arm wD, (R) leg, (R) Arm, and chest dry dsg's. Minimal drainage, Ø infection. Foley to gravity clear yellow urine. Will continue to monitor. [redacted]
~~27OCT03 2200~~	~~Assumed care of Pt @1800. Denies pain @ this time. Dsg to Abd Ad applied Silvadene cream Dsg to chest and RUE present c WS. Colostomy has minimal output. Stable. J tube flushed and patent. Jevity infusing [redacted] 75cc/h via J tube. RLE Dsg CDI. Will continue to mon[redacted] Spc 91WM~~
28Oct	OK 15/24 [redacted]

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

[redacted] b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
29oct@0445	Assumed Care @1800; All VSS, pt A&O speaking arabic; dsg to (R) UE Δ[illegible] W → D ∃ s/sx infection; dsgs to (R) LE & (R) UE CDI ∃ drainage Noted; FTC draining QS, c/o, ∃ complications; cont ∈ PO abx; Restraints in place, ⊕ circ, ⊖ skin breakdown, cont to monitor [redacted]
29 OCT 03 1200	VSS. AO. Sent to OR for STSG to RUE. DSG's to LUE and RLE CDI and to be changed appropriately. Voiding light yellow urine QS. ⊕ pulses to all extremities ⊖ c/o pain. Cont to monitor. [redacted]
29 OCT03 2300	[redacted] Assumed care of pt @ 1800. Pt ⊖ c/o pain, controlled ∈ percocet. Drsg to RUE, LUE RLE CDI. Drsg to Abdomen Draining copious amounts of Sero. Sang. Fluid. Drsg re-inforced @ 193[illegible]. RUE Drsg moistened ∈ NS @ 2200 [redacted] will continue to Monitor. [redacted] Spc 9/WMC
30 Oct POD #1 STSG	Surgery day [redacted] b(6)-2
30OCT03 (1455)	Assumed care @ 0600. Pt alert, speaking Arabic. VSS. ⊖ c/o pain. Drsg to (R) arm moistened ∈ NS. Staples to LUE CDI, wrapped ∈ Kerlex. Drsg to Abd. reinforced ∈ 4x4s. Vaseline gauze intact ∈ mod. amount sero-sang drainage. Drsg to (R) flank Δd WTD. Sutures to RLE CDI. WTD drsg placed on wound on RLE. All wound sites ∃ s/sx infection. Pt OOB to chair. Amb in hallway ∃ difficulty. Tol. well. SL in (R) arm flushes well ∃ s/sx infiltration/

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

[redacted] b(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
29Oct03	Op Note
	STSG R arm
	[redacted]
	b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
1007			

DATE	NOTES
30OCT03	(cont) infection. 2 point restraints in place ~~s~~ s/sx complications. Will continue to monitor. [redacted] 47A
30 OCT 03 2200	Assumed care of Pt @ 1500. A&O. Drsg to (R) Arm, (L) Arm (R) Leg & Abdomen CDI. ~~Keeping~~ Continue to keep (R) Arm Drsg moist. Tol PO well. Amb ~~s~~ [redacted] Fluity. 2 point restrain. [redacted] 91WMb
31oct03@1550	Assumed Care ~~[redacted]~~ 0600; All VSS, pt A&O speaking arabic; ⊕ cms throughout, pain controlled c̄ percs; staples to (L) UE CDI, ⊖ drainage, ⊖ s/sx infection, well approximated; (R) UE moistened c̄ NS, wrapped c̄ ace bandage; (R) LE Δd W→D, minimal drainage on old dressing, sutures intact, well approximated; abd dsg Δd, vaseline gauze intact, reinforced c̄ combine dsg & 4x4 gauze; dsg to (L) Flank Δd W→D; all dsg ⊖ s/sx infection; S/L patent, easily flushes ~~s~~ s/sx infection/infiltration, pt OOB to amb in hall, TOI PO well, Restraints in place, ⊕ circ, ⊖ skin break ↓, Cont to monitor. [redacted]
NOV@0400	VSS. Cont to keep (R) arm damp c̄ 0.9 NS as per order. Sutures to (L) arm ⊖ s/sx of infection + well-approximated DSG to (R) Leg CDT. Pt c/o pain. Med c̄ 2 perc. Will continue to monitor. ⊕ foley, draining clear yellow urine. [redacted] DTI/RN
11/1/3 Day #3	Syne 7 No well + p-lye [redacted]

b(6)-2

b(6)-2

#[redacted] b(6)-4

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
01NOV03	(1745) Assumed care of pt @ 0000 ~~p~~ report. Pt alert, speaking Arabic. VSS. 0 c/o pain. Amb well. Drsgs Δd. NS applied to moisten skin graft drsg. Staples to LUE and sutures to RLE CDI. 0 s/sx infection in wounds. SL in @ arm dlcd - catheter intact. 2 point restraints in place ~~s~~ s/sx complications. Will cont. to monitor. — [redacted] UMA
01NOV03 1900	VSS Alert & Oriented. (R) UE drsg intact & moist wrapped c̄ ace wrapping. OOB Amb. to BR. Drsg intact & dry to mult. wounds on arms leg & chest. Consumed 100% of Regular diet for dinner. Foley cath draining clear yellow urine. Will continue plan of care. [redacted] ZUM
11/2	S-n e 7 100% h/l e [redacted] b(6)-2
02NOV03	(1220) Assumed care @ 0000. Pt alert, speaking Arabic. Drsg to @ arm skin graft dlcd per MD. Staples to LUE dlcd - steri strips applied. Incision CDI. WTD drsgs to RLE and @ side of chest Δd, sutures to RLE CDI. 0 s/sx infection @ wound sites. Amb well. 0 c/o pain. Foley dlcd. Pt aware he is DTV by 1500. Tol. reg

[redacted] b(6)-4

STANDARD FORM 509 (REV. 5/1990) BACK

USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
3NOV03	(CONT) dressings, pain control. 2pt restraints on ~~s~~ s/sx of skin or circulation compromise. Will monitor. - [redacted]
3 NOV03	Surgery Wound, OK d/c 11/4 [redacted] b(6)-2
04NOV03	(1135) Assume care @ 0000 ~~p~~ report from night shift. Pt alert, speaking Arabic. VSS. ~~0~~ c/o pain. Drsg to @ dorm skin graft ~~Δ~~d. Vaseline gauze applied to wound WTD drsgs on @ side of chest and RLE ~~Δ~~d. Sutures to RLE CDI. ~~0~~ s/sx infection @ wound sites. Pt amb well. Tol. reg diet well. Voiding ~~s~~ difficulty. Steri strips to LUE CDI. @ point restraints in place ~~s~~ s/sx complications. Will cont. to monitor. [redacted]
	(1145) Pt d/c to EAW camp - amb. - escorted by MPs. [redacted] b(6)-2

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

b(6)-2

DATE	NOTES
02NOV03 (1220)	(cont) diet well. 2 point restraints in place ⊼ sign complications. Will cont. to monitor. [redacted] (1745) Pt voiding clear yellow urine via urinal ⊼ difficulty. Monitoring. [redacted]
02NOV03 2000	VSS alert & Oriented. Ambulate to BR independently. Urine clear yellow urine. Consumed 50% of Regular diet for dinner. Drsg intact to RLE & (L) side of chest and Clean. Pedal pulses palpable +2. Radial pulses +2. Will continue care as planned. [redacted]
3NOV03@ 1400	Pt. sitting up in bed, V.S.S. A&O, ∅ c/o pain. Vaseline gauze to ABD skin graft donor site. DRY DRSNG's to (R) arm, chest, & (R) thigh Δd, small amount seroserg. drainage. Pt. OOB to BR ⊼ difficulty. Ambulated @ bedside, clear yellow urine. All other assessments WNL. [redacted]
3NOV03@ 2030	assumed care of pt @ 1800. VSS. ∅ pain in (R) hand from wrist to fingertips of 5th digit, controlled c̄ percocet. LS CTA @ BS void per urinal, tol reg diet well. abd & leg drsgs CDI. (R) FA drsg Δd & vaseline gauze applied; tissue healing well. Pt up amb ⊼ difficulty. Plan: cont amb, monitor (CONT)

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME		
	LAST	FIRST	MI [redacted]

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO. KW1

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
4Nov03	DC Sum
	adm.t 10/21/3
	d/c 11/4/3
	dc dx- GSW arms + R leg
	c̄ brachial artery
	injury (L)
	Operators
	10/21 - repair brachial artery
	10/25 - closure of leg wound
	10/29 - STSG R arm
	hx- I male shot multiple
	sites
	hosp course - uncomplicated
	above operations
	d/c Meds - ASA ± po q day x 30 days
	Tylenol prn
	Tylenol #3 prn →

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

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

b(6)-2

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
4 Nov 03	DC Sum (cont)
	Plan 1) Vas Gauze to STSG site q day x 1 more week
	2) remove leg sutures in 1 week + steristrip
	3) ASA x 1 month
	4) No activity restrictions
	5) May shower
	b(6)-2 [redacted] MD
	[redacted], LTC, MC
	Gen Surg

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. 5/1995)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10
USAPA V1.0

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY												
POST- DAY												
MONTH-YEAR	DAY	30	31	01 NOV	02	03	04					
19	HOUR	8 9	8 8	2 0 0 0	8 9	1 9 0 0	1 0	1 8 4 5	2 0 0 0	8 8		

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

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

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

RESPIRATION RECORD

	30	31	01 NOV	02	03	04
BLOOD PRESSURE	156/45	143/4	131/61	135/40	137/46	118/48	111/59	119/59
Pulse			94			93	94	
Temp			98.7			97.6	97.2	
HEIGHT: / WEIGHT →						97%	97%	
O2 sat	97(RA)	97(RA)	98%	98(RA)	98(RA)	98(RA)	97(RA)	

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] b(6)-4

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

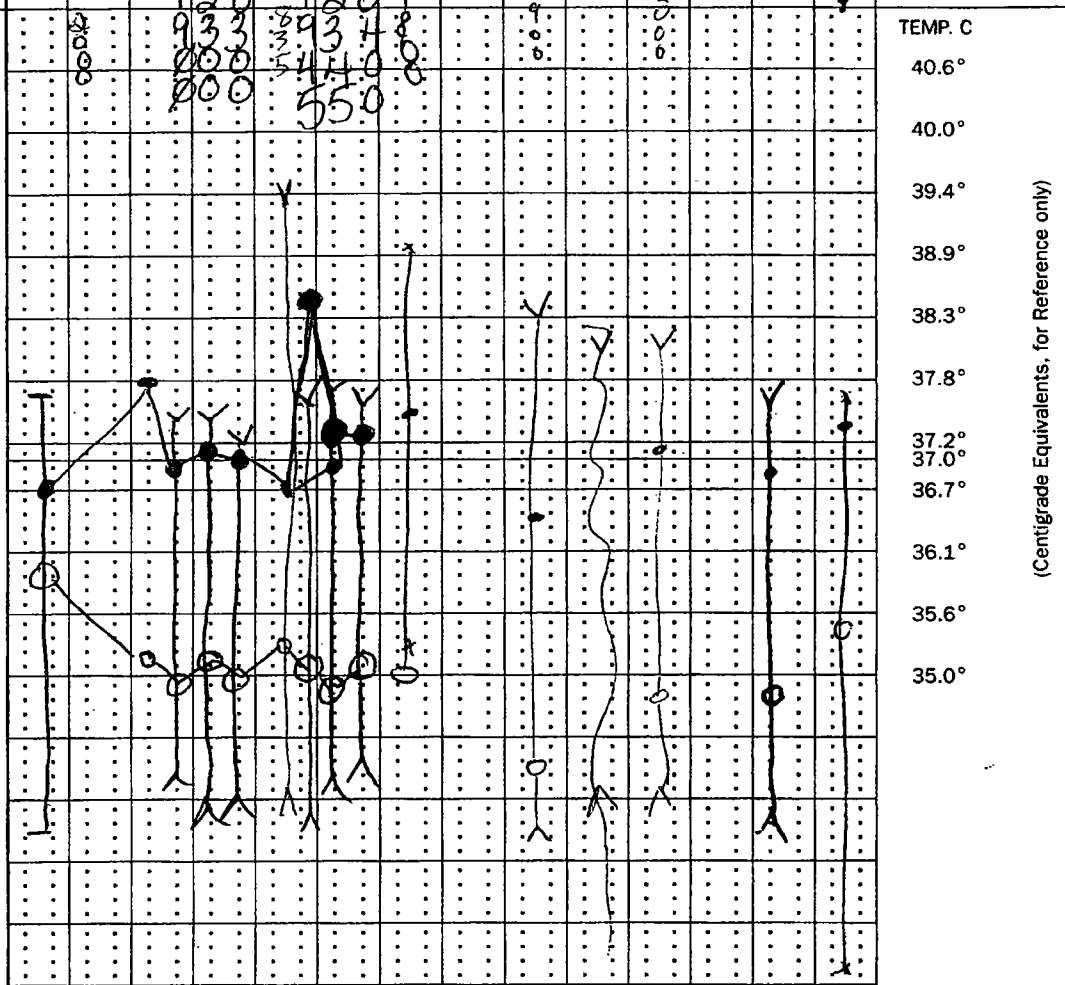
MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR OCT 19~~20~~03 — DAY: 22, 23rd, 24/25, 26, 27, 28, 29 OCT — HOUR

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



RESPIRATION RECORD

	22	23rd	24/25	26	27	28	29 OCT
BLOOD PRESSURE	137/65	134/68	169/72 136/76	149/48 162/95	160/65 145/72	145/72	137/66 137/43
H 106		93	130/70 134/67	97 90			87 97
T 98°		100°		99.8 99.5			98.3 99.3
HEIGHT: WEIGHT →	97%	95% RA	96%	98% 98%			98% 98%
	RA		95% (RA)	96%	95% RA 95%	95% RA	RA
		134/74 96% (RA)	96% (RA)				
		96% (RA)					

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

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

4. PROPOSED SURGICAL PROCEDURE:

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

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

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

[redacted] b(6)-4

EPW

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

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

[redacted] b(6)-2 21 Oct 03 DATE

11. POSTOPERATIVE EVALUATION:

Bovie site:
Dsq:
LOC:
Resp:

b(6)-2

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)	13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)
[redacted] CPT/AN DATE: 21 Oct 03 TIME: 0330	DATE: TIME:

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

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 anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY

3. DATE 21Oct 03 TIME PATIENT ARRIVED IN SUITE 0223

4. PATIENT IN ROOM TIME 0223 NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: No English b(6)-2

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	
	Maj. [redacted] (start-0315)		

7. POSITION AND POSITIONAL AIDS

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

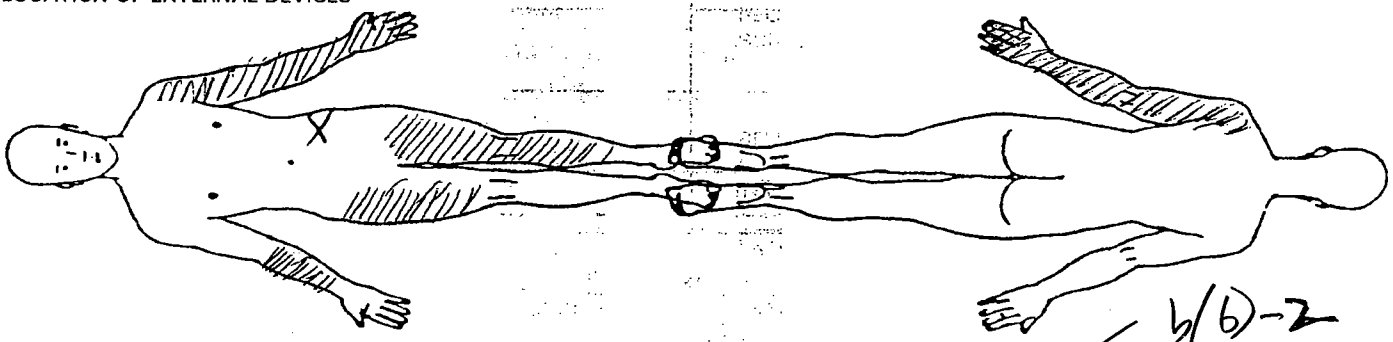
COMMENTS: Proper body alignment maintained. Bump under (L) knee

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine scrub/sol'n
SITE: Lt. arm, Lt leg BY WHOM [redacted]
SITE: Rt leg, Rt arm BY WHOM: [redacted]
COMMENTS: No pooling of fluids

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect Initial C [redacted] b(6)-2

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

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

[redacted] b(6)-2

EPW

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

☒ ESU NO: Force 40 R8B10239S 30/30
GROUND PAD: BRAND Valleylab REM
LOT NO: [redacted]

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

b(6)-2

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Hep. Saline	1u/1cc	intraop	inj	[redacted]	[redacted]
Surgicel		intraop	topical		

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):

0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY
None		

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☐ NO ☒ 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. 3/8 Penrose	2. 3/8 Penrose	3.
SITE	1. Lt. Upperarm	2. Rt. Leg	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs, Kerlix, ABD 4x4 — Arms, Legs

19. ADDITIONAL INFORMATION

Surg: [redacted] Anesth: [redacted] CRNA Anesth. Type: General

b(6)-2

Foley in place PTA

20. OPERATION(S) PERFORMED

1. Repair of Lt. Brachial Artery
2. Debride Rt. Arm Wound
3. Debride Rt. Leg Wound

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU1 b(6)-2	0540	Litter

22. REGISTERED NURSE SIGNATURE

[redacted] CPT/AN

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA letter BY anesthesia

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

3. DATE 25 OCT 03 TIME PATIENT ARRIVED IN SUITE —

4. PATIENT IN ROOM TIME 0850 NUMBER 2-2 (3)

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Pt not english speaker. b(6)-2

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted], 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted], 66E	RELIEF CIRCULATOR	MAJ [redacted] (Prep)

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: b(6)-2

8. SKIN PREPARATION

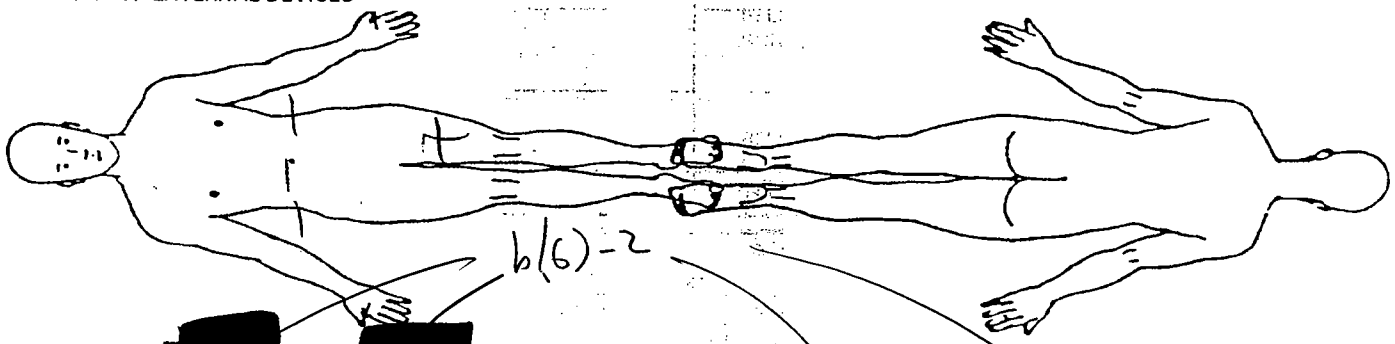
HAIR REMOVAL ☒ YES ☐ NO CPT [redacted]
DONE BY: ☒ OR ☐ NURSI[redacted]
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP

COMMENTS: no nicks or cuts noted.

PREP SOLUTION *(Specify)* Beta/Beta [redacted]
SITE: R arm BY WHOM: CPT [redacted]
SITE: R leg BY WHOM: MAJ [redacted]

COMMENTS: no pooling of prep noted.

9. LOCATION OF EXTERNAL DEVICES



b(6)-2

LEGEND X [redacted] -- S[redacted] === Tourniquet

C = Correct I = Incorrect

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

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

[redacted] b(6)-4

[redacted] b(2)-2

25 OCT 03

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

☒ ESU NO: Valleylab CUT 30-40 COAG 30-40 2-2
GROUND PAD: BRAND Valleylab E7507
LOT NO: 70011 2005-04

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

13. PROSTHESIS, IMPLANTS ☐ Y NO IF YES NAME: ID NUMBER; ACTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NACL

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

18. DRESSING/IMMOBILIZATION *(Specify)*

fluff
- kerlix
- 4x8

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 3/8 Penrose	2.	3.
SITE	1. R leg	2.	3.

19. ADDITIONAL INFORMATION

b(6)-2

20. OPERATION(S) PERFORMED

I & Right arm, Right leg c̄ DPC of wounds.

21. PATIENT TRANSFERRED TO ICU3 TIME 1015 METHOD Gurney

22. REGISTERED NURSE SIGNATURE [redacted] CPT/AN

REVERSE

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY MA[redacted]

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY MA[redacted]

3. DATE 29 Oct 03 TIME PATIE[redacted]N SUITE 1023

4. PATIENT IN ROOM TIME 1023 NUMBER 2-1

b(6)-2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SGT [redacted] 91D b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ [redacted] 66E b(6)-2	RELIEF CIRCULATOR	CPT [redacted] (1030-end) b(6)-2

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: b(6)-2

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO CPT [redacted]
DONE BY: ☒ OR ☐ NURS[redacted]
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP

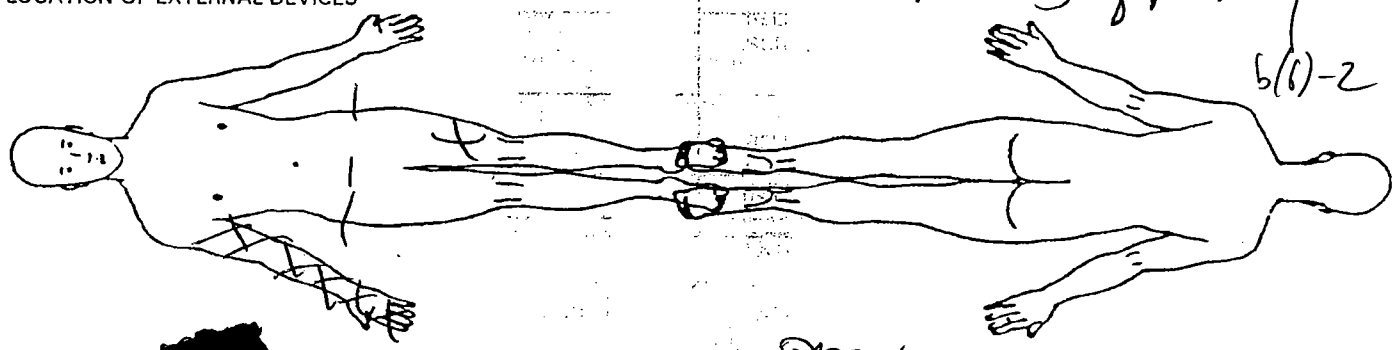
COMMENTS: no nicks or cuts noted.

PREP SOLUTION *(Specify)* Betadine/Betadine
SITE: ABD BY WHOM: CPT [redacted]
SITE: (R) arm BY WHOM: MAJ [redacted]

COMMENTS: no pooling of prep noted.

b(6)-2

9. LOCATION OF EXTERNAL DEVICES



LEGEND X [redacted]d -- Safety Strap = = = Tourniquet Prep

10. COUNTS

C = Correct I = Incorrect

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

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

#[redacted] b(6)-4

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

☒ ESU NO: CUT 30 COAG 30 RSB 102395
GROUND PAD: BRAND Valleylab
LOT NO: 70011 Exp 2005-04

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S): 10cc EPI 1:1000 mixed c̄ 1 Liter NS. SOAK.

NACL

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*

- fluffs
- 4x8

19. ADDITIONAL INFORMATION

b(6)-2

20. OPERATION(S) PERFORMED

STSG (R) arm.

21. PATIENT TRANSFERRED TO ICU 3 TIME 1130 METHOD letter

22. REGISTERED NURSE SIGNA[redacted] CPT I AN

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

LAST, FIRST, MI. #[redacted] | DATE | TIME | SSN/PSEUDO SSN:

(i-STAT)			(Piccolo) Chemistry 12			(Piccolo) Metabolic Panel		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Na	142	138-146 mmol/L	ALB		3.5-5.5 g/dl	GLU		73-118 mg/dl
K	3.5	3.5-4.9 mmol/L	ALP		26-84 u/l	BUN		7-22 mg/dl
Cl					10-47 u/l	CA++		8.0-10.3 mg/dl
pH	7.194				14-97 u/l	CRE		0.6-1.2 mg/dl
PCO2	50.6				11-38 u/l	NA+		128-145 mmol/l
PO2	152				0.2-1.6 mg/dl	K+		3.3-4.7 mmol/l
TCO2	21				7-22 mg/dl	CL-		98-108 mmol/l
HCO3	20				8.0-10.3mg/dl			18-33 mmol/l
sO2	99				100-200 mg/dl			
BEecf	-9				0.6-1.2 mg/dl			
AnGap					73-118 mg/dl			
Ca	1.12				6.4-8.1 g/dl			
BUN								
GLU								
Creat								
Hct	29							
Hgb	10							

Misc. Chem	
TEST	RESULT
Troponin-I	
Drug of Abuse	

REMARKS:

REPORTED BY: | DATE: | LAB

```
======= PICCOLO =======
21/10/03                01:41
REFERENCE RANGE:                MALE
PATIENT #: [redacted]  b(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: [redacted]
OPER #: [redacted]  DR #: 000
SERIAL #: [redacted]
.......................
ALB   3.5   3.3-5.5   G/DL
ALP   61    26-84     U/L
ALT   30    10-47     U/L
AMY   53    14-97     U/L
AST   51*   11-38     U/L
TBIL  0.6   0.2-1.6   MG/DL
BUN   17    7-22      MG/DL
CA++  8.4   8.0-10.3 MG/DL
CHOL  157   100-200   MG/DL
CRE   1.0   0.6-1.2   MG/DL
GLU   126*  73-118    MG/DL
TP    7.4   6.4-8.1   G/DL

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

b(6)-2

```
======= PICCOLO =======
21/10/03                01:40
REFERENCE RANGE:                MALE
PATIENT #: [redacted]  b(6)-4
METLYTE 8
DISC LOT #: b(6)-4 [redacted]
OPER #: [redacted]  DR #: 000
SERIAL #: [redacted]
.......................
GLU   124*  73-118    MG/DL
BUN   15    7-22      MG/DL
CRE   1.3*  0.6-1.2   MG/DL
CK    586*  39-380    U/L
NA+   129   128-145   MMOL/L
K+    3.7   3.3-4.7   MMOL/L
CL-   102   98-108    MMOL/L
tCO2  20    18-33     MMOL/L

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

b(6)-4

Ward/Section: AMT | REQUESTING PHYSICIAN

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

LAST, | DATE | TIME | SSN/PSEUDO SSN: [redacted]

IAL [redacted] 10/21/03 01:42

TEST

WBC

RBC

Hgb

Hct

MCV

Plt

Lymph

(Hem

Segs

Bands

Lymph

Atyp

RBC Morph

ient ID: [redacted] b(6)-4
est Name :PT
est Result:= 12.8 sec.
atio = 1.0
alculated INR = 1.08
mple Type:citrated wh. blood
est Date :10/21/03
est Time :01:41
rd Lot [redacted]
erator [redacted] b(6)-2

DPOINT COAG ANALYZER V4.54
AL [redacted] 10/21/03 01:45

ent ID: [redacted]
st Name :APTT
st Result:= 2 sec.
RESULT OUT OF RANGE***
le Type:citrated wh. blood
t Date :10/21/03
me :01:42
[redacted] b(6)-2

analysis

REF. RANGE	TEST	RESULT	REF. RANGE
N/A	RPR		Negative
N/A	Mono		Negative
Negative	**Microbiology**		
Negative	Source		
Negative	Gram Stain		
N/A	Occ Bld		Negative
Negative	H. pylori		Negative
N/A			
Negati			
0.2-1.0			
Negati			
Negati			
Negati			

[redacted] b(6)-4

				Patient Limits	
WBC	17.4 H	x10^3/uL		4.5	10.5
RBC	6.50	x10^6/uL		4.00	6.00
HGB	12.7	g/dL		11.0	16.0
HCT	39.8	%		35.0	50.0
MCV	88.6	fL		80.0	99.9
MCH	28.3	pg		27.0	31.0
MCHC	31.9 L	g/dL		31.0	37.0
PLT	385.	x10^3/uL		150.	450.
LYM%	16.2	uL %		20.5	51.1
LYM	2.8	x10^3/uL		1.2	3.4

-4+

Spun Hematocrit		42-52% (M) 37-47% (F)	CSF	
Sed Rate			Cell Count	
Other			Directigen	Negative

518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coag [redacted] b(6)-4

TEST	RES			Patient Limits	
WBC	12.1 H	x10^3/uL		4.5	10.5
RBC	3.57 L	x10^6/uL		4.00	6.00
HGB	10.2 L	g/dL		11.0	16.0
HCT	31.8 L	%		35.0	50.0
MCV	89.1	fL		80.0	99.9
MCH	28.5	pg		27.0	31.0
MCHC	31.9 L	g/dL		31.0	37.0
PLT	385.	x10^3/uL		150.	450.
LYM%	16.5	uL %		20.5	51.1
LYM	1.8	x10^3/uL		1.2	3.4

APTT

D dimer

FDP

REMARKS:

REPORTED BY

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

UNIT	TYPE	CROSSMATCH

LAB ID NO.:

5
37
1.8
66.6
32

b(6)-4 b(6)-2

Ward/Section: ICU | RE [redacted] | CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. [redacted] | DATE 21 OCT 03 | TIME 0588 | SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

b(6)-4

======= PICCOLO ======
21/10/03 06:10
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTF 8
DISC LOT #: [redacted]
OPER # [redacted] DR #: 000
SERIAL #: [redacted]

GLU	144*	73-118	MG/DL
BUN	10	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	1448*	39-380	U/L
NA+	133	128-145	MMOL/L
K+	3.9	3.3-4.7	MMOL/L
CL-	107	98-108	MMOL/L
tCO2	18	18-33	MMOL/L

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

b(6)-2

REMARKS:

REPORTED BY: | [illegible] ID NO.:

b(6)-4 b(6)-2

Ward/Section: ICU	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FO (Subject to the Privacy Act of 19
LAST, FIRST, MI. [redacted]	DATE 20OCT03 / TIME 0888	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RB		
Hgl		
Hct		
MC		
Plt		
Lyn		
(I		
Seg		
Ban		
Lym		
Atyp		Imm
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

b(6)-4

[redacted]

21-10-03
06:19
Patient
Lab173

WBC	14.4	K/uL x10^3/uL	4.5	14.5
RBC	3.01 L	M/uL x10^6/uL	4.00	6.00
Hgb	10.6 L	g/dL	11.0	18.0
Hct	31.6 L	%	35.0	60.0
MCV	88.7	fL	80.0	97.0
MCH	27.9	pg	27.0	31.0
MCHC	31.5 L	g/dL	33.0	37.0
Plt	347.	x10^3/uL	150.	450.
Lym	34.4 *	%	20.5	51.1
Lym	3.5 *H	x10^3/uL	1.1	3.4

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. R
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WI
EVERY UNIT REQUESTE

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATC

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

ICU 1 NKDA Ø med H- Ø surg 1

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)												
Propofol	(mg)	100						30					
Fentanyl	(mg)	150			100	100		100		50			
Sch	(mg)	120											
Vecuronium	(mg)		5		5		5		5		2		
	( )												
	( )												
VOLAT AGENT	I-50 % del		1.5	1.3	1.5	1.0	0.8	1.0	1.5	0.8	1.3	1.5	1.0X
	% e.t.												
AIR	L/Min												
N2O	L/Min												
O2	L/Min	10	3	3	3	3	3	3	3	3	3	3	3

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

TOTALS	TOTAL EBL
500	200
	TOTAL URINE
	800

FLUIDS - SUMMARY

CRYSTALLOID- 2800

COLLOID- Ø

BLOOD- Ø

FLUIDS

LINE site 18G (L/E) ☐ Warmed — NS (700) — X LR → (2500) — 2500

20 gauge ☐ Warmed — X

(R) IJ cath ☐ Warmed — NS (700) — X LR →

☐ Warmed

LOSSES — EST BLOOD LOSS

URINE - Foley — 200 — 200 (400) — 200 (600) — 200 (800)

PHYS STATUS: 1 2 3 4 5 (E)

BODY WEIGHT: 90 KG LB

HEMATOCRIT: 12/38

INITIAL DATA:

BP- 143/72

HR- 111

EQUIP CHECK

OK?- (Y) N

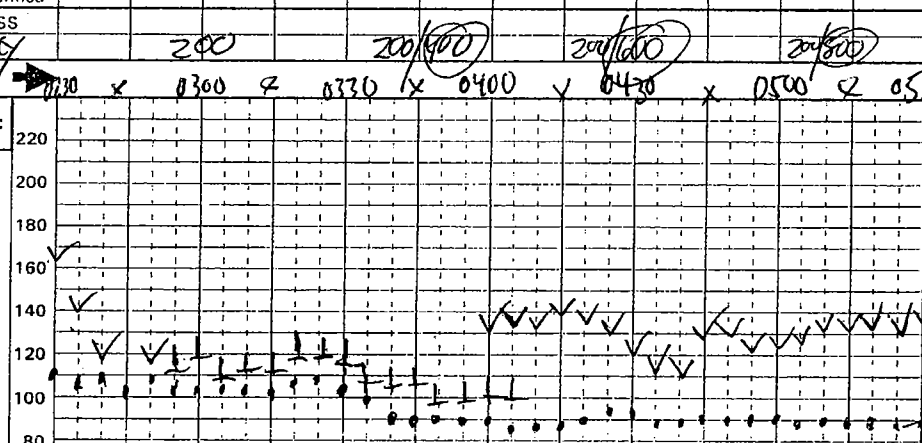
PATIENT RECHECK

OK for PROCEDURE Okay

TIME- 0215

TIME: 0230 x 0300 ♀ 0330 x 0400 ✓ 0430 x 0500 ♀ 0530

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



VENTIL	0230	0300	0330	0400	0430	0500	0530	0600	0630	0700	0730	0800
VT - ml				600	610	610	600	620	620	610	630	620
f - breaths/min				16	16	16	16	16	16	16	16	16
Peak inf pres / PEEP			30	26	26	26	27	27	26	27	27	27
MODE - S(pon), A(ssist), C(on)	S A	C	C	C	C	C	C	C	C	C	C	C
BP/Auto Cuff	(+)	(+)	50	40	39	36	37	35	35	35	35	35
BP/oth	FM	.74	.74	.74	.74	.76	.76	.76	.76	.76	.76	.76
ART line	100	100	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ST	ST	ST	ST	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	Warm				35.4	35.6	35.6	35.6	35.6	35.6	35.6	35.6
N-M Block (T/4)	Λ						4/4		0/4	0/4	1/4	
Warming blkt												
Conv warmer												

MONITORS/ACCESSORIES: ET CO2 (torr); FIO2 (Frac or %); SpO2 (%); ECG; TEMP-site

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

REMARKS

Code drugs with numbers, events with letters

Pre-emptive analgesia for fracture/dislocation of ankle (R) morphine 25 mg, IV, 1 over 60 sec. (R) IV 2.5 for cardiac stress. Sch given by single dose (E) transducer. 0400 Standard A-line waveform - trace dampened. 0432 7000 units Heparin IV. 0435 Surgeon notified 3 minutes. 0500 since IV Heparin. 0505 2 gm Ancef IVPB per surgeon request. 0535 Reversed (5) Neostigmine (+) 0.5 (+) 0.7 mg Robinul. 0543 Extubated 5 deep breaths - All criteria met. To ICU, T-piece mask O2 - stable.

RECOVERY AT 0540

PACU ICU (Specify)

OTHER

CONDITION: Stable/Awake

RESP- SpO2

BP- HR-

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0215	0230	0530
	Ready	Begin	End
PROC	0240	0300	0535

PROCEDURES and CPT Codes: Repair Brachial Artery (L); Debridement (R) leg & Arm

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

[redacted] b(6)-4 b(6)-2

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

GETA

AIRWAY MANAGEMENT: Intubation route, blade/ technique, comments

RSI (+) Cricoid pressure, MLx Tube ETT #7.5 ETT Grade 1 view. (+) BBS (+) ETCO2, Secured @ 23 cm teeth. Sciatic block

SURGEONS: [redacted]

ANES: [redacted] CRNA [redacted]

PROCEDURE LOCATION: OR 2

DATE: 21 Oct 03

PAGE 1 OF 2

DA FORM 7389, FEB 1998 MEDCOM - 21819 COPY 2 - ANESTHESIA PROVIDER USAPA V1.00

MEDICAL RECORD - ANESTHESIA

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

ANESTHETIC AGENTS AND DRUGS

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

DRUG	(Units)
	( )
	( )
	( )
	( )
	( )
	( )
VOLAT AGENT Fsc	% del
	% e.t.
AIR	L/Min
N2O	L/Min
O2	L/Min

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

FLUIDS

LINE site	
	☐ Warmed
	☐ Warmed
	☐ Warmed
	☐ Warmed

LOSSES

EST BLOOD LOSS

URINE -

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: KG LB

HEMATOCRIT:

INITIAL DATA:

BP /

/

HR-

EQUIP CHECK

OK?- Y N

PATIENT RECHECK

OK for PROCEDURE?

TIME-

TIME → 530 45

SYMBOLS:

BP by cuff V

Heart rate ∧

Resp rate ●

BR (transduced)

TOURNIQUET T—T

ANES- X-X

PROC- ⊙-⊘

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

VENTIL

VT - ml	600
f - breaths/min	16
Peak inf pres / PEEP	5
MODE - S(pon), A(ssist), C(on)	

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	40
BP/oth	FIO2 (Frac or %)	.76
ART line	SpO2 (%)	100
Steth- PC/ES	ECG	SR
Gas analyzer	TEMP-site	
	N-M Block (T/4)	4/4
Warming blkt		
Conv warmer		

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

TOTALS	TOTAL EBL
	TOTAL URINE

FLUIDS - SUMMARY

CRYSTALLOID-

COLLOID-

BLOOD-

REMARKS

Code drugs with numbers, events with letters

SEE

RECOVERY AT

PACU ICU _____ (Specify)

OTHER _____

CONDITION:

RESP- SpO2-

BP- HR-

ANESTHESIA / PROCEDURE TIMES

ANES	Start	Room	End
PROC	**Ready**	**Begin**	**End**

PROCEDURES and CPT Codes:

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

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

[redacted] b(6)-4

b(6)-2

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

SURGEON [redacted]

ANESTH [redacted] CRNA

PROCEDURE LOCATION: OR 2

DATE: 21 Oct 03

PAGE 2 OF 2

MEDCOM - 21820

DA FORM 7389, FEB 1998 ANESTHESIA PROVIDER USAPA V1.00

Chart review 1 pre-op
No Δ since last anesthesia 14.6 > 10.6 < 347 / 33.9 WKVA

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)	
Fentanyl	(mcg)	(150) 100
Propofol	(mg)	180
SCH	(mg)	100
Vec	(mg)	4 3
MSCN	(mg)	3 2
	( )	
VOLAT AGENT: I-50	% del	1.7 – 1.5 – 1.5 – 0.6X
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	10 – 2 – 2 – 2 – 2 – 10

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "I" = CONSTANT INFUSION

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

TOTALS	TOTAL EBL
250	~~300~~ min
5	TOTAL URINE 100

FLUIDS – SUMMARY
CRYSTALLOID – 300 cc
COLLOID – Ø
BLOOD – Ø

FLUIDS: LINE site 18g (L) Arm ☐ Warmed; ☐ Warmed; ☐ Warmed; ☐ Warmed — LR → → (300)

LOSSES: EST BLOOD LOSS; URINE – Foley 100

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 90 KG/LB

HEMATOCRIT: 10/33

INITIAL DATA: BP – 149 56; HR – 101

EQUIP CHECK: OK? – Y N

PATIENT RECHECK: OK for PROCEDURE? Okay; TIME – 0830

TIME → 0845 0900 15 30 45 1000 15

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

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

VT – ml	–	780	700	740	740	1,300
f – breaths/min	16	12	10	12	10	12
Peak inf pres / PEEP	–	26	27	26	26	–
MODE – S(pon), A(ssist), C(on)	S	C	C	C	C	S
ET CO2 (torr)	(R)	36	35	37	35	38
FIO2 (Frac or %)	.76	.76	.76	.75	.75	.75
SpO2 (%)	100	100	100	100	100	100
ECG	ST	SR	SR	SR	SR	ST
TEMP – site	Available					
N-M Block (T/4)			4/4		1/4	4/4 ST

MONITORS & EQUIPMENT: BP/Auto Cuff; BP / oth; ART line; Steth – PC/ES; Gas analyzer; Warming blkt; Conv warmer

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

REMARKS – Code drugs with numbers, events with letters

0845 Pt in OR – ⊕ monitors / ⊕ O2. Start IV induction, eyes taped, PP padded
0907 Procedure started
0957 Reversed & Sxy
Neostigmine ⊕ atropine ⊕ Robinul
100 Pt awake. PO sxw x 2. Extubated – ⊕ HL > 5 sec. To PACU stable. Report to RW

RECOVERY AT 1005
PACU / ICU _____ (Specify)
OTHER _____
CONDITION: stable
RESP – 16 SpO2 – 96 RA
BP – 150/89 HR – 110

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	0835	0845	1000
	Ready	Begin	End
PROC	0855	0907	0953

PROCEDURES and CPT Codes: Debride (R) Arm Wound; (R) leg Wound

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: DVL x 1 attempt 1 MAC 4, #8 ETT, Grade I view, ⊕ BBS ⊕ ETCO2 secured @ 23 cm teeth, soft bite block placed

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

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

SURGEONS: [redacted]

ANESTHETIST: [redacted] CPT CRNA

PROCEDURE LOCATION: OR 2

DATE: 25 Oct 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 21821

*U.S. GPO: 2002-729-180/40137

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)														
fentanyl	(ug)	250													
propofol	(mg)	150			20										
SUX	(mg)	140													
ROC	(mg)	30													
	( )														
	( )														
VOLAT AGENT -550	% del	2.0	2.0	2.0	X										
	% e.t.														
AIR	L/Min														
N2O	L/Min														
O2	L/Min	6-2	2	2	6										
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS		(1) (2)	(3)	(4)	(5)										

TOTALS	TOTAL EBL
250	min
	TOTAL URINE
	250

FLUIDS - SUMMARY

CRYSTALLOID- 600

COLLOID- Ø

BLOOD- Ø

FLUIDS

LINE site															
20g LW	☐ Warmed	LR	200	600											
	☐ Warmed														
	☐ Warmed														
	☐ Warmed														

LOSSES

EST BLOOD LOSS		X	~~25.0~~ Ø												
URINE -		X	250												

REMARKS

Code drugs with numbers, events with letters

(1) To OR via litter, SOC monitors, prep
(2) RSI & I-tep
(3) Zantac 50mg & Reglan 10mg
(4) Enlon 20mg & Robinul 0.1mg
(5) Suctioned & extubated, to PACU stable

PHYS STATUS 1 (2) 3 4 5 E

BODY WEIGHT: 90 (KG) LB

HEMATOCRIT:

INITIAL DATA:

BP- 105/45

HR- 110

EQUIP CHECK

OK?- (Y) N

PATIENT RECHECK

OK for PROCEDURE [redacted]

TIME- 1010

TIME → x 30 x 11 x 30 x 12 x 30 x 13

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

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

VENTIL

VT - ml	860	850	860	276
f - breaths/min	12	12	12	17
Peak inf pres / PEEP	30	30	30	—
MODE - S(pon), A(ssist), C(on)	C	C	C	S

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	34	34	33	40
BP/oth	✓ FIO2 (Frac or %)	0.9	0.9	0.9	0.9
ART line	✓ SpO2 (%)	100	100	100	100
Steth- PC/ES	✓ ECG	ST	SR	SR	SR
Gas analyzer	TEMP-site				
	N-M Block (T/4)			4/4 T	
				just tetany	
Warming blkt					
Conv warmer					

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

RECOVERY AT

(PACU) ICU _____ (Specify)

OTHER _____

CONDITION:

RESP- 16 SpO2- 98

BP- 129/70 HR- 102

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1010	1020	1020
	Ready	**Begin**	**End**
PROC	1025	1046	1010

PROCEDURES and CPT Codes:

STSG → Abdomen to RUE

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, [redacted]ical facility*

[redacted] b(6)-4

26 yo EPW

b(6)-2

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GETA 8.5 ETT, 4 MAC

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

Eyes taped. DL x 1 5 trauma, ⊕ ETCO2, B/EB. Secured 21 cm @ teeth.

[redacted]

ANESTHETIS[redacted]

[redacted] RNA, MAJ

PROCEDURE LOCATION: 2-2

DATE: 10/29/03

PAGE 1 OF 1

CLINICAL RECORD - DOCTOR'S ORDER

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 21 Oct 03 | TIME OF ORDER _____ HOURS | LIST TIME ORDER NOTED AND SIGN

1) admit to ICU ✓
2) dx - brachial art injury ✓
3) Ancef 2gm IVq 8° ✓
4) MSO4 2-6mg IV q1° PRN ✓

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

5) Lovenox 30mg SQ q12° start at 8PM today ✓
6) ASA 325 po q AM start 10/22 ✓
7) W → D tid to R arm L legs ✓

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

start bright
8) clear liq diet ✓
9) reg diet 10/22 ✓
10) N/V ✓ q1° ✓
11) (L) arm [redacted] sling ✓
b(6)-2 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

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

12) CBC [redacted] Chem 6 ✓ call me any abnormals do on arrival to ICU

[redacted] noted [redacted]

21 Oct 03

DA FORM 1 APR 79 4256 REPLACES EDI[redacted] JUL 77, WHICH M[redacted] 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

E[redacted]

b(6)-4

NURSING UNIT: ZCu A1 | ROOM NO. | BED NO.

DATE OF ORDER: 21 Oct | TIME OF ORDER: 2120 HOURS | LIST TIME ORDER NOTED AND SIGN

Emycin Ointment OU TID.

V.O. D[redacted] [redacted]

b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 21 Oct | TIME OF ORDER: 0930 HOURS

LR @ 125 cc/hr

D/C A-Line

b(6)-2

V.O. per DR [redacted]

24 [redacted] 21 2315 Oct 03 [redacted]

21 oct @ 093(

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 22 Oct 03 | TIME OF ORDER | HOURS

1) d/c neck lines
2) peripheral IV
3) w→D b.i.d on R arm, leg + L chest
4) dry dressing on (L) arm q day
5) to floor p #1+2

PATIENT IDENTIFICATION

NOTED 22 OCT 03 @ 1342 [redacted] 2LT, AN

b(6)-2

NURSING UNIT | ROOM NO. 210 | BED NO. [redacted]

DATE OF ORDER | TIME OF ORDER | HOURS

6) Reg Diet
7) D5 1/2 NS + 20 mEq KCl/L 60 cc/hr
8) VS q4° b(6)-2

[redacted]

DA FORM 1 APR 79 4256 REPLA

MEDCOM - 21824

b(6)-4

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] NOTED 22OCT03 1343 [redacted]			22 Oct 03 _____ HOURS 1) Lovenox 30mg SQ q12° 2) ASA ⊼ po q d 3) T#3 1-2 po q4° prn	
NURSING UNIT	ROOM NO.	BED NO.		
			q4° [redacted] 030CT03	

PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER	
[redacted]			_____ HOURS 1) hep lock IV	
NURSING UNIT	ROOM NO.	BED NO.		
NCW	2300 2001	2	[redacted] 10/23/03 1102	

PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER	
[redacted] noted [redacted]			_____ HOURS 1) NPO ⊼ MN	
NURSING UNIT	ROOM NO.	BED NO.	[redacted]	

PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER	
b(6)-2			[redacted] _____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.		

DA FORM 1 APR 79 4256 REPLACES ... WHICH MAY BE USED.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 25 Oct-03 TIME OF ORDER 10A HOURS

LIST TIME ORDER NOTED AND SIGN

1) RR → floor
2) Reg Diet
3) hep lock
4) Ancef 2gm IV q8° x 48° then Keflex 500mg po qid

PATIENT IDENTIFICATION

b(6)-2 Noted 25 Oct 03 1136 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

5) Lovenox 40mg SQ q AM start 10/26
6) ASA ? 325 po q AM
7) Tylenol #3 1-2 po q4° prn

PATIENT IDENTIFICATION

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

24° / 0200 2000 [redacted]

DATE OF ORDER TIME OF ORDER HOURS

8) Dry dressing ~~bid~~ q day to (L) arm + chest + R leg
9) W → D bid RAM

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

24° / 29 Oct 0300 0445 [redacted]

DATE OF ORDER 28 Oct [redacted] TIME OF ORDER [redacted] HOURS

1) NPO p MN
2) OR 10/29

[redacted]

28 Oct 03 1901

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

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

29 Oct 03 _____ HOURS

1) RR → floor
2) S/P STSG
3) VS q routine
4) hep lock
5) Keflex 500mg po qid x 7 days

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

_____ HOURS

6) Percocet-5 1-2 po q4° prn
7) Reg Diet
8) ASA ÷ po q day
9) Lovenox 4[redacted] SQ q24°

[redacted]

PATIENT IDENTIFICATION

b(6)-2

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

10/29/03 [redacted] 1130 HOURS

b(6)-2

1) MS 2-3 mg IV PRN pain in PACU q 10 min Max dose 10mg [redacted] ANA

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

_____ HOURS

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
b(6)-4 [redacted] b(6)-2 [redacted]	10/29	HOURS	
	Keep dressing on arm slightly damp with .9NS bid		
NURSING UNIT: 24 ROOM NO.: 0321S BED NO.: 3	[redacted] b(6)-2		
PATIENT IDENTIFICATION	DATE OF ORDER		
b(6)-2 Noted [redacted] 01NOV03 0800	10/31	HOURS	
	d/c hep lock		
NURSING UNIT: [redacted] BED NO.	[redacted] b(6)-2		
PATIENT IDENTIFICATION	DATE OF ORDER	[redacted]	
b(6)-2 Noted [redacted]	11/2	[redacted]	
	d/c foley		
NURSING UNIT	ROOM NO.: 02NOV03 0740	BED NO.: 3	d/c arm staples [redacted] b(6)-2
PATIENT IDENTIFICATION	DATE OF ORD[redacted]	TIME O[redacted]	
b(6)-4 # [redacted] b(6)-2 Noted [redacted]	11/3	HOURS	
	1) D arm dressing on STSA bid & vas gauze dotnis ADL b(6)-2 2) pt may shower take all dressings off		
NURSING UNIT: 24	ROOM NO.: 0800 4NOV03 [redacted]	BED NO.: 3NOV 0900	[redacted]

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 4 Nov 03 | TIME OF ORDER _____ HOURS | LIST TIME ORDER NOTED AND SIGN

1) d/c To EPN ramp

2) d/c Lovenox

3) sutures out in leg in 7 days

PATIENT IDENTIFICATION

b(6)-2

Noted [redacted] 04 Nov 03 0840

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

4) Vas gauze change daily x 7 days (send bag of supplies)

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER _____ HOURS

5) cont ASA x 1 mo

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER [redacted]

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.

Green Sheet

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 10 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 25	26	27	28	29	30	31	NOV 01	02	03	04	05	06	07
25 Oct 03	[redacted]	Reg diet	06 18	[redacted]													
			18 06														
25	[redacted]	Dry dressing q day to @ arm/chest/@ leg	10														
25	[redacted]	N→D BID @ arm	10	[redacted]													
			22														
29 OCT	[redacted]	VS: Q Routine	6														
			15														
29 OCT	[redacted]	Keep drsg on arm slightly damp with 0.9 NS B/D	10														
			22														
3 NOV	[redacted]	Δ arm drsg on STSG Bid c̄ vas gauze (Start this Am)	10														
			22														
3 NOV	[redacted]	Pt may shower & take all drsgs off.	10														
			18														

b(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: BRACHIAL ARTERY INJURY

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

Green Sheet

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 10 Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
25 Oct 03	[redacted]	RR → floor	25	—	—	[redacted]
28 Oct	[redacted]	NPO pMN	28	2400		
28 Oct	[redacted]	OR	10/29	O/C		
29 OCT	[redacted]	RR → floor s/p STSG	29	[redacted]		
02 NOV	[redacted]	D/C foley	02 NOV 03	0900	0900	[redacted]
02	[redacted]	D/C arm staples	02	0900	0900	[redacted]
04 NOV	[redacted]	D/C to EPW camp				[redacted]
04	[redacted]	Sutures out in leg in 7 days	11 Nov	—	—	
04	[redacted]	Vas gauze change daily x 7 days (send bag of supplies)	04	—	—	[redacted]

b(6)-2

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. 10 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 20	21	22	23	24	25
21OCT	[redacted]	W-P TID to	08	/	/	[redacted]			
		(R) arm & leg	16	/	/			D/C'd 22OCT03	
		Start tonight	24	/	[redacted]				[redacted]
21OCT	[redacted]	Clear liquid diet	08	/	[redacted]				
			12	/		D/C'd 10/22/03			
			16	/	[redacted]				[redacted]
21OCT	[redacted]	Reg diet 10/22	08	/	/	[redacted]			
			12	/	/	[redacted]			
			16	/	/	[redacted]			
21OCT	[redacted]	N/V ✓ q 1°	08	/	[redacted]				
			18	/	[redacted]				
21OCT	[redacted]	(D) arm in sling	08	/	[redacted]				
			16	/	[redacted]				
22OCT	[redacted]	W→D BID ON (R) ARM,	10	/	/	[redacted]			
		LEGS & (L) CHEST	22	/	/	[redacted]			
22OCT	[redacted]	DRY DRESSING ON (R) ARM	10	/	/	/	[redacted]		
		QD							
22OCT03	[redacted]	VITALS Q4°	06	—	[redacted]				
			18						
			18						
			06	—	[redacted]				

b(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Brachial artery

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

EPW [redacted] b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

MEDCOM - 21832

EDITION OF 4 DEC 77 MAY BE USED

USAPA V1.00

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 10 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
		Admit to ICU				
21Oct	[redacted]	CBC chem 6 call me any	21Oct	0600		
		abnormals do on arrival to ICU				
21 Oct	[redacted]	D/C A-line	21Oct	Now	1200	NC
22OCT	[redacted]	D/C neck lines	22OCT		DONE	[redacted]
22OCT	[redacted]	PERIPHERAL IV	22OCT		DONE	
22OCT	[redacted]	TO FLOOR W/ #1 & 2	22OCT		DONE	[redacted]
24OCT	[redacted]	NPO W/ MN	24OCT	0001	—	[redacted]
		b(6)-2				

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. 10 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	20	21	22	23	24	25
21OCT	[redacted]	W-P TID to	08	/	/	[redacted]			
		(R) arm & leg	16	/	/			D/C'd 22OCT03	
		Start tonight	24	/	[redacted]				[redacted]
21OCT	[redacted]	Clear liquid diet	08	/	[redacted]				
			12	/		D/C'd 10/22/03			
			16	/	[redacted]				[redacted]
21OCT	[redacted]	Reg diet 10/22	08	/	/	[redacted]			
			12	/	/				
			16	/	/				
21OCT	[redacted]	N/V ✓ q 1°	08	/	[redacted]				
			18	/					
21OCT	[redacted]	(D) arm in sling	08	/	[redacted]				
			16	/					
22OCT	[redacted]	W→D BID ON (R) ARM,	00	/	/	[redacted]			
		LEGS & (L) CHEST	22	/	/				
22OCT	[redacted]	DRY DRESSING ON (L) ARM	10	/	/	/	[redacted]		
		QD							
22OCT03	[redacted]	VITALS Q4°	00		[redacted]				
			04						
			08						
			06						
		b(6)-2							

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Bronchial asthma

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

EPW [redacted] b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

EDITION OF 1 DEC 77 MAY BE USED
USAPA V1.00

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 10 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
	----	Admit to ICU				
21Oct	[redacted]	CBC chem 6 call me any	21Oct	0600		
	[redacted]	abnormals do on arrival to ICU				
21 Oct	[redacted]	D/C A-line	21Oct	Now	1200	[redacted]
22OCT	[redacted]	D/C neck lines	22OCT		DONE	[redacted]
22OCT	[redacted]	PERIPHERAL IV	22OCT		DONE	[redacted]
22OCT	[redacted]	TO FLOOR P #1 & 2	22OCT		DONE	[redacted]
24OCT	[redacted]	NPO P MN	24OCT	0001	—	[redacted]

	----					

b(6)-2

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

USAPA V1.00

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. 10 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 20	21	22	23	24	25
2 Oct	[redacted]	Ancef 2 gm IV q 8°	08	/	[redacted]				
			16	/	[redacted]				
			24	/	[redacted]				
21 Oct	[redacted]	Lovenox 30 mg SQ	08	/	/	[redacted]			
		q 12° start @ 8pm	20	/	[redacted]				
		today							
21 Oct	[redacted]	ASA 7 po q AM	10	/	/	[redacted]			
		start 10/22							
21 Oct	[redacted]	LR @ 125 cc/hr	06	/	[redacted]	D/C'd 22 OCT 03			
			18	/					
21	[redacted]	Eyemycin Ointment OU	08	/	/	[redacted]			
		TID	16	/	/	[redacted]			
			24	/	[redacted]				
		(Pharm out of stock)							
22 OCT	[redacted]	D5 1/2 NS c 20 Meq KCl @	08	→	[redacted]	D/C'd			
		60 cc/hr	18	→	[redacted]				
23rd	[redacted]	Heplock IV	06	→	[redacted]				
			18	→	[redacted]				

b(6)-2

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: Brachial artery injury

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

EPW [redacted] b(6)-4

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)					Mo. 10 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials	
10/23	[redacted]	Heplock IV	10/23			[redacted]	
		b(6)-2					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED														
21 Oct	[redacted]	MSO4 2-6mg IV q1°	D	21 oct 03	21 oct 03	21 oct 03	21 oct 1900	21 oct 1100	21 oct 2200	21 oct 2300	22 oct 0410	22 oct 03	23 oct 1945	23 oct 2000			
		prn	T	0725	0830	1415	2mg	2mg	2mg	2mg	4mg	4mg	6mg	5mg			
			I	4mg	6mg	2mg	[redacted]					0830	[redacted]				
22 OCT.	[redacted]	TYLENOL #3 1-2 POD	D	2500													
		Q4° PRN	H	0545													
			D	8													
			H	[redacted]													
		b(6)-2															

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

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 10 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 25	26	27	28	29	30	31	1	2	3	4
25 Oct 03	- [redacted]	Heplock-flush q	06	[redacted]										
	-----	shift	18	[redacted]										
			06											
25	- [redacted]	Ancef 2gm IV q8°	08	[redacted]										
	-----	X 48°	16	[redacted]										
	-----	then	24	[redacted]										
25	- [redacted]	Keflex 500mg po	06	[redacted]										
	-----	qid x 7 days	12	[redacted]									X	T
	-----	D/C on 11/4/03 after	18	[redacted]									X	U
	-----	last dose	24	[redacted]									X	P
25	- [redacted]	Lovenox 40mg SQ q	10	[redacted]										
	-----	AM (start 10/26)												
25	- [redacted]	ASA T po q AM	10	[redacted]										

	-----													

b(6)-2

DC 31 Oct 03

DC 04 Nov 03

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: BRACHIAL ARTERY INJURY

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted] b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 10 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
04 NOV	[redacted]	D/C Lovenox	04	—	—	[redacted]
04	[redacted]	cont ASA X 1 mo	04	—	—	[redacted]

b(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
25 OCT 03	[redacted]	Tylenol #3 1-2 po q4° prn	D/T	26 OCT 1300	3 NOV 2200											
			D/I	[redacted]												
28 OCT.	[redacted]	Percoset 1-2 tabs po q4° prn	D/T	29 OCT	31 OCT 0915	3 NOV	1 NOV 0100	3 NOV 2200								
			D/I	2	[redacted]		[redacted]	[redacted]								

b(6)-2

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

b(2)-2

VITA

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date): QI Appr 11 Jun 97

EMS REPORT

TIME: 0100 ETA: _____ UNIT: _____

MED COM: [Y] [N] EPW presented to ER
c multiple GSW

ARRIVAL STATUS

TIME 0100 ☐ IV x _____ ☒ O_2 NS 1/min ☐ C-Spine Immob

Meds: ☒ UKN ☐ None ☐ Yes: _____

Allergies: ☒ UKN ☐ None ☐ Yes: _____

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

LMP: 0 N/A ☐ _____

PRIMARY SURVEY

AIRWAY
☒ Natural Patient [Y] [N]
☐ ETT _____ ☐ _____
☐ Secretions _____

BRETHING
☐ Labored ☒ Unlabored ☐ Absent
TRACHEA: ☒ Midline ☐ Deviated [L] [R]
CHEST SYMMETRY: [L] > = < [R]

CIRCULATION
PULSE: ☒ Present ☐ Absent
BLEEDING: [Y] [N]
HEART TONES: ☐ Clear ☐ Muffled
SKIN: ☒ Warm ☐ Cool ☐ Hot
☒ Pink ☐ Pale ☐ Cyanotic ☐ _____
☒ Dry ☐ Moist ☐ Diaphoretic

Enough for (L) OR. ↓ cap refill

SECONDARY SURVEY

DISABILITY
GCS: E _____ V _____ M _____ 15
SPHINCTER TONE: ☐ WNL ☐ None

HEAD
PUPILS: ☒ Equal ☐ Fixed ☒ React ☐ Dilated [L] [R]
TM: ☐ Clear ☐ Blood [L] [R]

NECK
C-Spine Tenderness: [Y] [N]
Pain @ _____
JVD: [Y] [N]

HEART
RHYTHM: ☒ Regular ☐ _____
PULSES: ☒ Central ☒ Peripheral

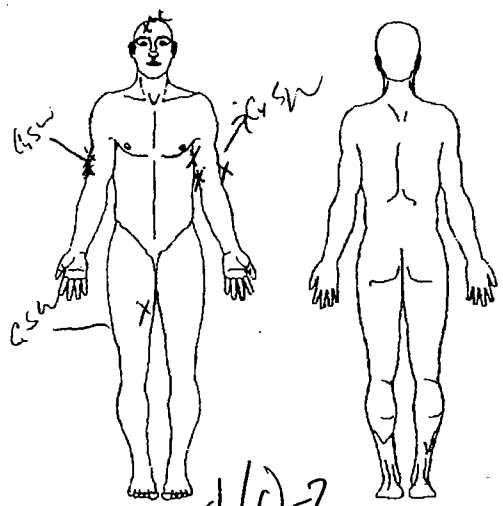
LUNGS
BREATH SOUNDS: ☒ Bilat ☐ Equal ☐ Clear
Decreased [L] [R] Absent [L] [R]
Wheezes [L] [R] Crackles [L] [R]

ABDOMEN
☐ Soft ☒ Rigid ☒ Non-Tender
☐ Tender: —

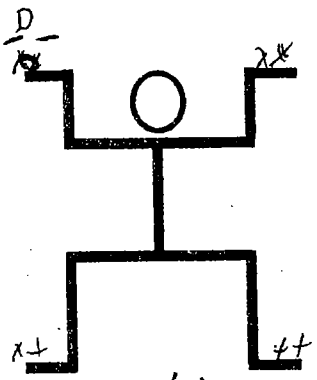
PELVIS
☒ Stable ☐ Unstable ☐ _____
Blood at meatus/vagina: [Y] [N]
Heme + ☐ Prostate: ☒ WNL ☐ Abnl

USE DIAGRAM TO DOCUMENT INJURIES AND PAIN

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



VASCULAR ASSESSMENT



b(6)-2

++ Strong	+ Palpable	D Dopler

b(6)-2

RN: ICT [redacted]

PHYSICIAN: Dr. [redacted] b(2)-2 (Continue on reverse)

PREPARED BY (Signature): SGT [redacted]

DEPARTMENT/SERVICE: [redacted]

DATE: 01 Oct 03

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

#[redacted] b(6)-4

Male 27yrs.

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